

County Durham and Darlington NHS Foundation Trust University Hospital of North Durham Quality Report

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Date of inspection visit: 3-4 and 25 February 2015 Date of publication: 29/09/2015

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

Ratings

Overall rating for this hospital	Requires improvement	
Urgent and emergency services	Requires improvement	
Medical care	Requires improvement	
Surgery	Good	
Critical care	Good	
Maternity and gynaecology	Good	
Services for children and young people	Good	
End of life care	Requires improvement	
Outpatients and diagnostic imaging	Good	

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Letter from the Chief Inspector of Hospitals

The University Hospital of North Durham was one of two acute hospitals forming County Durham and Darlington NHS Foundation Trust. This trust was one of the largest hospital and community healthcare providers in the NHS. County Durham and Darlington NHS Foundation Trust served around 600,000 people across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside, with services including health and wellbeing services, community-based services, and acute and planned hospital services.

In total the trust had 1,331 beds across two acute hospitals and the community, and employed around 7,555 staff. The University Hospital of North Durham had 460 beds.

The University Hospital of North Durham provided medical, surgical, critical care and maternity services, and services for children and young people in County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside. The hospital also provided emergency and urgent care (A&E) and outpatient services.

We inspected the University Hospital of North Durham as part of the comprehensive inspection of County Durham and Darlington NHS Foundation Trust, which included this hospital, Darlington Memorial Hospital and the trust's community services. We inspected the University Hospital of North Durham on 3, 4 and 25 February 2015.

Overall, we rated the University Hospital of North Durham as 'requires improvement'. We rated it 'good' for being caring and responsive, but it required improvement in providing safe, effective and well-led care.

We rated surgical services, critical care, services for children and young people, and outpatient and diagnostic imaging services as 'good', with A&E, medical care, maternity and gynaecology and end of life care as 'requires improvement'.

Our key findings were as follows:

- Arrangements were in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found that all areas we visited were clean. Rates of Methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile) were within an acceptable range for the size of the trust.
- Patients were able to access suitable nutrition and hydration, including special diets, and they reported that, on the whole, they were content with the quality and quantity of food.
- There were processes for implementing, and monitoring the use of, evidence-based guidelines and standards to meet patients' care needs.
- There was effective communication and collaboration between multidisciplinary teams.
- There were staff shortages, particularly on some medical wards and in the maternity and gynaecology service, mainly due to vacancies for nursing and medical staff. The trust was actively recruiting following a review of nursing establishments. In the meantime, bank, agency and locum staff were being used to fill any deficits in staff numbers, and staff were working flexibly, including undertaking overtime.
- Mortality rates were within acceptable limits for a hospital of this size.

There were areas of poor practice where the trust needed to make improvements.

Importantly, the trust must:

- Review the achievements and actions taken to address national targets within A&E.
- Review consultant levels against CEM guidance.
- Ensure the A&E department meets cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.
- Ensure all toys are cleaned properly to reduce the risk of infection within the A&E department.

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- Ensure sharps bins are managed appropriately to reduce the risk of needle stick injury within the A&E department.
- Ensure that all resuscitation drugs and equipment within the A&E department are regularly checked, cleaned and in date. This should include all grab bags and anaphylaxis kits.
- Ensure that all relevant staff know where the difficult airway kit is kept.
- Ensure that there are robust risk assessments in place for the paediatric environment within the A&E department. These must be readily accessible and available to all staff in the department. Risk mitigation must be outlined and an action plan to improve the area must be written.
- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance and taking into account patients' dependency levels on medical wards, particularly where patients are receiving non-invasive ventilation (NIV) and require Level 2 intervention.
- Undertake a review of current documentation relating to the care and management of patients receiving NIV to ensure that it is consistent across both the University Hospital of North Durham and Darlington Memorial Hospital.
- Have arrangements in place for patients who are in receipt of NIV that comply with the British Thoracic Society guidelines (2008) for the use of NIV for acute exacerbation of chronic obstructive pulmonary disease.
- Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and to the appropriate quality.
- Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with best practice guidance.
- Ensure that patient records are maintained up to date, are patient-centred and contain the relevant information about their treatment and care, including patients awaiting discharge to eliminate unnecessary delays.
- Ensure that staff know the syringe driver policy and carry out/record syringe driver checks in line with this policy.
- Add audits of syringe driver administration safety checks to the annual end of life audit programme.
- Ensure medical staff record mental capacity assessments for patients who are unable to participate in decisions about do not attempt cardiopulmonary resuscitation (DNACPR).
- Ensure audits of mental capacity assessments are incorporated into audits of DNACPR forms.
- Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.
- Ensure data are available to identify and demonstrate the effectiveness of the end of life service.

In addition the trust should:

- Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcomes are met.
- Direct medical staff to check resuscitation equipment and drugs before the start of their shift even when nursing staff have completed the checks.
- Encourage all relevant staff within the A&E department to attend violence and aggression training.
- Ensure that patients have their medicines reconciled in accordance with trust targets.
- Review access to patient information in languages other than English.
- Review dedicated management time allocated to ward managers.
- Review the patient flow of higher dependency patients throughout the hospital to ensure care was given in the most appropriate setting.
- Have an up-to-date standard operating procedure (SOP) which clearly sets out the management of patients requiring NIV who are admitted to the University Hospital of North Durham.
- Ensure that this guidance/SOP includes clarity on the setting/specific ward in which patients can be managed.
- Ensure that this guidance/SOP includes staffing to patient ratios that are in line with current guidance.
- Ensure that there is a training plan in place, which is delivered to all staff involved in the care of patients receiving NIV, and that it is competency-based and in sufficient detail to demonstrate competence in all aspects of NIV.
- Ensure that any guidance/SOP includes an escalation plan that includes action to be taken when a bed is unavailable in an appropriate setting and when patient numbers do not match agreed staffing ratios.

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- Ensure that the intensive care unit has an outreach team to identify and monitor deteriorating patients.
- Ensure that there is clinical pharmacist input in the intensive care unit in line with Core Standards for Intensive Care guidelines.
- Consider ways of improving engagement between staff and managers within the care closer to home directorate with a view to achieving a joined up approach within maternity and gynaecology services. Also, consider ways of improving responsiveness and efficiency in respect to service-level decisions within this service.
- Consider ways in which it can identify the required standards within the maternity service dashboard.
- Consider within the maternity and gynaecology services clinical and quality strategy for 2014–16 timelines for review and achievement.
- Consider ways of developing a coherent plan for joint working on improvements in maternity and gynaecology services.
- Consider ways of improving timely and responsive human resource management processes, including personnel issues that impact on service delivery in maternity and gynaecology services.
- Ensure that the paediatric high dependency unit room has specific standard operating procedures or protocols available to guide suitably trained staff.
- Ensure that advanced paediatric nurse practitioners have a set of standard operating procedures available to guide their practice and care.
- Formally nominate an executive or non-executive director to represent children at board level, separate from the safeguarding children executive lead role.
- Ensure that actions against the National Care of the Dying Audit and other identified actions to develop the service are carried out in a planned and timely way with continued evaluation.
- Ensure that systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.
- Ensure that any out of date medication is removed from stock cupboards once it has expired, in line with the trust medication management policy, and have a process for monitoring this within outpatients.
- Ensure that all fridge temperatures are checked daily and that there is a system in place to monitor that checks are taking place within the outpatient department.
- Ensure that all resuscitation equipment is checked daily, stored securely and introduce a monitoring system to ensure that checks take place within the outpatient departments.

Professor Sir Mike Richards Chief Inspector of Hospitals

Our judgements about each of the main services

Service

Rating

Urgent and emergency services

Requires improvement



Overall, urgent and emergency services at this hospital required improvement. Some areas in the department were not visibly clean when we completed our announced inspection visit. We found high level and low level dust on cupboards, curtain rails, equipment and floors. Spilled blood was found around equipment and some staff did not always observe good hand hygiene. We found some resuscitation medication was out of date and not all resuscitation drugs, equipment and fridge temperatures were checked regularly. We reviewed these issues during our unannounced inspection visit and found all equipment in the department was clean and free from dust and resuscitation medication was in date. Fridge temperatures were regularly checked, however, there were some missing entries in the resuscitation equipment checklist in the resuscitation and monitoring bay areas. There were appropriate nurse staffing numbers but consultant numbers were lower than the recommended level. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets.

Why have we given this rating?

Policy and protocols were underpinned by national guidelines but the department did not meet several patient outcome targets. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited. Some patients told us they were not provided with adequate pain relief. There were good arrangements in place for patients to obtain food and drinks. There was a rolling programme of regular training and appraisal for staff. Multidisciplinary team arrangements were in place.

		interactions with patients that showed patients were treated well and with compassion. Between October 2013 and October 2014 the department did not meet national targets. It did not meet the standard of admitting, transferring or discharging 95% of patients within 4 hours. The trust also had a higher than England percentage average for patients waiting 4–12 hours in the department from the decision to admit until being admitted into an inpatient bed. In addition, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was not met. It was evident that staff understood that access and flow was a top priority and they worked well together to try to comply with national standards. Paediatric facilities were severely limited and children often used the adult waiting area; ambulatory paediatric patients were treated in areas where adults were cared for. Systems were in place for investigating complaints, learning the lessons of those complaints and communicating lessons to staff. There was clear management structure in the department and senior managers worked closely together to meet strategic objectives, monitor and improve care. Regular governance and information-sharing meetings were held and staff told us the felt empowered to take responsibility for issues. However, there was a lack of monitoring systems and processes which had resulted in issues with cleanliness, equipment and medication checks. Staff were focused on giving patients a positive experience.
Medical care	Requires improvement	Overall, the medical care and treatment received by patients within the hospital was responsive, caring and well-led, with some areas of patient safety and effectiveness requiring improvement. Medical staffing was made up of a higher proportion of junior doctors and was higher than the England average. The proportion of consultants, middle career and registrars were all lower than the England averages. The trust was working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe

Patients received a caring service in the

nurse staffing. Nurse staffing establishments were determined using the safer nursing care tool (SNCT), however, actual staffing numbers on duty were sometimes below the planned level. We were particularly concerned about the staff to patient ratios for patients requiring non-invasive ventilation (NIV) who were being nursed in general ward areas. We found examples of patient care records that were not fully completed or kept up to date. We also found that supportive documentation on some wards, such as fluid balance charts and risk assessments were not consistently completed in all cases. We found during the unannounced inspection that care planning was not robust and this was reflected in the ward documentation audits.

Policies and guidelines were available to staff and the medical directorate participated in local and national audits. Indicators from some national audits showed mixed performance with some indicators being better than the England average, while others were below the national average. There was no evidence to support any detailed competency based assessment for nursing staff regarding the initiation and ongoing management of patients requiring NIV.

Wards were visibly clean and cleaning schedules were in place. A recent patient-led assessment of the care environment (PLACE) rated the hospital as achieving over 90% compliance in all of the four areas of: cleanliness, food, privacy/dignity and wellbeing and condition/appearance and maintenance. Systems were in place to report incidents and wards were monitored for safety and 'harm-free' care. Results were positive, overall, and were prominently displayed at the entrance to wards for staff, patients and visitors to view. Planned and actual nurse staffing levels were also clearly displayed.

Staff were well trained, provided with good support and worked within locally or nationally agreed guidance to ensure that patients received appropriate care and treatment for their conditions. Patients were protected from the risk of harm by adherence to policies and procedures which ensured care needs were managed appropriately.

Surgery

Good

Patients were happy with the care they received and found the service to be caring and compassionate. Most patients and relatives spoke very highly of staff and told us that they, or their relatives, had been treated with dignity and respect, had been listened to and given enough information in a way they could understand. Nutrition, hydration and comfort needs were met. The trust had consistently achieved its referral-to-treatment times (RTT) for all care groupings with the exception of gastroenterology. RTT was better than the England average. The trust had consistently achieved their performance targets for national cancer waiting times.Services were delivered in a way that responded to patients' needs and ensured the departments worked effectively and efficiently. Clear governance structures were in place to facilitate analysis of information from incidents and

facilitate analysis of information from incidents and complaints, identify themes and ensure communication from ward to board. Key messages from incidents and complaints were communicated across the trust via staff meetings, training and newsletters. There had been a number of developments made and there were projects ongoing to improve services, outcomes and patient experience. Most staff were clear about the vision and strategy for the service.

Surgery at this hospital was good. There were effective arrangements in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff told us they were encouraged to report incidents and most received feedback on what had happened as a result. Staffing establishments and skill mix had been reviewed to maintain optimum staffing levels during shifts and effective handovers took place between staff shifts and included daily safety briefings to ensure continuity and safety of care. Care records were completed accurately and clearly and in line with patients' needs. There were arrangements in place for the effective prevention and control of infection and the

management of medicines.

Critical care

Good

Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Mortality indicators were within expected ranges. The learning needs of staff and opportunities for professional development were identified. There was effective communication and collaboration between multidisciplinary teams. We observed positive, kind and caring interactions on the wards between staff and patients. All patients we spoke with felt they understood their care options and were given enough information. There were services to ensure patients received appropriate emotional support.

Systems were in place to plan and deliver services to meet the needs of local people, particularly those with dementia, a learning disability or a physical disability. There were also systems in place to capture concerns and complaints raised within the division, review these and take action to improve the experience of patients. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

The trust vision, values and strategy had been communicated to wards and departments and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and there was good ward leadership.

Overall the services within critical care were good. However, some aspects of safety required improvement. The intensive care unit did not have an outreach team to identify and monitor deteriorating patients. The purpose of the service would be to assess the critically ill or deteriorating patient on wards and to stabilise them at ward level and so avoid the need to escalate to the unit. There was no clinical pharmacist input to the daily multidisciplinary ward rounds. This was not in line with the national Core Standards for Intensive Care Units 2013. The unit had just started to have its own mortality and morbidity meetings, which were still to be further embedded. Medical and nursing staffing levels were adequate, but there was no

supernumerary sister or charge nurse to cover areas such as peak activity times, facilitating admissions and discharges or coordinating nurse staffing on the unit.

Patients received treatment and care according to national guidelines and the unit used an audit programme to check whether their practice was up to date and based on sound evidence. The unit was obtaining good-quality outcomes as shown by its Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the unit. However, the full multidisciplinary team did not attend the ward rounds.

Staff cared for patients in a compassionate manner with dignity and respect. Relatives we spoke with told us their loved ones had all their care needs met by dedicated staff. Relatives told us they were involved with their loved ones' care and felt supported in making decisions as a family. Bed occupancy rate within the unit was 92% which enabled it to plan admissions and accept emergencies. The unit experienced some delay in discharges, often due to the lack of available beds and due to delays in determining what the parent team was when patients were admitted via the A&E department; this also caused delays in discharges to a ward.

Staff felt well supported within an open, positive culture. The governance processes still needed time to become embedded, with medical and nursing leadership within the unit needing further development.

Overall, maternity and gynaecology services at this hospital were good. However, the well led domain required improvement. Medical and midwifery staffing arrangements generally ensured sufficient numbers of skilled and knowledgeable staff were on duty to meet people's individual needs. Staff were aware of the trust's values and expectations. Staff, including trainee doctors and midwives, felt that the service encouraged and supported learning and development. There were effective arrangements in place for reporting adverse events and for learning from these. Consent was sought

Maternity and gynaecology

Good

from patients prior to treatment and care delivery. Patients received consultant-led care, and staff had the support of specialist staff for advice and guidance.

Procedures were in place to continuously monitor patient safety and recommended guidance was followed by staff. Maternity outcomes were monitored and information was communicated through the governance arrangements to the trust board.

The experiences of the care and attention provided by nursing, midwifery staff and doctors were described positively by women using the service. The views of the public and stakeholders were sought in relation to developing services. Staff were encouraged and supported to develop better ways of working and to develop the service. Senior leaders understood their roles and responsibilities to oversee the standards of service provision. However, within the medical team there were concerns that there was a lack of a joined up approach to the service. Efficiency was compromised by the structure of the care closer to home directorate, with decisions being lost or delayed. The arrangements for managing the service were further affected by issues within specific staff groups, which had not been dealt with proactively.

The care closer to home directorate had not identified a number of actual and potential risks at a service level and therefore did not have sufficient mechanisms in place manage such risks and monitor progress.

The directorate had an apparent direction of focus, defined by strategic aims and an associated vision, although it was unclear as to the time frames for specific work streams

Services for children and young people

Good

Overall, services for children and young people were good at this hospital. Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms and we saw these were reviewed and acted upon by the management team. We found risks were assessed and monitored, and control measures were put in place. We found all children's clinical areas were kept clean and

		 were regularly monitored for standards of cleanliness. Medicines were stored and administered correctly. Medical records were handled safely and protected. Members of staff of all grades confirmed they received a range of mandatory training, although training records did not always accurately reflect training uptake. Medical staffing had some gaps but these were being managed and addressed. The levels of nursing staff were adequate to meet the needs of children and young people. Children's services had made improvements to care and treatment where needs had been identified using programmes of assessment or in response to national guidelines. Children, young people and parents told us they received compassionate care with good emotional support. Parents felt fully informed and involved in decisions relating to their child's treatment and care. The service was responsive to children's and young people's needs and was well led. The service had a clear vision and strategy. The service was led by a positive management team who worked together. The service had introduced innovative improvements with the aim of improving the delivery of care for children and families.
End of life care	Requires improvement	End of life care services at this hospital required improvement. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were not always being completed accurately and comprehensively with clinical information relating to the decision, and discussions with patients and relatives not always being recorded. Mental capacity assessments were not being recorded when there was an indication that patients did not have capacity to be involved in decision making. The trust had taken part in the 2013/14 NCDAH, where it had not achieved six out of seven organisational key performance indicators. The trust performed below the England average and failed to meet all of the 10 clinical key performance indicators. The trust had an action plan in place to address areas identified as part of the National Care of the Dying Audit (NCDAH), including the implementation of training and staff surveys.

Outpatients and diagnostic imaging

Good

Staff were seen to be caring and compassionate and we saw that the development of pastoral and spiritual services were planned for. The specialist palliative care team provided support for patients at the end of life and for the ward staff caring for them. We observed specialist nurses and medical staff providing specialist support in a timely way, and this was aimed at developing the skills of non-specialist staff and ensuring the quality of end of life care. We were told that staff were caring and compassionate and we saw the service was responsive to patients' needs. There were prompt referral responses from the specialist palliative care team and a good focus on preferred place of care for patients at the end of life wishing to be at home. The specialist palliative care team had addressed issues around staff attending specialist training by attending the wards on a regular basis every day and supporting staff to develop the skills needed to care for people at the end of life through a mentoring programme. Education had been identified as a priority area by the trust and recruitment to a dedicated end of life educator post had been included in service action plans. Structural development of the services had begun in terms of the identification of workforce needs and plans being developed to address these needs, but at the time of our inspection we saw that staffing difficulties had impacted on the ability of the specialist palliative care team to take action to develop the service. Examples included taking timely action to develop the service and address issues identified, the development of out of hours consultant cover and the use of data to monitor the effectiveness of the service.

Overall the care and treatment received by patients in the University Hospital of North Durham outpatient and imaging departments was safe, effective, caring, responsive and well led. Patients were very happy with the care they received and found it to be caring and compassionate. Staff were supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm

because there were policies in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

The departments took part in the NHS Friends and Family Test and another satisfaction scheme called 'I want great care'. There were comment boxes in waiting areas.

On the whole, the services offered were delivered in an innovative way to respond to patient needs and ensure that the departments worked effectively and efficiently.



University Hospital of North Durham

Detailed findings

Services we looked at

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

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Background to University Hospital of North Durham

The University Hospital of North Durham was one of two acute hospitals forming County Durham and Darlington NHS Foundation Trust. This trust was one of the largest hospital and community healthcare providers in the NHS. County Durham and Darlington NHS Foundation Trust served around 600,000 people across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside services including health and wellbeing services, community-based services, and acute and planned hospital services.

In total, the trust had 1,331 beds across two acute hospitals and the community, and employed around 7,555 staff. The University Hospital of North Durham had 460 beds.

The University Hospital of North Durham provided medical, surgical, critical care and maternity services, and services for children and young for people in County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside. The hospital also provided emergency and urgent care (A&E) and outpatient services.

The accident and emergency (A&E) department was open 24 hours a day, 7 days a week. Between April 2013 and March 2014, A&E provided a service to 64,679 patients of which 12,207 were children under the age of 16 years. The provider anticipated that this figure will rise by 5% per year. The department was originally established for the purpose of caring and treating 30,000 patients annually and since April 2014 had seen 50,399 attenders of which 9,376 were children under the age of 16 years. Daily attendance rates for this time period for this hospital were192.

Medical care at the University Hospital of North Durham was provided by the care group acute and long-term conditions and comprised seven medical wards: a stroke unit, an acute medical unit (AMU), an ambulatory care provision and a discharge lounge. The medical centre included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology, endocrinology, haematology and stroke services. Hyper-acute and sub-acute stroke services for County Durham and Darlington NHS Foundation Trust were centralised at the University Hospital of North Durham. The hospital provides elective and non-elective colorectal surgery, trauma and orthopaedics, plastics and vascular surgery. The intensive care unit was a 10-bed facility and was funded for five level three intensive care beds and four level two intensive care beds.

The maternity departments offered a range of services to meet the needs of the communities of Derwentside, Durham city and surrounding villages, Bishop Auckland and Darlington, Weardale and Teesdale. In addition to antenatal, intrapartum and postnatal services, there were facilities available to support women in all aspects of motherhood, from ultrasound scanning through breastfeeding and pregnancy loss. Choices for place of delivery included a home birth service or one of two consultant-led units.

Services for children and young people at this hospital included one 24-bed children's ward (treetops ward 7) which included an assessment area, inpatient area and additional day surgery beds. Next to treetops ward was a dedicated children's outpatient department. Located next to treetops ward was the special care baby unit (SCBU), which had 12 level one (special care) cots. The service was responsible for providing community neonatal and paediatric outreach services. Based on statistics provided by the trust, the Durham services paediatric medicine specialty (not including sub-specialties or surgery) had a total of 5,116 non elective admissions, 31 elective admissions and 63 day case admissions during the period January to December 2014. The SCBU had a total of 210 admissions in the same period.

The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the specialist palliative care team. Specialist palliative care was provided as part of an integrated service across hospital and community teams.

Outpatient clinics were held in four different locations at this hospital: main outpatients, dermatology outpatients, orthopaedics outpatients and ophthalmology outpatients. The outpatient departments ran a wide range of clinics, some being nurse led, some led by allied

Detailed findings

health professionals and some by doctors across a large number of specialties such as urology, gynaecology, orthopaedics, general surgery, breast surgery, orthodontics, ophthalmology, ear nose and throat, and respiratory medicine. There were a total of 252,705 outpatient appointments between April 2013 and March 2014. The ratio of new appointments to review appointments was approximately 1:2. Radiology was part of the trust's surgery and diagnostics care group directorate. Radiology provided a trust wide diagnostic imaging service. The acute work of the trust was concentrated at the University Hospital of North Durham and Darlington Memorial Hospital, which offered a comprehensive range of diagnostic imaging and interventional procedures, as well as a substantial plain film reporting and ultrasound service. Radiology services were managed by a clinical lead radiologist, head of service for imaging and radiology manager.

Our inspection team

Our inspection team was led by:

Chair: Iqbal Singh, Consultant Physician in Medicine for Older People.

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission (CQC).

The team included CQC inspectors and a variety of specialists: consultant in emergency medicine, consultant paediatrician, consultant physician, consultant obstetrician and gynaecologist, consultant anaesthetist, consultant in oncology, consultant surgeon, junior doctors, senior nurses, student nurses and experts by experience.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to

share what they knew about the hospital. These organisations included the clinical commissioning group, local area team, Monitor, Health Education England and Healthwatch.

We carried out announced visits on 3 and 4 February 2015. During the visits we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, critical care, outpatients, maternity and A&E departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We completed an unannounced visit on 25 February 2015.

We held listening events on 26 January and 2 February 2015 in Darlington and Durham to hear people's views about care and treatment received at the hospitals. We

Detailed findings

used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Facts and data about University Hospital of North Durham

One of the largest hospital and community healthcare providers in the NHS, County Durham and Darlington NHS Foundation Trust serves around 600,000 people across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside services included health and wellbeing services, community-based services and acute and planned hospital services.

Inpatient activity at this trust was 121,346, with A&E attendances being 126,239, split between this site and

Darlington Memorial Hospital. There were a total of 252,705 outpatient appointments between April 2013 and March 2014. There were 4,764 outpatient attendances in the same period for paediatric medicine.

Darlington is ranked 75, and Durham 62 out of 326 local authorities which means there are high deprivation levels within these areas. County Durham has high levels of health deprivation with 71% of the population classed by the Department of Health as being within the most deprived nationally. Deaths from smoking and early deaths from cancer, heart disease and stroke are all higher than the England average.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Requires improvement	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires	Requires	Good	Good	Requires	Requires

Notes

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

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

Information about the service

The University Hospital of Durham is part of the County Durham and Darlington NHS Foundation Trust. The accident and emergency department (A&E) was open 24 hours a day, 7 days a week. Patients were cared for in three main areas: ambulatory care, which included 'see and treat', 'majors' and resuscitation. The resuscitation area had two bays, majors had 13 cubicles and the ambulatory care area had five cubicles. There was also a six-bed monitoring bay and a relative's room near the resuscitation area.

Between April 2013 and March 2014, A&E provided a service to 64,679 patients of which 12,207 were children under the age of 16 years. The provider anticipated that this figure will rise by 5% per annum. The department was originally established for the purpose of caring and treating 30,000 patients annually and since April 2014 had seen 50,399 attenders of which 9,376 were children under the age of 16 years. Daily attendance rates for this time period for this hospital were192.

During our inspection, we spoke with approximately 24 patients and their relatives, 33 staff, including doctors, nurses, allied healthcare professionals, managers and domestic staff. We observed care and treatment and reviewed 27 sets of care records. Before and after our inspection, we reviewed a range of performance information about the department.

Summary of findings

Overall, urgent and emergency services at this hospital as required improvement. Some areas in the department were not clean when we completed our announced inspection visit.We found high level and low level dust on cupboards, curtain rails, equipment and floors. Spilled blood was found around equipment and some staff did not always observe good hand hygiene. We found some resuscitation medication was out of date and not all resuscitation drugs, equipment and fridge temperatures were checked regularly.

We reviewed these issues during our unannounced inspection visit and found all equipment in the department was clean and free from dust and resuscitation medication was in date. Fridge temperatures were regularly checked, however there were some missing entries in the resuscitation equipment checklist in the resuscitation and monitoring bay areas.

There were appropriate nurse staffing numbers but consultant numbers were lower than the recommended level. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets.

Policy and protocols were underpinned by national guidelines but the department did not meet several patient outcome targets. The trust had a clinical audit

programme and categorised its centrally coordinated clinical audit activity according to priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited. Some patients told us they were not provided with adequate pain relief. There were good arrangements in place for patients to obtain food and drinks. There was a rolling programme of regular training and appraisal for staff. Multidisciplinary team arrangements were in place.

Patients received a caring service in the department. We observed respectful and courteous interactions with patients that showed they were treated well and with compassion.

Between October 2013 and October 2014, the department did not meet national targets. It did not meet the standard of admitting, transferring or discharging 95% of patients within 4 hours. The trust also had a higher than England percentage average for patients waiting 4-12 hours in the department from the decision to admit until being admitted into an inpatient bed. In addition, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was not met. It was evident that staff understood that access and flow was a top priority and they worked well together to try to comply with national standards. Paediatric facilities were severely limited and children often used the adult waiting area; ambulatory paediatric patients were treated in areas where adults were cared for. Systems were in place for investigating complaints, learning the lessons of those complaints and communicating lessons to staff.

There was clear management structure in the department and senior managers worked closely together to meet strategic objectives, monitor and improve care. Regular governance and information-sharing meetings were held and staff told us they felt empowered to take responsibility for issues. However, there was a lack of monitoring systems and processes which had resulted in issues with cleanliness, equipment and medication checks.Staff were focused on giving patients a positive experience.

Are urgent and emergency services safe?

Requires improvement

We rated safe in this service as required improvement. Some areas in the department were not visibly clean clean when we completed our announced inspection visit.We found high level and low level dust on cupboards, curtain rails, equipment and floors. Spilled blood was found around equipment and some staff did not always observe good hand hygiene. We found some resuscitation medication was out of date and not all resuscitation drugs, equipment and fridge temperatures were checked regularly.

We reviewed these issues during our unannounced inspection visit and found all equipment in the department was clean and free from dust and resuscitation medication was in date. Fridge temperatures were regularly checked, however there were some missing entries in the resuscitation equipment checklist in the resuscitation and monitoring bay areas.

There were appropriate nurse staffing numbers but consultant numbers were lower than the recommended level. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets.

Incidents

- Nursing staff were knowledgeable about the reporting process for incidents using 'Safeguard' (the hospital incident reporting system). Staff said they were encouraged and supported to report incidents. We saw evidence of post-incident feedback to staff through our review of departmental communication processes.
- There were no 'never events' in the department in 2013/ 14 (never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented).
- In 2014, the department reported 29 serious incidents to the Strategic Executive Information System (STEIS). The highest number of serious incidents reported related to ambulance handover delays. Senior staff informed us

that all serious incidents were investigated, a full root cause analysis was conducted and action plans were put in place as a result of the analysis. We read the 'Incident Actions Report' for the first and second quarters 1 of 2014/15 that confirmed that appropriate action plans were in place and staff confirmed that actions from these plans were being completed.

- Between 01 August 2014 and 30 November 2014, 270 general incidents were reported. Incident themes reported included violence and aggression towards staff, security issues and ambulance delays.
- Specific departmental mortality and morbidity meetings were not held. However, staff informed us that mortality and morbidity was discussed at a quarterly clinical governance meeting attended by consultants and senior nurses. Minutes of these meetings confirmed this. Deaths that occurred in the department did not form part of the trust's regular weekly mortality review process.

Cleanliness, infection control and hygiene

- During our announced inspection visit we found the environment was not visibly clean in all clinical areas. We found high level and low level dust on, cupboards, curtain rails, equipment and floors in areas such as the decontamination room, clinical equipment store and the patient monitoring bay.
- In the resuscitation area we found that the Resuscitaire machine, airway trolley and paediatric resuscitation trolley were dusty. We saw blood staining around the blood gas machine and boxes were stored on the floor. We raised these issues of bloodstaining and dust with senior managers and while we were at the hospital, the managers had taken action to clean the resuscitation area.
- On two separate days, we found trolleys with visible blood staining stored in a staff room adjacent to the reception area. We raised this issue with the matron on our first visit, but the same issue was in the same area 3 days later.
- We noticed that some of the plastic toys in the paediatric waiting area were dirty. We read the toy-cleaning schedule, which showed that a member of staff had signed to say that toys had been recently cleaned on 01 and 02 February 2015.
- We read the departmental cleaning schedule and spoke with the domestic staff who were employed by the trust's contractor; domestic staff said they did not feel

they could clean as well as they wanted to due to staff shortages. The trust had previously informed us that senior staff had met with the domestic manager to define responsibility of staff for cleaning equipment.

- The department was developing a display board to show how many times cleaning was carried out along with a poster to show who the cleaners were and what hours they worked. These improvements had not been implemented at the time of our inspection.
- Hand washing facilities were readily available and we saw staff washing their hands and using hand gel between patients. Personal protective clothing such as gloves and aprons were available in all clinical areas and the 'bare below the elbow' policy was adhered to.
- We looked at the department's hand hygiene audit results and saw it had recorded 100% compliance in January 2015.
- A daily resuscitation-cleaning schedule had only been completed for 3 days in the month of January 2015.
- An infection control audit completed by a trust infection control nurse specialist dated 27th January 2015 showed a 73% compliance rate in terms of the department's environment. This audit identified similar issues with cleanliness. An action plan was in place, however this was not dated in terms of when actions would be completed.
- We reviewed these issues during our unannounced inspection visit and found all equipment in the department was clean and free from dust and resuscitation medication was in date.
- There was no dust, dirt, debris or staining on or inside cupboards, curtain rails or ceilings and the domestic staff told us that bed curtains had been replaced throughout the department since our last visit.
- There had been no cases of hospital-acquired C. difficile or MRSA/MSSA between April 2013 and December 2014.
- The minors/majors area had appropriate facilities for isolating patients with an infectious condition.

Environment and equipment

- There was a dedicated ambulance entrance that ensured patients had direct access to the resuscitation and majors areas. People who self-referred used a separate entrance to the ambulance entrance and all entrances were clearly signposted.
- The resuscitation area was not stocked appropriately and some medication such as adrenaline and amiodarone were out of date.

- We also checked the paediatric transfer bag and found that two boxes of adrenaline were out of date. A guide (Bougie) was open and attempts had been made to tape it up and it was therefore not sterile. There was no drug and equipment checklist for the bag.
- In the monitoring bay we found the anaphylaxis box had expired on 31 December 2014. We checked inside the box and found that the hydrocortisone had expired in December 2014.
- A senior nurse did not know where the difficult airway kit was kept.
- The resuscitation equipment daily checklist had not been completed for 17 days between 12 October 2014 and 3 February 2015. There was also a further 6 days with incomplete entries. This meant that staff could not be sure that the resuscitation area was equipped appropriately and clean.
- We immediately raised the out of date drugs and equipment issues with senior managers, and while we were at the hospital, the managers had taken action to replenish drugs and equipment with in-date stock.
- We reviewed these issues during our unannounced inspection visit and found there was no out of date medication or equipment. However there were some missing entries in the resuscitation equipment checklists in the resuscitation and monitoring bay areas. In the resuscitation area, the daily resuscitation equipment checklist had missing entries on 8,9,14,15,16 and 21 February 2015

Medicines

- Medicines were stored correctly in locked cupboards or fridges. Fridge temperatures were not checked regularly and records showed that in resuscitation, fridge temperature checks were not done on eight occasions between 2 January 2015 and 3 February 2015; maximum and minimum temperatures were not recorded.
- During our unannounced inspection visit we checked fridge temperatures and found that they had been regularly checked since our original visit.
- Medical gases were found to be stored appropriately within a locked room.
- We asked nursing staff about standards of checking medications before, during and after administration and found they understood the Nursing and Midwifery Council (NMC) 'Standards for medicines management'.

- Guidelines for the use of antibiotics were on the trust intranet and staff told us they routinely accessed the guidelines as a point of reference.
- Ninety-nine per cent of A&E medical and nursing staff had completed medicines management training.

Records

- Patient care records were in an electronic format on a system known as 'symphony' and all healthcare professionals recorded care and treatment using the same document.
- We reviewed 14 adult and 13 paediatric patient records and we found that records had the appropriate assessments recorded, including risk assessments, observations, care and treatment and, where necessary, discharge plans. However, five sets of patient notes did not have the type of allergy reaction to particular drugs documented. The majority of records we reviewed were completed appropriately.
- Seventy-five per cent of A&E medical and nursing staff had completed health record keeping training.

Safeguarding

- Staff told us they were aware of their responsibilities to protect vulnerable adults and children and described the processes to follow.
- We reviewed five paediatric care records and found that in four of the records, appropriate safeguarding assessments had been completed. We noted that one potential safeguarding concern had not been highlighted and this was brought to the attention of the trust safeguarding lead who dealt with the matter.
- The trust informed us that a more robust risk assessment form was under development with improvements planned such as reception staff asking more questions of patients. They told us further development was required to fully implement all of the recommendations, and a 'task and finish' group led by paediatrics was in place in order to complete the changes required.
- Safeguarding children training was part of the mandatory training programme; 79% of medical and nursing staff had completed level 1 safeguarding training.
- We read the trust's safeguarding training record, which showed that relevant staff members received level 2 safeguarding training. Senior nursing staff and doctors

received level 3 safeguarding training. This meant senior decision makers within A&E had received additional safeguarding training and were aware of the processes to follow if they had concerns about a patient.

• There was a safeguarding adults training programme in place and 74% of trust A&E staff had completed this.

Mandatory training

- We looked at trust data for A&E staff mandatory training relating to the period 2014/15. The majority of staff were up to date with their mandatory training.
- Seventy-four per cent of medical and nursing staff had completed fire safety training.
- Seventy-nine per cent of medical and nursing staff had completed hand hygiene training and 66% had completed hand wash assessments.
- Seventy-nine per cent of medical and nursing staff had completed moving and handling training.
- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning. Managers were informed when staff did not attend training, to help to ensure staff completed all modules.

Assessing and responding to patient risk

- Patient flow staff were employed within the hospital and worked closely with departmental staff. Managers said missed targets were usually caused by not enough inpatient beds being available. A dedicated member of staff from the North East Ambulance Service was located in the department over the winter period to monitor and deal with meeting targets and patient flow. The trust informed us that it employed a band five nurse between the hours of 2pm and 9pm, 7 days a week, to monitor, assess and manage patients arriving by ambulance. We saw examples of the escalation plan having been implemented. This meant that the department used its internal escalation plans to manage the number of patients queuing.
- Adult patients were assessed and managed using a variety of risk assessment tools, which included the use of the Early Warning Score (EWS). Children were risk assessed with the Paediatric Early Warning Score system (PEWS).
- Ambulatory patients were first seen by the triage nurse and were either referred to either the emergency care practitioners (ECPs) for treatment of minor illness or injury, emergency nurse practitioners (ENPs) for

treatment of minor injury or 'major's' where they were seen by a doctor. Referrals were also made to the urgent care centre, which was staffed by GPs between 6pm and 8am.

• The department was piloting a new staff role known as 'majors practitioners'. Majors practitioners were ECPs that had undertaken a competency programme to allow them to work at junior doctor level. They attended junior doctor teaching sessions once a week and were supervised by a consultant. The role allowed them to work in the 'majors' area.

Nursing staffing

- Nursing numbers were not assessed using an acuity tool although senior managers told us they were working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe staffing for nursing in A&E departments (February 2015).
- Paediatric nurse staffing levels were challenging and not all shifts had a paediatric-trained nurse on duty. We found that there were three WTE paediatric trained nurses. Advice and support was provided from the nursing staff on the paediatric wards if required.
- The overall nursing skill mix was appropriate and included clinical sisters, senior sisters/charge nurses, ENPs/ ECPs, band five nurses and healthcare assistants.
- ENPs and ECPs were employed in the department. ENPs and ECPs are advanced trained nurses or paramedics able to see, treat and discharge certain categories of patients so that patients do not have to wait to see a doctor. ENPs and ECPs were not counted in the shift nursing numbers due to their role being to assess, diagnose and treat patients.
- At the time of our visit 7.76 WTE band seven nurses, 7.96 WTE band six nurses and 39.7 WTE band five nurses were employed. There was also one WTE band three healthcare assistant and 27.21 WTE band two healthcare assistants in post. The department also employed 1 WTE TARN nurse, shared between 1 band six nurse and 1 band 5 nurse acting up.
- Senior managers informed us that they used agency nurses from two agencies. We spoke with agency nurses who told us they had worked in the department before and knew how to use the electronic patient records system. We also observed them being inducted by a senior nurse before the start of the shift.

• Handovers and information sharing sessions were held three times a day. Any complaints, concerns or incidents were also discussed.

Medical staffing

- The College of Emergency Medicine (CEM) recommends a minimum of 10 consultants in each emergency department. The department employed 4.5 WTE consultants.
- Consultant cover was from 9am until 10pm, Monday to Friday and 10am to 8pm, Saturday and Sunday. There was an on-call rota for consultants out of hours.
- The department also employed four associate specialists (middle grade doctors).
- There was some reliance internally to cover shifts using overtime. Locum doctors were also used but the department tried to cover shifts with doctors who had worked in the department before.
- Consultant handovers took place twice a day and we observed a handover, which was found to be appropriate.

Major incident awareness and training

- There was a major incident plan and business continuity plan for the department.
- A senior nurse in the department was responsible for coordinating the plan and overseeing the decontamination room and equipment.
- The trust informed us there was an Ebola exercise every Monday where key departmental staff walked through an Ebola scenario to identify and share learning.
- There were appropriate security arrangements in the department. CCTV had recently been installed in the paediatric waiting area and CCTV was evident throughout the department. Security staff were employed within the hospital 24 hours a day, 7 days a week, and could be summoned easily to support staff as they were located close to the department.
- Only 9% of trust A&E staff had completed violence and aggression training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Policy and protocols were underpinned by national guidelines. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited. There were good arrangements in place for patients to obtain food and drinks. There was a rolling programme of regular training and appraisal for staff. Multidisciplinary team arrangements were in place.

Evidence-based care and treatment

- We found that the service followed NICE guidelines as part of its practice and protocols. These guidelines were discussed at quarterly clinical governance meetings.
- The department had several specific protocols such as the management of fractured neck of femur, stroke, sepsis and rapid access chest pain assessment.

Pain relief

- Most of the patients we spoke with told us that they were offered and/or provided with appropriate pain relief, but two people said they were in pain and told us staff had not asked about pain or offered pain relief.
- Patient group directives were used in the department. A recognised pain scale for children and adults was in use. Nursing staff confirmed they used patient group directives to manage pain.
- The Care Quality Commission (CQC; 2014) A&E survey rated the trust as about the same as other trusts for administering pain relief in a timely way and for staff doing everything they could to help control pain.

Nutrition and hydration

- Staff were able to order hot food for patients before 10am. After 10pm patients were offered light snacks and drinks. Special diets were also catered for.
- Patients told us that they were offered food and drink. We saw patients being offered meals and drinks.

• In the CQC (2014) A&E survey the trust was about the same as other trusts for supplying suitable food and drinks.

Patient outcomes

- The hospital participated in national CEM audits so it could benchmark its practice and performance against best practice and other A&E departments.
- In the CEM vital signs in majors audit of 2010/11, the department almost met the three of the six standards for measuring and recording vital signs after arrival/ triage by scoring between 94% and 98% (CEM standard 100%). It scored 70% for measuring and recording a temperature (CEM standard 100%) and 68% for recording the Glasgow Coma Scale (CEM standard 100%). The department did not meet any of the six standards for observations being repeated and recorded within 60 minutes. It almost met the standard for abnormal vital signs being communicated to the nurse in charge by scoring 95% (CEM standard 100%) but only scored 14% for the standard for appropriate actions being taken (CEM standard 100%). It should be noted that this audit was undertaken in 2010/11.
- The department did not meet CEM standards for renal colic in the 2012 audit. The standards relating to the re-evaluation of pain were not met, and neither was the one standard for recording an initial pain score. It did not meet standards in relation to the 20-, 30-minute and 60-minute targets for providing analgesia to patients in severe pain. None of the standards for carrying out and recording appropriate investigations prior to discharge were met but the scores for this standard ranged between 76% and 96% compliance with the CEM 100% standard. It should be noted that this audit was undertaken in 2012.
- In the CEM fractured neck of femur audit of 2012, the department did not meet the standards for the provision of analgesia to patients in severe pain after they arrived into A&E at 20 minutes, 30 minutes and within 1 hour. It did not meet the two standards for the provision of analgesia to patients in moderate pain after they arrived into A&E at 30 minutes or within 1 hour. It scored 34% for the standard for time to imaging and admission (CEM standard 75% within 60 minutes) and scored 86% for patients to be admitted within 4 hours (CEM standard 98%). It should be noted that this audit was undertaken in 2012/13.

- In the CEM severe sepsis and septic shock audit of 2013/ 14, the department nearly met the standard for vital signs being measured and recorded by scoring 96% (CEM standard 100%). It scored 76% for capillary blood glucose measurements being taken and recorded on arrival to A&E (CEM standard 100%), scored 52% for high flow oxygen being initiated before leaving A&E (CEM standard 100%), 74% for blood cultures being obtained (CEM standard 100%), 96% for the administration of antibiotics before leaving A&E (CEM standard 100%) and 56% for evidence that urine output measurements were instituted in A&E (CEM standard 100%). It scored 40% for the standard relating to evidence in the notes that first intravenous crystalloid fluid bolus was given in A&E in under 1 hour (CEM standard 75%) and scored 92% for the same intervention before the patient left A&E (CEM standard 100%). It nearly met the standard by scoring 98% for evidence that serum lactate measurements were obtained (CEM standard 100%). It nearly met the standard for the administration of antibiotics before the patient left A&E by scoring 96% (CEM standard 100%) but only scored 26% for the administration of antibiotics in under 1 hour of arrival into A&E (CEM standard 50%).
- The department met one of the six CEM fever in children standards relating to the measurement and recording of vital signs. It scored between 58% and 92% on the other five standards relating to the measurement and recording of vital signs (CEM standard 100%). It met the standards for providing written advice to parents/carers and having an accessible copy of the NICE traffic light system.
- In the CEM pain in children audit (2011), the department did not meet the standard that 75% of patients in severe pain should receive medication within 30 minutes as it scored 57%. However, it scored 100% for giving analgesia within 60 minutes (CEM standard 98%). It scored 0% for re-evaluating analgesia for patients in severe pain within 30 minutes, 29% within 1 hour and 43% within 2 hours (CEM standard 90%). It should be noted that this audit was undertaken in 2011.
- The trust did not take part in the last CEM consultant sign-off audit. This audit related to three types of patient groups that should be reviewed by a consultant. These were adults with non-traumatic chest pain, febrile children less than 1 year old and patients making an unscheduled return to the department with the same condition within 72 hours of discharge.

- We read the clinical audit annual programme dated 2014/15. It showed that the department had a clear clinical audit programme with timescales for each clinical audit activity. The CEM severe sepsis and septic shock audit had been repeated in November 2014 and a summary and action plan was available. TARN 2014/15 data collection was underway with the results were due out in June 2015.
- The trust informed us they made use of a coder who reviewed all records to help ensure accurate coding and submitted trauma audit research network (TARN) data. There were plans to employ another TARN coordinator in March 2015 to help with trauma audits.
- Results of CEM audits were discussed at a quarterly clinical governance meeting and actions were written to improve outcomes for patients.
- The trust met the national standard of less than 5% unplanned re-attendances to A&E within 7 days (January 2013 to May 2014).

Competent staff

- There was a rolling programme of regular training for staff in the department. Several staff had enrolled on master's degree programmes or foundation degrees and staff took part in a trauma-training programme.
- Medical and nursing staff told us they felt well supported with training.
- The trust was ranked as good in the latest junior doctors training survey.
- Nursing and medical staff were appraised regularly. Sixty-eight per cent of appraisals were in progress within trust guidelines, 14% had been successfully completed and 18% of appraisals were overdue. Managers told us they were working towards 100% completion by the end of March 2015.

Multidisciplinary working

• We saw evidence of multidisciplinary working with different healthcare professionals. An example included joint working with a local mental health trust – Tees, Esk and Wear Valleys NHS Foundation Trust. Over the winter period this involved staff from the mental health teams working closely with the department, 24 hours a day, 7 days a week. The objective was to provide patients with timely assessments and referrals as well as trying to reduce or avoid unnecessary admissions to hospital. Staff also had access to the Child and Adolescent Mental Health Services (CAMHS).

- The department had two dedicated physiotherapy practitioners who worked from 8.30am until 4.30pm, Monday to Friday. They assessed and treated minor traumas, all musculoskeletal injuries including soft tissue injuries and fractures.
- The alcohol and drugs team reviewed every patient within the department to identify and assist with drug or alcohol issues.
- There was 24-hour access to CT scans and the department had its own x-ray department. The MRI service was open from 9am to 5pm, Monday to Friday. Out of these hours, MRI scans were performed in a Newcastle NHS hospital.

Access to information

- The trust had a real time electronic patient record system.
- We reviewed a sample of patient records which contained all the necessary information required for ongoing care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before the intervention was carried out.
- Staff training on the Mental Capacity Act was offered and 74% of A&E staff had completed this. Staff we spoke with were clear about their responsibilities in relation to patient capacity, consent and the deprivation of liberty safeguards.
- We observed parents/carers being asked for verbal consent to care and treatment of their children.
- There was a dedicated room where mental health patients could be accommodated. Patients who were at risk of harm were cared for in the room where they would be closely supervised.

Are urgent and emergency services caring?



Patients received a caring service in the department. We observed respectful and courteous interactions with patients that showed patients were treated well and with compassion.

At the end of 2014 between 81% patients would recommend this service at this hospital in the NHS Friends and Family Test.

Compassionate care

- The trust used the NHS Friends and Family Test to capture patient feedback. It asks people if they would recommend the services they have used and offers a range of responses. The test highlights both good and poor patient experience. Low response rates are common for A&E departments.
- At the end of 2014 between 81% patients would recommend this service at this hospital in the NHS Friends and Family Test . The response rate was 26%.
- Positive themes from the Friends and Family Test for the department included good nursing care and that patients were treated with dignity and respect. Negative themes included communicating with patients and relatives, waiting times and cleanliness.
- The CQC (2014) A&E survey rated the trust around the national average on most of the 33 questions and better than average on one of the questions that asked patients 'before you left the department, did you get the results of your tests'?
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We saw that patients were attended to promptly when staff were called to assist them and patients we spoke to told us "I feel listened to by staff, they have been great", and "I feel I have been treated with dignity and respect".
- We spoke with many staff of all grades who displayed a passion for delivering good quality care and gave us an overall sense of caring about patients. This was also evident during our observations of interactions between patients and the staff.

• We looked at patient records and found they were completed sensitively, and detailed discussions that had taken place with patients and relatives.

Understanding and involvement of patients and those close to them

• Patients and relatives told us that their care and treatment was explained to them in a way they could understand and we observed this interaction throughout our inspection.

Emotional support

- Staff told us there were good links to sources of specialist support, such as counselling and 24-hour chaplaincy services.
- We spoke with the lead chaplain who confirmed there was a good chaplaincy service. He explained how staff could access different leaders from different faiths.

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

Requires improvement

Between October 2013 and October 2014, the department did not meet national targets. It did not meet the standard of admitting, transferring or discharging 95% of patients within 4 hours. The trust also had a higher than England percentage average for patients waiting 4–12 hours in the department from the decision to admit until being admitted into an inpatient bed. In addition, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was not met.

It was evident that staff understood that access and flow was a top priority and they worked well together to try to comply with national standards. Paediatric facilities were severely limited and children often used the adult waiting area; ambulatory paediatric patients were treated in areas where adults were cared for.

Systems were in place for investigating complaints, learning the lessons of those complaints and communicating lessons to staff.

Service planning and delivery to meet the needs of local people

- The A&E department had undergone a service transformation. The transformation team had worked closely with a nurse from the department's service improvement team to review the registering and streaming of patients, to develop consultant-led rapid assessment teams to improve patient transition through the department and to introduce the role of navigator and experienced practitioner to stream ambulatory patients before registration.
- In order to improve the service provided by A&E, the trust had plans to build a new department by 2018.

Meeting peoples individual needs

- Interpretation services were used for patients whose first language was not English. There was a member of staff employed within the department who could communicate with hearing impaired patients by using a recognised sign language method.
- Work had begun to identify people who attended A&E frequently because of mental health issues so that management plans could be put in place.
- Staff knew about the passport document system for people with learning disabilities used at the trust. These passports set out people's specific needs.
- There was no separate children's entrance into the department, which meant children who attended with their parent or guardian used the same entrance as adults. We found the paediatric environment was not fit for purpose. The children's waiting area was situated in the reception area and it was difficult for nursing staff to observe children. The children's waiting area was small and seating was limited for families. We saw children sat in the waiting area where adult patients were sat throughout the 3 days we were present. We asked for environmental risk assessments but were told these were not readily available or accessible.
- There was no paediatric resuscitation area and very ill children were cared for in the two-bed adult resuscitation area. Senior managers told us that paediatric facilities would be improved when the new A&E department was built.
- There was a room near to resuscitation where relatives or partners of people being resuscitated could wait, so as to be near to their loved ones. The room allowed staff to give emotional support in a private environment.

• There was a remembrance room located next to the relative's room where families could spend time with their deceased relative.

Access and flow

- Trusts within England are set a government target of admitting, transferring or discharging 95% of patients within 4 hours of their arrival in the A&E department. The department's average performance for this target ranged from 84% to 74% (October 2014 to January 19th 2015), which meant the target was not met.
- From January 2014 to September 2014, the trust had a higher than England percentage average for patients waiting 4–12 hours in the department from the decision to admit until being admitted into an inpatient bed. However, in October 2014 the trust's percentage average was better than the England average.
- The national standard for patients who arrive by ambulance states that 95% should receive an initial assessment by a registered healthcare professional within 15 minutes of arrival into the department. The department's average performance for this target ranged from 49% to 80% (October 2014 to February 2015), which meant the target was not met.
- Managers told us the main issue with maintaining compliance with the 4-hour target was patient flow, particularly for patients who were waiting for medical beds. We saw evidence of staff working well together to monitor patient flow and evidence of the escalation plan being implemented when necessary.
- Staff told us that the trust had a project to look at patient flow across the hospital.
- A&E departments across England have to record the rate of people who leave the department without being seen. The quality threshold is 5%; the hospital had a rate of between 1.9% and 4.1% of people who left without being seen by a doctor or a nurse (October 2013 to October 2014). This meant the standard was met.

Learning from complaints and concerns

- We saw information displayed around the department that explained to patients how they could make complaints and give feedback.
- Staff were aware of how to manage complaints and how to support patients who wished to complain. We talked

with nursing staff who told us they knew how to put patients in touch with the Patient Advice and Liaison Service (PALS). Information about this service was displayed in patient areas.

- Managers told us that any verbal complaints would be discussed with staff at team meetings and we read the department meeting standing agenda, which contained an item for complaints feedback. This meant that staff were informed of any complaints so that learning could take place.
- There were 35 formal complaints from April 2014 to December 2014. Themes included staff attitude and waiting times. Feedback from these complaints was given to staff at department meetings.

Are urgent and emergency services well-led?

Requires improvement

There was clear management structure in the department and senior managers worked closely together to meet strategic objectives, monitor and improve care. Regular governance and information-sharing meetings were held and staff told us the felt empowered to take responsibility for issues. However, there was a lack of monitoring systems and processes and as a result of this, resuscitation medication was out of date, not all resuscitation drugs, equipment and fridge temperatures were checked regularly and the environment was not clean. This was not included in the departmental risk register or governance meetings.

Staff were focused on giving patients a positive experience.

Vision and strategy for this service

- Staff we spoke with were aware of the trust's vision and values.
- By 2016, the trust aim was to offer 24 hours a day, 7-days a week service in the hospital and community, with senior staff, including consultants and senior nurses, on the frontline around the clock. The objective was to reduce avoidable emergency admissions.

Governance, risk management and quality measurement

- There was a lack of monitoring systems and processes and as a result of this, resuscitation medication was out of date, not all resuscitation drugs, equipment and fridge temperatures were checked regularly and the environment was not clean. This was not included in the departmental risk register or governance meetings.
- Quarterly governance meetings were held and the matron had a weekly meeting with consultants to discuss issues around staff rotas, performance of the department and any major incidents.
- A quarterly information governance report was presented to the trust's 'Quality and Healthcare Governance Committee' that included reports on trends, incidents, complaints, assessment compliance and sickness absence.
- Nursing staff we spoke with told us they were not aware of the new statutory 'duty of candour' although some doctors were aware of it. The duty of candour was introduced for NHS bodies in England in November 2014. Certain key principles are set out, including a general duty to act in an open and transparent way in relation to care provided to patients, and as soon as is reasonably practicable after a notifiable patient safety incident occurs, the organisation must tell the patient (or their representative) about it in person.
- Any member of staff could identify risks but their formal inclusion on the risk register was controlled through the quarterly governance meetings and bi-monthly 'care group' meetings. Risks documented on the risk register had an action plan in place. Progress on risks was discussed at these meetings and overdue actions were brought to the attention of management on a monthly basis via the trust wide quality team.

Leadership of service

- The leadership structure consisted of a consultant who offered overall leadership to the medical team. Each member of the medical team had designated areas of clinical and leadership responsibility.
- The matron and six band seven nurses all had responsibility for a defined team and specific clinical responsibilities.
- The matron was undertaking a master's degree in transformational leadership and the band seven team had undertaken a course in 'great line management', which included recruitment training and reducing sickness absence.

Culture within the service

- We saw good team working in the department between staff of different disciplines and grades. Staff worked well together and there was respect between specialties and across disciplines.
- Staff were well engaged with the rest of the hospital, reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority and staff were aware of their responsibilities under 'duty of candour'.
- Staff exhibited a drive to give a positive experience to patients.

Public and staff engagement

- The department had strong links to a young people's 'good to talk about health issues' group.
 Representatives from the group had recently visited the department for an educational session.
- Staff reported that there was a strong culture of learning and improvement and training and development was actively encouraged.
- NHS staff survey data (2013) showed the trust scored as expected in 19 out of 30 areas and better than expected

in nine areas. There were two negative findings: the percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver, and the percentage of staff receiving job-relevant training, learning or development in last 12 months.

Innovation, improvement and sustainability

- The trust was a finalist for a North East Leadership Academy Award (NELA) for service improvements to change practice.
- The trust informed us that over the past 2 years, A&E staff had taken the opportunity to improve the service for patients. They gathered information from a range of sources, including over 300 patients. The team identified the need to make improvements from the first point of contact and beyond. With support from the transformation team, they ran improvement events to redesign the patient journey and moved the senior decision makers to the front of the process. Live trials were held to test new ways of working and results showed significant improvements to assessment, diagnosis and treatment. The team was working with partners in urgent care and paediatrics to deliver a fully integrated front of house service.

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

Information about the service

Medical care at the University Hospital of North Durham was provided by the care group acute and long-term conditions and comprised seven medical wards: a stroke unit, an acute medical unit (AMU), an ambulatory care provision and a discharge lounge. The medical centre included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology, endocrinology, haematology and stroke services. Hyper-acute and sub-acute stroke services for County Durham and Darlington NHS Foundation Trust were centralised at the University Hospital of North Durham.

During the inspection, we looked at the care records of 12 patients. We spoke with 20 patients and relatives and over 40 members of staff, including doctors, nursing staff, therapists, non-clinical staff and managers. We visited all medical wards including the AMU, ambulatory care area and the discharge lounge. We carried out observations on the areas we visited. Before the inspection, we reviewed performance information from, and about, the trust.

Summary of findings

Overall, the medical care and treatment received by patients within the hospital was responsive, caring and well-led, with some areas of patient safety and effectiveness requiring improvement.

Medical staffing was made up of a higher proportion of junior doctors and was higher than the England average. The proportion of consultants, middle career and registrars were all lower than the England averages. The trust was working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe nurse staffing. Nurse staffing establishments were determined using the safer nursing care tool (SNCT), however, actual staffing numbers on duty were sometimes below the planned level. We were particularly concerned about the staff to patient ratios for patients requiring non-invasive ventilation (NIV) who were being nursed in general ward areas.

Policies and guidelines were available to staff and the medical directorate participated in local and national audits. Indicators from some national audits showed mixed performance with some indicators being better than the England average, while others were below the national average. There was no evidence to support any detailed competency based assessment for nursing staff regarding the initiation and ongoing management of patients requiring NIV.

Wards were visibly clean and cleaning schedules were in place. A recent patient-led assessment of the care

environment (PLACE) rated the hospital as achieving over 90% compliance in all of the four areas of: cleanliness, food, privacy/dignity and wellbeing and condition/appearance and maintenance. Systems were in place to report incidents and wards were monitored for safety and 'harm-free' care. Results were positive, overall, and were prominently displayed at the entrance to wards for staff, patients and visitors to view. Planned and actual nurse staffing levels were also clearly displayed.

Staff were trained, provided with good support and worked within some locally or nationally agreed guidance to ensure that patients received appropriate care and treatment for their conditions. There was no formal competency based training for staff regarding the administration of non-invasive ventilation NIV. Patients were protected from the risk of harm by adherence to policies and procedures which ensured care needs were managed appropriately.

Patients were happy with the care they received and found the service to be caring and compassionate. Most patients and relatives spoke very highly of staff and told us that they, or their relatives, had been treated with dignity and respect, had been listened to and given enough information in a way they could understand. Nutrition, hydration and comfort needs were met.

The trust had consistently achieved its

referral-to-treatment times (RTT) for all care groupings with the exception of gastroenterology. RTT was better than the England average. The trust had consistently achieved their performance targets for national cancer waiting times.Services were delivered in a way that responded to patients' needs and ensured the departments worked effectively and efficiently.

Clear governance structures were in place to facilitate analysis of information from incidents and complaints, identify themes and ensure communication from ward to board. Key messages from incidents and complaints were communicated across the trust via staff meetings, training and newsletters. There had been a number of developments made and there were projects ongoing to improve services, outcomes and patient experience. Most staff were clear about the vision and strategy for the service.

Are medical care services safe?

Requires improvement

Medical staffing was made up of a higher proportion of junior doctors that was higher than the England average, while the proportion of consultants, middle career and registrars were all lower than the England averages. The trust was working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe nurse staffing. Nurse staffing establishments were determined using the SNCT, however, actual staffing numbers on duty were sometimes below the planned level. We were particularly concerned about the staff to patient ratios for patients requiring NIV, who were being nursed in general ward areas.

Systems were in place to report incidents and wards monitored for safety and 'harm-free' care. Results were positive, overall, and were prominently displayed at the entrance to wards for staff, patients and visitors to view. Planned and actual staffing levels were also clearly displayed. Wards were clean and staff were observed adhering to infection control principles regarding hand hygiene and use of personal protective equipment (PPE).

Patients' records and observations were mostly recorded appropriately and concerns about deteriorating patients were escalated in accordance with the trust guidance. However, across the service we found examples of patient care records that were not fully completed or kept up to date. We also found that supportive documentation on some wards, such as fluid balance charts and risk assessments were not consistently completed in all cases. We found during the unannounced inspection that care planning was not robust and this was reflected in the ward documentation audits.

Incidents

• There had been 632 incidents on the medical wards and acute admissions unit reported at University Hospital of North Durham over the three months prior to the inspection. Eighteen of these were classified as resulting in moderate harm, one resulted in major harm and three incidents were categorised as catastrophic. All

incidents graded as moderate or above were investigated using root cause analysis (RCA) methodology. The most common reported incidents related to patient falls and pressure ulcers.

- There were systems in place to report incidents. Incidents were reported using an electronic system. Staff told us they were aware of how to use the system to report incidents.
- Incident trends were reported and monitored through the quarterly information governance report that is presented to the trust's quality and healthcare governance committee and the care groups clinical governance group.
- A monthly action log of all moderate harm and above incidents was maintained and discussed at the monthly sisters, staff and clinical governance meetings.
- Relevant incidents and required actions were also discussed at ward safety huddles to ensure staff learning took place and improvement actions were put into place.
- The patient safety team produce a simple "One liner" bulletin to cascade key messages and reminders to staff across the trust. We saw that this was available in paper format on wards and online.
- An example of learning and making improvements from incidents was given by staff on the coronary care unit (CCU). An incident of a patient going "missing" had led to the implementation of an improved tracking system for cardiac patients on general wards that have telemetry (cardiac monitoring) in place. This was being monitored by the CCU.
- Clinical pharmacists were involved in medication reviews as part of falls RCA meetings, to ensure issues relating to medicines were highlighted and lessons learned.
- The pharmacy department produced regular medication incident reports for each care group that provided a detailed analysis of the incidents related to medications. The pharmacy team shared the learning from their findings through: regular medication bulletins, key prescribing messages, 'How to' guides and 'Did you know' posters.
- As a result of a common theme identified by pharmacy, a checklist had been implemented on the AMU to prevent out-of-date medicines stock.
- Other actions taken as a result of falls investigations included the introduction of movement sensors for high-risk patients, high/low beds and cohorting of falls

risk patients to facilitate close observation by a dedicated member of staff. A number of wards used cohorting of patients to reduce risk when staffing numbers would not allow for one-to-one care, with the Patient's level of supervision (i.e. intentional roundings, cohort supervision or one-to-one supervision) being based on individual patient assessment.

• Staff were aware of the Duty of Candour and their responsibility in involving patients and families when incidents resulted in moderate harm or above.

Safety Thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. All the medical wards recorded the Safety Thermometer information monthly.
- Over the previous year, the medical directorate had maintained a consistently low rate for pressure ulcers except for one peak in May 2014. Falls and catheter-associated urinary tract infections remained low throughout the year.
- Information regarding the results of the Safety Thermometer were routinely displayed on all of the wards.

Cleanliness, infection control and hygiene

- There were four cases of MRSA across the trust between January and December 2014. One case of MRSA was attributable to the medical wards.
- Clostridium difficile (C. difficile) rates for the trust had been consistently lower than the England average from March 2013 to December 2014. Nine of the 22 cases across the trust were attributable to medical wards at University Hospital of North Durham. A post-infection review was held for each case and actions were identified, implemented and reviewed.
- Cases of methicillin-sensitive staphylococcus aureus (MSSA) had been relatively lower than the England average, aside from one spike in September 2014.
- Monthly infection control audits were undertaken with regard to hand hygiene, the environment and high impact interventions, such as: insertion of central venous catheters, peripheral intravenous catheters and urinary catheters. We saw actions were planned and reviewed as a result of these audits.
- Ward areas were visibly clean, tidy and well maintained.

- Personal protective equipment and alcohol hand sanitising gel was available at the entrance to, and throughout, the wards.
- We observed that staff wore personal protective equipment and staff applied the principles of infection control. We observed good hand hygiene practice.
- Equipment was cleaned after use and labelled as clean and we observed that sluices and storage areas were clean and mostly tidy.
- Clear signs, which could be understood by staff, patients and visitors, were present on the ward where there was an infection risk.

Environment and equipment

- The environment in the ward areas appeared clean and well maintained. Wards 5 and 6 had recently been reconfigured and had also undergone additional works to make them 'dementia friendly'.
- Staff said that equipment to meet patient needs was available. Equipment such as infusion devices and pressure-relieving equipment could be obtained at any time of day or night via a central equipment loan library.
- Resuscitation equipment was accessible on all medical wards and a prompt repair and maintenance service was provided.
- The AMU had access to new modern equipment such as computers, electrocardiogram (ECG) machines and other patient-monitoring equipment. AMU did not have a blood gas machine, which meant blood gas samples had to be transported to accident and emergency department (A&E) or the respiratory Ward 1 for testing.
- There was a coded safe for drug cupboard keys, which were returned there after use. This meant staff no longer had to go looking for the member of staff who had them and saved time.
- AMU staff reported that there were insufficient single rooms for treating oncology patients with neutropenic sepsis.
- Storage areas on most wards were well organised, equipment had been cleaned and labelled as clean.
 Labels were in place on equipment showing the date of the last maintenance check.
- Ward 14 reported they did not have enough storage space and needed to keep equipment on the ward next door.

- We looked at equipment and refrigeration and found they were appropriately checked, cleaned and maintained. Maintenance contracts and service-level agreements were in place with an external provider to service, maintain and repair equipment.
- Resuscitation equipment was available and checked regularly in most areas. There were a number of gaps noted during January on the daily checking sheet on Ward 6. The trolley on AMU was not locked, due to frequent use and each drawer was individually checked and recorded as being correct on a daily basis.
- The facilities team carried out audits on the environment at University Hospital of North Durham and also reviewed environmental feedback from NHS Friends and Family Test forms. Actions were taken to address any areas of concern.
- Wards were visibly clean and cleaning schedules were in place. A recent patient-led assessment of the care environment (PLACE) rated the hospital as achieving over 90% compliance in all of the four areas of: cleanliness, food, privacy/dignity and wellbeing, condition/appearance and maintenance.

Medicines

- A ward-based pharmacy team was available from Monday to Friday, 8.30am to 5pm. There was an on-call pharmacist for the trust, out of hours.
- Provision for dispensing emergency medications was available through the patient flow manager and a central record of medicines was stored on each ward. The department was accessible on the trust intranet.
- Pharmacists visited all wards daily to: review medications prescribed, carry out an in-depth assessment and reconciliation for new admissions, coordinate prescriptions for discharge and liaise with community services regarding medications which required ongoing monitoring, such as warfarin.
- An antibiotic team conducted a twice weekly hospital round, carried out antibiotic audits and attended monthly antibiotic meetings and weekly C. difficile multidisciplinary team meetings.
- As a result of identifying dual prescribing of co-amoxiclav and metronidazole through antibiotic audits, the pharmacy team had implemented posters to remind medical staff of the necessity of not prescribing both antibiotics.

- The pharmacy team told us that attendance at multidisciplinary team board rounds allowed for effective planning and had enabled improvements to discharge prescriptions being dispensed in a timely manner.
- Summary of care records were available and facilitated continuity of care between community and hospital allowing for effectiveness of medicine reconciliation.
- Trust-wide data from September 2014 showed that 58% of patients had their medicines reconciled, with 26% seen within 24 hours. The trust target for medicine reconciliation was 90% by April 2015.
- Antibiotic audit data from September to December 2014 showed consistently good compliance with choice of antibiotic and with stop or review dates recorded. Results from December 2014 showed 93% and 98% respectively for these two indicators.
- An audit of controlled drugs was undertaken weekly on all wards. We looked at the storage, recording and administration of controlled drugs on the wards we visited. No concerns were identified.
- We reviewed a sample of medication administration records on each of the wards we visited. Most of the medication had been administered as prescribed. We found that medicines had been administered at appropriate times.

Records

- Nursing staff told us that quality of record keeping was high profile in the trust and matrons and ward managers told us they carried out weekly documentation audits on live records in all wards.
 Where issues were noted, they were addressed immediately on a one-to-one basis with the relevant staff. Common issues were shared with all staff at ward meetings or via safety huddles.
- However, across the service we found examples of patient care records that were not fully completed or kept up to date. We also found that supportive documentation on some wards, such as fluid balance charts and risk assessments were not consistently completed in all cases. We found during the unannounced inspection that care planning was not robust and this was reflected in the ward documentation audits.
- Medical staff on the stroke unit were observed to ask for consent prior to commencing a patient assessment and also before sharing information with relatives.

- We found that most patient records were completed appropriately, although there were some risk assessments such as venous thromboembolism (VTE) risk assessments that were not completed. Pain scores were reliably recorded, as were food and nutrition, falls risk assessments and cannula assessment records.
- We observed a small number of instances of patient information/records being left in unsecured areas. Staff were advised of this at the time of the inspection.

Safeguarding

- Data for the medical care wards showed an average of 87% compliance, with adult safeguarding awareness and 88% compliance with Level 1 children's safeguarding training.
- All clinical staff were expected to undertake Level 2 safeguarding training and the safeguarding team had developed an electronic workbook to facilitate compliance with this requirement.
- Compliance with Level 2 training across the trust was 58% as of December 2014. Actions were in place to improve, such as a new reporting template that allowed the training team to contact members of staff via email to inform them that they were about to lose compliance and needed to book training within the next quarter.
- Staff we spoke with were aware of how to raise a safeguarding concern or alert and knew who to contact if they required advice or guidance. Guidance information was readily available.
- Where medication issues were raised via a safeguarding alert a pharmacist participated in meetings to provide support and take forward any required actions regarding the prescribing and administration of medicines.

Mandatory training

- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning (an electronic learning package on a PC).
- Staff found training easy to access and were given protected time to complete it.
- Managers were alerted when staff training was required.
- Compliance rates with mandatory training for the medical directorate were between 67% for VTE and 98% for medicines management training.

Assessing and responding to patient risk
- Every ward used the early warning score (EWS) system to identify patients whose conditions were deteriorating. At the time of the inspection two wards on the UHND site were piloting the national early warning score (NEWS) system as part of e-observations, but these wards have reverted to using EWS too. Patient observations were recorded appropriately and concerns were escalated in accordance with the guidance.
- Nursing staff reported good responses from medical staff when a patient's condition deteriorated.
- Risks associated with falls, pressure ulcers, VTE and catheter and urinary infections were assessed on a monthly basis using the NHS Safety Thermometer assessment tool.
- During the inspection, we reviewed the care and treatment of patients requiring non-invasive ventilation (NIV). The British Thoracic Society guidelines state that patients being initiated on NIV should be identified as requiring Level 2 care and have increased nurse staffing levels that equate to 1:2 nurse to patient ratio for the first 24 hours. The staffing rotas we viewed did not meet this requirement. We asked staff if nurse staffing levels increased when patients were initiated on NIV and they confirmed that this did not happen. Staff told us that they could request extra staff when necessary and would cohort patients if practical to allow a dedicated nurse for the NIV patients. However, it was not possible to meet the recommended ratio of 1:2. There was no evidence of formal escalation plans to increase staffing levels when patients were on the ward with NIV.
- We carried out an unannounced visit on Wednesday 25 February 2015 at the University Hospital of North Durham. We spoke to a senior member of nursing staff on Ward 1, who informed us that there was no formal competency-based training for staff regarding the administration of NIV. The member of staff did confirm that staff received training for taking capillary blood gas samples. A second member of staff on Ward 1 confirmed that the training for NIV was to be shown by the staff on the ward with no formal competency-based training. • We were told that, when possible, NIV patients would be nursed as a cohort in a single bay to facilitate the provision of a 1:4 ratio. The ward did not have a separate area or dedicated bay for the management of these patients. We were told that, when patients escalated to Level 2, a high dependency or intensive bed was sought. The trust would not mix sexes.

- We reviewed the training programme documentation available, however, there was no evidence to support any detailed competency-based assessment for the initiation and ongoing management of patients requiring NIV.
- We reviewed the British Thoracic Society audit data 2013 for University Hospital of North Durham, which showed that 14 of the 16 patients initiated on NIV (87.5%) failed to respond successfully to treatment. This was compared to treatment given at Darlington Memorial Hospital for which data showed that treatment failed in six out of a total of 20 patients (30%) as compared to the national average of a 29.8% failure rate. We reviewed the paperwork and pathway documents associated with the treatment of patients requiring NIV. Although there was a pathway for NIV used in A&E, ward staff were unaware of this and there was no standardised clinical pathway across the trust. There was a clinical pathway and NIV prescription chart in place at Darlington Memorial Hospital, but this was not used at University Hospital of North Durham.
- Multidisciplinary safety huddles and board rounds took place each morning on all wards. This was observed to be an effective means of discussing patient safety issues, coordinating care and treatment and managing patient flow. The huddle system involved the use of a checklist to ensure all key issues were raised, such as: falls risks, patients needing assisted mealtimes, patients who had a do not attempt cardio-pulmonary resuscitation (DNA CPR) order. Discharge dates were determined and plans for discharge were agreed. Issues that arose during the matron's huddle, such as reasons for discharge delays, were fed back for action. A sense check was taken of staff morale.
- AMU core trainee doctors supported foundation year one (FY1) doctors with their patient workload and complex patients while on their AMU rotation.

Nurse staffing

- The trust was working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe nurse staffing.
- During the inspection week, medical wards were, in the main, observed to have nurse to patient ratios of 1:8, in line with NICE staffing guidance. There were some incidents of 1:9 for day shifts and a higher ratio was noted during night shifts.

- Staff on AMU told us they had a nurse to patient ratio of 1:8, but often shifts were filled with agency staff due to nurse vacancies and recruitment difficulties. We were told that a large proportion of shifts were covered by agency nurses and that, although these staff could provide general nursing care, they were often not trained in technical skills such as cannulation and venepuncture. Shortages of staff were impacting on access to training as it was difficult to be released from the unit. It was also reported that charge nurses/sisters often gave up management time, or came in to work during their time off to carry out stock checks and other organisational tasks.
- Information on planned versus actual staffing numbers was displayed at the entrance to all ward areas. These figures were reported to the trust board monthly and were submitted nationally, in accordance with requirements.
- Additional staffing (above funded establishment) was secured, wherever possible, when one-to-one patient care and cohorting were needed.
- Shortfalls in staffing were covered by substantive staff working additional hours and bank or agency staff. The trust had its own bank of nurse staff.
- Planned and actual staffing levels observed included the ward manager in the ratio unless he/she was having protected management time.
- Ward managers and matrons told us that protected management time was sometimes given up to care for patients when alternative cover was not available.
- Recent appointments of three band 6 sisters on Ward 11 meant that sister grades were able to cover weekend shifts.
- Occasionally, staff needed to be moved from one ward to another to ensure safe staffing. Decisions to move staff were made by the matrons and the senior nurse for patient flow and were based on risk and patients' needs. The matrons continually reassessed risks to patient safety when staff shortfalls occurred, to ensure staff were moved appropriately.
- To maintain safe staffing levels, if ratios fell below a 1:8 nurse patient ratio the matrons and patient flow manager closed beds where possible.
- Additional healthcare assistants were also made available when numbers of registered nurses fell below what was required and could not be filled.

- Following the latest biannual review of nurse staffing levels by the director of nursing using the SNCT, nursing establishment uplifts had been agreed and approved by the board of directors.
- Ward managers told us that staff establishments had recently been reviewed using the SNCT and this meant that most wards would receive an increase in numbers of qualified staff. Ward managers were pleased with the results of the acuity assessment and felt that the assessment tool had reliably estimated required staffing levels. AMU would have enough RN staff to provide a nurse to patient ratio of 1:6 when vacancies were filled. Staff were confident this would provide safe staffing levels for AMU patients.
- In January 2015, four out of the six wards within the medical directorate filled over 90% of the required shifts for both registered nurses and support staff for day and night duty. One of the other two wards had a shortfall of qualified staff on day duty and support staff at night. The other ward was short of support staff through the day.
- The respiratory ward at University Hospital of North Durham had an average fill rate of 92% for registered nurses on day shifts and 94% on night shifts in January 2015. More support staff were used than planned for day and night shifts.
- However, we had concerns that the planned staffing levels for the respiratory ward were not based on accurate dependency levels for patients requiring NIV. Over January 2015 there were 16 patients requiring NIV. Staffing levels had not been calculated based on them requiring Level 2 care. In accordance with the Intensive Care Society core standards for levels of care (2009), these patients required Level 2 care.
- There was no separate unit or area on the ward for patients requiring Level 2 respiratory care. There was no trust guidance or protocol in place to ensure that staffing requirements matched the number of patients requiring Level 2 care who could safely be admitted to the ward. Additional staff were requested on an ad hoc basis, based on individual need.
- The medical wards at University Hospital of North Durham had experienced difficulties in recruitment and supply of registered nurses and the care group had developed a retention strategy which made pledges to improve retention of staff and to make the care group a more positive place to work.

- Staff felt that there was a high turnover of nurses in the AMU and that it was difficult to recruit and retain staff. Nursing staff in the AMU expressed a need for: phlebotomy support, an increase in housekeeping and support staff and a discharge coordinator.
- Information provided by the trust indicated that WTE nursing posts had increased from 59 WTE in January 2014 to 62 in January 2015. The leavers in this period was 3.82 with a turnover of 6%.
- There has been a skill mix review and AMU were in the process of recruiting a Discharge Facilitator, Phlebotomist, medicines management assistant and a house keeper.
- Managers and staff we spoke to told us of the medical directorate's approach to supporting staff development and succession planning for talented staff. Matrons and ward managers were dedicated to protecting time for staff development and training as far as possible and stated that the trust supported this approach.
- We were also told about initiatives to consider a different skills mix of registered and non-registered staff, where the recruitment of registered nurses was particularly difficult.
- Wards 5 and 14 had recently introduced the role of a band 3 discharge facilitator, which had proved very successful and was being rolled out to other wards. Ward 14 had also introduced a band 4 support worker role, due to difficulties in recruiting RNs.
- The stroke unit had developed the role of a band 4 assistant practitioner role. Recent advertising of this post had attracted a high number of skilled and experienced healthcare workers from other sectors.
- A role for a physiotherapy assistant who will be part of the ward team had also been introduced on the elderly medical wards.

Medical staffing

- There was 24-hour consultant cover and junior doctor availability, seven days a week. Out-of-hours cover was provided at weekend and at night. Junior doctors reported good supervision and support from senior doctors and consultants.
- Medical consultants carried out daily ward rounds. The on-call physician carried out ward rounds at weekends.
- The elderly wards used a 'physician of the day' system for on-call and weekend cover and junior doctors flagged patients who needed to be reviewed.

- Medical staff reported good communication and handover of patients and attended daily board rounds as part of the multidisciplinary teamwork activities.
- The AMU had 24-hour medical cover. Three teams, consisting of one consultant, one core trainee and one foundation year 1, covered the unit from 6am until 8pm. Consultant presence on the AMU had been extended to provide cover from 8am to 10pm. All patients were seen on a daily basis by either an acute care physician or the physician of the day.
- Night-time cover was provided by one specialist registrar, a senior staff grade doctor, two foundation year 2 doctors and one foundation year 1 doctor.
- Medical staff on the AMU told us that they felt more medical and nursing staff were needed out of hours. A locum senior house officer had been hired and this had helped alleviate night-time pressures. Junior doctors reported being stretched on AMU and having between 16 and 21 patients to looked after at any one time. Senior medical cover was provided by a physician of the day system. Medical consultants reported that that there were difficulties filling posts at all doctor levels and there was a need for more acute trainees.
- The ambulatory care unit was covered by a specialist GP, Monday to Wednesday, and by registrars from Thursday to Friday.
- There was 24-hour consultant cover, seven days a week for stroke services.
- The County Durham Rapid Early Specialist Team (CREST) service was supported by an elderly care consultant physician, who was available from Monday to Friday.

Allied Health Proffessionals staffing

- The pharmacy team reported staffing pressures limited the level of service they were able to deliver. Not all medical wards had a dedicated pharmacist, but all wards received daily visits from either a pharmacist or pharmacy technician. Dispensary capacity was limited to one pharmacist, which impacted on the speed of issuing discharge prescriptions and may have impacted on patient flow and time spent waiting for discharge.
- Where wards had a dedicated pharmacist, this was felt to be of great benefit to the rest of the ward team and facilitated patient flow.
- On-call cover was limited to one pharmacist across the whole of the trust.

Major incident awareness and training

- The trust had a major incident plan, which provided guidance on the actions to be taken.
- The head of service was HIMSS (an international health information body) trained and had acquired instructor status.
- A business continuity plan was accessible to staff on AMU and medical staff had knowledge of responding to major incidents.

Are medical care services effective?



Policies and guidelines based on National Institute for Health and Care Excellence (NICE) guidance and/or Royal College guidelines were available and easily accessible to staff. The trust participated in national clinical audits. The results from the Sentinel Stroke National Audit Programme (SSNAP) showed a recent improvement. However, there were a number of indicators from other national audits that were below the national average. British Thoracic Society audit data (2013) showed that the rate of successful response to NIV was poor. There was no evidence to support any detailed competency based assessment for nursing staff regarding the initiation and ongoing management of patients requiring NIV.

Any relevant NICE guidance was implemented as it was issued. NICE guidance was discussed at monthly clinical governance meetings and at sisters meetings. NICE implementation was monitored on a monthly basis by the trust-wide quality team, who alerted departments who were non-compliant.

Pain relief and nutrition and hydration needs were met.

Appraisal rates for the medical directorate in January 2015 averaged 73% for all staff. Consultant appraisal rates for the medical directorate in January 2015 were 67% completed or were completed within guidelines.

The medical directorate had widespread multidisciplinary team working and staff reported very good working relationships within the multidisciplinary teams.

Evidence-based care and treatment

- Policies and pathways were based on NICE and Royal College of Physicians guidelines and were available to staff and accessible on the trust intranet site.
- Medical staff on the AMU told us they could reference trust protocols for complex cases when needed and that the provision of additional computers on the unit had improved access as well as improving their ability to manage workflow.
- The medical directorate at University Hospital of North Durham had care plans and pathways for a number of presenting conditions, which included: stroke, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis.
- Audits were undertaken to monitor compliance with guidance, such as those which related to infection prevention and control. Results seen showed good levels of compliance.
- There was a trust-wide nursing quality and clinical strategy 'Quality matters' and 'High Impact Intervention' audit programme for ward sisters to complete. Staff confirmed they had completed audits and we were able to see results and action plans in ward files. Action plans were updated regularly and progress could be seen.
- Staff training files also reflected training initiated and completed as a result of lessons learned from audit.
- Medical staff undertook clinical audits and these were discussed at clinical governance meetings. There was recognition of the need to improve the number of audits that were being undertaken.
- The AMU carried out regular audits to monitor mortality, time that it takes the patient to be seen by the consultant, readmissions, falls recently and pain management. Audit results and action plans were monitored through the departmental meetings noted above. Medical staff told us that all deaths in AMU were reviewed and feedback and any areas for change were received.
- Foundation year 1 (FY1) doctors on the AMU told us there were too busy to undertake quality assurance and audit activity.

Pain relief

- Pain assessments were carried out and recorded.
- Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief could be accessed via medical staff, if required.
- Patients we spoke with had no concerns about how their pain was controlled.

Nutrition and hydration

- Protected meal times were in place and we observed that these were adhered to in most cases.
- Patients were assessed regarding their nutritional needs and care plans were in place.
- Systems, such as the 'red tray' system, were in place to identify patients who needed additional support with eating and drinking.
- We observed patients being supported to eat and drink.
- Drinks were readily available and we saw that drinks were in easy reach of the patients.
- Food and fluid intake were recorded in most cases.

Patient outcomes

- During 2013/2014 County Durham and Darlington NHS Foundation Trust participated in national clinical audits and national confidential enquiries, as well as undertaking a programme of local, clinical and quality audits.
- To improve patient outcomes, acute stroke services for County Durham and Darlington NHS Foundation Trust had been centralised at University Hospital of North Durham. The stroke unit received patients directly from emergency services, A&E and from other local hospitals. University Hospital of North Durham offered full stroke pathway assessment and treatment and had eight hyper acute and 16 subacute beds. Patients accessed step-down/rehabilitation beds at Bishop Auckland Hospital, where they were transferred when the acute phase had passed. The stroke unit had dedicated speech and language therapy, occupational therapy and physiotherapy support, Monday to Friday. Physiotherapy also provided weekend and night-time cover for emergency and urgent treatment. Early supported discharge for stroke patients was also in place.
- County Durham and Darlington NHS Foundation Trust achieved an overall organisational score of D, on a scale of A to E, with E being the worst in the Sentinel Stroke National Audit Programme (SSNAP), 2014. This had improved on the previous rating. An action plan to continue improving the service was in place. Further actions were due to be discussed following the receipt of the latest report.
- The heart failure audit for University Hospital of North Durham did not meet any of the England and Wales averages for clinical practice in England discharge

measures (according to the 2012/2013 audit). In hospital care, indicators exceeded the England average for input from consultant cardiologists, cardiology inpatient and patients receiving an echocardiogram, while input from specialists scored less than the England average.

- The University Hospital of North Durham Myocardial Ischaemia (heart attack) National Audit Project (MINAP) for 2012/2013 showed patients with non-ST segment elevation myocardial infarctions (NSTEMIs) – a heart attack – were seen by a cardiologist or their team in 85% of cases against and England average of 94%. Patients were admitted to a cardiac unit or ward in 46% of cases, against an England average of 53%. Numbers of patients that were referred for angiography was 47.2% against an England average of 73%.
- The University Hospital of North Durham performance in the National Diabetes Inpatient Audit (NaDIA) in September 2013 showed that, on average, the trust performed better than England and Wales in 15 out of 22 indicators. Of the seven indicators that performed below the national average, these predominantly related to staff knowledge and foot disease and risk assessment. No data was available for whether or not patients were involved in their treatment plans or what the percentage for renal replacement therapy was.
- Emergency readmissions to University Hospital of North Durham within 28 days of discharge from medical wards was higher than the England average for elective admissions and lower than the England average for non-elective admissions. Raised readmission rates were mainly in the areas of haematology and gastroenterology.
- The British Thoracic Society audit data for 2013 for the University Hospital of North Durham showed that 14 of the 16 patients initiated on NIV (87.5%) failed to respond successfully to treatment. This was compared to treatment given at Darlington Memorial Hospital for which data showed that treatment failed in six out of a total of 20 patients (30%) as compared to the national average, which had a 29.8% failure rate.

Competent staff

- Appraisal rates for the medical directorate in January 2015 averaged 73% for all staff.
- A report to the board in May 2014, showed that 95% of doctors in the medical directorate completed an appraisal in 2013/2014. Sixty-two recommendations were made by the trust to the General Medical Council

(GMC) in relation to 'revalidation' between 1 April 2013 and 31 March 2014. All recommendations were completed on time. Consultant appraisal rates for the medical directorate in January 2015 were 67% completed, or were within guidelines.

- Medical staff reported that training and academic support was good and they had access to lunchtime teaching sessions three times a week.
- All staff working within elderly medicine had received a dementia awareness pack and had undertaken e-learning.
- Allied Health Professionals (AHPs) told us that new staff were given a shadowing period as part of induction to ensure staff were competent and confident to carry out their duties before undertaking unsupervised practice. It was reported that the trust was supportive of training, but staff needed to travel out of the area to access specialist training.
- Junior pharmacists and junior doctors received good support from senior members of the pharmacy team.
- Practice placement facilitators and preceptorship arrangements were in place to support newly qualified nursing staff. New staff on the AMU felt well supported and inducted. Healthcare assistants we spoke to told us they received good support and training from qualified staff and were encouraged to undertake learning and development activities. The hospital offered healthcare apprenticeships and supported staff to achieve NVQ qualifications. Sponsorship opportunities were available for healthcare assistants wishing to commence nurse training.
- There was no evidence to support any detailed competency based assessment for the initiation and ongoing management of patients requiring NIV.
- During our unannounced visit to University Hospitals of North Durham. We spoke to a senior member of nursing staff on Ward 1 who informed us that there was no formal competency based training for staff regarding the administration of NIV. The member of staff did confirm that staff received training for taking capillary blood gas samples. A second member of staff on Ward 1 confirmed that the training for administering NIV was demonstrated by the staff on the ward and there was no competency based training.
- Sisters and ward managers received updates and training relevant to their role through away days.

- There were good records of training available and certificates of competence were displayed in ward areas.
- Medical staff contributed to the ongoing training and professional development of nursing staff through weekly topic-based sessions in the ward areas.

Multidisciplinary working

- Nursing and medical staff reported good multidisciplinary working and all medical wards participated in multidisciplinary board rounds, which were observed to be an effective means of flagging potential patient issues and updating all staff on management plans. This facilitated a holistic approach to treatment plans and decisions.
- Specialist nurses were available to review patients in some specialties, such as respiratory and diabetes. These specialists were also readily available to support staff groups with support, training and to participate in multidisciplinary meetings to discuss patient care and treatment.
- Staff on the elderly care wards confirmed that there were good links with the mental health team who visited the wards daily if necessary. The team provided the ward with advice and support as well as giving direct intervention to patients.
- AHPs confirmed good multidisciplinary working and also offered training, such as dysphagia training to nursing staff ,where appropriate. Dieticians also undertook daily reviews of those patients highlighted for their input.
- The pharmacy department provided a 'buddy' system for all new junior doctors to give informal support around prescribing, when needed.
- Medical staff on the AMU told us staff on the unit worked well together and multidisciplinary and interdisciplinary relationships were good.
- The AMU had input from specialist nurses, the Integrated Short-term Intervention Service (ISIS), as required, Acute Respiratory Assessment Service (ARAS) a community support team and CREST (an early senior and multidisciplinary assessment for frail older people, which facilitated safe, early supported discharge and managed patients with an anticipated short length of stay. The team also identified and transferred patients requiring longer stays to the appropriate specialist team).

- The AMU also had dedicated occupational therapy and pharmacist support Monday to Friday, 8.30am to 5pm, CREST services were available from 8am to 6pm, seven days per week, supported by an elderly care consultant physician who was available Monday to Friday.
- There was a strong multidisciplinary approach to assessment and facilitated/fast-track discharge.
- Medical staff had good access to specialist support such as radiology and cardiology. The cardiology team usually reviewed AMU patients on a daily basis and this worked well when there was a full complement of staff. However, medical vacancies meant this did not always happen every day. There was not enough capacity on the cardiology ward to take all cardiac patients from AMU.
- There was a dedicated pharmacy post for the unit.
- AHPs told us that referrals were of a good standard with the reason for referral clearly outlined.
- Staff could also access a coordination centre for district nursing and community matron referrals from 8am to 8pm, seven days per week and a single point of access (SPA) for local authority referrals from 8am to 7pm, seven days per week.

Seven day services

- Consultants provided seven day cover for the medical wards and acute assessment unit. On-call consultants covered weekends and nights. Night-time cover was provided by one registrar, two foundation year 2 and two foundation year 1 doctors. There was 24-hour access to computerised tomography (CT) scanning available seven days a week.
- In order to meet the demands for consultant delivered care, senior decision-making and leadership consultant presence on the AMU has been extended to provide cover from 8am to 10pm. All patients were seen on a daily basis by either an acute care physician or the physician of the day.
- The discharge lounge was open from 9am to 7pm, Monday to Friday. Opening hours had been extended to include a Saturday morning for a short-term period.
- An over-labelled cupboard, emergency drug cupboard and on-call pharmacist were accessible out of working hours.
- Physiotherapists covered weekends on a rota system to deliver interventions to identified patients, however, routine rehabilitation was not provided.

 The trust was planning to improve access to other services following a self-assessment using the NHS Improving Quality (NHS IQ) National Seven Day Service Self-Assessment Tool (7DSAT).

Access to information

- Staff reported a prompt response to information and test results.
- Discharge letters were sent to GPs on discharge.
- Training, guidance, policies and procedures could be easily accessed on the staff intranet.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding of consent, mental capacity and best interest decisions and accessed training through an e-learning platform. Compliance with Mental Capacity Act 2005/Deprivation of Liberty Safeguards training was 87.85%.
- Staff had readily accessible guidance and information and knew who to contact for advice and support, if needed.
- Medical staff were observed asking for consent to undertake assessments and to share information.

Are medical care services caring?



Most patients and relatives told us that they or their relatives had been treated with dignity and respect and that staff were caring and compassionate.

NHS Friends and Family Test information showed a lower response rate and lower percentage of patients who would recommend the services than the national average in February 2015. The trust performed around the same as other trusts when it came to relevant questions in the national inpatient survey 2014.

Patients we spoke with were aware of what treatment they were having, understood the reasons for this and had been involved in decision-making. Relatives felt they were listened to and given enough information about their loved one's care.

Patients said they felt supported by all staff and gave positive feedback about clinical nurse specialists, ancillary staff and AHPs, as well as nursing and medical staff.

Compassionate care

- Patients and relatives we spoke to told us that staff were very caring and explained everything well.
- A relative told her that her mother was receiving very good care and commended the team on Ward 14, from the domestics to the consultants, saying that the leadership on the ward was excellent and the care provided was much better than care she had experienced in other areas. She told us that communication was very good, saying: "I was taken aside and everything was explained." The ward might have been short staffed "but they don't allow you to feel it". Relatives said they were listened to and response was immediate.
- An observation of care was carried on Ward 6 in a bay with a cohort of patients who had dementia and were at high risk of falling. The observation was carried out using the short observational framework for inspection (SOFI). There was a dedicated healthcare assistant (HCA) providing care to a group of four patients. The staff member was observed to interact warmly with the patients when performing activities or tasks such as undertaking clinical observations or promoting patient comfort. The HCA was seen to spend time conversing with patients to alleviate anxiety and simply to provide social interaction and alleviate boredom and restlessness. Medical staff were observed to speak to patients warmly and politely and draw curtains to promote privacy and dignity. Interactions with patients were two way and patients were observed happily chatting to the staff. Two of the patients were sleeping for periods during the observation and appeared comfortable and pain free. The HCA intermittently checked on the comfort and condition of the sleeping patients.
- During our visit to the coronary care unit (CCU), a patient suddenly deteriorated. Staff were observed to deal with the emergency situation in a calm, competent, efficient and caring manner. Communication with relatives was observed to be informative, timely and caring. Staff in all areas were observed to be caring and compassionate and interacted with patients in a cheerful and friendly manner.
- Patients told us that visiting times were accommodating and that this was valued and appreciated.
- Latest data for the national NHS Friends and Family Test showed University Hospital of North Durham medical

wards to have an average response rate of 33.5% and 90% of patients would recommend this service to their friends or family if they needed similar care or treatment.

- NHS choices showed six reviews relating to the medical services at University Hospital of North Durham between November 2014 and February 2015. Four out of eight reviewers indicated that they were happy with the care delivered and the compassion and attitude of staff. One reviewer stated that her mother's basic care needs and had not been met and the other reviewer gave mixed feedback.
- The trust performed around the same as other trusts in relevant questions in the national inpatient survey for 2014.
- We spoke with 16 patients and relatives throughout the inspection. Most patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful.
- Staff were observed to address their patients in a friendly, caring and professional manner. We saw patients being treated with respect and dignity and privacy was maintained.

Understanding and involvement of patients and those close to them

- We saw that wards displayed 'You said, we did' posters to show actions taken from NHS Friends and Family Test feedback.
- Wards had quiet rooms where relatives could be taken speak to staff in private, or to use when distressed.
- The trust had set up a "Dragon's den" initiative, which allowed staff to submit ideas that would improve services to their patients and bid for funding to make their ideas happen. Two ward managers in the medical directorate were successful in securing £1,600 to support the development of calendars to be displayed visually in the elderly care wards in both Darlington Memorial Hospital and the University Hospital of North Durham.
- Relatives told us they had received information about their loved one's care and felt listened to. Patients and relatives told us information and explanations were given to them in a way they could understand.

Emotional support

• There were rooms available where relatives could speak to staff or use if they were distressed.

- Ecumenical chaplaincy services were available and easily accessible when requested.
- The elderly care wards were introducing volunteers who would focus on the social and emotional needs of patients with dementia.
- There was a range of clinical nurse specialists at the trust and patients and staff spoke positively about their input. For example, the diabetes and respiratory nurse specialists provided a high level of emotional support and practical advice.
- Staff on the medical wards and acute assessment unit spoke positively about links with mental health services and liaison staff who visited the ward regularly to see patients with mental health needs and give advice to staff on issues such as managing challenging behaviour.



There were processes in place to ensure most patients were cared for in the right place at the right time. Reconfiguration of the services was underway to further develop these pathways.

Referral-to-treatment times (RTT) for the trust had exceeded standards for all specialty groupings, with the exception of gastroenterology, which had achieved 80.6% patients meeting the 18-week wait standard against a target of 90%. RTT has been consistently better than the England average since February 2014.

The trust was better than the England average for national cancer waiting times. Data regarding the number of medical outliers outside of the directorate was collected using bed days. Outliers at University Hospital of North Durham ranged between a maximum of 198 days in August 2014 and a minimum of 150 days in October 2014. Management arrangements were in place to provide appropriate, ongoing care and treatment to outlying patients.

Length of stay at University Hospital of North Durham was better than the England average for elective admissions in the specialty of haematology. General medicine and cardiology showed longer than average length of stays at 5.7 days against an England average of 4.8 and 2.7 days against an England average of 1.8, respectively. General medicine and diabetic medicine showed a shorter length of stay than the England averages for non-elective admissions and cardiology showed a longer average length of stay of 6.1 days against an England average of 5.5, according to Hospital Episode Statistics (HES) for 2013/2014.

Staff worked to meet the needs of individual patients. The elderly care wards had developed practices and the environment to meet the needs of patients living with dementia. However, patient information was not readily available in languages other than English.

Service planning and delivery to meet the needs of local people

- Durham is ranked 62 and Darlington 75 out of 326 local authorities, which means there are high deprivation levels within these areas. Deaths from smoking, early deaths from cancer and from heart disease and stroke are all higher than the England average.
- The services at County Durham and Darlington NHS Foundation Trust are predominantly commissioned by NHS North Durham, Durham Dales, Easington and Sedgefield and Darlington clinical commissioning groups, to meet the needs of the local people.
- Bed occupancy rates suggested that there were a sufficient number of hospital beds available for the population, but the trust had identified that reconfiguration, particularly of the acute medical beds, required further work to meet patient needs. The reconfiguration was in progress and some changes had already been implemented, such as the extension of the ambulatory care unit.
- The ambulatory care unit had been developed alongside the AMU and had capacity for 12 patients. The area was staffed by nurse practitioners and healthcare assistants. Medical cover was provided by a specialist GP from Monday to Wednesday and registrars from Thursday to Friday. The ambulatory care staff worked closely with the AMU and A&E and proactively initiated the transfer of appropriate patients into their area for treatment.
- Planning was ongoing to develop integrated working between orthopaedic and geriatric consultants to improve services and pathways for elderly patients admitted with a fractured neck of femur and develop further integration with community care teams and primary care.

Access and flow

- The trust was better than the England average for national cancer waiting times.
- General medicine achieved 100% against the 18-week RTT target.
- Figures for April to January 2015 showed the trust had consistently achieved their performance targets for national cancer waiting times.
- Bed occupancy over the previous financial year for the trust was 83% or below for general and acute beds.
- Routine/elective admissions and outpatients were admitted directly to the relevant base ward.
- Non-elective/emergency patients were predominantly admitted from the A&E to either the AMU or the ambulatory care area. This was based on established criteria.
- The AMU operated a telephone triage system to establish whether a patient needed to attend the unit or if patient needs could be better met by diverting them elsewhere, for example, to community services.
- AMU admitted patients 24 hours a day and it was intended that the length of stay was a maximum of 48 to 72 hours. Staff in this area reported that, occasionally, patients' length of stay could be up to five or six days. It was reported that, occasionally, patients who required a high level of support were not transferred to wards, due to insufficient staff on the main wards. It was also reported that bottlenecks on wards led to patients remaining in the unit longer than necessary.
- We saw that estimated dates of discharge were planned for most patients on admission to AMU. The discharge management team, CREST, and the ISIS team supported patients and staff with complex discharges from AMU.
- The stroke unit took acute admissions from emergency services, A&E and other local hospitals. The ward also accepted walk on patients who were referred directly from GP to consultant for assessment. Walk on patients were an unpredictable demand on nursing and medical resources.
- Medical patients from other specialties were sometimes boarded on the stroke unit.
- Data regarding the number of medical outliers outside of the directorate was collected using bed days. Between July and October 2014 the number of outliers for the University Hospital of North Durham ranged between a maximum of 198 days over the month of August 2014 and a minimum of 150 days during October 2014.

- A daily list was generated of all patients boarded outside of the medical wards. All patients that were outlying on other wards were reviewed daily by a medical team.
- Access to the James Cook University Hospital tertiary centre for cardiac patients awaiting surgery was reported to be anything from a few days to three weeks, but averaged around 10 to 15 days.
- Data regarding inpatient moves for April to June 2014 and July to October 2014 showed that 66% of patients were not moved to another ward during their hospital stay. Twenty-two percent of patients had one ward move and 12% had two or more ward moves during their stay.
- There was 24hr access to CT scanning with consultant cover for thrombolysis seven days a week.
- Step down from ITU to medical wards was reported to be problem free in the majority of cases and only took place after a senior clinician to clinician discussion.

Discharge and transfer

- Discharge and transfer from University Hospital of North Durham was facilitated by a discharge management team.
- Band 3 discharge facilitators had recently been appointed to some of the medical wards and initial feedback from staff was that effectiveness and timeliness of discharge had improved and workload pressures for other members of staff had also been alleviated to some extent.
- Support for complex discharges was also available from CREST, the ISIS team, community matrons and the local authority.
- The medical ward staff had good links into the community.
- Staff on the medical wards and AMU told us they tried to identify patients for discharge or transfer as early in the day as possible and aimed not to transfer patients later than 10pm. However, it was acknowledged that, occasionally, patients were transferred out during the night.
- We reviewed two sets of notes on Ward 6 and it was observed that the estimated date of discharge had not been recorded in either set and a discharge plan had not been started for one patient who was due to be discharged later in the week.
- Staff told us that they could not always access step-down beds at Bishop Auckland Hospital due to patients there often waiting for re-housing.

- Ward 6 had a full-time pharmacist who was able to ensure that patients had appropriate medications reviews, reconciliations and were assisted with effective, timely discharge as patients rarely had to wait for discharge medications.
- An electronic handover system was being used in AMU. This was observed to be very effective, relevant patient information and department activity level at a glance. For example, it showed how many patients were in the department, how many were waiting for review, patient category, patients with a high EWS and patients who had been reviewed by other services, such as CREST or by another medical specialty. Feedback from staff regarding the system was that it had improved efficiency of handovers and patient safety.
- In December 2014, all new junior medics received dedicated one-to-one support at local induction and were given a flow chart to enable them to successfully complete electronic discharge letters in a timely manner.
- The University Hospital of North Durham had a discharge lounge where some patients were sent from wards to await for transport and or prescriptions. The nurse on the discharge lounge was notified by the wards of patients who were to be discharged that day and then she would coordinate transport and pharmacy requests. The discharge lounge was well used by more than 500 patients a month.
- In the discharge lounge, we spoke with three patients. None had been waiting for longer than an hour. Staff told us that patients often wait a long time for discharge letters or prescriptions.

Meeting people's individual needs

- Recent refurbishments had included changes to make ward areas more dementia friendly. For example, red door frames and toilet seats were visible on the elderly wards.
- Ward staff used red trays to highlight patients who needed assistance with eating and drinking. Staff on Ward 6 told us there were often so many patients needing assistance with meal times that it was difficult to provide this to a good standard.
- Staff in all areas could give examples of when reasonable adjustments had been made to improve the patient experience, such as flexible visiting hours and

family members being involved in meeting patients' care and emotional needs. This was confirmed through feedback from patients and relatives spoken with during the inspection.

- A member of staff on AMU felt that staff needed more awareness of the needs of people with dementia and better provision of specialist dementia advice. A specialist lead nurse for dementia had been appointed, but was not yet in post. We were told that there was a lack of dementia friendly eating utensils and a lack of meal choices. There was good access to one-to-one care for patients on the unit when needed. Visiting times were 11am until 7pm to meet the needs of patients and relatives.
- The environment in the discharge lounge was observed to be in need of refurbishment. There were eight chairs available, but if patients needed a stretcher or bed they needed to wait on Ward 2. The room appeared to be an old clinical room with cupboards around the sides. There was the facility to make hot and cold drinks and snacks were provided at lunch and teatime. There were magazines available for patients, but no current newspapers. There was a television that was turned off and only switched on if patients requested it. There were no curtained/private areas available if a patient felt unwell or needed any aspect of personal care. A patient was observed to be offered a mouthwash in the waiting area where other patients and ambulance drivers were waiting. Patients we talked with in this area said they felt safe and comfortable and that staff were pleasant and caring. Our observations were that staff were caring and friendly, but the environment made it difficult to afford privacy and dignity at times.
- Patients on AMU told us that staff explained things in a way they could understand. A nurse was observed to provide extra support to a patient with breathing difficulties who was extremely frightened.
- Staff were observed providing assistance with feeding on the stroke unit.
- The trust had a dedicated learning disabilities nurse that was available across site and a lead nurse for dementia had recently been appointed.
- Translation services were available and staff knew how to access these.
- We noted that information leaflets were available for patients, but these were not readily available in languages other than English.

- We saw examples of additional staff being employed to provide individual care for patients.
- The elderly care wards had developed practices to meet the needs of patients living with dementia. There was recognised good practice in place, such as memory boxes and the 'forget me not scheme'.

Learning from complaints and concerns

- The trust had a Patient Advice and Liaison Service (PALS), which was available to all patients. Information was available to patients on how to make a complaint and how to access PALS.
- Complaints trends were reported and monitored through the quarterly information governance report that was presented to the trust's quality and healthcare governance committee.
- All complaint response letters were prepared by the matron/clinical staff involved in the patient's care. Response letters were sent to a head of service for final sign-off, which meant that senior managers within the care group were cited on all complaints.
- The care group's complaints coordinator analysed complaints and identified themes. In conjunction with the corporate patient safety team, a thematic action plan was developed. This was reported as part of the Integrated Governance Report.
- Matrons and ward managers disseminated learning from complaints monthly through sister and staff meetings. Minutes of these meetings confirmed this.
- Staff we spoke to explained how they would deal with a patient's concerns immediately, as they arose wherever possible and escalate to their ward sister or manager when necessary. Staff were able to signpost patients to the PALS department, where appropriate.
- Staff were able to give examples of complaints that had happened in their area and were aware of the findings from investigations and any actions that were needed.
- Records of complaints and action plans were held in staff information files with audit reports and action plans, which were available on the wards.
- During the inspection, we observed that the theme of staff not introducing themselves was cascaded and actioned from the matrons' performance meeting and that ward managers returned to their areas to promote staff adopting a "Hello my name is..." approach.

Are medical care services well-led?

Good

There had been some recent changes to the leadership of the medical directorate as part of a wider trust restructure. Staff were positive about the leadership and the recent appointments. Managers and senior clinicians had a vision for the future of their services and were aware of the risks and challenges faced by the directorate.

Medical staff informed us they were provided with good senior cover and support.

Staff told us they were well supported by their ward managers and clinical matrons and were encouraged to develop to improve their practice. There was a good culture of learning and staff were supported to undertake additional training, be innovative and try out new ideas. Most staff were clear about the vision and strategy for the service.

Clinical governance meetings were held at directorate and care group levels. There was generally good clinical engagement and attendance.

There were examples of innovation and improvement.

Vision and strategy for this service

- Most staff were clear about the vision and strategy for their service. This was particularly evident in AMU, where the service improvement team were working with the department.
- The pharmacy department had a strategy document for 2012/2015 and was updating this. The department was a pilot site for the development of the Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy Services: Optimising Patient Outcomes from Medicines and had assessed its services against them. There were plans in place to address any identified shortfalls.
- The trust had two major projects ongoing: implementation of chemotherapy care in haematology and also criteria-led discharge.
- The University Hospital of North Durham was also planning further development of integrated pathways, including a better approach to the management of elderly patients who suffer a fractured neck of femur.

Governance, risk management and quality measurement

- Each care group had a governance lead who attended two regular governance meetings: a patient safety and patient experience group attended by care group matrons, lead nurses and a quality and clinical governance meeting, which was attended by consultant leads and heads of service. Any issues were escalated from these meetings to the care group governance meetings. We reviewed notes of meetings and saw there was generally good clinical engagement and attendance.
- Information from the governance meetings was cascaded to staff through: ward meetings, sister's meetings and other department governance meetings.
- A quarterly information governance report was produced, which included a dashboard showing trends and details of incidents, claims, complaints, pressure ulcers, healthcare-associated infections (HCAI), venous thromboembolism (VTE) assessment compliance, falls and sickness absence.
- A risk register was in place for the medical directorate, which included some, but not all, the issues identified during the inspection. The risks associated with the care of the non-invasive ventilated patients were not identified.
- Risks could be identified by any member of staff and were taken to the care group risk management meetings. Progress on risk management was discussed at these meetings and the risk register updated accordingly.
- There were processes in place to share learning and ensure accountability for improvement actions.

Leadership of service

- There had been some recent changes to the leadership of the medical directorate and staff were generally positive about the leadership and the recent appointments.
- Staff reported that the senior management team and the board were visible.
- The service had a clinical director for inpatient medicine and a chief of service for elderly care and stroke services.
- Junior medical staff informed us they were provided with good senior cover and support. There was a named consultant for academic and pastoral support.

- Matrons reported that they had good relationships with the hospital executives.
- At ward-level, there was clear leadership of the services with sister grades available for weekend cover. During 2013, Ward 11 had won the chief executive's team award.
- Ward sisters on the acute medical wards occasionally needed to give up dedicated management time, due to staff shortages. This impacted on their capacity to lead their teams effectively.
- Locally, ward staff stated they were well supported by their managers, who were visible, approachable and provided clear leadership. Sisters and ward managers appreciated that they were able to access the matrons easily if needed and that they walked around the wards on a daily basis.
- Ward managers and matrons took part in a daily huddle, which was attended by a representative from all wards. The aim of the meeting was to take a consistent approach to patient flow, risk management and safe staffing. Matron and managers also reported back at this meeting on their own and their staff's morale. One day a week the meeting also received and monitored performance management information. During the site visit, we observed a matron/performance huddle and saw that this facilitated a good flow of information and feedback between ward managers, matrons and more senior managers. During the meeting, performance data was reviewed and compared to previous weeks. The process meant that problems were identified early and people were identified and made accountable for improvement action.
- The meeting looked at information, including: average length of stay, time of discharge, weekend discharges and discharge delays. Staffing vacancies and staffing levels were reviewed and progress shared, as well as any issues that may have arisen from incidents or complaints, such as staff not always introducing themselves.
- Staff felt that managers communicated well with them and kept them informed about the running of the wards and relevant service changes.
- Staff were encouraged to undertake professional development and received annual appraisals.
- Staff told us they would be confident in raising a concern with their managers and that this would be investigated appropriately.

- Staff knew who they could contact at a senior management level if they had concerns or lack of response from middle managers.
- Staff felt managers were interested in their work and encouraged them to express ideas for service development.
- Staff were actively encouraged to undertake professional development activities.

Culture within the service

- It was evidently a period of change across many of the services we inspected.
- Most staff acknowledged the need for change and medical and nursing staff were positive and enthusiastic about recent changes made to service delivery. Staff could clearly articulate the benefits to patients of service improvements in their area.
- Staff reported that there was a strong culture of learning and improvement and training and development was actively encouraged.
- There was a good ethos of multidisciplinary working and respect for, and value placed on, multi-professional skills and knowledge. There were a number of examples of training and support offered across disciplines.
- The care group had in place a retention strategy, which made a number of pledges to improve retention of staff and to make the care group a more positive place to work.

Public and staff engagement

- The medical wards and departments engaged with patients through methods such as NHS Friends and Family Test, a post-discharge survey and in the way they handled complaints and incidents.
- Managers told us how they had engaged with the public regarding significant developments through public consultation events.
- The wards displayed the NHS Friends and Family Test results on 'You said, we did' boards, so patients and the public could see changes made as a result of their feedback.
- Staff were involved in consultation discussions regarding any proposed changes to services in their area. Staff in AMU told us they were involved in driving improvements and working with the corporate service improvement team.

• Methods had been adopted to promote staff engagement, such as huddles and safety briefings.

Innovation, improvement and sustainability

- There were a number of examples of innovation, improvement and sustainability, such as:
- The electronic handover system in AMU, which had improved the safety and effectiveness of handovers and patient management within the unit.
- The development of an e-patient flow system, which was to be implemented in the near future.
- Work was ongoing to develop integrated working between orthopaedic and geriatric consultants to improve services and pathways for elderly patients admitted with a fractured neck of femur.
- One ward was piloting an innovative e-observations tool using smart phone technology, which could directly alert medics of patients with deteriorating NEWS. Staff had found the system easy to use and effective.
- The pharmacy department had implemented a 'buddy' system for all new junior doctors where a pharmacist was assigned a junior doctor to provide informal support, where necessary. This initiative was commended by the president of the Royal College of Physicians on a recent visit and they asked for additional information, as they felt it was a scheme that could be promoted more widely through the Future Hospital Programme. (The Future Hospital Programme exists to implement the recommendations of the Future Hospital Commission. These recommendations are based on the very best of our hospital services, taking examples of existing innovative and patient-centred services to develop a comprehensive model of care.)
- A tracking system had been implemented for the tracking of prescriptions.
- Projects were underway to implement electronic prescribing and medicines administration across the trust and electronic prescribing (for chemotherapy).
- Skills mix initiatives to develop the role of band 3 discharge coordinators and band 4 practitioners in clinical areas were being put in place to mitigate difficulties in recruiting RNs. A post for a physiotherapy assistant who will be part of the ward team had also been introduced on the elderly medical wards.

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

Information about the service

University Hospital of North Durham provided a range of surgical services for the population of County Durham and the immediate surrounding area and was also servicing the population of the north east of England.

The hospital provided elective and non-elective colorectal surgery, trauma and orthopaedics, plastics and vascular surgery.

During this inspection we visited the following surgical wards: ward 12 (plastics and orthopaedic trauma), ward 13 (vascular and general surgery), ward 15 (elective orthopaedics and plastic surgery) and ward 16 (colorectal and general surgery), as well as the surgical assessment unit and the short stay unit. We visited all theatres and recovery areas on site and observed care being given and surgical procedures being undertaken.

We spoke with 38 patients and relatives and 22 members of staff. We observed care and treatment and looked at care records for 26 people.

Summary of findings

There were effective arrangements in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff told us they were encouraged to report incidents and most received feedback on what had happened as a result. Staffing establishments and skill mix had been reviewed to maintain optimum staffing levels during shifts and effective handovers took place between staff shifts and included daily safety briefings to ensure continuity and safety of care. Care records were completed accurately and clearly and in line with patients' needs.

There were arrangements in place for the effective prevention and control of infection and the management of medicines.

Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Mortality indicators were within expected ranges.

The learning needs of staff and opportunities for professional development were identified. There was effective communication and collaboration between multidisciplinary teams. We observed positive, kind and caring interactions on the wards between staff and patients. All patients we spoke with felt they understood their care options and were given enough information. There were services to ensure patients received appropriate emotional support.

Systems were in place to plan and deliver services to meet the needs of local people, particularly those with dementia, a learning disability or a physical disability. There were also systems in place to capture concerns and complaints raised within the division, review these and take action to improve the experience of patients. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

The trust vision, values and strategy had been communicated to wards and departments and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and there was good ward leadership.

Are surgery services safe?

Surgery services at this hospital were safe. There were effective arrangements in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff were encouraged to report incidents and most received feedback on what had happened as a result.

Good

Staffing establishments and skill mix had been reviewed to maintain optimum staffing levels during shifts. Effective handovers took place between shifts and included daily safety briefings to ensure continuity and safety of care.

There were arrangements in place for the effective prevention and control of infection and the management of medicines.

Care records were completely accurately and clearly and in line with patients' needs.

Incidents

- Staff were familiar with the process for reporting incidents, near misses and accidents using the trust electronic systems.
- Staff said they were encouraged to report incidents and were aware of how to complete appropriate systems.
 Feedback was given to ward managers on reported incidents and outcomes. They confirmed that themes from incidents were discussed at staff meetings and displayed in staff rooms.
- There had been two never events reported at this trust, one of which was recorded as a surgical error. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.) We saw this had been fully investigated, identifying the root causes of the errors, contributory factors, lessons learnt, arrangements for sharing learning and actions needed to stop reoccurrence.
- Within surgery, 11 serious incidents had been reported in the last 12 months. The reporting of serious incidents was lower than the England average for the size of hospital. One of these incidents related to a grade 3 pressure ulcer.

- We saw incidents were discussed at ward and clinic manager meetings from across the trust to promote shared learning.
- Mortality and morbidity meetings were held monthly in all relevant specialties. All relevant staff participated in mortality case note reviews and reflective practice.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Information was clearly displayed on boards on all wards and theatre areas visited.
- Safety thermometer information included information about all new harms, falls with harm, and new pressure ulcers.
- The hospital was performing within expected levels for these measures – the numbers of falls, pressure ulcers and urinary tract infections across the division had all remained low in the 12 months up to July 2014. This was reflected in information displayed within ward areas.
- Care records showed that risk assessments for these were being appropriately completed on admission.

Cleanliness, infection control and hygiene

- All wards and patient areas were clean and we saw staff wash their hands and use hand gel between treating patients. 'Bare below the elbow' policies were complied with.
- Infection control information was displayed in all ward and patient areas.
- Hand hygiene audit results showed very high levels of compliance during 2014.
- All patients undergoing elective surgery were screened for methicillin-resistant Staphylococcus aureus (MRSA), and policies were in place to isolate patients when appropriate in accordance with infection control policies.
- Data did not show any cases of MRSA or Clostridium difficile (C. difficile) for the surgical wards in the previous 12 months. Trust wide data showed the incidences of MRSA remained low, with only four reported in the period March 2013 to September 2014). Cases of C. difficile were consistently lower than the England average in the same period.

- We saw that clinical waste bins were covered and had foot opening controls, and the appropriate signage was used for the disposal of clinical waste. Separate hand washing basins, hand wash and sanitiser was available on the wards, theatres and patient areas.
- Nursing staff had received training in aseptic non-touch techniques. This included the necessary control measures to prevent infections being introduced to susceptible surgical wounds. The division participated in the ongoing surgical site infection audits run by Public Health England. Each case of surgical site infection was identified, discussed at formal meetings and actions identified to avoid a repetition.
- Swab, pack surgical instrument and sharp count audits were completed and identified areas of non-compliance. These were discussed at divisional meetings and actions identified.
- Cleanliness in theatres and recovery areas was observed to be exceptional.
- We saw extensive contact between the primary nurses and consultants during surgery.
- The introduction of a housekeeper role to assist the teams and maintain cleanliness standards had been seen as a success and a review was considering implementing the role in other areas within the hospital.
- Local audits relating to infection control and use of personal protective clothing in theatres and recovery showed full compliance.

Environment and equipment

- We observed checks for emergency equipment, including equipment used for resuscitation.
 Resuscitation equipment in all areas had been checked daily.
- Records showed equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. This included theatre ventilation systems.
- All freestanding equipment in theatres was covered and had been dated when cleaned. Equipment was appropriately checked and cleaned regularly. There was adequate equipment in the wards to ensure safe care.
- The division had developed a 'hybrid theatre' combining scanning and surgical facilities. This improved the availability of scans to support the throughput of patients through theatre.

Medicines

- Medicines were stored correctly including in locked cupboards or fridges where necessary. Fridge temperatures were checked and recorded.
- We observed that the preparation and administration of controlled drugs was subject to a second independent check.
- After administration the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- All wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure patient confidentiality was maintained.
- Records reviewed included pre-assessment, medical notes, consent forms (written in detail and signed/ dated), pre-operative checklists, anaesthetic records, medication charts, discharge checklists and letters, and prescriptions.
- Care pathways were in use including enhanced recovery where appropriate, for example colorectal surgery.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trust's whistleblowing procedures and the action to take including the safeguarding team they could contact for advice and support.
- Information provided by the trust showed 95% of staff requiring training in safeguarding adults and children within the clinical group had completed the training.
- Staff we spoke with were able to describe action they would take if they had any safeguarding concerns.

Mandatory training

- Performance reports within the care group showed staff were up to date with their mandatory training.
- For example 95% of staff had attended health record keeping training, 85% had attended slips, trips and falls training, 87% had attended moving and handling training.

• Staff we spoke with confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training.

Assessing and responding to patient risk

- All wards used an early warning scoring (EWS) system for the management of deteriorating patients.
- There were clear directions for escalation printed on the observation charts and staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.
- Theatre lists were updated in 'real time' to reflect changing priorities and timescales.
- We observed that theatre staff practiced the World Health Organization (WHO) 'Five steps to Safer Surgery' and audits across all specialties showed good compliance results, with the exception of liver biopsy and angioplasty procedures.
- In July 2014, 55% of liver biopsy and angioplasty procedures audited did not have the relevant checklist completed; the trust had identified the reasons for this, introduced a series of detailed actions to improve the level of compliance and committed to undertake a re-audit to confirm that actions introduced had had a positive effect.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool. Work had been undertaken recently by the trust to ensure that staffing establishments reflected the clinical need of patients.
- We reviewed the nurse staffing levels on all theatres and wards visited and found that levels were compliant with the required establishment and skill mix. Overall the trust employed 7% more nurses at band eight and above than establishment, and 8% less staff at band seven and below than establishment (October 2014).
- There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster and clinical needs of patients. Staffing numbers on surgical wards had been adjusted flexibly between registered and unregistered staff to meet the needs of patients and in line with the protocol.

• Bank and agency staff were not used and staff told us they were asked to cover staff shortages. The use of bank and agency staff within surgery and diagnostics was 7.1% (October 2014) against an England average of 6.1%.

Surgical staffing

- Surgical consultants from all specialties were on call for a 24-hour period and arrangements were in place for effective handovers. The general surgical on-call team comprised the general consultant and a consultant vascular surgeon.
- Patients who required unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant, and the hospital published a rota for general surgical emergency provision.
- Consultants were available on call out of hours and would attend when required to see patients at weekends. Medical staffing within the division was made up of 44% at consultant level (England average 40%), 25% registrar level (England average 37%), middle career 16% (England average 11%), and 15% junior doctors (England average 13%).
- Medical staff handovers were comprehensive.

Major incident awareness and training

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



Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to

meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges.

Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams who met regularly to identify patients requiring visits or to discuss any changes to the care of patients.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, Great Britain and Ireland and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients where appropriate and after individual assessment.
- Local policies were written in line with national guidelines and updated every 2 years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.

Pain relief

- Pre-planned pain relief was administered for patients recovering after surgery.
- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool.
- All patients we spoke with reported their pain management needs had been met. The trust had undertaken an audit of post-operative pain relief with patients. This showed that 90% of patients received information about pain relief from their anaesthetist and 84% of patients recalled a visit from the acute pain nurse on how to manage their pain.

Nutrition and hydration

• Patients were screened using the Malnutrition Universal Screening Tool (MUST). Patients at risk of malnutrition were referred to the dietician.

- Audits regarding completion of the Malnutrition Universal Screening Tool (MUST) were completed at ward level and overall demonstrated good levels of compliance.
- Food and fluid intake were recorded where appropriate.
- Records showed that patients were advised about what time they would need to fast from. Fasting times varied depending on when the surgery was planned.
- Patient-led assessments of the care environment (PLACE) audit scored the trust above the England average for food (93, England average 90) in 2014.

Patient outcomes

- There were no Care Quality Commission (CQC) mortality outliers relevant to surgery at this trust. This means that there had been no more deaths than expected for patients undergoing surgery at this hospital.
- Patient reported outcome measures (PROMs) were worse than the England average in seven categories and better than the England average in six categories, including all three knee replacement measures.
- Standardised relative readmission rates for elective surgical patients ran higher than the England average (100) for general surgery (117), plastic surgery (125) and trauma and orthopaedics (113). For non-elective patients, standardised relative readmission rates ran higher than the England average (100) for general surgery (101) and better than the England average for trauma and orthopaedics (94) and plastic surgery (64).
- The trust contributed to all national surgical audits for which it was eligible.
- In the National Bowel Cancer Audit (2013), the trust did better than the England average results for clinical nurse specialist involvement (100%, England average 89%), discussion at multidisciplinary meetings (100%, England average 98%) and scans undertaken (99%, England average 89%); 69 % of patients undergoing major surgery stayed in the hospital for an average of more than five days (higher than the England average of 69%).
- Lung cancer audit results 2012 showed the percentage of patients having surgery was lower than the England average (16%) at 13%. The audit showed results better than the England average for multidisciplinary team discussion (100%, England average 96%) and slightly lower results for scans undertaken before bronchoscopy (89%, England average 89%).
- The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the hospital was

better than the national average in areas such as patients being admitted to an orthopaedic ward within 4 hours (52%, national average 47%), falls assessment (96%, national average 95%), abbreviated mental health test performed (99%, national average 94%) and 30 day follow-up completion rate (46%, national average 39%).

- The hospital was worse than the national average for surgery on the day of or day after admission (68%, national average 72%), senior geriatric review within 72 hours of admission (74%, national average 82%), bone health medication assessment (96%, national average 96%), and the mean length of total trust stay (acute and post-acute) (25 days, national average 20 days).
- The division had introduced initiatives to improve adherence with national targets. Business cases and focus on additional weekend working and the introduction of additional theatre sessions had been designed to reduce backlogs.

Competent staff

- Staff told us that appraisals were undertaken annually and records for 2014 showed that staff across all wards in surgery and theatres had received an appraisal or had an appraisal planned to be completed by end of March 2015. 47% of staff and 61% of consultants within surgery had an up-to-date appraisal (January 2015).
- Although nursing staff said they did not receive clinical supervision or formal one-to one sessions, informal one-to-one meetings did take place.
- Monthly staff meetings were taking place and minutes were available to staff.
- Junior doctors we spoke with told us they attended teaching sessions and participated in clinical audits. They told us they had received ward-based teaching, were supported by the ward team and could approach their seniors if they had concerns.
- Revalidation of doctors' outcomes were assessed and monitored by the Deanery.

Multidisciplinary working

- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists when needed.
- Daily handovers were carried out with members of the multidisciplinary team.

- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision for each ward was planned. .
- Staff explained to us the processes for working with local authority services to ensure effective discharge planning.

Seven-day services

- Daily ward rounds were arranged for all patients and patients were seen on admission at weekends.
- Access to diagnostic services was available 7 days a week, for example, x-rays.
- There was an on-call pharmacist available out of hours. Pharmacy staff were available on site during the week and on-call arrangements were in place.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that all patients had been consented appropriately and this was in line with the trust policy and Department of Health guidelines.
- Staff told us mental capacity assessments were undertaken by the consultant responsible for the patient's care, and deprivation of liberty safeguards were referred to the trust's safeguarding team.
- These were appropriately recorded in patient notes when appropriate.

Are surgery services caring?



We observed positive, kind and caring interactions on the wards between staff and patients. Patients spoke positively about the standard of care they had received.

All patients we spoke with felt they understood their care options and were given enough information about their condition.

At the end of 2014 between 81% and 95% of patients would recommend this service at this hospital in the NHS Friends and Family Test .

Compassionate care

- We observed all patients being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw that patients were spoken with and listened to promptly.
- We observed staff were attentive to the comfort needs of patients. Patients and relatives were positive about the care and treatment they had received.
- We saw doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- Patients told us, "...care was very good...best seen. Culture of best care, driven by matron and sisters who lead by example.", "...kept well informed, nothing but praise for the staff – they are friendly, happy about the treatment and information given". One person said "...I feel very safe here with the nursing staff, they are very caring".
- Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment. We observed patients being kept informed throughout their time in the anaesthetic room and theatres.
- The group's NHS Friends and Family Test (a survey that measures patients' satisfaction with the healthcare they have received) response rate varied from 26% to 69% (averaging 34%) compared to the England average of 31% between April 2013 and July 2014.

- At the end of 2014 between 81% and 95% of patients would recommend this service at this hospital in the NHS Friends and Family Test .
- Numbers of written complaints to the trust had decreased in each of the last 2 years.

Patient understanding and involvement

- All patients said they were made fully aware of the surgery that they were going to have and that it had been fully explained to them. Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the relevant consultant.
- We saw ward managers and matrons were available on the wards for relatives and patients to speak with. Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- The CQC inpatient survey (2013) showed an increase (7.7 from 6.8) in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year.

Emotional support

- Assessments for anxiety and depression were done at the pre-assessment stage and extra emotional support was provided by nursing staff for patients pre- and postoperatively.
- There was information within care plans to highlight whether people had emotional or mental health problems and what support they required.
- Patients were able to access counselling services, psychologists and the mental health team.
- Patients said they felt able to talk to ward staff about any concerns they had either about their care, or in general. Patients did not raise any concerns during our inspection.
- The CQC inpatient survey showed an increase (7.9 from 6.9) in patients believing they had received enough emotional support from hospital staff in 2013, from 2012.

Are surgery services responsive?

Systems were in place to plan and deliver services to meet the needs of local people. Staff were responsive to people's individual needs. Services were available to support patients, particularly those with dementia, a learning disability or a physical disability. There were also systems in place to capture concerns and complaints raised within the division, review these and take action to improve the experience of patients.

There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation and surge policy and procedure to deal with busy times.
- Capacity bed meetings were held to monitor bed availability and review planned discharge data to assess future bed availability.
- During high patient capacity and demand, patients having elective surgery were reviewed in order of priority for cancellation to prevent urgent operations being cancelled.

Access and flow

- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- Trust wide information showed the division was meeting the referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral within ear nose and throat surgery (95%), ophthalmology (92%), plastic surgery (91%), thoracic surgery (100%) and oral surgery (94%).
- RTTs were not met within trauma and orthopaedics (85%), urology (89%) or general surgery (86%). The reasons for these shortfalls had been identified. Recruitment to additional to consultant posts had been undertaken and locum cover had been arranged to reduce backlogs.
- Delays to discharge within the trust were caused mainly by delays in completion of assessment (59%, England average 18%), patient or family choice (12%, England average 14%) and waiting for further NHS non-acute care (11%, England average 21%).

Good

- The average length of stay for elective patients was above the England average for general surgery (4.2 days, England average 3.5 days) and trauma and orthopaedics (4 days, England average 3.5 days).
 Average length of stay for patients having non-elective surgery was the same or below the England average across all specialties.
- Nine patients had their operations cancelled and were not treated within 28 days during 2014; this was lower than the England average.

Meeting people's individual needs

- The service was responsive to the needs of patients with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs.
- We saw suitable information leaflets were available in pictorial and easy-read formats and described what to expect when undergoing surgery and postoperative care. We were told these were available in languages other than English but these were not displayed within ward or surgery areas.
- Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- The trust had in place policies covering the Mental Capacity Act (2005) and deprivation of liberty safeguards. There was access to an independent mental capacity advocate for when best interest decision meetings were required. Training on these had been planned throughout 2014 and 2015 and 89% of staff had completed the training.

Learning from complaints and concerns

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

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

- We saw that complaints and concerns were discussed at monthly staff meetings where training needs and learning was identified as appropriate
- If patients or their relatives needed help or assistance with making a complaint the Independent Complaints Advocacy Services contact details were visible in the wards and throughout the hospital.

Are surgery services well-led?



The trust vision, values and strategy had been communicated to wards and departments and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and there was good ward leadership.

The service recognised the importance of patient and public views and there were mechanisms in place to hear and act on patient feedback. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Vision and strategy for this service

- The trust vision and strategy was well embedded with staff. Staff were able to articulate to us the trust's values and objectives across the surgical wards and they were clearly displayed on ward areas.
- We met with senior managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division.
- During meetings, staff spoken with were able to repeat this vision and discuss its meaning with us during individual interviews.

Governance, risk management and quality measurement

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

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

- Reports identified risks throughout the care group, actions taken to address these risks, and changes in performance. These monitored (among other indicators) MRSA and C. difficile rates, RTTs, pressure ulcer prevalence, complaints, never events, complaints and mortality ratios.
- We saw that action plans for the never event were monitored across the division and subgroups were tasked with implementing elements of action plans where appropriate. The risk register reflected identified risks and demonstrated the progress in addressing them.

Leadership of service

- Staff said divisional managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level. However, some staff told us the governance structure within the group sometimes delayed and made decisions difficult.
- Staff spoke positively about the service they provided for patients and emphasised that quality and patient experience was a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers although we were told one-to-one meetings were informal.
- Medical staff stated that they were supported by their consultants and confirmed they received feedback from governance and action planning meetings.

Culture within the service

- We saw good team working on the wards between staff of different disciplines and grades. At ward and theatre levels we saw staff worked well together and there was respect between specialties and across disciplines.
- Staff were well engaged with the rest of the hospital, reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority and staff were aware of their responsibilities under 'duty of candour'.

Public and staff engagement

- The hospital's NHS Friends and Family Test response rate varied from 26% to 69% (averaging 34%) compared to the England average of 31%, between April 2013 and July 2014.
- NHS staff survey data (2013) showed the trust scored as expected in 19 out of 30 areas and better than expected in nine areas. There were two negative findings: the percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver, and the percentage of staff receiving job-relevant training, learning or development in last 12 months.

Innovation, improvement and sustainability

- There were systems in place to enable learning and improve performance, which included the collection of national data, audit and learning from incidents, complaints and accidents.
- Evidence showed staff were encouraged to focus on improvement and learning. We saw examples of innovation such as the development of the 'hybrid theatre'.

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

Information about the service

The intensive care unit at the University Hospital of North Durham was a 10-bed facility, with nine funded: five level three intensive care beds and four level two intensive care beds. Sixty per cent of the occupancy was at level two with the remaining 40% being level three patients.

Level two beds were for patients requiring more detailed observation or intervention including support for a single failing organ system or postoperative care and those 'stepping down' from higher levels of care. Level three beds were for patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level included all complex patients requiring support for multi-organ failure

Patients were admitted to the intensive care unit (ICU) from the emergency department, operating theatres and wards within the hospital. The majority of these patients were patients having elective and non-elective surgery.

As part of our inspection we spoke with 20 staff, six patients and five relatives. We spoke with a range of staff including nursing staff, junior and senior medical doctors, physiotherapists, dieticians, a pharmacist, domestic staff and managers. We sought feedback from staff and patients at our focus groups and listening events.

Summary of findings

Overall the services within critical care were good. However, some aspects of safety required improvement. The intensive care unit did not have an outreach team to identify and monitor deteriorating patients. The purpose of this service would be to assess the critically ill or deteriorating patient on wards and to stabilise the patient at ward level and so avoid the need to escalate to the unit. There was no clinical pharmacist input to the daily multidisciplinary ward rounds. This was not in line with the national Core Standards for Intensive Care Units 2013. The unit had just started to have its own mortality and morbidity meetings, which were still to be further embedded. Medical and nursing staffing levels were adequate, but there was no supernumerary sister or charge nurse to cover areas such as peak activity times, facilitating admissions and discharges, or coordinating nurse staffing on the unit.

Patients received treatment and care according to national guidelines and the unit used an audit programme to check whether practice was up to date and based on sound evidence. The unit was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the unit. However, the full multidisciplinary team did not attend the ward rounds.

Staff cared for patients in a compassionate manner with dignity and respect. Relatives we spoke with told us

their loved ones had all their care needs met by dedicated staff. Relatives told us they were involved with their loved ones' care and felt supported in making decisions as a family.

Bed occupancy within the unit was 92%, which enabled it to plan admissions and accept emergencies. The unit experienced some delay in discharges, often due to the lack of available beds on a ward and due to delays in determining what the parent team was when patients were admitted via the emergency department; this also caused delays in discharges to a ward.

Staff felt well supported within an open, positive culture. Historically, intensive care was covered by anaesthetists who were part of a wider anaesthetic group, before, some years ago, becoming part of the Surgical directorate. The unit has now moved to become its own team with its own reporting and governance processes. The governance processes still need time to become embedded, with medical and nursing leadership within the unit needing further development.

Are critical care services safe?

Requires improvement

Some aspects of safety required improvement. The intensive care unit did not have an outreach team to identify and monitor the deteriorating patient. The purpose of the service was to assess critically ill or deteriorating patients on wards and to stabilise them at ward level and so avoid the need to escalate to the unit. There was no clinical pharmacist input to the daily multidisciplinary ward rounds. This was not in line with the national Core Standards for Intensive Care Units 2013. The unit had just started to have its own mortality and morbidity meetings, which were still to be further embedded. Medical and nursing staffing levels were adequate, but there was no supernumerary sister or charge nurse to cover areas such as peak activity times, facilitating admissions and discharges and coordinating nurse staffing on the unit.

The environment was clean and staff followed infection control procedures. The NHS Safety Thermometer was used and monitored to ensure a high level of practice was maintained.

Incidents

- Staff we spoke with could articulate the process for reporting incidents. A number of staff who had experienced an incident had received feedback. Monthly meetings were held where incidents were discussed. All incidents were cascaded and documented through daily staff handovers.
- There were 31 incidents reported during 2014. Of these, 16 caused no harm to patients, 11 caused minor harm and one patient experienced moderate harm. There were three near misses reported.
- On reviewing the incidents there were three unobserved patient falls in the past 6 months. The matron reported that the reason these were unobserved was because they were patients who could have been cared for on a general ward and were therefore more mobile. The reports and action plans on the incidents were not available to view at the time of the inspection.
- The unit had a mortality review group which staff described as being 'in flux'. A review of mortality was

discussed at the unit's monthly clinical governance meetings but staff were unsure of its direction at present. A form was being developed to document discussions of the mortality reviews.

Safety thermometer

- The NHS Safety Thermometer was in use and was being monitored and displayed for patients and relatives to view in the reception area. The NHS Safety Thermometer is a monthly snapshot audit of avoidable harms such as pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls.
- We found the unit had had no methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. difficile) cases.

Cleanliness, infection control and hygiene

- Hand hygiene audits were regularly carried out, with the last audit showing 100% compliance.
- Cleaning logs were available, which were regularly audited and demonstrated compliance with the schedule. However, there was no record of when the bedside curtains were last changed.
- We observed staff adhering to infection control policies, and saw them use personal protective equipment such as gloves and aprons. The 'bare arms below the elbow' policy was adhered to.
- There were arrangements in place for the safe disposal of sharps and contaminated items. Dates that the sharps box had begun were clearly marked.
- A rapid response team was available to decontaminate cubicles when needed.
- The unit used antibacterial keyboards on the computers, which were on wheels.

Environment and equipment

- The unit purchased the same equipment as the Darlington Memorial Hospital so that if staff worked in either of the units they would be familiar with the equipment.
- We found equipment to be clean and fit for purpose, although some equipment wasn't labelled as clean.
- We observed cardiac arrest and airway trolleys, transfer bags and emergency drug packs were clean and checked daily.

• We did not observe staff carrying out equipment safety checks at each shift handover. Nor did we see these were recorded on the patient's care plan.

Medicines

- The unit did not have a dedicated clinical pharmacist as part of it multidisciplinary, nor was there a clinical pharmacist on the daily ward rounds. This was not in line with national Core Standards for Intensive Care Units 2013 which states that there should be at least 0.1 WTE specialist clinical pharmacist for each level 3 bed and for every level two level 2 beds.
- Although the pharmacy department produced regular medication incident reports for the unit, there were no medication errors reported from July 2014 to January 2015. The pharmacy department was reviewing how clinical pharmacists could support the unit via electronic prescribing and prioritising patients who have complex medication regimes. This was not imminent and the lack of pharmacy support still posed a risk to patients.
- Fridge temperatures were monitored daily and controlled drugs were secured safely.

Records

- The unit used standardised medical and nursing documents for admissions and daily reviews. These documents included prompts for key findings such sedation scores and key observations.
- Documentation was kept at the patient's bedside and observations were recorded clearly.
- There was a pressure sore screening tool, which included timely assessment and review dates, risk assessments and VTE assessments. These were all complete, but were not individualised.
- There was evidence of medical assessment taking place, the documentation was thorough and the outcome of ward rounds was documented with clear plans and evaluation.
- There was evidence of microbiology input into the notes daily.

Safeguarding

- Staff confirmed they had received safeguarding awareness training as part of their mandatory training and updates.
- Staff we spoke with told us how they would make a safeguarding referral.

• Attendance rates for safeguarding adults awareness and safeguarding children level 1 training were 89%

Mandatory training

- Attendance at mandatory training ranged between 89% and 91% for training such as record keeping, moving and handling, hand hygiene, fire training, Mental Capacity Act assessments, medicines management, slips, trips and falls and safeguarding children training.
- There had been no violence and aggression training for staff on the unit; this meant that staff may not be up to date with legislation relating to caring for patients who may aggressive or violent.
- The unit had action plans for full compliance with mandatory training
- For new staff mandatory training would be included in their 3-month induction.

Assessing and responding to patient risk

- The unit did not have an outreach service to identify and monitor deteriorating patients. The purpose of the outreach service would be to assess the critically ill or deteriorating patient on wards and to stabilise them at ward level and so avoid the need to escalate to the unit.
- Medical staff told us there were no plans to revisit the business case to support developing an outreach service.
- The unit also did not take part in the medical emergency team call outs, which meant that staff on the unit were not aware of deteriorating patients on the wards, nor could they give their expert advice on how to manage deteriorating patients. This had the effect of the unit not being part of escalating concerns before admission to the unit.
- Staff told us they had regular nursing handovers, which enabled them to review patients' scores with another member of staff.
- The bedside handovers we observed did not include checking of infusions. Also, one handover of a level three patient was carried out outside of the cubicle. The nurse noted that the patient needed constant observation but it was clear that this was not happening.
- The staff gave an example where using the National Patient Safety Agency (NPSA) guidelines on nasogastric tube safety led to the introduction of a new more radio-opaque nasogastric tube and nasogastric tube insertion stickers.

Nursing staffing

- There were 57 whole time equivalents (WTE) of nursing staff, four of whom were team assistants and 1 who was a data clerk. There were no vacancies at the time of the inspection.
- Nursing staff worked 7.5 hour shifts with a 2-hour handover mid-afternoon. This gave time for a full handover and also gave staff the time for education sessions.
- There was not always senior (band 6) nurse cover throughout the night shifts.
- Nurse to patient ratios were in line with national guidance: 1:1 for level three patients and 2:1 for level two patients. Staff worked on a rotational basis of days and nights.
- The unit met the Core Standards for Intensive Care Units for nurse staffing levels. There was one senior nurse (band seven). There was a very low use of bank and agency staff, and where agency staff were used these worked at the unit on a regular basis.
- However, there was no supernumerary sister or charge nurse to cover areas such as peak activity times, facilitating admissions and discharges, or coordinating nurse staffing on the unit. This was not in line with national Core Standards for Intensive Care Units 2013.
- The unit was considering increasing the HCA establishment to allow one HCA per four critical care beds, to support the registered nurses.
- We observed a morning handover from the night staff to the day staff. This was quite broad and quite brief. However, the staff undertook individual bedside handovers that were much more comprehensive.

Medical staffing

- Consultants did not work in five-day blocks; this was not in line with Core Standards for Intensive Care Units 2013. Instead, consultants worked blocks of 3 days throughout the week. Both medical and nursing staff stated that there were no problems with continuity of care due to this arrangement.
- There were 10 consultants with 30% anaesthetists and 70% intensive care trained, and a separate consultant on-call rota for intensive care.

- Junior medical staffing was provided by a combination of trainees completing basic intensive care unit training blocks and specialty doctors. However, at the time of our inspection one of the consultants was doing a trainee locum shift to cover the previous night's shift.
- Weekend and evening consultant cover was not sessioned but was included in the on-call arrangements. With the regular weekend ward rounds, the consultants appeared to be doing significantly more weekend hours than they were being paid for, using a model that, though flexible, was not robust.
- There had been an expansion of consultant staff with dual anaesthetic and intensive care medicine over the last 4 years. We were told this had allowed the creation of a dedicated consultant on call for intensive care medicine 24 hours a day, 7 days a week.
- The unit trained anaesthetic and emergency medicine core trainees. We were told all trainees had dedicated educational supervisors and a structured induction which was continually developing to meet their needs.
- The lead consultant had sufficient dedicated time for administrative work which was separate from clinical commitments
- Ward rounds were consultant led and undertaken twice a day.

Major incident awareness and training

- The trust had a major incident plan. Staff could tell us the procedure for if there was a major incident. All staff well aware of the major incident procedures which could be found on the intranet.
- The unit followed the North of England Critical Care Network escalation policy and was developing internal escalation guidelines.



Patients received treatment and care according to national guidelines and the unit used an audit programme to check whether its practice was up to date and based on sound evidence. The unit was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the unit. However, the full multidisciplinary team did not attend the ward rounds.

Evidence-based care and treatment

- The unit had an increasing amount of guidelines for common intensive care conditions. It kept a file for ICU guidelines, but there were no ICU protocols on the intranet as these were being reviewed and some were waiting to be approved by the trust.
- There were no care bundles for ventilator-associated pneumonia or catheter-related bloodstream infection (both these conditions are the most frequent infections attributed to ICUs). However, the ITU care plan for ventilated patients had been written to reflect the ventilator-associated pneumonia bundle and observations were recorded in line with this.
- Teaching sessions were provided regularly for trainees and nursing staff to ensure they were aware of the best evidence in intensive care medicine.
- The unit could demonstrate auditing and improving practice such as the audit of the implementation of therapeutic hypothermia in ICUs, and compliance with NICE 50 guidelines on discharge, which had shown improvements since the unit's last audit.
- The unit had audited compliance against NICE 50 discharge information and delirium guidance and had made changes to paperwork to improve the unit's compliance in these areas. Levels of compliance were good following the changes made.
- The unit had also developed and introduced tracheostomy and laryngectomy documents, which included insertion details and the national displaced airway algorithms.
- The unit also took part in the regional peer review system run by the North of England Critical Care Network.

Pain relief

• The acute pain nurse informed us that both units at this hospital and Darlington Memorial Hospital had recently purchased new patient controlled analgesia (PCA) pumps. **PCA** is a method of pain control that gives patients the power to control their pain.

- Staff had been trained and new protocols had been developed in order to keep staff up to date. The acute pain team also produced a video which could be accessed on the trust intranet which could be used as an aide memoir for staff.
- Patient's pain was assessed but there was no pain score used unless the patient was on a PCA. A generic care plan was used but lacked individualisation.
- Patients on the unit with pain issues were reviewed daily by the acute pain team; this ensured that their pain management was seamless between the unit and the wards.
- During our visit we observed a postoperative patient who had ongoing pain which inhibited and delayed their mobilisation. However, the pain score with a plan for regular review following the administration of pain relief was not documented.

Nutrition and hydration

- All patients had a malnutrition universal screening tool (MUST) assessment on admission to the ICU/HDU. The MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese.
- We saw that nutritional risk scores were updated and recorded appropriately, and completed nutritional assessments and scores audits confirmed this.
- The unit had regular dietetic input for patients.
- All patients unable to take oral intake had appropriate nutritional support such as enteral to ensure adequate nutrition. There was appropriate guidance in place for initiating nutritional support.
- We reviewed the notes of one patient with delirium who had a nasogastric tube in place. The patient had been seen by the dietician 2 days previously, the patient's nutritional needs had been assessed and a daily calorie intake had been recommended. The following day the notes demonstrated that the patient's nutritional needs were not being met. There was no evidence of re-assessment nor was this escalated to the dietician. The next day showed there was no food chart being kept for the day and the nasogastric tube was not in place. This meant that this patient was not receiving adequate nutrition or hydration. This was reported to the staff on duty at the time of our inspection.

Patient outcomes

• We reviewed the data from ICNARC for the unit for 2014.

- The unit's ICNARC standardised mortality ratio (the ratio of observed deaths in a study group compared to expected deaths in the general population) for 2013/14 was approximately 1.1.but had risen to 1.29 over the previous 3 months. A standardised mortality ratio greater than 1 suggests a higher than expected death rate.
- For other ICNARC outcome measures (including ventilated admissions, admissions with severe sepsis, pneumonia, elective surgical and emergency surgical admissions) there were no areas of concern and figures were within expected ranges.
- There were no concerns, from the data, in relation to MRSA and C. difficile infections for the unit.
- ICNARC data were discussed at clinical governance meetings and the unit were about to undertake an audit of coding accuracy to ensure the figures were correct.

Competent staff

- Forty-five per cent of nursing staff and 73% of consultants had an appraisal between January 2014 and January 2015. There were plans in place to increase this number.
- Fifty per cent of nursing staff were registered as critical care nurses and other nursing staff were attending courses to prepare them for further critical care qualifications
- All consultants who covered intensive care on call had a daytime commitment to critical care and had annual appraisals. Junior medical staff had educational supervisors and learning plans.
- All nursing staff new to the unit had an induction and a 3-month mentorship programme during which they were supernumerary and supported by a mentor.
- All staff had clinical supervision; it was expected they would have 12 clinical supervisions per year. Teaching sessions were provided weekly for trainees and nursing staff to ensure that they were aware of the best evidence in intensive care medicine.
- Revalidation for doctors was in progress.

Multidisciplinary working

• Multidisciplinary team briefings were held daily and there were bi-monthly multidisciplinary meetings. There was no pharmacy provision for the unit and no charge

nurse, which limited the unit's ability to have full multidisciplinary representation on all ward rounds. However, the unit did achieve a multidisciplinary handover round at least once a day.

- There was a strong multidisciplinary approach to care throughout the unit. Team ward rounds were well represented. The dietician was not formally part of multidisciplinary working, but felt welcomed and involved in patients' care planning. The dietician was on the unit at least 3 days per week.
- We were told the speech and language therapy services had a relationship with the unit and there was an effective referral pathway in place. The therapist would visit at the first available slot.
- Physiotherapists worked on the unit throughout the day and provided a weekend service. Two physiotherapists worked on the unit until 11am and another would work in the afternoon. If more time was needed the staff on the unit would request more hours for specific patients. The support for each patient would be dependent upon the patient's individual needs.
- Physiotherapists' notes were comprehensive and any actions were documented clearly.
- A consultant microbiologist did daily ward rounds and provided advice over the weekends.

Seven-day services

- There was consultant cover 24 hours a day, 7 days a week on the unit.
- Physiotherapists were available 7 days a week with pharmacy, dietetics and microbiology available Monday to Friday and via an on-call system at weekends.
- The unit had access to CT scanning and there was a protocol pathway in place with two local trusts for access to MRI.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Deprivation of liberty safeguards (DoLS) were assessed daily as part of the morning handover although staff recognised this was a complex area, especially for intensive care units, and so more education was required so staff were kept up to date with deprivation of liberty safeguards complexities.
- Wherever possible patients were asked for their consent to treatment and care. If patients were unconscious staff were able to provide examples of how they would act in the patient's best interest.

- Staff told us they considered all patients for deprivation of liberty safeguards if the patient has no capacity, is subject to 1:1 supervision and is not free to leave the unit.
- The notes also explained how nurses articulated the reason for a DNACPR discussion with relatives.

Are critical care services caring?



Staff cared for patients in a compassionate manner with dignity and respect. Relatives we spoke with told us their loved ones had all their care needs met by dedicated staff.

Staff on the unit were not only passionate about how they cared for their patients but it was evident they were also passionate about how they looked after their patients relatives and significant others.

Relatives told us they were involved with their loved ones' care and felt supported in making decisions as a family.

Compassionate care

- We observed staff on the unit introducing themselves to patients and relatives. They also used a 'getting to know you' form for relatives to fill in so that staff could learn and get to know more about their patients such as interests, pets and hobbies. This meant that staff could talk with their patients about their interests even when sedated or ventilated.
- We observed nursing and medical staff maintaining patients' privacy and dignity, for example curtains were used when carrying out examinations or treatments.
- The unit undertook patient satisfaction surveys, with responses being very positive, such as: "Because my illness turned into a serious matter very quickly I was looked after very well, the nurses always managed to keep me calm as much as possible. I have no complaints at all with the care I received. Thank you." and "I have been amazed by how kind and helpful everyone has been. Even to my family. I was uncertain when I came in but put at ease immediately".
- The unit had a 'Memory box' which was used for relatives when patients died on the unit. There were items such as equipment to take hand and lip prints, flowers and tea lights which could be placed in the quiet room where relatives would sit.

- Staff on the unit were not only passionate about how they cared for their patients but it was evident they were also passionate about how they looked after their patients relatives and significant others. For example; the staff used a poem which was written by a patient in 1990 which made it clear that the staff looked after relatives as well as patients.
- During the inspection we saw cards and thank you letters from patients and relatives for the care they had received on the unit.

Understanding and involvement of patients and those close to them

- We observed staff interacting with patients in a compassionate and informative manner.
- We spoke with patients and relatives who all confirmed that they were involved in decisions about their care.
- In some instances, patients were aware of their medical treatment and we observed staff explaining and supporting patients to understand their plan of care.

Emotional support

- All relatives we spoke with gave positive feedback on being supported through difficult times.
- We were told that all staff gave emotional support where needed and if necessary the chaplaincy service was available 24 hours a day.
- We were told the counselling services were used regularly not just for bereavement purposes but also for staff's personal concerns.
- Information was available in the relatives' room regarding local ICU support groups.

Are critical care services responsive?

The unit was responsive to patients' needs. It had a bed occupancy of 92% which enabled it to plan admissions and accept emergencies.

The unit experienced some delays in discharges often due to the lack of available beds on a ward and due to delays in determining what the parent team was when patients were admitted via the emergency department; this also caused delays in discharges to a ward. Translation services were available to people whose first language was not English. Although there were very few complaints, staff within the unit learnt from these.

Service planning and delivery to meet the needs of local people

• Both units at this hospital and Darlington Memorial Hospital had recently formed a trust wide critical care delivery group (CCDG) to ensure that critical care provision meets the needs of the population. Both units also participated in a regional securing quality in health services (SeQIHS) project along with trusts in the Tees Valley. As part of this group, they were reviewing how critical care was provided and developing a model for critical care to meet the needs of patients in the region.

Access and flow

- We were told the unit regularly had patients on the unit who could have been cared for on a ward. At the time of our inspection there were two patients who could have been cared for on a general ward rather than the unit.
- There were a number of delayed discharges from the unit. Forty-nine per cent of patients being discharged from the unit experienced a delay of at least 1 day. However, delayed admissions were rare events.
- There were no set criteria for admission to the unit which meant that patients could be admitted inappropriately when they could have been cared for on a more general ward. During our visit a patient was admitted to the unit postoperatively due to lack of a ward bed.
- When patients were admitted from a specialty team within the hospital, they did not always receive a daily review from the parent consultant/specialty team. The surgical team reviewed their patients before the morning operating lists but the medical teams did not do this in a timely manner. This approach meant some patients did not always have a seamless transfer from the unit to the ward. There was a need to establish a process to overcome this situation.
- This became more of a problem when a patient was admitted via the emergency department and did not have a parent team to communicate with. This then resulted in a delay in discharge back to a general medical ward as the medical teams did not always agree to take the patient into their care.

- The unit had no delayed admissions to the unit and met its target of 4 hours from the decision to admit to actual admission to the unit. Data showed that only five elective cases were cancelled due to a lack of an intensive care beds during 2014.
- The unit used a discharge proforma with prompts for discharge information recommended by NICE clinical guideline 50. This had been audited, which showed high levels of compliance with the guidance. The unit's ICNARC data demonstrated low numbers of early readmissions to intensive care.
- There were no transfers for non-clinical reasons over the previous 3 months, and only one over the previous year.
- The unit were trying to review patients 48 hours after discharge but this was seen as a tick box exercise. A business case had been developed to support the progress of rehabilitating patients once they have left the unit.

Meeting people's individual needs

- There was access to an interpreting service if needed and patients were asked whether they wanted their relatives to interpret on the patient's behalf.
- Visiting times were limited between 13.00 and 14.00 and 19.00 and 20.00 although we observed a more flexible approach being used when specifically needed.
- DNAR discussions were held with patients daily. For example we discussed with a nurse about the care of a patient who had a terminal illness. The nurse had daily discussions with the patient and the patient dictated the time frames for their care and treatment.

Learning from complaints and concerns

- The unit received very few complaints although staff were aware of how to support patients and relatives in making a complaint. We were told that following an investigation of a complaint an action plan would be developed where appropriate and would be sent to the complainant with a response. A quarterly newsletter called 'Quality vibes' was also developed highlighting examples of lessons learned.
- There was a quarterly 'Lessons learned' report on the trust intranet.
- We did not see any PALs posters on display in the unit to direct patients and relatives if they wanted to raise a concern.

Are critical care services well-led?



The trust had recently identified a designated executive director to take lead responsibility for critical care services and a CCDG had been set up. Staff felt well supported within an open, positive culture. However, the process for governance was still to be embedded.

Vision and strategy for this service

- In September 2014, the trust requested a North of England Critical Care Network appraisal of the ICU services at the University Hospital of North Durham and Darlington Memorial Hospital. As a result, a multidisciplinary CCDG had been established, the trust had recently identified a designated executive director to take lead responsibility for critical care services, and there was an action plan in place to make improvements to the service. A number of actions had already been completed by staff on the unit. The first meeting of the CCDG took place in January 2015
- The vision for the unit was in its infancy as the CCDG had only recently been set up and needed time to become embedded.
- The unit operated its anaesthetic rotas jointly between the operating theatres and the unit, with a separate consultant rota for ICU.
- Staff on the unit were aware of the trust overall strategic direction and understood its values.

Governance, risk management and quality measurement

- The unit had recently started holding monthly multidisciplinary clinical governance meetings and there were medical and nursing leads for clinical governance.
- There was a strategy being developed for critical care across both the University of North Durham Hospital and Darlington Memorial Hospital which included the use of a rehabilitation after critical care (RaCI) programme. This had been passed to the surgical and diagnostics clinical group for consideration and approval.

- The unit had recently started holding monthly multidisciplinary clinical governance meetings and there were medical and nursing leads for clinical governance. The unit was organising an internal audit calendar including key guidelines relating to intensive care such as NICE clinical guideline 50 on discharge information, delirium screening, nasogastric tube documentation and consultant ward rounds.
- There was a risk register for the unit, including controls and assurances to mitigate risk, which was reviewed every 2 months.
- The senior management teams had a good understanding of the risks to the service and could effectively articulate the controls and assurances in place to mitigate these risks.
- We were told the units' mortality and morbidity meetings were in flux and need to be reviewed.

Leadership of service

- There was a clinical lead for intensive care who had time allocated to support this role. Consultants had specific roles including clinical governance, audit lead, trauma link, paediatric link, obstetric link, clinical lead for organ donation, ICNARC lead and microbiology link. There were consultant, senior nurse and multidisciplinary meetings on a bi-monthly basis.
- Leadership from the senior medical and nursing staff was transparent but still needed further development as the team was still in its infancy.
- Staff felt valued and time was spent with junior staff developing and training them as a team.

Culture within the service

- There was an open culture and staff were aware of written guidelines on raising concerns.
- Both medical and nursing staff had recently undertaken insight training. This was an individualised training package to enhance staff skills and competencies within a lifelong learning programme.
- Staff felt supported and spoke to us about the culture being open. Staff felt the unit was small, there were a number of new consultants and team work was good.

Public and staff engagement

- Patient and relative engagement was actively sought on the unit. This was completed both informally and formally through questionnaires, and results were disseminated to staff. Feedback from patients and relatives was very positive, particularly in relation to care and communication.
- The management teams had a number of effective ways of engaging with staff, including formal staff meetings, informal discussions at handover, and by having a strong presence on the unit.
- Information about the units, including details of incidents and minutes of meetings, were all accessible to staff. Information was openly shared and discussed between all levels of staff.

Innovation, improvement and sustainability

- Staff on the unit developed an arterial line dressing which has been adopted in other ICUs regionally and nationally.
- The unit gained second place in an NHS innovations award for improving services on ICUs.

Maternity and gynaecology

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

Information about the service

Since the trust re-organisation in November 2011, the maternity services form part of the care closer to home care group, situated within the families clinical specialty.

The maternity departments offered a range of services to meet the needs of the communities of Derwentside, Durham city and the surrounding villages Bishop Auckland, Darlington, Weardale and Teesdale. In addition to antenatal, intrapartum and postnatal services, there are facilities available to support women in all aspects of motherhood, from ultrasound scanning through breastfeeding and pregnancy loss. Choices for place of delivery included a home birth service or one of two consultant units.

Subspecialty services included a rapid access clinic for gynaecological cancer services, in addition to outreach services including colposcopy, urogynaecology services, infertility services, fertility control, menstrual disorders, foetal medicine and early pregnancy services.

Acute and elective gynaecology is provided at the University Hospital of North Durham. Inpatient care for medical and surgical termination of pregnancy is centralised at Bishop Auckland General Hospital.

We visited the gynaecology ward (ward 9), the antenatal and postnatal ward (ward 10) and the labour ward (ward 8) and theatre. We spoke with six women using the service and 19 staff. We made observations and reviewed treatment and care records for 10 individuals.

Summary of findings

Overall, maternity and gynaecology services at this hospital were good. However, the well led domain required improvement. Medical and midwifery staffing arrangements generally ensured sufficient numbers of skilled and knowledgeable staff were on duty to meet people's individual needs. However, there were 11 occasions during the previous year where maternity sevices were closed to new admissions as a result of excess activity and/or a shortage of Labour Ward and Postnatal beds. There was one occasion when this was due to midwifery staffing issues and patients were diverted to Darlington Memorial Hospital. Staff were aware of the trust's values and expectations. Staff, including trainee doctors and midwives, felt that the service encouraged and supported learning and development. There were effective arrangements in place for reporting adverse events and for learning from these. Consent was sought from patients prior to treatment and care delivery. Patients received consultant-led care, and staff had the support of specialist staff for advice and guidance.

Procedures were in place to continuously monitor patient safety and recommended guidance was followed by staff. Maternity outcomes were monitored and information was communicated through the governance arrangements to the trust board.

The experiences of the care and attention provided by nursing, midwifery staff and doctors were described positively by women using the service. The views of the

Maternity and gynaecology

public and stakeholders were sought in relation to developing services. Staff were encouraged and supported to develop better ways of working and to develop the service.

Senior leaders understood their roles and responsibilities to oversee the standards of service provision. However, within the medical team there were concerns that there was a lack of a joined up approach to the service. Efficiency was compromised by the structure of the care closer to home directorate, with decisions being lost or delayed. The arrangements for managing the service were further affected by issues within specific staff groups, which had not been dealt with proactively.

The care closer to home directorate had not identified a number of actual and potential risks at a service level and therefore did not have sufficient mechanisms in place manage such risks and monitor progress.

The directorate had an apparent direction of focus, defined by strategic aims and an associated vision, although it was unclear as to the time frames for specific work streams

Are maternity and gynaecology services safe?

Good

Medical and midwifery staffing arrangements generally ensured sufficient numbers of skilled and knowledgeable staff were on duty to meet people's individual needs. Incidents were reported within the maternity and gynaecology services and action was taken to understand the cause of serious incidents and learn from the experience to improve the safety of the service. The wards and units were clean and uncluttered. Technical equipment was readily available and had been tested for use. Medicines were stored, managed and administered appropriately.

Processes for safeguarding, assessing and responding to risk were appropriate and there was a system for the escalation of concerns.

The stand-alone midwifery led unit had been closed on safety grounds as the ambulance service could not provide assurances about transfer times.

Staff had access to mandatory training in addition to other safety-related development opportunities.

Incidents

- Clinical and medical staff were fully aware of the reporting process for incidents, near misses and never events. A never event is a situation which arises when safety measures are not followed correctly.
- Staff were aware of a never event that occurred at the Darlington Memorial Hospital. We saw that actions had been taken to reduce the risks of future incidents. This included the provision of small white boards in each labour room to enable staff to record counts of equipment used in procedures. A hook was also attached to this board for the red tie.
- There was a good understanding from staff who spoke with us of the reporting process. For example, a healthcare assistant said although they had not had to report any incidents themselves, they knew about the reporting forms and how to escalate incidents.
- Staff understood the incident investigative processes and confirmed they were involved in learning from such incidents. The risk meetings were cited as a means of sharing the learning, along with ward meetings and newsletters.
- Information provided to us indicated that staff reported 135 maternal/baby related incidents between August and November 2014. Incidents were graded according to impact, such as near miss or moderate harm. We did not identify any particular underlying themes from these to suggest concerns with treatment or care.
- Medical staff said they attended risk meetings and gave an example of learning from an incident related to incorrect syringe used for drawing up insulin.
- We saw 'Key message' notices displayed on wards. These provided information to staff about incidents reviewed.
- Multidisciplinary meetings had taken place, in which risk management issues had been discussed. However, we noted that the incidents listed on the provided spreadsheet seemed to have been entered since August 2014 and it was not clear how they had spread across the year.
- Staff confirmed there were mortality and morbidity meetings every 2 months and we reviewed a number of minuted meetings and the associated reports for these. We saw detailed discussion and actions recorded.
- The quarterly obstetric and gynaecology integrated governance report for October 2014 indicated that there had been a number of maternal/baby incidents reported and investigated for the months of August, September and October. These had resulted in no harm or minor harm, or were recorded as near misses. An example of an incident reviewed was moderate harm following the development of a pulmonary embolism, despite the person having received appropriate prophylaxis.

Safety thermometer

• Each ward area we visited in maternity and gynaecology collected information as part of their safety monitoring. This included the number of incidents related to pressure sores being acquired in hospital, falls and infections. We saw, for example, ward 10 had 100% harm free care in December 2014, with no reported safety incidents.

- There had been one episode of methicillin-resistant Staphylococcus aureus (MRSA) on ward 10. There were no reported incidents of Clostridium difficile during 2014.
- We found the environment in which women were receiving treatment and care was suitably clean. We saw guidance on the frequency of cleaning, including daily and weekly cleaning standards.
- Separate cleaning requirements were in place for clinical staff to follow. We saw, for example, cleaning checks on incubators and we found other equipment to be clean and ready for use.
- We saw domestic staff had been provided with the recommended colour coded cleaning equipment for different areas of the departments. This enabled them to minimise risks arising from cross contamination.
- Environmental checks had been carried out on a monthly basis and results were displayed. For example, the gynaecology ward achieved 94% in December 2014 and ward 10 had an environmental score of 92%.
- Feedback from people using the wards indicated satisfaction with the cleanliness of the wards, bathrooms and toilet facilities. Comments made included "The ward looks clean" and cleaners were around "a lot".
- There were infection control link nurses who were responsible for attending monthly meetings and monitoring standards on the wards. They collected information about urinary catheters, blood cultures and epidural cannulas. Meetings were used as a forum for discussion of infections and any incidents.
- Staff complied with the trust's dress code, which included having bare arms below the elbow to facilitate full hand washing. Staff were seen using personal protective equipment, such as gloves and aprons, and there was a plentiful supply of these in all areas.
- There was good access to hand washing and drying facilities and staff were seen by patients and us to use hand washing facilities and hand sanitiser gel. Hand hygiene monitoring indicated 100% compliance on the labour ward.
- Training information supplied to us indicated 87% of the care closer to home staff had completed a hand wash assessment.
- We observed staff handling and disposing of clinical and household waste correctly and sharps items were disposed of in safety receptacles.

Cleanliness, infection control and hygiene

• We saw staff had access to up to date guidance in the form of infection prevention and control policies. These were accessible on the hospital intranet. In addition to this we saw the desktop image included important information, such as on Ebola awareness.

Environment and equipment

- The gynaecology ward (ward 9) had 12 beds made up of two bays each with four beds and four side rooms. Additionally, there were two emergency assessment beds. Four beds on the ward were assigned for surgical patient use. The ward had recently been reclassified as a Women's Health Ward comprising of surgical and gynaecology beds.
- The labour ward had 10 delivery rooms, each having beds suitable to accommodate bariatric weights. Built in technical equipment was available in each room, such as Resuscitaires, oxygen and suction. There were two bariatric chairs and one wheelchair available.
- There was one operating theatre with a one-bay recovery room immediately accessible on the labour ward itself. Separate areas were available to manage theatre processes, such as a clean preparation room and a dirty utility. Main operating theatres were said to be used 2 days per week.
- Ward 10 was used for antenatal and postnatal care. There were 23 beds, seven side rooms and one room used for isolation.
- The areas in which women were receiving their care were noted to be suitably laid out and afforded privacy. We observed that staff ensured privacy was provided at all times when discussing matters or supporting women with their care.
- There was good access to resuscitation equipment and regular safety checks had been undertaken. Drugs required for resuscitation were available and in date.
- Emergency equipment for pregnancy-related complications was accessible to staff. This included pre-eclampsia (a disorder of pregnancy characterised by high blood pressure and large amounts of protein in the urine) and postpartum haemorrhage kits. Primary postpartum haemorrhage is the most common form of major obstetric haemorrhage.
- Equipment used within the labour ward had been checked to ensure safe use and records were reviewed to confirm this.

- We saw that cardiotocography equipment used for monitoring foetal wellbeing was available. A number of the monitors had telemetry, which enabled greater range of movement and facilitated monitoring while in the birthing pool or bathing.
- Resuscitaires, used to support newborn babies who may need warming or resuscitation after delivery, were available in each delivery room. These were checked daily, with records made to support this.
- An electronic tagging system was in use for babies, and the trust abduction policy gave staff guidance on ensuring the safety of babies.

Medicines

- We reviewed the systems and processes for managing medicines, such as ordering, storage and administration. We found there were systems for overseeing the availability of stock, with checks by the pharmacy on a weekly basis confirmed by staff. Medicines were stored safely, within locked cupboards in secure treatment rooms. Medicines trolleys used for staff to administer prescribed medicines were locked and secured to walls. There was a secure key storage unit on the postnatal ward, which enabled staff to access medicines promptly.
- We saw that controlled drugs were stored correctly and there were processes in place for undertaking routine counts of stock, with signatures to support such checks.
- Staff on ward areas had carried out checks on fridge temperatures used for storing temperature controlled medicines.
- There was access to emergency medicines, such as those used for allergic reactions and treating low blood sugar.
- Staff had access to up-to-date information on medicines. Pharmacy information was supplied in the form of a bulletin.
- There was information about listed medicines which could be given under patient group directives.
- Simple analgesics and antibiotics were available on the wards to supply out of hours take-home medication.
- Training information provided to us indicated that 97% of required staff within the care closer to home directorate had completed medicines management training.
- Drug errors were said by staff to be reported via the incident reporting system and were reviewed under the

normal incident process, but also with the midwifery supervisor. Medication errors were also reviewed within the quarterly obstetric and gynaecology integrated governance meetings.

- Pharmacy support directly to the wards was provided on a weekly basis for review of supplies. There were designated staff with a responsibility for medicines and intravenous fluids.
- Antibiotic stewardship was said to be overseen by pharmacy and the consultant microbiologist. Staff said there was good access to the microbiologists.

Records

- The records we reviewed for women in the maternity areas indicated their individual needs, including options and wishes about delivery. Women's wishes during the delivery were recorded.
- We saw information required to support continuity of care and updated progress notes. We saw that staff recorded all aspects of the delivery including post-delivery skin to skin contact of baby and mother, and time of commencement of post-delivery stitching, where a tear had happened.
- Records had been recorded of medicines given and any post-delivery interventions required.
- Women had their own maternity records, which were brought into the hospital, and these were supported by hospital-based records. Staff also completed an electronic record, which detailed the specifics of the delivery and registered the baby's birth.
- We noted detailed assessment of newborns and any required care was entered in notes.
- The discharge arrangements for women after birth included provision of a 'red book'. This was used to provide a record of the child's health.
- Medical staff said they had half an hour's training on electronic records in their induction. They found the system difficult for finding previous pregnancy details because of items not being scanned correctly. The risk was that aftercare could be affected when important information was not known. Concerns had been fed back and staff said there had been some improvements.
- We reviewed formal audit reports for the completion of treatment and care records at each stage of the woman's journey. For example, we saw the audit for caesarean section records carried out in October 2014. This showed the trust wide audit of documentation had achieved a minimum compliance of 90%, and none of

the required criteria had scored below 50% compliance. The intrapartum documentation conducted in October 2014 showed that 29 of the 40 criteria audited achieved at least 90% compliance, with only two scoring below 50%. These two areas related to absence of stickers in records and stop times not having always been recorded for intravenous syntocinon.

• The medical and nursing records we reviewed for gynaecology patients were detailed and provided information related to their pathway of care. For example, we saw information recorded about the purpose of the individual's admission and pre-operative preparation including discussion around benefits and risks related to surgery and informed consent.

Safeguarding

- The executive nurse director was the accountable officer for safeguarding in the trust. The director of nursing was supported by an associate director of nursing who was the corporate lead for safeguarding and managed the adult safeguarding lead.
- Other members of the safeguarding team, which was managed by the head of children and families, in the care closer to home care group, included: A named doctor, named midwife and specialist midwife for safeguarding children. Staff confirmed their awareness of these arrangements.
- Training information for the care closer to home directorate indicated that safeguarding adults awareness training had been completed by 90% of staff. Safeguarding children level 1 had been completed by 92% of required staff.
- Staff confirmed they had attended safeguarding training and there was a good understanding of identifying and reporting concerns.
- We saw staff were provided with safeguarding children's newsletters, which contained relevant updates on information.
- Matters that resulted in triggering a safeguard report were said to be reviewed weekly on each acute site.
 These were then reviewed for compliance with clinical guidelines and graded for likelihood, harm and severity.
- A monthly safeguard report was said to be generated from these reported incidents to ensure timely monitoring of themes or trends. We saw monthly safeguarding reports within the quarterly obstetric and gynaecology integrated governance reports for quarters two and three.

- Safeguard automated reminders were sent to line managers when incidents had not been actioned or were not been completed within designated time scales.
- We asked staff how they assessed and reported concerns about female genital mutilation (FGM). FGM is defined by the World Health Organization (WHO) as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. A link nurse for FGM explained their role in escalating concerns through safeguarding, and told us staff came to them for advice and guidance.
- Senior clinical staff told us there had been training on FGM the previous year, which raised awareness. Staff were expected to record information in patient records and to fill in an incident report form. However, at the time of our inspection there was no formal process in place for identifying those at risk.
- Since September 2014 it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM is identified in NHS patients, it is now mandatory to record this in the patient's health record. Since September 2014, all acute trusts have been required to provide a monthly report, which is anonymous and does not share personal confidential data. We found there was no system established for reporting to the Department of Health.

Mandatory training

- New employees were required to attend a formal induction, during which essential training was covered so that staff understood their responsibilities and were safe.
- Staff confirmed the required mandatory safety training they had to complete. This included, for example, manual handling, infection prevention and control, fire safety and falls prevention.
- Midwifery staff were required to complete additional mandatory training to other nursing staff, such as breastfeeding, post-partum haemorrhage and potential delivery complications.
- Midwives told us they had additional training related to their role. This included infection control and sepsis, skills drills and scenarios and cardiotocography monitoring.

- We asked to see the training figures for the maternity and gynaecology staff and saw compliance rates of training on health record-keeping (90%), moving and handling (89%), fire safety and prevention (89%).
- Training was discussed in the quarterly obstetric and gynaecology integrated governance report for October 2014, but we did not see any reference to compliance rates for mandatory training or any actions for increasing attendance.

Assessing and responding to patient risk

- We saw in notes that nursing and midwifery staff had carried risk assessments as part of routine practice. Risks assessed included individual's skin condition and risk of tissue damage over bony prominences, manual handling, falls and venous thromboembolism (blood clot). Where interventions were required we saw these were acted upon. For example, thromboprophylaxis had been prescribed where needed or special compression stocking were fitted.
- The early warning score (EWS) tool was used in the maternity department. The recording of observations and completion of the EWS was identified in the Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standard report for January 2014 as an area that required improvement. We saw in the records reviewed that the required monitoring of women's risks had been completed.
- For individuals attending the operating theatre, including gynaecology patients and women who required a caesarean section, we saw safety checks had been carried out. These had taken place prior to undergoing surgery, during and post-surgery. These checks were in accordance with the WHO recommended best practice guidance.
- An audit of compliance with completion of WHO checks had been carried out in December 2014. The results indicated a good level of compliance with all but one aspect of the requirements achieving above 94% and many at 100%.
- Surgical patient records included the use of risk assessments, which required nursing staff to undertake various observational and physical recording of the wellbeing of the person. Where deterioration was identified the staff followed an alert protocol for requesting review by medical staff or urgent attention.

- We noted in our review of cardiotocogram reports that these had been dated, timed and signed by the midwife appropriately. This use of cardiotocogram reports was based on risk. For example, a high risk pregnancy in labour would require continuous monitoring.
- The stand-alone midwifery led unit had been closed on safety grounds as the ambulance service could not provide assurances about transfer times. Although no adverse events had occurred, the decision was made on risk and safety grounds.

Midwifery staffing

- Guidance in respect to staffing levels was described within the maternity services staffing guideline documentation, a copy of which we reviewed.
- Staffing was said to be monitored on a daily basis by the senior midwives, ward managers and lead obstetricians.
 Short-term management of issues with staffing was described in the escalation and staffing policy.
- Each ward displayed the staffing requirements at the entrance along with the actual staff on duty for the day and night shift. Figures included trained staff and healthcare support workers.
- Maternity services should work towards the recommendations on staffing levels within 'Safer childbirth' (Royal College of Obstetricians and Gynaecologists [RCOG] 2007). The trust reported that the midwife to patient ratio was better than the England average. For example, for March and July 2014 the ratio was 1:25 for the trust, against an average of 1:29 for England.
- We saw information that demonstrated ratios varying from 1:23 in August 2014 to 1:28 for September and October 2014.
- We reviewed information supplied to us, which indicated low rates of nursing bank and agency use. Figures for the period of April to October 2014 indicated between 0.6% and 1.5% of gaps were filled by staff from bank or agency.
- The trust published staffing figures and we reviewed these for maternity and gynaecology for December 2014 and January 2015. We saw in December the percentage of midwives on day duty was 97.8% and 98.1% for nights. During January 2015 the figures were 100.5% and 77% respectively.

- Gynaecology registered nurse levels in December 2014 were 97.2% on days and 100.5% on nights. In January 2015 the figures reported were 102.2% and 100.2% respectively.
- Staff turnover in the care closer to home division was reported for nursing and midwifery staff to be 2% between April and June 2014 and 3% from July to October 2014.
- Several staff reported inadequate staffing levels because of sickness and maternity leave. They described having to stay beyond their finish time, not having breaks and that training was cancelled as a result. Despite this they said patient care was good.
- Staff explained how they supported theatre staff in the case of elective caesarean sections. One midwife was said to be supplied from the ward to look after the mother and baby.
- A Band 3 Maternity Care Assistant was on duty each shift, providing enhanced care for babies.
- There was detailed handover of information for each person on the ward. This took place at a formal shift change and included discussion of confidential information in the office and bedside communication of general matters.

Medical staffing

- Medical staffing in the maternity and gynaecology service across the two sites was reported to be similar to the England average, with 34% consultant grade staff (the same as the England average). Middle grade staff that had at least 3 years as a senior house officer or at a higher grade was 5% at the trust and the England average was 7%. Registrar staff formed 55% of the staff, against an England average of 52%. Junior doctors (those in foundation years one or two) made up 6% of staff, with the England's average at 7%.
- There were nine consultants listed as working at this hospital, but at the time of our inspection, sickness absence had resulted in only four senior members of the team taking part in the obstetrics on-call rota and one other was due to return from sickness the following week. Cover for sickness absence was provided through locum usage. This locum provision was usually provided by the permanent consultant staff.

- There was dedicated anaesthetic consultant cover between the hours of 8am and 6pm Monday to Friday. Out of hours the anaesthetist was covered by the on-call team and at night there were two anaesthetists available for the hospital.
- There were staff vacancies at specialist registrar grade. Locums were being used to address any shortfalls. There was a degree of uncertainty expressed that this issue would be resolved in the medium or long term, although there was a short term plan in place by using locums. The impact of staffing gaps was such that training opportunities could not always be accessed and some sessions such as scanning took place infrequently.
- Trainee doctors reported that surgical and anaesthetic consultant support was readily available and their responses were "prompt and supportive".
- A unit delivering more than 3,000 women per annum should have 60 hours of consultant cover on the delivery suite and this was being achieved.
- Handovers took place between medical staff when shifts changed. This provided an opportunity to communicate all relevant information.

Major incident awareness and training

• Staff said that major incidents were communicated by the coordinator on the ward. Elective surgery would be cancelled if necessary. Four hourly updates on bed status were provided to the capacity team, so that there was good oversight.

Are maternity and gynaecology services effective?

Good

Staff had access to and were using evidence-based guidelines to support the delivery of effective treatment and care. Women reported having their pain effectively managed and that there were choices for managing pain. An anaesthetist was on duty to administer epidurals. Support was offered to women feeding babies, and food and drinks were available for mothers at all times.

Patient outcomes were being closely monitored via the maternity dashboard.

Staff were competent in their roles and received performance reviews and supervision. They worked well within the multidisciplinary team to serve the interests of patients.

Evidence-based care and treatment

- We found that the care of women using the maternity services was in line with RCOG guidelines (including 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance on organisation, safe staffing levels, staff roles, and education, training and professional development.
- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet. However, it was reported that guidelines had been removed from the intranet and some staff had difficulties in having them re-instated.
- We were able to see from our review of maternity care records and through discussion with staff that care was being provided in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- The care of women who planned for or needed a caesarean section was seen to be managed in accordance with NICE Quality Standard 32. This included evidence in records reviewed of discussion with the consultant prior to elective caesarean and a debrief after the delivery.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period.
- There were arrangements in place that recognised women and babies with additional care needs and referred them to specialist services. For example, there was an on-site special care baby unit (SCBU).
- The neonatal service was provided on site from a level one SCBU. The unit had 12 cots available to support neonates who had ventilation failure or failure of lung

function. This could be addressed through continuous positive airway pressure and short-term ventilation pending retrieval by the transport service of the Northern Neonatal Network (NNN).

- A neonatal nursing outreach service facilitated early discharge of selected babies from both units.
- Staff followed a care bundle for identifying and managing sepsis, which included provision of antibiotic therapy. Sepsis is a potentially life-threatening complication of an infection. We saw staff reported incidences of sepsis within the safe reporting practices as part of incident management.
- In conjunction with The NHS Litigation Authority Clinical Negligence Scheme for trusts, maternity clinical risk management standards were assessed in January 2014 against five standards. Each standard contained 10 criteria giving a total of 50 criteria. In order to gain compliance at level two the organisation was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard. The organisation scored 49 out of 50 for safety standards such as high risk conditions, postnatal and newborn care and clinical care.
- The risk management operation policy indicated that there was an obstetric audit lead on each site. The clinical governance audit half days and the obstetric and gynaecology clinical governance forum were said to be held together when possible. There was an annual audit calendar in place in line with trust requirements, which focused on clinical priorities. The audits were delegated by the obstetric audit lead and the patient safety and quality midwives.

Pain relief

- One new mother explained to us how they had experienced unresolved pain during their pregnancy and as a result they were admitted for respite care, which helped to a degree. The anaesthetist had been involved in assessing and managing their pain and the situation was said to be improving.
- We saw from our review of medical records and from our discussion with individuals that options were offered for pain relief during caesarean section and other surgical procedures. One person said they had a spinal anaesthetic and monitoring of their pain had taken place throughout their stay. Pain relief was said to have been given when needed.

- Management of pain relief in gynaecology was reported as responsive with no delays for pain relief administration.
- Options for pain relief were also discussed for the management of labour. We saw this included epidural, Entonox gas and controlled drugs such as pethidine.
- Information leaflets were available, for example on instructions for after an epidural/spinal injection.
- A surgical patient said they had struggled with pain control due their inability to swallow. This person said the team had adjusted their pain relief and they had been seen by the anaesthetist.
- Pain scores had been frequently recorded in patient notes that we reviewed on the gynaecology ward.

Nutrition and hydration

- Feedback on the quality and choices of food was positive, such as, "It's OK" and, "food has been good."
- We saw on the gynaecology ward that there was a mealtime coordinator and a nutritional link nurse available to support people and to advise staff.
- Nutritional risk assessments had been used and there was a system in use identifying individuals who required observation or help with meals and drinks. This was a red tray, red jug lid and red tumbler system.
- Dietician involvement had been sought and was recorded in patient notes where an individual had specific problems.
- Health promotion was available from clinical staff in relation to healthy eating and alcohol consumption.
- Special diets and preferences were catered for, such as vegetarian, diabetic or gluten free.
- Women received support and help with feeding their babies as required. We saw there was information available for parents who chose to bottle feed their baby and promotional literature about breastfeeding.

Patient outcomes

- The service was not identified as a risk for maternity outliers, such as maternal readmissions, puerperal sepsis or other puerperal infections. (A puerperal infection, or puerperal sepsis, is a condition that occurs when a woman experiences an infection related to giving birth.)
- Five of the National Neonatal Audit Programme (NNAP) for 2013 indicated that the University Hospital of North Durham scored less than the standard benchmark. This included only 67% of babies having had their

temperature taken within an hour of birth, against a standard of 98–100%. The trust had reviewed the data and established that three babies were eligible for 28+6 weeks temperature within 1 hour after birth criteria. This was not achieved as the baby was being resuscitated. Benchmarking in relation to the proportion of babies

- below 33 plus 0 weeks gestation at birth being given their mother's milk when discharged from hospital was rated as 13% for this location, against a 2012 benchmark of 58%. There was a very slight (1%) difference in percentage of mothers being given a dose of antenatal steroid when they delivered a baby between 24 plus 0 and 34 plus 6 weeks gestation. The fifth area below standard was an 83% score for the documentation of a consultation with parents by a senior member of the neonatal team within 24 hours of admission, which was set at 100%.
- We compared data for the modes of delivery in relation to the trust and that of England. Normal delivery (spontaneous vertex) accounted for 59.9% of deliveries at the trust, slightly less than the England score of 60.4%. Elective caesarean section delivery at the trust was the same as England at 10.8%. Other or emergency caesarean delivery made up 14.3% of deliveries at the trust against the England average of 15%.
- The labour ward (ward 8) presented information on the notice board, which included 61% of deliveries up to the end of December 2014 as normal, the elective caesarean section rate as 12%, emergency caesarean section as 13% and instrumental deliveries as making up 13% of the total.
- Patterns of maternity care were monitored in accordance with the RCOG 11 quality indicators. 10 out of 11 RCOG indicators were within expected range for this trust, with the clinical indicator for third degree tears being above expected range.
- The trust had no post partum hysterectomies reported in 2014.
- There had been 1,618 deliveries at the location for the period April to September 2014.

Competent staff

• There was a nominated maternity lead for coordination of education and training. This person was responsible for monitoring of the training needs analysis for the maternity services in conjunction with the Employment Services Bureau.

- We reviewed information which outlined the training programme for obstetrics covering 2014/15. We saw specific sessions were listed with duration and named speakers. Subjects covered included early recognition of seriously ill pregnant women, antenatal and newborn screening and medicines management.
- New nursing and midwifery staff had a period of 'preceptorship', where they received additional support and went through a programme of competencies. A nurse in the gynaecology area said as they had trained elsewhere they were required to undertake an intravenous medicines competency check.
- Staff who spoke with us explained how they had the opportunity to achieve various competencies. This included suturing, cannulation and phlebotomy (taking blood).
- Issues with regard to any training could be escalated by adding to the risk register. The measurable standard for level of staff training was set out in the trust training policy and maternity training needs analysis.
- In addition to the trust mandatory training, there was a separate maternity services training needs analysis. The dates for all mandatory training were agreed in advance to enable members of the team to book and maintain high compliance with the training requirements.
- We saw from the training programme there were skills drills in subjects such as cord prolapse and breech delivery, shoulder dystocia, eclampsia and obstetric haemorrhage. (Shoulder dystocia occurs when, after delivery of the foetal head, the baby's anterior shoulder gets stuck behind the mother's pubic bone.) We saw too that staff had training in cardiotocogram monitoring.
- For elective and emergency caesarean sections midwives acted as the scrub nurse in theatre. We were told they had been trained and prepared for this, both within midwifery training and through induction.
- Healthcare support workers were required to attend training to support the delivery of maternity services and information we reviewed indicated examples of subjects covered. This included: the care of deteriorating patients and MEOWS, maternal observations, skills drills, breech births, eclampsia and neonatal life support.
- Medical staff said there was a good education programme across both hospital sites. We were told the

experience gained was good and there were "good opportunities." Other medical staff said it was a good supportive environment for obstetric and gynaecology trainees.

- Staff working in both maternity and gynaecology confirmed they had an annual performance review or that they were expecting to have one in the immediate future. Training and development needs were identified in these meetings.
- We reviewed information which indicated that out of 26 medical personnel, six were behind on having their annual appraisal. We could not be clear if this related to the location or across the trust.
- We were advised that revalidation, which is part of the appraisal, was up to date.
- Separate to their appraisal, midwives said they had access to and support from a midwifery supervisor, of which there were 10 on site (with one on maternity leave). The delivery of midwifery supervision was in line with the required standards. The supervisor ratio was usually 1:15 but at the time it was 1:16. The role of the supervisor was said to include a review of practice alongside management matters. Supervision was described as being "Strong here, does what it is meant to do".
- The Local Supervising Authority had a statutory role and responsibility to deliver the standards for effective statutory supervision of midwifery set by the National Midwifery Council. The Local Supervising Authority midwifery officer monitored the standards through national, regional and local quality assurance processes.
- We reviewed the Formal Local Supervising Authority Audit Report 2013/14 for County Durham and Darlington Foundation NHS Trust. We saw a number of recommendations were made from the audit review and an action plan was to be produced for consideration.
- The trust reported that they had a specialist midwife for safeguarding, a patient safety and quality midwife, a research midwife and a diabetes specialist. There was access to other specialist nurses such as tissue viability nurses.

Multidisciplinary working

- There was cross-site working within the leadership team for maternity and gynaecology. Multidisciplinary meetings took place in relation to gynaecology cancer patients.
- There were arrangements in place for the redirection of women using the maternity service between sites when required.
- Staff confirmed they were able to access advice and guidance from specialist nurses/midwives and other allied health professionals. This included infant feeding coordinators, an antenatal screening midwife and ultrasonographers.
- The health visitors and the community midwife team worked together to identify and report potential risks to hospital staff. Any risks were notified via health visitors and community midwives held the pathway in respect to vulnerability or learning disabilities. Staff said that information was shared through a concerns form and a red flag alert was added to the Maternity Information System.
- We saw there were effective arrangements in place for communication with the community maternity team. This included the completion of information in each expectant mother's personal records, and the postnatal care pathway being sent to the community team at discharge. Staff confirmed these arrangements and told us community midwives were given information on delivery and immediate post-delivery care.
- Communication with GPs during antenatal care and around discharge was seen in women's hand-held records.
- Staff confirmed there were systems in place to request support from other specialties, such as physicians, consultant microbiologists or pharmacy.
- The obstetric staff were very positive about the calibre and experience of the senior midwifery staff and felt it provided a very good safety structure in the department. There was clear evidence of good collaborative clinical team working at senior level.

Seven-day services

- Consultant obstetrician cover was provided 7 days a week, either rostered day duty on site or via on-call arrangements. Anaesthetic consultant cover was provided between 8am and 6pm Monday to Friday and out of hours cover was provided by the on-call team.
- Paediatric support was provided by a resident paediatrician with access to an on-call consultant.

- No elective obstetric work was undertaken at weekends, with the exception of inductions of labour booked to take place over the weekend (admitted Sunday for induction Monday). These tend to be women who have been on the low risk pathway and are post-term. However, because they are being induced, they are part of the elective obstetric work.
- There was access to out-of-hours pharmacy support, physiotherapy and other specialists through on-call arrangements.

Access to information

- Patients using the gynaecology service said they had been given good explanations from staff. We saw patient information leaflets on gynaecology procedures such as colposcopy.
- An example of information was explained to us by one new mother. They had had an emergency lower segment caesarean section. The reasons for this had been fully explained and they understood the information provided. Following the delivery she had been given the opportunity to discuss things further.
- People who used the women's and maternity services had access to a range of informative literature. We saw examples on display, such as skin to skin contact, whooping cough in pregnancy and smoking cessation.
 We saw information about local birth and baby information groups (BABi). Leaflets were available on caesarean section.
- Website information available included a publication by the trust: 'Choosing where to have your baby'.
- Maternity care assistants had a particular role in supporting the provision of information to new mothers and their partners. This included health promotion, such as breastfeeding, nutrition and exercise. In addition they addressed smoking cessation.
- BABi group meetings were held across the region. These provided an opportunity to discuss maternity services and other matters, for example breastfeeding.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- With respect to informed consent we noted information was displayed informing women about the teaching of medical students and the option they had to decline participation.
- Women confirmed they had consented to examinations and tests as required.

- Staff described how they provided information to women receiving pregnancy care about matters such as intimate examinations. This enabled them to obtain informed verbal consent.
- Where women were to have a surgical procedure, including elective or emergency caesarean section or gynaecological operative procedures, these could not proceed without the required completed formal consent records. We saw consent forms in the notes and saw, for example, detailed information about risks and benefits of surgery having been discussed.
- Staff explained how they ensured patients had properly understood a proposed procedure after it was explained by the doctor. They provided further opportunity to ask questions. They also said that in addition to verbal consent they acted as a chaperone for examinations.
- Junior medical staff were not required to get consent for procedures they were not competent to perform.
- Staff were able to describe how they supported individuals with learning disabilities or who lacked capacity. This included involving carers, next of kin or advocates where decisions about treatment or care was required.
- We saw in the obstetrics and gynaecology integrated governance report for October 2014 that an update on the Mental Capacity Act and deprivation of liberty safeguards was provided as a result of learning from a previous incident. This included discussion around resources and classification of incidents and the implications of patients making a decision which was not deemed by clinical staff to be in the patient's best interests.
- Within the gynaecology services all women admitted over the age of 65 years of age were assessed in respect to cognition, which helped to identify anyone with impairment, such as those with dementia.

Are maternity and gynaecology services caring?



Good

reported receiving detailed information, of being involved and enabled to make informed decisions. Choices and decisions were respected by staff and explanations for alternative options were discussed where needed.

We observed the ward areas to be calm and organised and saw and heard that women receiving treatment and care were treated respectfully and with dignity.

Arrangements were in place to ensure women received appropriate emotional support and that their partners were involved.

Compassionate care

- Women using the maternity service spoke with us about their experiences. One new mother had used the community and hospital midwifery service on a number of occasions and reported positively on the experience. They said there had been good continuity of care in the community. Once in labour they had been supported fully by the midwife and staff were "friendly."
- Another new mother said midwives introduced themselves and they were generally nice, as were the doctors. They did say the consultant was not very easy to talk to.
- We were told by one new mother that their care in the hospital had been consultant led and they were happy and had been kept informed. This person told us they had one-to-one care while in labour and they felt "safe and in control."
- A patient who spoke with us on the gynaecology ward reported they had come in as an emergency the previous day and they were "pleased with the care so far". Staff were described as happy and attentive.
- Another surgical patient said she liked the nurses and they were always attentive if she needed them. This patient said she felt bad "bothering" staff, who she could see were busy and she felt there were not enough staff.
- One patient reported to us they had not had the opportunity to take a bath or shower. When we spoke to staff about this they considered this person to be self-caring in this regard, so were unsure why this may have happened.
- We saw that staff were responsive to the needs of women using the service. Staff were organised and attended to their duties in a calm and friendly manner.
- On ward 10 we saw feedback from the dignity campaign displayed. Staff were also able to describe how they ensured people were treated with dignity and respect.

- Six of the Friends and Family Test results were better than the England average. This included three elements about staff care during labour and birth and the care in hospital after birth.
- Friends and Family Test feedback for December 2014 was displayed on the postnatal ward. Of the responses, 63 indicated they were extremely likely to recommend the service, 12 as likely and one who didn't know. There had been 317 compliments between April and December 2014.
- The Care Quality Commission (CQC) survey of women's experiences of maternity services for 2013 indicated that the trust performed better than others for six of the questions asked. The remaining responses indicated the trust as being about the same as other trusts.

Understanding and involvement of patients and those close to them

- One woman told us their partner had been involved in decisions around planning for the birth.
- A new mother explained how they had a named midwife in the community and there had been good continuity.
 Full explanations of tests and the antenatal pathway had been given. Other comments made by women included having been given "good explanations of events when in labour."
- A gynaecology patient explained how a number of staff had been to see them and although there had been a delay in having their surgery, they had been fully informed of the reasons for this.
- Care plans and treatment were said by another patient to have been discussed with them. This patient was aware of the need for an investigation before going home but their discharge had been delayed by 3 days while awaiting the required diagnostics.

Emotional support

- The trust reported that they had a specialist midwife for safeguarding, a patient safety and quality midwife for the location, and a research midwife and diabetes specialist.
- We saw from the notes that staff included information about previous or existing anxiety and depression.
- Midwifery staff confirmed they could arrange access to an experienced midwifery counsellor for anyone needing support. Nursing staff leading the fertility control service also had a role to provide counselling to women using the service.

Are maternity and gynaecology services responsive?



Patient flow through the maternity unit enabled women to access the service at each stage of their pregnancy with ease. The individual care needs of patients and women at each stage of their pregnancy were fully considered by staff and acted on as far as possible. However, The maternity unit had been closed on 11 occasions in the period 1 January to 30 November 2014. The sites diverted work to each other at times when the unit was required to close.

Gynaecology patients had access to services and appropriate expertise. However, the availability of gynaecology beds was sometimes limited by medical patients being admitted to the gynaecology ward.

There were arrangements in place to support people with physical and learning disabilities. Translation services were available and information in alternative languages could be provided on request.

The complaints process was understood by staff, and patients were supported to raise concerns or discuss their worries. Where complaints were raised, these were investigated and responded to and lessons learned were shared with staff.

Service planning and delivery to meet the needs of local people

- A consultant obstetrician and gynaecologist said there was a 3–5 year vision across the trust. The strategy for the service was combined for both sites and was said to include moving diagnostic gynaecology services and treatments to outpatient departments and focusing on outpatient-based services. There was a focus on strengthening early pregnancy assessment and the gynaecology services. These were said to be working well on both sites.
- BABi groups held in the local community were attended by midwifery supervisors. This enabled them to be responsive to local needs.

• There was a referral process in place for gynaecology patients for elective procedures. Emergency admissions were accepted through direct referral or via urgent care.

- Staff said the gynaecology ward was not used for medical outliers. However, we found this not to be the case, as there were a number of medical patients on the ward at the time. Staff described the assessment area on the gynaecology ward as being "brilliant", as it stopped unnecessary admissions and reduced women's anxiety.
- The availability of scans out of hours and access to theatres further enhanced the service. Staff reported that there was open access for women who were bleeding in their pregnancy.
- The fertility control service was accessible to women using the location. The service was said to be led by a stable workforce of Gynaecology Nurses. Clear guidelines were in place to ensure women had access to the service. Staff confirmed that pregnancy terminations occasionally took place but only up to 16 weeks gestation and where there was a foetal abnormality or particular medical problem requiring the mother to be looked after more safely as an inpatient. All other terminations were undertaken at the community setting of Bishop Auckland.
- The maternity service consistently met the 90% target of maternity bookings before 12 completed week's gestation. Overnight bed occupancy for 2013 and the first quarter of 2014 was better than the England average, ranging between 45.5% and 49.5%.
- At the time of our visit the trust was not collecting data on the percentage of women during labour being seen by a midwife within 30 minutes and by a consultant within 60 minutes.
- The CQC's survey of women's experiences of maternity services for 2013 received information related to access and flow. The question 'If you used the call bell how long did it usually take before you got the help you needed?' scored 8.6, against an England average of 8.
- The maternity unit had been closed a relatively high number of occasions in the period 1 January to 30 November 2014 (11 times). The sites largely diverted work to each other at times when the unit was required to close.

Meeting people's individual needs

Access and flow

- There were arrangements in place to support individuals with complex needs, with access to clinical specialists and medical expertise. The trust advised that it had a lead nurse for learning disabilities and an acute liaison nurse covering. Staff were aware of their accessibility if required.
- Staff reported that they sometimes had individuals with learning difficulties and they recognised these individuals needed extra time and care. Staff said they encouraged family involvement.
- There was access to specialist clinical staff such as tissue viability nurses and breast care nurses so that individual care needs could be addressed.
- Staff confirmed there was a translation service available. We saw there was guidance to support staff through the interpretation and translation policy dated 10 April 2014. Information within this also made reference to using the services of the British Sign Language service.
- There was a designated member of staff to support individuals and their families who suffered bereavement. Facilities and aids were provided to ensure the bereaved parents had time with their baby and could keep mementos such as photographs.
- There were services available for teenage mums.

Learning from complaints and concerns

- Complaints were discussed as part of the governance arrangements and included a formal review in the quarterly obstetric and gynaecology integrated governance report for May to July 2014. We saw six complaints had been raised and investigated for the period April to June 2014.
- We saw in information provided to us that between April and December 2014 there were 28 complaints raised. It was not possible to identify which location these related to.
- The trust advised us the chief executive officer had overall responsibility for the management of complaints across the service. The director of nursing managed the complaints process together with the associate director of nursing. Individual complaints were managed by the corporate patient experience officer team, one of whom was assigned to each care group. Investigating officers provided the response to the complaint, supported by complaint leads.
- The care closer to home directorate had one patient experience officers dedicated to the complaints investigative role.

- Senior clinical managers told us complaints had declined in general but themes were identifiable and included attitudes and behaviour of staff. Where such complaints arose, individual conversations took place with respective staff. This included discussions about expectations. Insight training was said to have been used positively to improve staff communications.
- We saw information displayed on ward notice boards, which indicated the number of compliments and complaints for the month. For example on ward 8 we saw there had been 36 compliments and three complaints in January 2015. There were no themes identified from the latter.
- A listening service was also provided to women and their partners, which they were able to self-refer to. We saw from information recorded that nine such discussion meetings had taken place between July and September 2014 for women who used the University Hospital of North Durham. In each case the reason for referral was recorded. This included, for example, women wanting to know the reasons for a caesarean section and understanding the cause of a traumatic birth. The outcome from the discussion was also evaluated and recorded.

Are maternity and gynaecology services well-led?

Requires improvement

Senior leaders understood their roles and responsibilities to oversee the standards of service provision. However, within the medical team there were concerns that there was a lack of a joined up approach to the service. Efficiency was compromised by the structure of the care closer to home directorate, with decisions being lost or delayed. The arrangements for managing the service were further affected by issues within specific staff groups, which had not been dealt with proactively.

The care closer to home directorate had not identified a number of actual and potential risks at a service level and therefore did not have sufficient mechanisms in place manage such risks and monitor progress.

The directorate had an apparent direction of focus, defined by strategic aims and an associated vision, although it was

unclear as to the time frames for specific work streams. There were governance arrangements in place to monitor, evaluate and report both upwards to the trust board and downwards to all staff.

Nursing and midwifery staff reported positively on the level of engagement with their immediate line managers and medical staff. They reported their areas to be well-led, with open communication channels and a good level of support. However, they did not identify with the senior members of the care closer to home directorate, nor did they feel they provided support or leadership.

The nursing and midwifery team encouraged innovation, learning and continuous improvement. Medical teams worked well across sites on subject-specific projects such as high risk pregnancy but this was largely due to personal interest and motivation, rather than being part of a coherent plan for joint working.

There were opportunities for people using the service, staff and the public to contribute to service improvements.

Vision and strategy for this service

- Discussion with the clinical director for maternity indicated that he thought there was a vision for the service, which was focused on re-organisation of the services. The strategy was to maintain two maternity units within the trust for the foreseeable future, as analysis undertaken by the trust had indicated a centralised service would disadvantage the population. However, there was an awareness of the pressures in maintaining standards, particularly as it was anticipated that there would be increasing demands from other regional areas.
- Plans were said to have been presented to the trust board in relation to restructuring and environmental development of the infrastructure and the senior team were "pushing hard for release of funding from the trust board."
- We asked staff to describe the vision for the service. We were told in relation to gynaecology that the focus was on increasing diagnostics and delivering on the 2-week target from referral to diagnosis. Additionally, the focus was on achieving more consultant presence on the delivery suite and establishing an alongside midwifery service on both sites.
- We reviewed the draft clinical and quality strategy for 2014–16 and saw this outlined work streams aimed at

achieving centres of excellence in gynaecology and pregnancy assessment. We noted there were identified measures of success and milestones, although there were no dates identified for achievement or evaluation.

Governance, risk management and quality measurement

- The obstetrics and gynaecology quarterly clinical governance forum was a multidisciplinary group, representative of the trust wide overarching group that considered patient safety, clinical governance and clinical quality. The group met on a quarterly basis to review activity on the labour ward as well as governance matters. This included clinical obstetric and gynaecological issues and organisational matters.
- The quarterly obstetric and gynaecology integrated governance reports for May to July 2014 and August to October 2014 were reviewed and we saw that these contained information on safety, such as incident and medication incidents, with investigation outcome and action taken to address practice. This included additional supervision and training. We saw the risk register was reviewed and updated to reflect closed matters or new additions.
- We reviewed the obstetric and gynaecology risk management operational policy in conjunction with the trust risk management strategy. Information contained therein outlined the purpose, methods and responsibilities for managing risks in the maternity services. We noted there were a number of key measurable objectives set for 2014/15, such as safe staffing levels, safe practices and incident review reporting processes.
- We noted too that within the obstetric and gynaecology risk management operational policy it stated a core aim was to 'maintain and update a dynamic maternity risk register. This will demonstrate that risks have clearly been identified and the corresponding controls and requirements are agreed and identified on the risk register or escalated and shared with the trust board'.
- The risk register for maternity services was reviewed and we noted in particular the lack of risks identified. The one risk reported related to sickness absence. This was accompanied by an action plan, designated responsible person and review dates. However, in our discussion with senior clinical staff they described another risk related to the pregnancy assessment clinics, linked to the ultrasound service. We asked why this was not on

the risk register and it was explained to us that the Care Group evaluated the risk and considered that mitigations were in place, hence it was removed from the risk register but monitored through the issues log in accordance with the Care Group's local practice and this was acceptable under the Trust's Risk Management Strategy. Several issues were not listed on the risk register which we might have expected to see, such as staffing at senior and middle grade levels. The Care Group Governance Lead had advised that pressures around staffing and middle grade levels were reviewed wthin the Care Group's governance process and it was considered that suffiicent mitigations were in place. We noted in the quarterly obstetric & gynaecology integrated governance report for October 2014 two risks described in respect to maternity services. One related to non-compliance with national screening standards and recommendations about storage of antenatal ultrasound scans. The second related to the lack of availability of cell salvage facilities for emergency use and therefore recommendations of safer childbirth could not be met and the service for women who refused blood products was compromised.

- The maternity service dashboard did not have much detail on it and it was not clear where the standards had come from. Maternity dashboards are generally used to provide an early alert to the maternity service and the trust board. Performance of the maternity service would be expected to be assessed against Mothers and Babies; Reducing Risk through Audits and Confidential Enquiries-UK (MBRRACE-UK) reports, RCOG and the Royal College of Midwives (RCM) guidance, National Patient Safety Awareness (NPSA) never events, and patient experience/complaints.
- Staff confirmed the directorate had a voice through the nursing and midwifery director but they were not sure there was dialogue to ensure their voice was heard.

Leadership of service

• The poor function of the care closer to home directorate structure within the maternity and gynaecology service was commented on by several people who felt that it did not work. The care group were said by a number of senior staff to be made up of large divisions, with too many layers, which impacted on efficiency. Complicated decisions were said by one consultant to get lost or delayed in escalation. Another comment made to us by a separate senior member of medical staff included it was difficult to be "listened to". Examples of the difficulties included the time taken to consider matters, such as agreement to expand the consultant team. The plan was said to have been put forward more than 4 years previously and a business case and funding was agreed but had since got lost in the system. Clinical staff at senior level said the channels of communication needed to be reviewed but they "made it work". They added, "A flatter structure works better for us" and "staff want to be valued and this impacts at a local level".

- We reviewed the organisational structure for midwifery and gynaecology, which was overseen by the designated senior team, recognised by all staff as being the head of midwifery and the clinical director. The clinical director had been appointed after competitive interview by the senior members of the care closer to home group. There was a lead matron and nurse colposcopist for the gynaecology service reporting to the head of midwifery and gynaecology. Named individuals for gynaecology, colposcopy/hysteroscopy, gynaecology outreach, fertility and infertility services reported upwards accordingly.
- The senior midwifery and gynaecology clinical staff explained how there had been divisional restructuring over the past few years in order to create a "strong and visible leadership." A senior midwife post had been created for each site and managers undertook clinical work one day per week. Although the units were said to be different with differing needs, the senior team worked together to ensure that themes worked across the sites.
- Matrons were said by staff to be very available and willing to come to the gynaecology ward if needed.
 Medical and nursing staff were said to be approachable and generally there were good working relationships at ground level.
- One member of staff said matrons were, "very visible" and that they also phoned in on their day off to check if all was well. This person added that they were "very happy with the way we work, there's good leadership".
- Medical leadership on the Durham site was difficult to determine with no-one in an appointed role with defined responsibilities. One consultant had stepped forward to act in a lead role but at the time had no recognition or reward for this.
- Senior medical staff reported concerns around the lack of management of chronic sickness from a human

resource perspective. We were told there was a lack of proper return to work support arrangements and on-call arrangements were not shared appropriately. The service was said to be safe only because of "good will".

- Several consultants suggested that job plans were not completed and signed off as final work plans and that some colleagues did not work to their allocated job plans. This resulted in tensions about work that needed to be covered being undertaken by smaller groups of people than those listed on the appointment list.
- Senior midwifery meetings were said to be held monthly, where information was communicated from other organisational meetings, service developments and feedback from complaints, incidents or best practice. These were organised and led by the senior midwife on each site.

Culture within the service

- The culture was observed to be based around team work and mutual respect. Staff reported that colleagues across grades and roles were approachable and could be challenged if necessary.
- Midwifery and nursing staff were very aware of the targets around patient care.
- There was significant appreciation of the good collaborative working between senior midwives and consultants on the delivery suite to the benefit of women's care.
- Gynaecology staff reported that they were aware of the expectations of them. One nurse said, "We are not always able to get it right all of the time."
- There was an openness and willingness to report adverse events and to learn from these for the benefit of patient treatment and care. However, it was reported to us that responses to other issues, such as staffing expansion, were poor.
- The clinical director perceived that despite the merger of the trust, both locations were working separately.
- We were made aware of a number of issues related to performance and working practices, which medical staff said had not been addressed early on. As a result there was an impact on working relationships, demands on some medical staff and inflexibility from others. Another comment made to us by medical staff was that support was not good after issues were raised.

Public and staff engagement

- Staff, commissioners and stakeholders had been consulted with in respect to the trust wide clinical strategy 'Right first time 24x7.' This had resulted in a public discussion document being produced in January 2014. We found evidence that staff were aware of the campaign and supported it fully. However, they found it difficult to reconcile with the slow responses and decisions from the care closer to home team and the executive team about concerns and service innovations, which they felt were essential to service improvement.
- There had been engagement with members of the public and staff as part of a focus on improving service user experience and that of staff in respect to dignity in 2013. This work was conducted as part of the action plans related to complaints received within maternity services. Feedback was gathered from people who had used the service and staff on their perception of dignity.
- We reviewed the dignity campaign report for November 2013 and noted some of the themes raised by patients had already been addressed. For example, clear patient information leaflets, consistent handover of patient care and increased involvement in treatment plans.

Innovation, improvement and sustainability

- Medical teams worked well across sites on subject specific projects such as high risk pregnancy. However, this was largely due to personal interest and motivation, rather than being part of a coherent plan for joint working on improvements.
- We were told about and saw information that indicated discussion was taking place around cell salvage in obstetrics for this location. The use of cell salvage is recommended for women with various problems such as placenta previa and also for women who follow the principles of a Jehovah's Witness. The document reviewed outlined the issues to be considered including benefits and risks, as well as requirements if it was to go ahead.
- The senior clinical team for midwifery and gynaecology described a number of measures under development or for future change, which were expected to improve services for people. This included creating an outpatient hysteroscopy and colposcopy service for the Bishop Auckland site. Trained nurse hysteroscopists/ colposcopists were available to support this service.

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

Information about the service

The children's service at this hospital was responsible for inpatient services for babies, children and young people. Services at the University Hospital of North Durham included one 24 bed children's ward (treetops ward 7) which included an assessment area, inpatient area and additional day surgery beds. Next to treetops ward was a dedicated children's outpatient department and a special care baby unit (SCBU) which had 12 level one (special care) cots. The service was responsible for providing community neonatal and paediatric outreach services.

Based on statistics provided by the trust, the Durham services paediatric medicine specialty (not including sub-specialties or surgery) had a total of 5,116 non elective admissions, 31 elective admissions and 63 day case admissions during the period January to December 2014. The SCBU had a total of 210 admissions in the same period. There were 4,764 outpatient attendances in the same period.

During our inspection we visited all clinical areas where children were either admitted or which they attended on an outpatient basis, including the SCBU, treetops ward, and the children's outpatient department. We talked with five medical staff and 11 nursing and allied healthcare professionals, and examined eight medical/nursing records. We spoke with 13 parents and children/young people.

Summary of findings

Overall, services for children and young people were good at this hospital. Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms and we saw these were reviewed and acted upon by the management team. We found risks were assessed and monitored, and control measures were put in place. We found all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. Medicines were stored and administered correctly. Medical records were handled safely and protected.

Members of staff of all grades confirmed they received a range of mandatory training, although training records did not always accurately reflect training uptake. Levels of nursing staff were adequate to meet the needs of children and young people. Medical staffing had some gaps but these were being managed and addressed.

Children's services had made improvements to care and treatment where the need had been identified using programmes of assessment or in response to national guidelines.

Children, young people and parents told us they received compassionate care with good emotional support. Parents felt fully informed and involved in decisions about their child's treatment and care.

The service was responsive to children's and young people's needs and was well led. It had a clear vision

and strategy, and was led by a positive management team who worked together. The service had introduced innovative improvements with the aim of improving the delivery of care for children and families.

Are services for children and young people safe?

Good

Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms and we saw these were reviewed and acted upon by the management team. We found risks were assessed and monitored, and control measures were put in place. We found all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. Medicines were stored and administered correctly. Medical records were handled safely and protected.

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Incidents

- Staff demonstrated an awareness of how to report incidents using the trust's reporting mechanisms. The management team and ward managers in all clinical areas felt their staff were good at reporting incidents. We were told by most staff that they received feedback about incidents they had reported.
- Minutes of meetings of the monthly 'SAGE day' (safety, audit, governance and education meeting) and the 'children's management team meetings' held during 2014 showed incidents were routinely discussed. The SAGE meetings were attended by consultant paediatricians who discussed incidents that had occurred during the previous month included any actions arising out of the review. The incidents and actions arising out of the SAGE meetings were also discussed at the children's management team meetings.
- We reviewed incident data for the period 1 January 2014 to 31 December 2014. A total of 204 incidents had been reported across all children's service areas at both Durham and Darlington hospitals.
- Two serious incidents had been reported within the children's service over the previous 12 months. Neither of these had occurred at Durham hospital. However the

children's management team explained that learning had occurred following review utilising a root cause analysis approach, which was applied to inpatient areas at both Durham and Darlington. For example, one incident review had led to the development of guidance for staff on what to do if a baby had reduced movement in a limb.

Cleanliness, infection control and hygiene

- We found the children's ward (treetops), children's outpatient department and the SCBU were kept very clean and tidy. Various infection-prevention measures were in place, such as multiple wall-mounted hand gel dispensers and hand-wash sinks.
- We observed members of medical, nursing and other staff regularly performing hand hygiene measures.
- Regular hand-hygiene audits and infection-control audits were undertaken in the clinical areas. For example, the SCBU at Durham had a full infection control audit conducted 22 January 2015 by the trust wide infection control nurse specialist. Findings showed the SCBU scored 100% for handling of linen, sharps and waste, 98% for patient equipment, 97% for hand hygiene and 92% for environment. The audit included an action plan which included actions such as cleaning items like fans and ensuring hand sanitizers were available next to all cots.
- The 'children's management team meeting' included a standing agenda item for infection control. Discussion included hand hygiene audits and other updates when tabled. The management team explained that the ward and SCBU had nominated infection-control link nurses who attended hospital wide meetings and disseminated information to staff members via team meetings and notice boards.

Environment and equipment

- We saw and staff told us that all clinical areas had a wide range of clinical and other equipment to assist them in providing care for children and young people. Records showed the trust tested and serviced equipment according to its own policies. Some equipment, such as incubators on the SCBU, were maintained and serviced via external manufacturers.
- All the children's clinical areas we visited had suitable resuscitation equipment available, which had been checked regularly by members of staff.

• The SCBU unit was also adjacent to treetops ward on one side and the maternity unit on the other side. Staff told us they felt the SCBU unit was 'tight' for space in places although we did not identify that this caused any specific risks and none were recorded on the risk register.

Medicines

- We reviewed a sample of paper-based treatment records on the children's ward and SCBU and observed the administration of medications. We found that medicines had been appropriately stored, checked and administered in these areas.
- The management team explained that children's services had a named pharmacist who attended the children's clinical areas weekdays at Durham and Darlington. The management team told us the service felt well supported by their pharmacist who also conducted regular prescribing checks of treatment records.
- Mandatory training records supplied by the trust prior to the inspection showed that 100% (188 nursing staff) had completed medicines management training.

Records

- We found records were managed and handled safely during our inspection. For example, we did not identify any unattended medical notes during our inspection.
- We observed medical notes being carefully managed during the ward round on treetops ward. The notes trolley lid was kept closed and we observed the nurse ensuring notes were immediately placed back in the trolley during the ward round.
- Care records were paper based during an admission/ inpatient stay. Following discharge these records were scanned and uploaded to an electronic system which made these records accessible for medical and nursing staff at any later admission. Staff appeared to have differing views about this system. Some found it very useful and easy to use while other staff said it was sometimes difficult to find the information they needed.
- Nursing documentation was completed via a paper based record. On treetops ward, these included an assessment of the child/young person's activities of daily living, which had been individualised where

needed to reflect the child and family's needs. We saw that a combination of core care plans (pre-written care plans) and individually written care plans were used following the assessment.

- The nursing evaluation was written alongside each medical review entry. It was clear what treatment and care the child had received and what care was required by the child.
- A permanent stamp was placed in the evaluation record for each formal ward round. The stamp acted as a safety check reminder to ensure the medical/nursing team checked and recorded an 'update from the nurse', the paediatric early warning score chart (PEWS) had been reviewed, the drug chart had been reviewed and feed/ fluid charts had been checked.
- On the SCBU we found detailed daily records were being maintained. We were told by SCBU staff that the 'plan of care' was recorded within the evaluation record. When we checked records there was a statement relating to 'plan of care' but this was usually a sentence highlighting the main form of treatment, for example, phototherapy or intravenous infusion of 10% dextrose.
- However, at the time of our inspection, dedicated nursing care plans were not used by the SCBU nursing team. This meant the care which was delivered did not follow an agreed documented plan of care, which may lead to inconsistency in care. For example, the nursing team had access to a neonatal pain assessment tool and we saw evidence that babies received pain relief when required. However, there was no neonatal pain care plan to guide staff on how often they should assess pain and how they should manage the pain. The records being used by SCBU did not underpin or reflect the appropriate care being actually delivered by staff. The SCBU did use the 'kangaroo care record' which monitored all skin to skin contact between parent and baby.

Safeguarding

- Managers and members of staff within children's services demonstrated a clear awareness of the referral processes they must follow if a safeguarding concern arose.
- Records showed 93% of children's service staff (all grades) had received level one safeguarding training. The ward manager of treetops ward told us that 85% of staff had completed level three safeguarding children training. Some staff had recently retired which had

lowered the number of staff with level three training. The SCBU was run as one unit between Durham and Darlington and the neonatal service manager told us 97% of SCBU staff had completed level three training. All other relevant staff had also completed level three training.

- We observed a weekly safeguarding meeting, which was held on treetops ward and was attended by paediatricians, safeguarding leads and social services. We were told this meeting had run for over 4 years and included a peer review function. As an area of good practice this meeting also discussed cases other than safeguarding, for example, the discussion of young people who were 'deliberate self-harm' cases.
- At a local ward and unit level staff had access to safeguarding advice from a nominated safeguarding nurse and nominated safeguarding midwife.
- The trust had the necessary named safeguarding staff in post, including the named nurse and designated doctor. There was initially some confusion over the named doctor role although we found this role was being covered by a consultant paediatrician. The children's management team told us the service felt well supported by safeguarding processes in place throughout the trust.

Mandatory training

- Members of staff we talked with, including staff from treetops ward, children's outpatients and the SCBU, confirmed they received mandatory training. This covered subjects such as fire safety, health record keeping, hand hygiene, moving and handling and safeguarding.
- Training records submitted by the trust prior to the inspection showed good levels of training uptake. For example, 91% (331 out of 365 staff) had completed 'health record keeping training', 91% (333 out of 365 staff) had completed moving and handling training and 90% (329 out of 365 staff) had completed fire safety and prevention training.
- Training specific to children's services was also maintained to good levels of uptake although these training numbers were not provided by the trust prior to inspection. The ward manager explained 90% were up to date with the paediatric life support (EPLS) course and the neonatal unit manager told us 95% of SCBU

staff across Durham and Darlington were up to date with the neonatal life support (NLS) course. The SCBU had three members of staff who were trained to deliver the NLS course.

Assessing and responding to patient risk

- We reviewed four care records on treetops ward. We saw that an initial risk assessment was made for moving and handling, tissue viability and nutrition. The level of risk was recorded on the initial admission assessment documentation. Should a child score a rating identified as a potential risk the nurse completed a full risk assessment tool for either moving and handling, pressure sore risk or nutritional screening. Other risk assessment and monitoring tools were used when required, for example, peripheral venous cannulation assessment and monitoring records.
- The SCBU had some risk assessment tools in place such as the peripheral venous cannulation tool. The unit had a neonatal pain assessment tool, although it was not clear how frequently the tool was used. The tool had a form on the back to record pain assessments, but this was blank because staff recorded the assessment in the evaluation record. One sister told us the unit did not use a neonatal skin integrity tool although one of the SCBU nursing team was hoping to introduce one shortly. We talked with the clinical services manager about the use of individual risk assessment tools on the neonatal unit and they explained they would work with the neonatal unit manager and SCBU team to review their use and effectiveness.
- The children's ward used PEWS. The tool included a clinical observation chart, coma scale and additional information such as the pain score tools along with an assessment table to assist clinical staff in determining the action that should be taken for a poorly child. It was explained the chart would assist with determining whether a child would require transfer to a tertiary centre for children such as Newcastle. Our review of a sample of charts showed staff thoroughly completed the PEWS charts. The SCBU used its own observation chart designed for capturing observations specific to neonates.
- The assessment area located within treetops ward used specially trained APNPs to assess and manage a child's

initial care. However, the APNPs had no protocols or standard operating procedures to guide them on processes they should follow to assess, manage, treat and discharge children they reviewed.

 The treetops ward had a nominated high dependency room for stabilisation of very poorly children. We were told the children's service had only recently identified a dedicated high dependency room even though the availability of one within a district general hospital setting has been a requirement for a number of years. Staff with high dependency training were in the process of being recruited or trained in this area of care. There were no protocols or standard operating procedures available for staff members who cared for children who required high dependency care or stabilisation on the ward prior to transfer.

Nursing staffing

- The clinical services manager, ward manager and neonatal unit manager explained that recruitment and retention were good within the children's clinical areas, so vacancy rates were low. Children's management meeting minutes included a section which discussed staffing matters within each of the clinical children's areas.
- The ward manager told us sickness rates on treetops ward were averaging 6% and the SCBU was averaging at 7% with fluctuations and a mixture of long- and short-term sickness.
- We found treetops ward was adequately staffed to meet the needs of children, young people and families and often reflected best practice guidance on children's ward staffing issued by the Royal College of Nursing. During daytime shifts for the inpatient and assessment areas there were three registered nurses and two healthcare assistants for the inpatient beds and two registered nurses for the assessment area (contained within the 24-bed area). There was also a day surgery unit (eight beds) staffed by two registered nurses. We talked with staff members on these ward areas who felt there were generally enough members of staff to meet the needs of children. Parents we talked with also felt there were enough staff available on the wards with one parent stating there were "plenty of staff".
- On the SCBU, which had 12 level one (special care) cots, there was a minimum staffing of three registered nurses per span of duty. The neonatal unit manager explained that approximately 90% of shifts per month met the

best practice British Association Perinatal Medicine (BAPM) qualified in specialty standards. Staffing on SCBU met the BAPM ratio of one registered nurse per four babies. However, one of the nurses also acted as the shift coordinator. The three nurses on duty were also responsible for supporting maternity 'transitional' care arrangements (where babies stay with the mother on the post-natal ward) and also provided a neonatal outreach service (where a nurse goes to the baby's home to offer support when discharged). The SCBU staff told us this was usually manageable but sometimes they felt 'stretched'. The neonatal outreach service was also supported by the paediatric outreach service.

Medical staffing

- We found medical staffing was reasonably covered within paediatric medicine and the SCBU. At Durham hospital we talked with five doctors of all grades, including three consultant paediatricians and two trainee doctors.
- We were told there were two gaps at tier one and two gaps at tier two (middle grade) in the medical staffing rota. These gaps were covered by regular locum doctors or a consultant paediatrician. We were told the service had a plan in place to manage the medical staffing gaps at tier one and tier two.
- The assessment area on the treetops ward was also covered by APNPs on some spans of duty who were trained in tier one medical staffing skills. This allowed the APNPs to assess newly arrived children to determine if they required admission or treatment/advice prior to discharge home. These staff did not form part of the medical staffing duty rota but their skills complemented the existing service.
- We attended a morning paediatric medical handover on treetops ward. We saw the handover was well attended by medical staff and one registered children's nurse. Handover included discussion of the child's medical plan and was followed by a ward round. Other medical handovers were held each day. The trainee doctors told us the "handovers [are] good here".
- Nursing staff did not raise any concerns over medical staffing and felt well supported. The foundation and specialist trainee doctors we talked with were complimentary about the training and support they had received from paediatric consultant staff.

 The trust had a major incident plan in place that set out actions to be taken for major incidents and other similar events. The clinical services manager, ward manager and neonatal unit manager we talked with demonstrated awareness of the plan. They explained that a table top exercise had been held within the last 12 months which had been attended by the APNPs. The clinical services manager also explained there had been two local major incidents (one in Durham and one in Darlington) over the last 12 months which had involved the initiation of the major incident plans.

Are services for children and young people effective?



The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. We reviewed information that demonstrated that the children's services participated in national audits which monitored patient outcomes when these were applicable.

Children and young people had access to a range of pain relief if needed and the service used an evidence-based pain-scoring tool to assess the impact of pain. The nutritional needs of children were addressed. Consent forms were completed to an adequate standard.

Staff had received an annual appraisal and received support and personal development. There was evidence of positive multidisciplinary working across various disciplines and specialties.

Evidence-based care and treatment

• The trust had systems and processes in place to review and implement NICE guidance and other evidenced-based best practice guidance. New guidance came to the children's service via the care closer to home group governance and was discussed via the SAGE meetings. The children's management team discussed recent examples of NICE guidance and how these had been reviewed, for example, neonatal guidance for the use of antibiotics for early onset infection.

Major incident awareness and training

- An audit plan submitted showed that NICE clinical guidelines were identified to be audited during 2015. For example the guideline on 'urinary tract infection in children' was due to be audited by 31 March 2015.
- We reviewed SAGE meeting minutes for 2014 and these included various examples of where the service had reviewed clinical pathways to ensure they reflected clinical practice. For example, the minutes for October 2014 noted the diabetes ketoacidosis guidelines had been updated and a new pathway had been developed. The same month also included a proposed new guideline for bronchiolitis prior to the commencement of that seasonal illness.
- Discussion with clinical staff and the review of submitted documents demonstrated the service participated in national audit such as diabetes, epilepsy and asthma. Other local audits had also been completed, for example 'prescribing practices for buccal midazolam and its use in the community'. An action plan had been completed for this audit which included actions to be taken to address an identified issue.

Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia, patient-controlled analgesics and epidurals where indicated.
- The service used evidence-based pain scoring tools to assess the impact of pain. The PEWS assessment chart included different pain scoring tools which were linked to a table which advised on the type of analgesic that should be used. We reviewed a sample of pain score ratings, which showed members of staff regularly assessed pain when required. Parents we talked with confirmed that their child had their pain assessed.
- The children's service had its own paediatric pain nurse available, which was good practice for a children's service based in a district hospital setting. The paediatric pain nurse was also supported by the adult pain team.

Nutrition and hydration

• Children's food likes and dislikes were identified and recorded as part of the nursing assessment of the child's daily activities of living. When triggered by an initial assessment the nursing team used the Malnutrition Universal Screening Tool (MUST). Observation of records and audits confirmed this. • Children were able to choose their food from the daily menu with the support of parents and staff. Children could eat food from the adult menu or have a meal from the 2-week children's menu. Snacks and drinks were available in between meals. We were told vouchers were available for parent meals.

Patient outcomes

- We reviewed information which demonstrated that children's services participated in national audits in order to monitor patient outcomes when this was applicable to the service. For example, we reviewed data and information relating to the National Neonatal Audit Programme (NNAP).
- The children's management team talked through examples of learning from the last NNAP audit. For example, the unit aimed to improve outcomes in relation to having discussions with parents within 24 hours of admission.
- The children's service also participated in other national audits such as diabetes, asthma and epilepsy audits. The last available diabetes audit from 2013 showed results were similar to the England and Wales average. The trust continued to make progress and had a high HBA1c (a blood test used to provide an average blood sugar reading) policy in line with the regional network. The service had expanded to include young people up to the age of 19 years as this age group nationally has poorer control of HbA1c. Multiple emergency readmissions for 1–17 year olds was worse than the England average for asthma and diabetes.
- The children's service also submitted ongoing data (where applicable to children), which contributed to the NHS Safety Thermometer (a tool designed for frontline healthcare professionals to measure harm such as falls, blood clots, pressure ulcers, and urinary and catheter infections) monitoring dashboard. Data showed that all participating children's clinical areas were scored 100% harm-free for the last 12 months.

Competent staff

- Formal processes were in place to ensure staff had received training and an annual performance development review (appraisal).
- We did not review any documents that captured appraisal statistics but the ward manager for treetops ward stated appraisal completion was 75%, with identified dates in place prior to 31 March 2015. The

neonatal unit manager explained the appraisal rates were low at 30%, although we saw the SCBU had identified dates for all members of staff prior to 31 March 2015. Staff we talked either confirmed they'd had an appraisal or were yet to receive one.

- Members of staff in the outpatient department, treetops ward and SCBU gave positive feedback about the individual support they received in their personal development.
- Trainee medical staff we spoke with were positive about the regular training and support they received to develop their clinical and educational knowledge and skills. They felt well supported by consultant staff within paediatrics and neonatology.

Multidisciplinary working

- Medical and nursing staff within children's services gave positive examples of multidisciplinary working. We were told the paediatricians and nursing teams worked closely together and also worked closely with other professionals such as dieticians, occupational therapists and physiotherapists.
- Staff told us children's services worked closely with surgeons and doctors in specialties such as emergency medicine, ear, nose and throat, and general surgery.
- The clinical services manager and ward manager explained how the children's service had developed positive working relationships with the Child and Adolescent Mental Health Services (CAMHS). We were told there was a nominated consultant paediatrician who coordinated close working with tier three CAMHS. We were given examples of how CAMHS had been supportive and responsive to the ward when children admitted required mental health support. During our inspection a CAMHS crisis nurse attended the ward and reviewed a young person with deliberate self-harm and liaised with the paediatric team.
- Formal adolescent transition arrangements were in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty.

Seven-day services

- The children's inpatient services accessed diagnostic services such as the x-ray department, pharmacy and laboratory during the weekend. The children's management team and members of staff did not raise any significant concerns over accessing these services.
- Trainee doctors working out of hours and at weekends told us they felt well supported by consultant staff, who were on call but readily available.
- Paediatricians were available up to 6 hours a day on weekends, then available on call.

Access to information

• Staff told us they were readily able to access patient information and reports, including at weekends and out of hours. For example, trainee medical staff explained they were able to access patient notes via the EDMS electronic system straight away. Some staff felt the EDMS system was difficult to use although recognised the information was there and available.

Consent

- The children's service included an eight-bed surgery day area for elective short stay surgery and treetops ward admitted children who required non elective surgery such as appendectomy.
- We reviewed a sample of four records where consent had been obtained for surgery, and found these had been appropriately completed, dated and signed by the doctor/surgeon and parent. Consent forms included a suitable explanation of the proposed benefits and risks of surgery
- Staff we talked with showed they understood the Gillick competency standard for consent for children. Staff explained surgeons encouraged young people to be involved in decisions about their proposed treatment, for example, we saw an example of a consent form for a 13 year old young person who had signed their own consent form along with their parent.

Are services for children and young people caring?

Children, young people and parents told us they received compassionate care with good emotional support. They felt they were informed and involved in decisions relating

Good

to treatment and care. We spoke with 12 parents and children who provided examples of how they had been provided with supportive care centred on their personal needs.

Compassionate care

- Throughout our inspection we observed members of medical and nursing staff who provided compassionate and sensitive care, which met the needs of the child, young person and parents.
- We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with them at an appropriate level of understanding.
- We spoke with five parents and families on treetops ward. The parents provided a number of examples of how they had received considerate and supportive care. For example, more than one parent explained how their child was admitted in the early hours of the morning and their child had been allowed to sleep rather than waking them for the admission process. A number of parents described staff as being very caring and "friendly" with some parents describing their overall experience as "brilliant" and "wonderful".
- Four parents we talked with were attending the outpatient department. These parents were also positive about their experiences within the department although they explained that parking at the Durham hospital was difficult with some parents stating parking was a "nightmare" and "difficult".
- On the SCBU we talked with three parents and they felt care was "safe" with care delivered by "competent staff". Parents explained how staff were very supportive, for example helping them to gain confidence in picking up their baby from the cot. One parent whose baby had also stayed in another neonatal unit felt more supported in the previous hospital. They said "In [the other neonatal unit] everything was done for you but at Durham you have to get on with it." One parent told us they were unhappy with the maternity unit handover to SCBU staff and intended to complain because they believed it had had a negative impact on their baby.
- A quality assessment tool was used to gain people's views and completed bi-monthly based on a sample of up to 15 people including children, young people and adults. Questions were split into five areas which reflected the Care Quality Commission (CQC) domains

used to assess services. The results were analysed and presented in the form of a report. Scores on the treetops ward for the period of November 2014 was safe 98%, effective 97%, caring 98% and responsive 93%.

- Children, young people and parents' results were also presented in a more detailed way which included individual feedback comments. For example, for the period of November 2014 out of 10 parent feedback forms 70% (seven parents) felt communication had been done well with 10% (one parent) stating communication could improve. Comments from parents, children and young people were positive. For example, four young people responded to the November survey and said "everything [was positive]" and "promptly seen to, friendly staff".
- We were told the children's services did not participate in the adult-based NHS Friends and Family Test. An alternative system had been set up to gain the views of children, young people and families about their experiences. A quality assessment tool for both staff and families was completed bi-monthly, based on a sample of up to 15 people including children, young people and adults. The results were analysed and presented in the form of a report. The overall score on the treetops ward for the period of November 2014 was 96% for patients/ parents.

Understanding and involvement of patients and those close to them

- We observed members of staff who talked with children and young people used language appropriate to their age-related level of understanding. This was supported by the November quality assessment survey of parents and young people's views. For example, 100% (four young people) felt they'd been listened to and understood their treatment. One young person stated "quick response to any questions or help ...felt that I was treated with respect."
- A number of families we talked with told us they had felt involved in the planning and decisions relating to the patient's care. For example, one parent explained staff were friendly and knew "what was going on, explaining everything". The same parent went on to explain how involved they'd felt in their child's care.
- Parents and children talked positively about the information they had received. Families also explained how they had been given sufficient information to make an informed choice about their children's care.

 Information leaflets about various treatments and other care were available within the hospital. Leaflets at this trust were written in English. Members of staff explained that they could get leaflets translated when required. We saw that some leaflets had been produced a number of years ago although the guidance was still appropriate. The clinical services manager explained the service was aware and was in the process of updating information leaflets.

Emotional support

- Parents and children told us they had been well supported during their visits or stays on the treetops ward, SCBU and children's outpatient areas.
- We observed members of staff who were responsive to and supportive of children's emotional needs. For example, we observed nurses, play specialists and other staff providing emotional care and support to children who were upset.
- Parents we talked with gave examples of how staff supported their children and themselves. For example, one parent outlined how supportive staff had been by making sure they knew how to use the various parent facilities on the ward and where they were.

Are services for children and young people responsive?



We found the service was responsive to children's and young people's needs. The children's service actively planned and delivered services to meet the needs of local families. We saw evidence which showed that complaints were reviewed and that the service learned from them.

Service planning and delivery to meet the needs of local people

- We found there was evidence of how the children's service engaged with the trust, commissioners, the local authority and other providers to address the needs of the local population.
- The children's management team explained that the clinical commissioning group (CCG) and its predecessor the primary care trust (PCT) and others had been fully

engaged with the 'poorly child pathway'. We were told there had been four or five stakeholder meetings which had contributed toward the ongoing development of the pathway.

- A poster produced by the NHS North East Leadership Academy outlined the aims and intentions of the poorly child pathway. The aim of the pathway was to 'safely reduce the number of children admitted to hospital through a range of approaches including education (including parents), supporting clinical practice, coordinating care across hospital and community, staffing and resources and by redesigning how and where children were treated'.
- The management talked through one area relevant to acute children's service, which was the development of the 'paediatric front of house' in partnership with emergency department staff. This involved APNPs performing an initial assessment and treating as required. These practitioners would be located within the emergency department. Other areas of development for this part of the poorly child pathway included extended consultant hours and other measures. The children's service was testing the development and introduction of the paediatric front of house approach at Durham and Darlington hospitals.

Access and flow

- Access and flow varied within the children's services provided throughout the trust. The emergency department facilities for children were limited at Durham and were part of the adult service. The children's directorate had no direct influence over the provision of emergency services within the emergency department although the children's management team explained positive relationships were developing between the specialties.
- The treetops ward area included an area where children received an initial assessment (and treatment when indicated) following referral from either the emergency department or GPs. We were told the APNPs employed as part of the development of the paediatric front of house initiative had been recently been placed in the assessment area at Durham hospital after being used within the facilities of the emergency department. Medical and nursing staff told us they thought the use of APNPs in the assessment area was working well and was leading to a reduction in admissions of children to the inpatient area.

- The treetops ward had a nominated high dependency room for stabilisation of very poorly children. The facility was in the early stages of development. Additional monitoring equipment was in place and the children's management team were in the process of recruiting and training some members of staff in the delivery of high dependency care. We were told the anaesthetic team were involved in the development of the area.
- The children's service used the PEWS monitoring chart which assisted staff in determining whether a child required stabilisation or transfer to a tertiary service such as Newcastle. The management team and other staff told us the North East Ambulance Service was responsive and facilitated transfer where this was required.
- The SCBU had facilities and appropriately qualified staff to stabilise babies under 30 weeks gestation prior to transfer to a level two or three neonatal unit within the north east area. We were told the neonatal network retrieval team responded promptly when its service was required.
- We found the needs of children who required surgery in a district general hospital setting were reasonably met in line with national guidance set out in the "standards for children's surgery" (2013).

Meeting people's individual needs

- Staff told us interpreting services were available when they needed them, and that they did not normally have any issues when accessing these services.
- The children's ward had facilities to promote family-centred care. For example, parents had access to a seated area and facilities to make hot drinks. Parents were able to sleep next to their child at night. There was a dedicated school room for children along with areas where children could play.
- We saw that the treetops ward took account of adolescents' needs. The ward had bed spaces where adolescents were placed. There was also an adolescent rest room accessible to teenagers on the ward.
- There were formal adolescent transition arrangements in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty, including jointly run clinics with the adult team. Other specialties had some form of transitional arrangements in place such as young people with complex needs. There wasn't an

overarching policy statement on the coordinated development of adolescent transitional services for children and there was no formally nominated lead member of staff to develop adolescent services.

- The clinical services manager and ward manager told us there was a range of equipment, such as hoists and an assisted bath area, along with other support for children and young people with complex physical health needs.
- The treetops ward was spacious, well maintained and organised into clinical areas such as an assessment area, inpatient area and a day case surgery area. There were suitable facilities for parents and young people, including a room where parents could make themselves a drink and adolescents had a separate area where they could relax and play computer games. The ward also had a dedicated school classroom which was used by the local authority school teacher to provide lessons for children in hospital.
- The children's outpatient department was located next to the treetops ward area and included four clinic rooms, other treatment rooms and an open waiting area.

Learning from complaints and concerns

- The clinical services manager and ward manager explained that complaints were handled and resolved straight away where possible.
- In the treetops ward quality assessment survey of parents for the month of November 2014, 86% of parents indicated they were aware of how to make a complaint. Complaints information was available within the children's areas.
- We reviewed SAGE governance meeting minutes from 2014 and these minutes showed complaints were regularly discussed and reviewed by consultant paediatricians and other attendees. At these meetings the clinical services manager conducted a presentation of the complaints received and outlined any actions arising out of the investigation of the complaint, including identified areas for improvement. The review of complaints in the meeting minutes noted apologies had been given to the family when needed.

Are services for children and young people well-led?



The service was well-led. Governance arrangements were in place and were very well attended by consultant paediatricians. The management team had a clear vision and strategy for the service and was formulating a new strategy at the time of our inspection. There was evidence of positive management at ward and unit level led by the clinical services manager. Management structures within the care closer to home group were complex and it was not always clear how some tiers of leadership worked together. Although there was an executive director for safeguarding children the trust did not have a formally nominated board level director who championed children's rights. The service engaged with people who used the service.

Vision and strategy for this service

- The children's management team had a clear vision and strategy for the provision of children's services in the Durham and Darlington areas. We reviewed a draft strategy in development entitled 'Quality improvement in the delivery of paediatric care within County Durham and Darlington 2015'. The head of child health explained how various stakeholders had been involved in the development of the strategy and that the timescale for publication would be the summer of 2015.
- The draft strategy noted the service was working towards a paediatric-led assessment model. This included the full development of the paediatric front of house initiative, which would see the assessment of children within a dedicated facility within the emergency department when the proposed upgrading of this department was completed.
- The draft strategy also centred on children's services delivering care close to home. It was proposed that this would be achieved by strengthening the paediatric community nursing service to enable more care to be provided in the home environment.

Governance, risk management and quality measurement

• The children's services' risks formed part of the care closer to home group risks. The children's services' risk register included two actual risks. One regarding the radiology department being unable to provide a sustainable, quality paediatric service due to the lack of a paediatric radiologist and the second risk was that there was no clear strategy to reduce the level of HbA1c (average blood sugar levels). In both cases the register listed actions to address the identified risk.

- The clinical services manager also explained that potential risks, such as medical staffing, were discussed at team meetings, and added to the risk register as appropriate. We reviewed draft meeting minutes from January 2015 which noted that medical staffing for foundation (tier one) and specialty (tier two) trainees should be elevated from a potential risk to an actual risk.
- The trust set out its governance arrangements/ structures in a document entitled 'Quality matters – governance counts'. The structure included ward/team meetings, service specialty governance meetings and care group governance meetings which fed through to the operational governance committee at executive level.
- The children's service monthly governance meetings were known as SAGE days and held each month. Minutes from 2014 showed these meetings were medical led and had been attended by a number of paediatricians each month. The structure of the meetings included safeguarding peer reviews, complaints and incidents updates along with discussion of audit, clinical pathways and other governance information. Attendance by nursing staff appeared low and the clinical services manager and ward manager recognised that attendance by members of the nursing team could be improved.
- The children's service management team also held a monthly meeting chaired by the head of child health and attended by the nursing leadership. This meeting covered a more business focused agenda such as finance but all included a range of governance items including medicines management, incidents and human resources.
- Other meetings held within the care closer to home care group included discussion and review of various matters in relation to children's services. For example, the group's patient safety meeting on 7 January 2015 included an agenda item for children's services which required approval of a number of revised policies and protocols. These were sent to attendees before the meeting.

Leadership of service

- The children's service formed part of the care closer to home group. The group included a range of other services such as maternity, children's community health and palliative care. There was a chart provided prior to our inspection which set out a multi-tiered structure within the service and care group.
- We found the management structure above the level of band eight (the clinical services manager) to be complex. Lines of accountability for all leaders was not set out within the group chart and it was not always clear how some leaders worked with other leaders. For example, the clinical lead paediatricians. We were told by the care group's associate medical director (who was also the clinical director for paediatrics) that there was one clinical lead each for Durham and Darlington hospitals. These clinical leads reported to the clinical director, paediatrics, who reported to the associate medical director. The group chart did not include these clinical leads so it was not clear how they fitted into the overall leadership structure. The associate medical director reported to the group clinical director.
- At service level, within nursing there was a clear leadership structure. The wards at both hospitals had a band seven ward manager who reported to the clinical services manager (a registered children's nurse). The ward managers were supported by band six sisters. The SCBU was managed across both hospitals by a neonatal unit manager who was supported by band six sisters. The clinical services manager reported to the head of child health who in turn reported to the head of children and families services, who was the line management link for nursing with the care closer to home group directors.
- Staff at service level we talked with told us they felt well supported by their band seven managers and the clinical services manager. The band seven ward managers felt well supported by the clinical services manager who displayed good knowledge and awareness of acute children's services throughout the inspection.
- We found that children did not have adequate representation at the trust's board level, which was a view shared by the management team and clinicians we talked with. There was an executive board lead for safeguarding children. However, we were told there was

no formal board-level director to promote children's rights and views as required by the National Service Framework (NSF) for Children standard for hospital services.

Culture within the service

- At service level we found a culture of openness among all medical, nursing and other staff we met within the children's service. Staff spoke positively about the care they provided for children, young people and parents. We saw how staff placed the child and the family at the centre of care delivery, and how this was seen as a priority and everyone's responsibility.
- The clinical services manager had a clear vision about future developments within the service, which considered staff members at ward and unit level.
- We saw that staff worked well together and that there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children.

Public and staff engagement

- We found that people's experiences were regularly asked about. A system had been set up to gain the views of children, young people and families about their experiences via a quality assessment tool. This was a formal survey undertaken bi-monthly in each area which asked a sample of parents/children their views about their experiences. These surveys resulted in a monthly report made available for parents and families to review.
- The management team provided other examples of engagement with people who used the service. For example, during 2014 the children's service asthma service was re-evaluated and awarded the 'investing in children' membership award. This award was a UK wide initiative which promoted the human rights of children and young people. To achieve the award organisations had to demonstrate dialogue with young people which could lead to change. In the assessment the reviewer who talked with young people accessing the service found "staff listen and take on board what patients and parents have to say".
- Staff views were regularly sought via a staff portion of the bi-monthly quality assessment tool which asked members of staff a number of questions relating to five domains which included safety, effectiveness, caring, responsiveness and professional development/

leadership. The overall score for treetops ward in November 2014 was 91%. Detailed scores were positive across all domains. Staff we talked with felt they could express their views to colleagues and managers.

Innovation, improvement and sustainability

- The children's service management team provided examples of areas of practice they felt were innovative. The team felt the development of the APNP role and testing of the paediatric front of house assessment approach was already providing positive outcomes for children, young people and parents. The management team also felt their paediatric community outreach service was "excellent" as it allowed and encouraged care at home avoiding admission to hospital.
- The service was particularly proud of its 'paediatric rapid response team.' In outline, when any child died in the community or acute setting within the County Durham and Darlington area a senior skilled nurse from the team attended the death to provide support and ensure appropriate skilled interaction from other agencies such as the police. We were provided positive examples of how the team had led to improvements in handling the death of a child delicately and sensitively by all agencies. The team was also supported by a nominated paediatrician.

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

Information about the service

The University Hospital of North Durham formed part of the County Durham and Darlington Foundation NHS Trust and provided end of life care services on site and in partnership with Darlington Memorial Hospital, community and hospice services. The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the specialist palliative care team. Specialist palliative care was provided as part of an integrated service across both hospital and community teams.

At University Hospital of North Durham, the specialist palliative care team comprised one 0.5 whole time equivalent (WTE) palliative care consultant and two WTE specialist palliative care nurses. All patients requiring end of life care could have access to the specialist palliative care team. We saw that referrals to the integrated service from April to October 2014 totalled 1,852, 98% of whom were patients with cancer.

During our inspection we spoke with the members of the specialist palliative care team, mortuary staff, chaplaincy staff, porters, medical staff, ward managers, nursing staff and allied healthcare professionals. In total we spoke with 28 staff. We visited a number of wards and clinical areas across the hospital including general medicine, haematology, general surgery, stroke services, respiratory medicine, orthopaedic surgery, the intensive care unit (ICU) and the accident and emergency (A&E) department. We reviewed the records of 14 patients at the end of life and reviewed 20 do not attempt cardiopulmonary resuscitation (DNACPR) orders. We spoke with one patient and three relatives and we reviewed audits, surveys and feedback reports specific to end of life care.

Summary of findings

End of life care services at this hospital required improvement. DNACPR forms were not always being completed accurately and comprehensively with clinical information relating to the decision, and discussions with patients and relatives were not always recorded. Mental capacity assessments were not being recorded when there was an indication that patients did not have the capacity to be involved in decision making. The trust had taken part in the 2013/14 NCDAH, where it had not achieved six out of seven organisational key performance indicators. The trust performed below the England average and failed to meet all of the 10 clinical key performance indicators. The trust had an action plan in place to address areas identified as part of the National Care of the Dying Audit (NCDAH), including the implementation of training and staff surveys.

Staff were seen to be caring and compassionate and we saw that the development of pastoral and spiritual services were planned for as part of the end of life care steering group. The specialist palliative care team provided support for patients at the end of life and for the ward staff caring for them. We observed specialist nurses and medical staff providing specialist support in a timely way that was aimed at developing the skills of non-specialist staff and ensuring the quality of end of life care. We were told that staff were caring and compassionate and we saw the service was responsive to patients' needs. There were prompt referral responses from the specialist palliative care team and a good focus on preferred place of care for patients at the end of life wishing to be at home.

The specialist palliative care team had addressed issues around staff attending specialist training by attending the wards every day and supporting staff to develop the skills needed to care for people at the end of life through a mentoring programme. Education had been identified as a priority area by the trust and recruitment to a dedicated end of life educator post had been included in service action plans. Structural development of the services had begun in terms of the identification of workforce needs and plans being developed to address these needs, but at the time of our inspection we saw that staffing difficulties had impacted on the ability of the specialist palliative care team to take action to develop the service. Examples included taking timely action to develop the service and address issues identified, the development of out of hours consultant cover and the use of data to monitor the effectiveness of the service.

Are end of life care services safe?

Requires Improvement

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Syringe driver monitoring was unclear. Staff told us that they carried out regular safety checks on syringe drivers during administration of medicines, but the recording form we were shown differed to the one aligned with the trust's syringe driver policy.

DNACPR forms were not completed consistently. Of the 20 forms we viewed, one had not been signed by a consultant until 12 days after the initial decision had been made, three did not have clear clinical reasoning documented and five did not include details of discussions with patients or their relatives.

There were effective procedures in place to support safe care for patients at the end of life. Staff demonstrated a good understanding of reporting procedures and there was evidence of learning from incidents. Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patients at the end of life.

Incidents

- There had been no never events (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers) or serious incidents reported in the twelve months prior to our inspection. There were no specific incidents relating to end of life care. We were told that the system for recording of incidents would not necessarily pick up an incident as being relevant to end of life care and as such themes and trends may not be identified within the reporting system.
- Staff were aware of their responsibilities in reporting incidents. On one ward the ward manager told us an incident had occurred where relatives of a patient had been concerned that nursing staff weren't as responsive as they needed to be in relation to managing a patient's symptoms. At the time there were a number of agency staff on the ward and one aspect of addressing the issue included block booking shift cover so that there was better continuity of care for patients.

- Staff told us they received feedback from incident reports they had made and that incidents were discussed, where appropriate, at staff meetings. We observed 'safety huddles' being held on the wards where relevant staff would meet to discuss specific issues or areas for concern during the course of a shift. Staff told us this enabled them to communicate more effectively and raised awareness of safety issues.
- Members of the specialist palliative care team told us that incidents were recorded based on the directorate they occurred in, and as the palliative care team sat in the care closer to home directorate, if incidents occurred in that directorate relating to end of life care they would be informed.

Environment and Equipment

- We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we viewed manual handling training records that showed staff had been appropriately trained in its use.
- There was specialist mortuary equipment available including bariatric and height adjustable trolleys.
- Staff told us that there were no issues with obtaining relevant equipment for the care of patients at the end of life.
- We were told that McKinley syringe drivers were used on the wards and that nursing staff had been trained in the use of the pumps. We viewed a syringe driver policy that included the use of a syringe driver monitoring chart, with 4 hourly safety checks of the administration of medicines via the pumps required.
- We did not see the syringe driver monitoring charts being used on the wards and staff on two separate wards showed us monitoring charts that were different to the ones attached to the policy. This meant that it was unclear how syringe driver checks were being recorded and there was no evidence of any audit being undertaken to monitor the recording of such checks.

Medicines

• The trust used the North of England Cancer Network's palliative and end of life care guidelines for cancer and non-cancer patients. The guidance included the use of

medicines in the management of symptoms including pain, nausea and vomiting, breathlessness and anxiety. Medical staff we spoke with were aware of the guidance and told us they could access it via the trust's intranet.

- The specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines (medication that they may need to make them more comfortable). The guidance they provided was in line with the end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- We reviewed 14 medication record charts of patients who were considered to be at the end of life and in all cases we saw that anticipatory medicines were prescribed appropriately and in line with the guidance.
- Controlled drugs were stored, administered and recorded in line with controlled drug guidance and medicines for anticipatory prescribing for key symptoms were in date, available and accessible.
- One of the palliative care consultants told us a 1 month re-audit of 30 cases of the use of opiates in end of life care was being carried out. The aim of the audit was to identify the medicines prescribed for the five key symptoms patients experience at the end of life, as well as auditing the correct use of opiates in patients who had impaired renal function.

Records

- An 'adult inpatient admission record' was used to record patient details, medical and nursing assessments and risk assessments and care plans.
- Patients identified as being at end of life were cared for using guidance that had been developed by the Northern England Strategic Clinical Network that was created in June 2014. The guidance stated that regular assessments and daily reviews should be documented in the medical and nursing notes.
- We viewed the records of 14 patients who were considered to be end of life. In all cases we saw that assessment and care records were completed appropriately and accurately.
- We reviewed 20 DNACPR forms. In all cases we saw that decisions were dated and approved by a consultant, but in one case there had been a 12 day delay in the form being signed by the consultant. In most cases there was

a clearly documented reason for the decision recorded with clinical information included, but we saw three examples of 'frailty of old age' being recorded instead of detailed clinical information.

 As part of the policy for the administration of subcutaneous medication via the T34 syringe pump we saw there was a syringe pump infusion monitoring chart available; however, we did not see this in use on the wards. When asked, staff on two separate wards showed us a different form that could be used. This meant it was unclear what process for syringe driver safety checks was being used.

Safeguarding

- We viewed mandatory training records and saw that members of the palliative care team had attended training in safeguarding children at level one or two, and safeguarding adults.
- Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns.
- A safeguarding system was in place for reporting all incidents and concerns.

Mandatory training

- We viewed training records and saw that members of the palliative care team had attended training in a number of mandatory areas. Examples included fire safety, safeguarding, the Mental Capacity Act, infection control, moving and handling and basic life support.
- End of life care awareness training was not part of the trust's mandatory training programme at the time of our inspection. Members of the specialist palliative care team told us they had participated in delivering end of life care training as part of the trust's regular mandatory training programme in the past but that this had not been consistent in recent years. We were told that mandatory training and development service and there were multiple priorities in terms of mandatory training subjects.
- We were told that mandatory training for foundation doctors included 1 hour of end of life care training, but that due to doctors having to attend a specific percentage of the overall training programme it was possible that end of life care training would be missed.

• There were plans to develop an end of life education strategy, once the post of end of life educator had been filled, including aims for aspects of end of life care training to become part of induction or mandatory training.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls, malnutrition and dehydration, the use of bed rails and the risk of pressure damage.
- Early warning tools were in use throughout the hospital, with regular assessments guiding staff in identifying patients whose condition was deteriorating. For end of life care specifically we saw that the use of the system helped to prompt discussions around care with the patients themselves or with family as appropriate.
- The trust had developed 'guidance for the care of patients who are ill enough to die', which was in place for the care of patients whose condition had deteriorated and the clinical team believed that the patient was ill enough that they may die within hours of days. The guidance included the requirement for the senior clinician in charge of the patient's care to review the patient within 24 hours and to make a plan for symptom control.

Nursing staffing

- There were 2 WTE band seven specialist palliative care nurses based at the University Hospital of North Durham.
- Members of the specialist palliative care team we spoke with told us that the trust had recently recruited to two band eight lead nurse posts, two discharge facilitator post and one nurse educator post. We were told it was expected that post holders would be in place from April 2015.
- Specialist palliative care nurses were available from 9am to 5pm Monday to Friday. There was no on-call specialist palliative nursing cover out of hours.
- Nursing staff on the wards told us they felt they had sufficient staffing to prioritise good quality end of life care when needed and that they had processes in place to escalate staffing concerns should they arise.

• There were link nurses available on the wards who had a special interest in end of life care and would take a lead with other nursing staff in terms of ensuring end of life care was sufficiently prioritised and developed at ward level.

Medical staffing

- There were 2.7 WTE palliative care consultants employed across the trust, including one locum. This included one 0.5 WTE consultant who was based at the University Hospital of North Durham.
- Staff told us that based on the population based needs assessment for specialised palliative care for the Northern England Strategic Clinical Network, there were consultant shortages across the trust with difficulties recruiting to posts.
- Ward-based doctors were supported to deliver end of life care by the specialist palliative care team and we observed the specialist palliative care nurses discussing prescribing guidelines with doctors on the wards.
- Medical staff we spoke with told us the specialist palliative care team was available for specialist advice as needed.
- There was no out-of-hours specialist palliative care medical cover in place, but the consultant in palliative care told us this had been discussed at a broader regional level with a view to developing a regional out-of-hours telephone service.
- Ward staff told us they would refer to the written guidance out of hours and that they could access more specialist advice from local hospices.

Major incident awareness and training

- We viewed a business continuity plan and saw that arrangements for major incidents included the use of temporary mortuary facilities, use of community funeral directors and transfers between hospital mortuaries was part of the trust's contingency planning.
- Major incident planning included the use of the chaplain in a support role and we saw that the on-call chaplain was included in a 'call-out cascade' when a major incident occurs.

Are end of life care services effective?

Requires Improvement



The trust had taken part in the 2013/14 NCDAH, where it had not achieved six out of seven organisational key performance indicators. The trust performed below the England average and failed to meet all of the 10 clinical key performance indicators. The trust had an action plan in place to address areas identified as part of the National Care of the Dying Audit (NCDAH), including the implementation of training and staff surveys.

We saw that where patients were identified by staff as lacking the mental capacity to be involved in DNACPR decisions, that family members were generally consulted. However, we did not see mental capacity assessments being completed and recorded in line with the principles of the Mental Capacity Act 2005.

Assessments of patients' pain were consistently carried out, with a variety of appropriate measures and tools in place for staff to use. Symptoms were generally addressed in a timely manner. Nutrition and hydration assessments were carried out and staff we spoke with were consistent in their awareness of quality of life issues relating to nutrition and hydration at the end of life.

The trust had taken action to plan and develop services in line with national guidance, with the implementation of an end of life care guidance document around the identification, assessment, care planning, coordination and symptom management of patients at the end of life. Members of the specialist palliative care team were appropriately qualified and experienced to give specialist advice and we saw evidence of good multidisciplinary team working as part of the approach to supporting ward-based staff and patients in delivering good quality end of life care. The Liverpool Care Pathway was no longer in use since the national phase out date of July 2014.

Evidence-based care and treatment

• We viewed a guideline document for end of life care that had been ratified in January 2015. The guidance included identifying patients at the end of life, holistic assessment, advanced care planning, coordinated care and the management of pain and other symptoms.

- End of life care documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life Care Strategy, the National Institute for Health and Care Excellence (NICE) and the Gold Standards Framework (GSF).
- The Liverpool Care Pathway (LCP) had been phased out nationally by July 2014 and staff we spoke with at the University Hospital of North Durham told us it had not been used since this time.
- We viewed a document titled 'Guidance for care of patients who are ill enough to die' which staff told us had replaced the LCP. We saw laminated copies of the guidance displayed in ward areas and in the files of patients who had been identified as being ill enough to die.

Pain relief

- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.
- The wards we visited had adequate stocks of medicines in line with anticipatory prescribing guidance around the five key symptoms most commonly experienced at the end of life.
- Pain assessment charts were available on the wards and that these included a universal pain assessment tool, the Abbey pain scale for patients who are cognitively impaired and the Wong-Baker FACES Pain Rating Scale. We saw that the different scales were used based on patients' ability to express, score or rate their pain.
- We viewed pain scales being used appropriately on the wards to assess patients' pain and to evaluate the effectiveness of medication administered.
- Relatives we spoke with told us that the nursing staff supported patients well in managing their pain and responded quickly to expressions of pain and other indicators.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was incorporated into the inpatient admission record to assess patients on admission, then weekly as appropriate.
- The assessment included identifying a risk score; if a patient had a score of 1 they were considered to be at moderate risk and if they had a score of 2 they were
considered to be at high risk. When a patient was at moderate risk there were prompts to direct nursing staff to take specific action in line with a nutrition care plan. When a patient was identified as being at high risk nursing staff were prompted to carry out a dietician referral.

- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in that part of a patient's care as appropriate, including the administration of mouth care when a patient was no longer able to eat and drink.
- Staff we spoke with told us they were led by patients' wishes at the end of life with regard to nutrition and hydration. A doctor we spoke with told us that nutrition and hydration was led by patients' wishes and comfort needs at the end of life and that time would be spent with the patient and family to discuss options in relation to this. Guidance was available from dieticians and medical staff if patients or family members wished to discuss options, and this was supported by the use of daily medical reviews as part of the end of life care guidance.

Patient outcomes

- The trust had taken part in the 2013/14 NCDAH, where it had not achieved six out of seven organisational key performance indicators. The trust performed well in the use of clinical protocols for the prescription of medications for the five key symptoms at the end of life. The trust performed below the England average and failed to meet all of the 10 clinical key performance indicators.
- We viewed a draft action plan that aimed to address issues raised following the audit, including the recruitment to an end of life care educator post, the appointment of a non-executive director to take the lead on end of life care, and the implementation of regional 'guidance for care of patients who are ill enough to die'.
- At the time of our inspection the 'guidance for care of patients who are ill enough to die' had been implemented in July 2014 but other actions had been delayed. Members of the specialist palliative care team told us that delays had been due to structural and staffing issues as well as the end of life steering group being newly established.

- There were two WTE specialist palliative care nurses based at the University Hospital of North Durham.
- Specialist palliative care nurses visited the wards on a daily basis to review patients at the end of life and to support ward-based medical and nursing staff in planning and delivering care to patients.
- There were end of life resource folders kept on the wards and in clinical areas, offering staff information on where they could obtain additional support or advice and details of aspects of symptom management and care at the end of life.
- There were end of life link nurses based on the wards; these were staff that had attended end of life care training and acted as a link between ward staff and the specialist nurses in terms of sharing learning and knowledge.
- Ward staff and the specialist palliative care nurses told us that training was often delivered on the wards as there had been some difficulties releasing ward staff for formal classroom-based learning. We observed the specialist nurses spending time on the wards and working with nursing and medical staff in a way that focused on the development of consistent end of life care.
- Ward based nurses were able to shadow the specialist palliative care nurses so that they could develop more specialist knowledge and there was a programme in place for specialist nurses to mentor staff who were undertaking end of life care training courses from external training providers.
- We viewed an action plan that included the development of a nurse educator role and end of life care training that included the use of staff surveys to measure the effectiveness of training delivered.

Multidisciplinary working

- Members of the specialist palliative care team participated in multidisciplinary meetings, working with other specialists to support good quality end of life care across clinical specialties.
- The specialist palliative care team told us it met daily to discuss patient care and workloads and that wider team meetings across both hospital sites were held every few weeks.
- Staff also told us they had the opportunity to meet with the wider multidisciplinary team as part of the end of life steering group meetings. We viewed minutes of

Competent staff

these meetings that demonstrated multidisciplinary action planning in a number of areas, one example being the development of spiritual services for patients at the end of life.

Seven-day services

- The specialist palliative care team provide a 5-day, 9am to 5pm face-to-face service with no out of hours input.
- The specialist palliative care team told us there were plans to join the Tees out-of-hours consultant on-call rota and we saw plans in place to progress this as part of action against the results of the 2013/14 NCDAH.
- Out-o- hours support at the time of our inspection was available from local hospices and the specialist palliative care team had developed resource folders for each ward/clinical area that included information and advice for staff.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out-of-hours cover.

Access to information

- Risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- Once a patient had been identified as being ill enough to die staff would use the regional guidance for the care of patients who are ill enough to die. The guidance incorporated prompts for staff to assess patient symptoms, identify advance decisions, discuss values and spiritual needs and agree options for hydration and feeding.
- We viewed records that included detailed information about the management of symptoms, discussions and interventions. We also saw that when patients were seen by the specialist palliative care team, information and advice was clearly recorded so that staff could easily access the guidance given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

• The trust's 'resuscitation and do not attempt cardiopulmonary resuscitation policy' provided guidance for completing a DNACPR form for an individual who does not have capacity, stating that when a specific care decision was to be made the 'Best interests' process under the Mental Capacity Act 2005 must be followed.

- Of the 20 DNACPR forms we viewed across a variety of wards in the hospital, seven were for patients who staff identified as lacking the mental capacity to be involved in resuscitation decisions. In most cases we saw that the decision was discussed with the patient's family, but on one patient's form discussion with family was recorded as not applicable. There was no reason for this recorded in the notes and the ward manager told us they would follow this up with the consultant. There were no mental capacity assessments recorded as part of the decision making process where patients had been identified as unable to participate in discussions. This meant that the process of identifying patients who lacked mental capacity was unclear.
- The trust was implementing guidance from the 'Deciding right' Northeast NHS document 'an integrated approach to making care decisions in advance'. We saw that this was incorporated into the DNACPR decision making form in terms of recognising when a patient has made an advanced decision. Emergency healthcare plans (a care plan covering the management of an anticipated emergency) had been piloted and we were told that arrangements were in place to deliver training for ward and community based staff in the use of the plans. We did not see emergency healthcare plans in use during our visit.

Are end of life care services caring?



End of life care services were seen to be caring. Relatives told us they were happy with the quality of care their loved ones received and that staff were kind, caring and compassionate in their approach. We saw evidence of plans to proactively develop the chaplaincy service in terms of pastoral and spiritual care that involved providing spiritual, pastoral and emotional support to patients and families from a number of faiths and for those who don't follow a faith at all.

Compassionate care

- During our inspection we saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that respected their individual choices and beliefs.

- Patients and relatives we spoke with told us they were happy with the quality of care they received. One relative told us that staff were quick to respond to the patient's needs and they were caring and compassionate in their approach. Relatives told us they were given reclining chairs to rest in if they were staying at the hospital for long periods of time and that there was open visiting for them.
- Responses from a bereaved relative survey were mostly positive in relation to the care patients at the end of life and family members received. Trust analysis of the results highlighted issues around communication, documentation and meeting people's spiritual support needs. We saw that these areas had been discussed at end of life care steering meetings and actions incorporated into the action plan following the NCDAH.
- We saw that care after death honoured people's spiritual and cultural wishes. Members of the chaplaincy team told us they were able to source expertise from the local community around different cultures and faiths and that there were staff within the trust that had specific knowledge in this area.
- We spoke with mortuary staff who told us they worked closely with family members regarding care after death and all mortuary staff had attended bereavement training.
- Staff on the wards told us they would support relatives following bereavement and would facilitate the completion of the death certificate and offer guidance and support around registering the death and other arrangements. A bereavement leaflet was available with information for people to take away with them.

Understanding and involvement of patients and those close to them

- Family members we spoke with told us they felt involved in the care delivered.
- Staff discussed care issues with patients and relatives where possible and these were mostly clearly documented in patients' notes.
- The end of life care guidance used by the trust included prompts for discussing issues of care with patients and relatives.
- Systems were being implemented to support patients in advanced care planning in the form of the development of emergency health plans. We saw that training was

planned in the 'Deciding right' approach to decision making and we saw minutes of the end of life steering group that included the use of a pilot to develop this approach across the trust.

Emotional support

- Members of the specialist palliative care team participated in the delivery of trust wide Sage and Thyme training for clinical staff. The Sage and Thyme model is focused on supporting staff to listen and respond to patients/carers who are distressed or concerned.
- Visiting times were flexible for family and friends when patients were at the end of life and we saw that reclining chairs were available for relatives who wished to stay with a patient. There were quiet rooms available on the wards that relatives could use and we were told there were showering facilities available for those staying overnight.
- Where possible, patients at the end of life were given the option to move to a side room to ensure their privacy and dignity during time with relatives.
- There was a multi-faith chapel available that held information relevant to people from different faiths. The chaplaincy services within the trust were geared towards providing support for patients and their relatives irrespective of their individual faith or if they did not follow a faith. There was also a prayer room available with ablution facilities.
- Plans were in place and there was evidence of discussion at end of life steering group meetings to develop the chaplaincy service in response to a decline in the number of patients and relatives referred to the service.
- A proposal had been developed that included a proactive approach to engaging with patients and family on the wards and offering pastoral and spiritual support directly. The development of this approach was based on an 'opt out' model of chaplaincy support in the last days of life based on that used by other trusts in the region.

Are end of life care services responsive?

Good

All patients requiring end of life care could have access to the specialist palliative care team. Referrals to the integrated service from 1 April to 1 October 2014 totalled 1,852, but specific data relating to the activity of specialist palliative care team based at the University Hospital of North Durham was not available. Specialist palliative care referrals were mostly for support with pain and symptom management, with additional support provided for patients and family members for people with complex end of life care needs.

Staff, patients and relatives told us that end of life care services were responsive and we saw evidence of this during our inspection. However, there was a lack of audit data available to show patient preferences or the response times and activity of the specialist palliative care team. There was evidence of service development to meet patients' needs in terms of the facilitation of discharge to preferred place of care at the end of life, including the development of dedicated discharge facilitator posts.

Specialist palliative care staff were not always made aware of complaints relevant to end of life care as complaints were not recorded in a way that categorised end of life care, meaning that learning from complaints may not always have specialist input.

Service planning and delivery to meet the needs of local people

- Preferred place of care at the end of life was recorded by the specialist palliative care team but not as part of routine admission data collected on the wards. This meant that patients who were referred to the specialist palliative care team would have had their preferences recorded but those who weren't referred may not have done.
- We viewed a bereaved relative survey in which 76% of respondents stated they felt their relative died in the right place; however the trust did not have data available for patients dying in their preferred location at the time of our inspection. Staff told us this was due to a lack of administrative support to the specialist palliative care team at the time of our inspection.

- The trust used a strategic commissioning plan that had been developed by local clinical commissioning groups (CCGs) with input from key staff within the trust, patients and external professionals. From this, we were told that the trust had recently recruited to two discharge facilitator posts.
- The aim of the strategic commissioning plan was to provide a framework for the provision of end of life care and identified priorities such as multidisciplinary working, advanced care planning, meeting the needs of people living longer with diseases, consultant led care, 7 day services and patients choosing where they want to be cared for at the end of life.

Meeting people's individual needs

- Staff on the wards told us that patients with complex needs would be referred to the specialist palliative care team for additional support, particularly when there were issues around managing their symptoms effectively. We also saw that clinical nurse specialists from other specialties would be involved in care as necessary, including a liver Clinical Nurse Specialist who worked with ward staff to ensure appropriate care at the end of life.
- We saw from training records that some staff had undertaken training in dementia and learning disability awareness via the trust's e-learning package, and we saw that the trust had plans to develop this training and improve uptake.
- Patients and family members we spoke with told us that their care was individualised and we observed discussions around care and treatment decisions that demonstrated this.
- Mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious and spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives.
- Chaplaincy services were described as 'a place of worship, reflection and quietness for people of all faiths and none' and that plans were in place to develop chaplaincy services to meet the needs of people from different and no faiths.
- Assessment documentation by the specialist palliative care team included recording patients' preferred location of care at the end of life.

Access and flow

- All patients we saw had gone through a process of assessment and risk assessment from both medical and nursing perspectives on admission.
- Ward staff we spoke with told us they knew how to access the specialist palliative care team and that the team was responsive to the needs of patients. We saw referrals being made in timely and appropriate ways.
- Members of the specialist palliative care team and ward staff alike told us that generally patients would be seen within hours of a referral to the specialist team. We saw examples of specialist palliative care nurses assessing patients on the same day as the referral was made.
- We saw that resource folders on the wards included information for ward staff on how to access specialist advice outside of normal working hours when the specialist palliative care team was not available.
- The chaplaincy service was accessible 7 days a week via an on-call system. We saw that the chaplaincy service was being developed as an open ended support for patients when identified as dying. There were plans in place to raise awareness among staff about the ability of the service to provide comfort and support outside of religious or faith beliefs.
- Staff across the trust told us they felt they were able to discharge patients quickly at the end of life if they chose to be cared for at home. We were told that arrangements with the pharmacy included the prioritisation of end of life medicines in this situation and that these could be available within an hour. The trust did not collect specific data regarding rapid discharge for patients requiring end of life care.
 Staff told us they worked with the Marie Curie rapid
- response team and hospice at home services to ensure patients got home as quickly as possible if this is what they wished.

Learning from complaints and concerns

- Members of the specialist palliative care team told us they were not always made aware of complaints relating to end of life care. We were told that the system for recording complaints would not necessarily pick up a complaint as being relevant to end of life care and as such themes and trends may not be identified within the current reporting system.
- We were told that the system in place relied upon summaries of complaints being given to the head of each directorate. This meant that complaints were

made related to patients being cared for in the care closer to home directorate, where the specialist palliative care team sits, the team would be made aware of them. However, if complaints were made from other directorates the team may not always be aware of them.

• Staff we spoke with told us they felt that the complaints management system needed to be more joined up in a way that enabled them to pick up themes.

Are end of life care services well-led?

Requires Improvement

There was no trust wide end of life strategy in place and there was not a non-executive director nominated as the lead for end of life care within the trust. The trust had been involved in the development of a regional end of life care commissioning strategy and progress had been made in terms of recruitment to some posts developed in line with this strategy. There had been some development in relation to end of life care being prioritised within the trust; however, staff we spoke with told us these developments were hampered by structural issues relating to staffing within the teams and leadership changes. In particular, while an action plan had been devised following the NCDAH, action had yet to be taken in many areas. For example 9 months following the receipt of the audit report, six out of eight objectives recorded on the action plan stated that the trust position remained unchanged. There were also limited data available to support the effectiveness of the service and staff told us this was due to a lack of administrative support to update the database and ensure up to date data were available and used effectively.

We saw plans in place to develop the service and staff we spoke with were motivated, committed and enthusiastic in taking this forward. There were plans in place to address staffing issues within the specialist palliative care team and some progress had been made in terms of recruitment; however this needs to be further developed, particularly in terms of adequate consultant cover and administrative support.

Vision and strategy for this service

• There was not a non-executive director nominated as the lead for end of life care within the trust.

- Staff told us that the director of nursing had agreed to chair the end of life steering group that had been developed in the past year; however, it had been identified that a more permanent chair was needed to ensure continuity of service development. We were told that the regular steering group meetings had been on temporary hiatus due to structural changes in the directorate but that there was a commitment to ensure these continued regularly.
- Staff felt there had been an improvement in understanding and commitment at board level for the need for good quality end of life care, with a genuine intention to improve. However, they felt that the level of engagement between the board and the services could be further improved.
- There was a strategic commissioning plan that had been developed by local CCGs, with input from key staff within the trust, patients and external professionals.
- There was not a trust wide end of life strategy in place, although we saw evidence of action plans being drawn up to address issues identified from external audit and local reviews. Members of the specialist palliative care team had a good understanding of the priorities that had been identified across the trust in the development of end of life care services.
- As part of the trust's 'Quality matters' 2015–17 strategy, end of life care had been identified as one of the priority areas. The aim of this was stated as 'We want people approaching the end of their life to have confidence that the care we provide will be consistent with their preferences. We want patients and their families to be supported and informed of all options available to them'.
- Ward staff were engaged in the provision of end of life care and we saw that with support from the specialist palliative care team they had a good understanding of what constituted good quality end of life care.
- There was an action plan relating to the results of the NCDAH that outlined the priorities for developing end of life care within the trust and we saw that this included the development and recruitment to new senior posts within the specialist palliative care team.
- Staff we spoke with told us they believed it had been difficult historically for end of life care to be seen as a trust priority, but that action taken in the past year, with the development of the end of life care steering group, would lead to better ownership and prioritisation.

Governance, risk management and quality measurement

- Specialist palliative care reports within the structure of the care closer to home directorate and the lead nurse/ head of clinical governance had been identified as the end of life lead from April 2015.
- We viewed minutes from the end of life care steering group and saw that these were attended by representatives from a number of clinical areas/groups. These included the head of clinical governance, a palliative care consultant, specialist palliative care nurses, a cancer nurse specialist, chief pharmacist, a sister from the cardiac arrest prevention team, a chaplain and a district nurse team manager. This ensured that representation was made from a wide range of services.
- The results of the NCDAH audit had been used to develop an action plan that was led by the end of life steering group, and the action points highlighted were geared towards improving end of life care. However, action had not been taken in a number of areas. For example the trust had not appointed a non-executive lead for end of life and the target action date (June 2015) was 13 months from the date the action had been identified (May 2014). Another example was that an audit of end of life care guidance implemented in July 2014 was not scheduled to begin until quarter 4 of the 2014/15 financial year. However, this did not happen due to lack of capacity within the SPC team, It has since has been undertaken in quarter 1 of the 2015/16 financial year.
- Staff we spoke with told us the report from the NCDAH had been received in May 2014 and that work had started on the action plan from this, but that it had taken time to agree the action plan due to the end of life care steering group being in its infancy as well as staffing and recruitment issues.
- Members of the specialist palliative care team told us that problems with staffing the service had impacted on the development of the service and their ability to take action in a timely and effective way. The care closer to home risk register included the identification of risk in relation to the specialist palliative care service. Specific examples included the lack of a lead nurse, vacant consultant hours and poor administrative support due to a pause in the management restructure within the care closer to home directorate.

- Action planned as a result of the risks identified had included addressing consultant recruitment issues with the CCG and the identification of interim clinical leadership roles.
- There were limited data available to demonstrate the effectiveness and quality of the service. Staff we spoke with told us this was due to a lack of administrative support to the specialist palliative care team and the database not being kept up to date.
- The trust had adopted the use of the End of Life Care Quality Assessment Tool (ELCQuA) in 2013/14. The ELCQuA is a tool that tracks progress in delivering end of life care services. We viewed a draft report dated March 2014 where priorities had been identified, but we did not see a further report illustrating progress in relation to this.
- We were told that mortality reviews took place and ere reviewed at board level and that a member of the specialist palliative care team had been involved in these reviews. We saw from steering group meeting minutes that meetings of the mortality review group focused on the reduction of avoidable deaths and that mechanisms to review palliative care at the end of life were being developed.

Leadership of service

- We saw evidence of good local leadership at ward level, with end of life care being seen by ward managers and staff as a priority in terms of quality and meeting patient needs and wishes.
- The director of nursing had stepped in to provide executive leadership, but there was no non-executive lead appointed at board level and the target date for this was 13 months following the date of the audit. Staff we spoke with told us they felt more needed to be done to prioritise end of life care within the trust.
- We saw a good level of commitment within the specialist palliative care team to the development of good quality end of life care within this hospital.
- The specialist palliative care team had been without a lead nurse for a period of several months leading up to our inspection and staff told us the limited structure had impacted on their ability to take forward initiatives they believed to be important to the development of the service. One particular example was that the action plan

resulting from the NCDAH report in May 2014 had limited action taken to date. In six out of eight objectives, the position of the trust remained unchanged since the audit.

• The recruitment of two band eight nursing posts to the specialist palliative care team had been successful and we were told these post holders were expected to start by April 2015.

Culture within the service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that ward staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- Members of the specialist palliative care team told us they were proud of the care they were able to deliver but that they felt they would be able to further develop the service once the new service structure had been embedded and new post holders were in place.

Public and staff engagement

- Although there was not a non-executive director with lead responsibility for end of life care at the time of our inspection, we saw there were plans in place to appoint a lay member at board level and to the end of life steering group.
- The results of a bereaved relative survey had been collated and compiled into a report that included action points relating to improving communication and access to spiritual support.

Innovation, improvement and sustainability

- The specialist palliative care team was focused on continually improving the quality of care and we observed a commitment to this at ward level as well.
- We saw elements of lessons learned to improve end of life care. However, because of the way incidents, complaints and patient experience issues were

recorded depending on where they received their care it was unclear how the trust ensured relevant specialist palliative care input in the review of learning relating to end of life care.

- We saw plans in place to develop an end of life education strategy in line with the appointment to an end of life educator post.
- The palliative care team staff told us they had successfully recruited to two discharge facilitator posts and we saw plans in place to develop the chaplaincy service.

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The University Hospital of North Durham outpatient departments and imaging department are situated on the main hospital site on the outskirts of Durham City. There were a total of 252,705 outpatient appointments between April 2013 and March 2014. The ratio of new appointments to review appointments was approximately 1:2.

Outpatient clinics were held in four different locations on the site: main outpatients, dermatology outpatients, orthopaedics outpatients and ophthalmology outpatients. The outpatient departments ran a wide range of clinics, some nurse led, some allied health professional led and some led by doctors across a large number of specialties such as urology, gynaecology, orthopaedics, general surgery, breast surgery, orthodontics, ophthalmology, ear nose and throat, and respiratory medicine.

Radiology was part of the trust's surgery and diagnostics care group directorate. Radiology provided a trust wide diagnostic imaging service. The acute work of the trust was concentrated at the University Hospital of North Durham and Darlington Memorial Hospital, which offered a full comprehensive range of diagnostic imaging and interventional procedures, as well as a substantial plain film reporting and ultrasound service. Radiology services were managed by a clinical lead radiologist, head of service for imaging and radiology manager.

During the inspection we spoke with 23 patients and eight relatives, two senior managers, two band five nurses, one matron, two band six nurses, three band seven nurses, two healthcare assistants, two administrative staff, one member of a technical team, one allied health professional, 22 radiology staff members including consultant radiologists, the radiology clinical lead, radiographers, a consultant physician and consultant surgeon, nurses and administrative staff.

We observed the radiology and outpatient environments, checked equipment and looked at patient information.

Summary of findings

Overall the care and treatment received by patients in the University Hospital of North Durham outpatient and imaging departments was safe, effective, caring, responsive and well led. Patients were very happy with the care they received and found it to be caring and compassionate. Staff were supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because there were policies in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

The departments took part in the NHS Friends and Family Test and another satisfaction scheme called 'I want great care.' There were comment boxes in waiting areas.

On the whole, the services offered were delivered in an innovative way to respond to patient needs and ensure that the departments worked effectively and efficiently.

Are outpatient and diagnostic imaging services safe?

Good

Incidents were reported using an electronic reporting system and all the staff we spoke with were able to report incidents using the system if they needed to. Incidents were investigated and lessons learned were shared with all of the staff. The cleanliness and hygiene in the departments was within acceptable standards. There was sufficient personal protective equipment in all of the areas we inspected and staff were aware of how to dispose of it safely and within guidelines. There was sufficient clean and well maintained equipment to ensure that patients received the treatment they needed in a safe way.

Staff were aware of the various policies in place to protect vulnerable adults and those with additional support needs. Patients were asked for their consent before care and treatment was given. Staff were clear about who could make decision on behalf of patients when they lacked or had fluctuating capacity.

Medical records were electronic and therefore there were few problems with information not being available for clinics.

Staff in all departments were aware of the actions they should take in the case of a major incident.

Incidents

- There had been 24 incidents within the outpatient department during 2014. Twenty caused no harm, three caused minor harm and one was classified as a near miss. There were no serious or moderate harm incidents at the University Hospital of North Durham.
- There were 50 radiation incidents (plus 4 near misses) affecting 50 patients during 2014. Nineteen of these required the Care Quality Commission (CQC) to be notified under IR(M)ER and three of these required dual reporting to the HSE under IRR99. The trust was not an outlier in terms of IR(M)ER notification requirements. The underlying causes of radiation incidents were:
- Imaging department error (wrong side, image transfer to the wrong patient folder, cassette double exposure): 25 out of 55 (45.5%)

- Referrer error (wrong patient or wrong clinical history): 17out of 55 (31%)
- Equipment error: 4 out of 55 (7%)
- Other: 9 out of 55 (16.5%)
- Of the 21 required notifications to an enforcing authority, 13 (62%) were due to referrer error. The wrong patient undergoing a medical exposure was the most common reason for notification.
- The trust used an electronic system to record incidents and near misses. All staff who worked in the departments were able to access the system to record incidents.
- We spoke with staff about their knowledge of the incident reporting system. All staff said they could access the system and knew how to report incidents.
- Staff were able to give examples of reported incidents and changes in practice that had resulted from the subsequent investigations.
- The departments had robust systems in place to report and learn from incidents, to reduce the risk of harm to patients.
- All of the staff we spoke with were able to describe how they reported incidents and how they used the hospital incident reporting system.
- The manager told us they encouraged a culture of open incident reporting across all of the diagnostic modalities and staff we spoke confirmed this.
- There were no 'never events' reported in 2013/14 (never events are serious, largely preventable patient safety incidents that should not occur if the available, preventative measures have been implemented).
- In 2014, the department reported three serious incidents to the Strategic Executive Information System (STEIS).
- We looked at one of the serious incidents reported and saw the incident had been categorised, described and investigated. The outcomes from the investigation were recorded and these had been discussed with the patient and an apology given.
- We saw evidence through our review of departmental communication processes of post-incident feedback, learning reviewed and changes in practice implemented.
- The managers told us that they continued to report radiation incidents to the CQC under IR(ME)R.

Cleanliness, infection control and hygiene

- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Personal protective equipment such as rubber gloves, protective eye glasses and aprons were available to staff.
- Once used, personal protective equipment was disposed of safely and appropriately.
- The outpatient areas and clinic rooms were clean and tidy and we saw staff maintaining the hygiene of the areas using appropriate wipes to clean equipment between patient use, thus reducing the risk of cross infection.
- The imaging and outpatient department staff took part in regular hand washing and environment audits. We saw the latest reports which showed that these were part of an ongoing process.
- An infection control audit had been carried out in the outpatient department in February 2014. The department was 93% compliant. An action plan had been written to ensure that areas of non-compliance were addressed. This included replacing damaged chairs, removing boxes stored on floors, improving dusting routines and having a rota in place for cleaning of curtains in treatment and consultation rooms. We observed that there were no damaged chairs, no boxes stored inappropriately and no problems with residual dust in the outpatient departments. Curtains in the treatment and consultation rooms we inspected were clean.
- The radiology department overall appeared clean, tidy and uncluttered.
- Patient waiting and private changing areas were clean and tidy. Single sex and disabled toilet facilities were available and these areas were also generally clean.
- Hand washing posters were displayed throughout the department and there was sufficient hand wash facilities.
- Staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control standards. Departmental cleaning schedules were not available.
- We saw staff wearing protective clothing such as disposable gloves, aprons and using hand wash gel appropriately and the 'bare below the elbow' policy was adhered to. The appropriate containers for disposing of clinical waste were available and in use across the department.

- The August 2014 infection control audit overall showed positive compliance results with infection prevention and control practices.
- The manager told us that for patients with infections, infection prevention and control principles were applied. Two radiographers would be involved in the patient's care, one to solely manage the equipment and the second to manage and support the patient during their diagnostic screening.

Environment and equipment

- The environments of the outpatient departments were well lit, spacious and pleasantly decorated.
- During our inspection we saw that the waiting rooms got busy and staff told us that sometimes there was not sufficient seating for patients in the waiting areas particularly if clinics were running late. There were rare occasions when patients had to stand.
- Overall, the outpatient departments were big enough to meet the needs of all patients and relatives.
- In some outpatient waiting areas, there were unsupervised play areas for children.
- We saw and staff confirmed that there was sufficient equipment to meet the needs of patients within the outpatient and imaging departments.
- We looked at the resuscitation equipment in the departments. The equipment had mostly been checked daily as required, but within the ophthalmology department we saw that in January, there were eight occasions when the record sheet for checks had not been completed. We additionally noted that a number of trolleys which contained needles and drugs were not closed with security tags in place. In dermatology for example, the trolley was located where patients could be left alone and could easily access the contents.
- We saw that on the resuscitation trolley in the main outpatient department, the children's size defibrillator pads stated 'Use by 01-2015'. This meant that as per the medication policy, the pads should have been either used by 31 December 2014 or disposed of and replaced.
- Within the orthopaedic department, the resuscitation equipment was stored in a cupboard with an Ambu bag which stated that it expired in 2013.
- Equipment was cleaned regularly and serviced in line with manufacturer guidance. Staff showed us how they cleaned equipment. The equipment we looked at was clean.

- The departments were able to replace broken equipment in a timely manner and able to order new equipment if needed. Staff we spoke with confirmed this. We also saw condemned notices were available for staff to place on broken equipment to make sure it wasn't used by mistake.
- Within training files, we saw evidence that staff who used equipment had their competencies checked at induction and then regularly to make sure that they had the skills and knowledge to use the equipment safely.
- We requested a copy of the latest radiation protection adviser (RPA) report from the trust. This was written in 2013. It contained a summary of key issues faced by the trust such as ageing x-ray equipment and gamma camera at Darlington Memorial Hospital, increased radiation incidents, theatre staff failure to wear dosimeters and lack of radiologist support, particularly at Bishop Auckland Hospital.
- The trust was aware of the issues and had a programme to improve compliance in place.
- During our observations we saw that there was clear and appropriate signage about hazards in the imaging and dermatology departments.
- We saw that one of the fluoroscopy rooms at the University Hospital of North Durham was being upgraded at the time of our visit. There were no signs or barriers in place warning that work was being carried out in this area and to prevent people from entering the room.
- The room had been left open and unattended and we saw materials such as ceiling fitments stored inappropriately outside the room adjacent to the main x-ray corridor. This issue was brought to the immediate attention of the departmental managers and the area was secured at the time of our visit.
- The manager told us that all modalities had appointed and trained radiation protection supervisors (RPSs) whose role it was to ensure that equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national and local guidance.
- The manager also confirmed that the RPA worked within the trust but was not a direct employee of the trust. The manager confirmed that regular contact was maintained between the RPA and the departmental RPSs throughout the year. The manager told us that the local rules for diagnostic x-ray were being updated at the time of our visit.

- The trust had policies and procedures in place in relation to principle radiation and protection regulations. We looked at the written 'Employers procedures'. We saw that these included the principle radiation legislation, local rules and descriptions of the duties to be undertaken by staff in accordance with the legislation.
- We saw the department had radiological protection/ hazard signage displayed throughout the department. Illuminated treatment room no-entry signs were clearly visible and in use throughout the department at the time of the inspection.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas.
- The manager told us that there were systems and processes in place to ensure the maintenance and servicing of imaging equipment.
- Within radiology, emergency resuscitation equipment for both adults and children was checked and readily available for use. We saw daily checks of this equipment had been completed.

Medicines

- The outpatient departments kept a limited supply of medication.
- Medication that needed to be refrigerated was stored in locked fridges. We looked at the temperature record charts for the fridges. All but one of these showed that temperature checks were carried out daily. Within the ophthalmology department we found that for January 2015, there were seven week days when the temperature had not been noted on the record sheet.
- Some staff used patient group directives to dispense drugs to patients. We checked these and found that they had been reviewed appropriately.
- There was no outpatient pharmacy on site and therefore when patients were prescribed medication, this was done using an 'FP10' which could be dispensed by any pharmacy. The FP10s were stored securely.
- We looked in the medication stock cupboards to check whether the drugs were being stored correctly and were in date. In one of the ophthalmology storage cupboards, we found three boxes of one drug that expired in December 2014. In three other rooms, we found boxes of another drug that expired in January 2015. We checked the medication policy which stated that, 'Date expired drugs must be returned to the pharmacy

department for destruction.' The policy further explained that if the drug box states 'Use by', the drug should be used by the 1st of that month. If it states 'Exp by', the drug should be used by the last day of the month and if the box states 'Use before' then the drug should be used before the first day of that month.

- Patients who needed medication such as insulin were asked to bring their own supply when they visited the outpatient departments.
- Within radiology, medicines were stored correctly in locked cupboards or fridges. Fridge temperatures were checked and recorded correctly.
- We were told medicine stocks were checked weekly by the nursing and pharmacy staff. We looked at a random sample of the medicines stored, including contrast medium, and found these items to be in date.
- We also looked at the controlled drugs register and saw stock counts were recorded correctly. However, at the University Hospital of North Durham we did find one of the controlled drugs to be out of date (expired January 2015). This issue was brought to the attention of the nurse present and they took immediate action to replace the stock.

Records

- Records in the outpatient department were electronic. The electronic record keeping was introduced in November 2014. All staff had been trained to use the system. Staff were able to access patients' current and previous medical records using the system. Staff and managers told us this meant that problems of missing records at outpatient clinics had been all but eradicated. Additionally, the use of electronic records had made it easier to run clinics at different locations.
- Within the imaging department, records were digitised and available to be viewed across the trust.
- Some services also used an electronic records system which staff in the community and in GP practices could access. This meant that information could be shared between healthcare professionals more easily.
- Records contained patient specific information relating to patients' previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- The use of electronic records and the introduction of an electronic dictation system meant that clinic letters were routinely sent to other clinicians and the patient within two working days of their appointment.

- Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatient department. We observed people being weighed and measured during our inspection.
- At the time of inspection within radiology, we saw patient personal information and medical records were managed safely and securely.
- Patient records were held electronically on the Computerised Reporting Information System (CRIS). We looked at three records and saw that they were up to date and completed correctly. We also saw as part of the electronic records imaging request that cards were also scanned into the patient records.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available for use by radiologists from across the trust and external reporting providers under contract with the trust.
- Records were audited monthly and the outcomes from the audits were reported and discussed with the staff at departmental governance meetings.

Safeguarding

- Information provided by the outpatient manager indicated that 94% of staff had completed safeguarding children level one training. There was no information available for the outpatient departments about how many staff had undergone safeguarding children level two or three training.
- Safeguarding adults awareness training had been completed by 94% of staff.
- Staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.
- We saw evidence of information available to staff and patients about who to contact should they have any concerns about the safety of children or vulnerable adults. This was displayed in some staff rooms and on the noticeboards of some outpatient departments.
- Within radiology, we observed patients reporting to the main reception and staff undertook a number of checks to verify patients' identity, for example their name, date of birth and GP.

 All of the staff we spoke with were aware of the responsibilities to safeguard adults and children and were aware of the safeguarding leads within the trust. One of the radiographers we spoke with had recently accepted to become the nominated safeguarding lead for the department.

Mandatory training

- The departments had systems and processes in place to ensure staff training was monitored.
- We looked at staff mandatory training levels provided to us. There were good levels of compliance with mandatory training, ranging between 93% for fire safety to 100% for medicine management training.
- Staff did some mandatory training online using e-learning and some during classroom-based days.
- All of the staff we spoke with in radiology told us they received ongoing mandatory training and they were responsible for ensuring they kept up to date.

Assessing and responding to patient risk

- There was a process in place for managing patients who were deteriorating. This included transferring patients to the accident and emergency department when required, which was on site.
- There were emergency assistance call bells in all patient areas including consultation rooms, treatment rooms and imaging. Staff confirmed that when emergency call bells were activated they were answered immediately.
- There were policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances was managed and minimised.
- We were told that requests for CT and MRI scans were vetted by consultant radiologists before appointments were made.
- The radiology service used a modified version of the World Health Organization (WHO) surgical safety checklist when carrying out non-surgical interventional radiology. An audit of the checklist had been completed in July 2014 and actions to address shortfalls on the level of compliance were agreed, implemented and compliance levels had increased.

- The manager told us that a spot check had been completed in December 2014, which demonstrated improved compliance. No formal evidence from this spot check was provided and a full re-audit of the checklist was planned for February 2015.
- A series of MRI safety checklists were developed and in use for patients, staff or family escorts and for next of kin to complete if the patient was unable to provide information for themselves.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed them before exposure to radiation. These checks were scanned into the patient's electronic records and were monitored as part of the monthly records audits.
- Nurses employed in the department recorded patients' observations prior to and during non-surgical interventional radiology procedures. Early warning scores were also recorded to detect any deterioration in patients' conditions during procedures.

Nursing and diagnostic imaging staffing

- The outpatient departments were staffed by a mixture of registered nurses and healthcare assistants. At the time of our inspection, there were vacancies within the various outpatient departments. These totalled approximately three whole time equivalent (WTE) band five nurses, three WTE band two healthcare assistants, 0.6 WTE band four healthcare assistants and 0.67 band two administration staff. There were, however, 1.84 WTE additional band three healthcare assistants, one WTE band six nurse and 0.15 WTE band seven nurses.
- Vacancies were being covered in the main by current staff, or occasionally staff who worked for the trust bank agency. Where possible, staff worked flexibly to cover shifts. There had been no visible impact on patient care, such as the need to cancel clinics.
- We asked the matron whether they were able to access agency or bank staff to fill any gaps, if staff went on long term sick leave or maternity leave. They told us they could use bank or agency staff if there was no other alternative and could advertise for replacement staff if a business case for the replacement was approved.
- The sickness rate in the outpatient department had over the past year been problematic and the matron told us that at one point was up to 14%. At this time, the department was offered support from the human resources department to address any underlying issues.

The matron confirmed to us that the rate was 3%. We were unable to verify this against the information sent to us by the trust as this was not broken down to show the outpatient departments separately.

- All of the staff we spoke with told us that they worked hard but that they enjoyed their jobs. They said that staff pulled together and worked as a team to maintain good morale.
- There was no formal system, such as an acuity tool, being used to decide the staffing levels needed in the outpatient departments to cover clinics. This was because each clinic needed different numbers and skill mixes of staff according to the levels of support patients and doctors needed as well as the type of clinic. The matron explained that it was down to the knowledge and experience of the manager to judge how many staff were needed and to be flexible.
- All of the staff we spoke with felt overall there were sufficient staff. However, the exception was in the provision of CT services. Staff had developed over the past year, on a trial basis, a 3-week shift system to provide 24 hour, 7 days a week cover for this modality within existing staffing resources and also supported by the trust and elements of overtime payments.
- The efforts of the staff were recognised by the trust in February 2014 as the CT service received a 'Making a difference' award for services to patients.
- The manager told us that in order to improve the staffing availability and cover for this service, a proposal to increase the number of radiographers by 4.5 WTE had been submitted to the board. At the time of the inspection this proposal was being revised in readiness to resubmit to the board for consideration and approval. This proposal would also provide an opportunity for the service to explore and develop 24 hours, 7 days a week MRI services.
- The manager also told us that agency staff were rarely used within the department.

Medical staffing

- Medical staffing was provided to the outpatient department by the various specialties that ran clinics. Medical staff undertaking clinics were of all grades, but we saw that there were always consultants available to support lower grade staff when clinics were running.
- Staff told us that locums were used within the outpatient clinics depending upon the staffing levels of the specialty.

- The Royal College of Radiographers visited the trust in September 2013 and produced a report to the trust of its findings.
- In response to the report the trust had developed an action plan and one the key actions was for the trust to maintain activity to appoint appropriately skilled consultant radiologists. The recruitment of appropriately skilled consultant radiologists had been identified as a risk and this was included on the corporate risk register for action.
- The department was funded for 16 radiologist positions and the clinical lead radiologist, and the management team told us that it had recently appointed appropriately skilled consultant radiologists. Where vacancies still existed these positions continued to be covered by the use of long-term locums.
- At the time of our visit we were told there were 11 permanent radiologists employed either in full or part time positions, with five locum radiologists covering outstanding vacancies. Two further permanent appointments were made, one starting in April 2015 and the second in May 2015. Two other radiologists had been interviewed and plans were in place to secure these appointments at the time of our inspection.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident.
- There were business continuity plans in place to make sure that specific departments were able to continue to provide the best possible safest service in the case of a major incident.
- Managers told us that mock exercises took place to make sure that business continuity plans were fit for purpose.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Care and treatment was evidence based and patient outcomes were within acceptable limits. The staff in the department were competent and there was evidence of multidisciplinary working.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments with a lead clinician taking responsibility for ensuring implementation. This was monitored using the 'Safeguard' system to provide assurance that action had been taken when necessary. Staff we spoke with were aware of the NICE and other guidance that affected their practice and could talk to us in detail about patient treatment pathways.
- We saw that the departments were on the whole adhering to local policies and procedures. Staff we spoke with were aware of how they impacted on patient care.
- Diagnostic reference levels (DRLs) were detailed within the 'Employers procedures'. Radiography dosage levels were monitored and audited. The 2013 radiography dose audit report showed positive compliance and dosage levels.
- The manager told us the diagnostic reference report showed positive compliance with national comparative DRL data from other similar sized trusts.
- The trust has a standard operating procedure in place for Ionising Radiation (Medical Exposure) Regulations (IR[M]ER).
- The imaging department carried out quality control checks on images to ensure that imaging met expected standards.

Pain relief

- Staff told us that the departments did not keep pain relief medication but that the doctors in clinics could prescribe medication for any patient needing pain relief during their attendance.
- Patients we spoke with had not needed pain relief during their attendance at the outpatient departments.

Patient outcomes

- In the 12 months before our inspection, the outpatient department saw 252,705 patients.
- Of these, 83,392 were new appointments and 146,569 were review appointments.
- All images were quality checked by radiographers before patients left the department. National audits and quality standards were followed in relation to radiology activity.

- The outpatient departments took part in trust wide audits such as record keeping, but there was little clinical audit being carried out that was initiated within the department.
- Outpatient departments displayed information about key performance indicators. We saw results displayed in the dermatology department. Out of five, the department scored 4.86 for dignity and respect (a fall from the previous month), 4.77 for involvement (an improvement on the previous month), 4.75 for information (an improvement on the previous month), 4.79 for cleanliness (a fall from the previous month), 4.88 for staff (a fall from the previous month) and 4.38 for family involvement (an improvement on the previous month).

Competent staff

- Staff we spoke with confirmed that they had received appraisals in the last year. From the information sent to us, 100% of staff had received an appraisal within the last 12 months.
- Staff and managers told us that there was no mechanism for formal clinical supervision as per the trust policy. Staff did however tell us that they felt supported and that the department managers were accessible.
- In both the outpatient and imaging departments, there were formal arrangements in place for induction of new staff. All staff completed full local induction and training before starting their role.
- In both the outpatient and imaging departments, performance and practice was continually monitored through appraisals and competency assessments.
- All qualified radiographers completed equipment competencies. Continual professional development was planned by the manager on an annual basis to ensure all statutory and topical subjects were covered.
- Medical revalidation was carried out by the trust. There was a process in place to ensure all consultants were up to date with the revalidation process.
- Staff we spoke with in the radiology department told us they had received appraisals and they were up to date with their mandatory training.
- Due to a national shortage of sonographers the trust had developed a 3-year scheme with a relevant training college to support radiographers to become sonographers. The scheme was in its second year and staff reported that the scheme was working well.

- The manager told us of the formal arrangements in place for mentoring students and new staff and for continually assessing staff performance through supervisions and appraisal.
- Training alert updates for all staff were flagged to managers for action.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatient and imaging departments. For example, nurses and medical staff ran joint clinics and staff communicated with other departments such as radiology and community when this was in the interest of patients.
- Radiologists were part of the multidisciplinary internal teams working between specialties, for example, gastrointestinal and breast multidisciplinary teams
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the department had links with other departments and organisations involved in patient journeys such as GPs and support services.
- A range of clinical and non-clinical staff worked within the outpatient departments and they told us they all worked well together as a team. Staff were observed working in partnership with a range of staff from other teams and disciplines including radiographers, physiotherapists, audiologists, nurses, booking staff and consultants.
- Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.

Seven-day services

- The outpatient department occasionally ran clinics on a weekend and later on an evening, but most activity within the outpatient departments happened between Monday and Friday.
- The radiology services across all of the trust's locations provided a range of services. Some covered 7 days a week and out-of-hours services, while some locations provided services within normal working hours, 5 days a week.
- For example at the University Hospital of North Durham, CT services were provided 24 hours a day, 7 days a week.
- MRI services operated from 08am to 6pm, 5 days per week, with occasional planned weekends dependent on

demand. MRI scans were not provided out of hours by the trust. The manager told us the referral pathways for out-of-hours MRI services were with Newcastle from Durham and Middlesbrough from Darlington. There were clear protocols in place to direct staff to the most appropriate hospital that could provide these.

• Ultrasound services operated from 8.45am to 7pm, five days per week, and from 9am to 1pm Saturdays and Sundays.

Access to information

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as imaging records and reports, medical records and physiotherapy records appropriately through electronic records.
- Radiology reports were part outsourced with an external provider under contract. The managers told us that reliance on outsourcing reports was reducing.
- We spoke with the managers and they told us of the systems and processes in place for monitoring the quality and tracking of radiology outsourced reports.
- Information leaflets about diagnostic imaging, for example CT and MRI scans, were sent out in the post with patients' appointment times. These leaflets were also available on the trust's website.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us that in the outpatient departments, consent was obtained verbally. This was the case for the majority of imaging procedures, although consent for any interventional radiology was obtained in writing on the ward before going to the imaging department.
- Approximately 94% of staff were up to date with Mental Capacity Act training.
- Patients told us that staff were very good at explaining what was happening to them before asking for consent to carry out procedures or examinations.
- Staff we spoke with in the radiology department told us they were aware of and had received training in relation to the Mental Capacity Act and deprivation of liberty safeguards.

• The trust had policies and procedures in place for staff to follow for obtaining consent from patients receiving diagnostic procedures.

Are outpatient and diagnostic imaging services caring?



During the inspection we saw and were told by patients that the staff working in the outpatient and imaging departments were caring and compassionate at every stage of their journey. People were treated respectfully and their privacy was maintained. There were services in place to emotionally support patients and their families, and patients were kept up to date and involved in discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.

Compassionate care

- All of the patients we spoke with spoke highly of the care and treatment they received in the departments. There were no negative aspects about care highlighted to us.
- During our inspection we saw patients being treated respectfully by all staff.
- People's privacy and dignity were respected.
- Staff made sure that patients were kept up to date with waiting times in clinics, and patients told us that this meant they were able to take comfort breaks if they needed to.
- We saw that patients and staff had a very good rapport especially as many patients had been attending clinics for a number of years. Some patients told us that they knew staff very well and some staff told us some patients felt like family.
- Staff were observed to knock on doors before entering and curtains were drawn and doors closed when patients were in treatment areas.
- We spoke with 10 patients using radiology services and five relatives and they told us they were very happy with the services provided. Staff presented as skilled, caring and helpful.
- Staff were courteous when caring for patients and were seen responding to patients' individual needs in a timely manner.

Understanding and involvement of patients and those close to them

- We spoke with 23 patients and eight relatives in the outpatient and imaging departments. All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Patients felt that they were given clear information and given time to think about any decisions they had to make about different treatment options available to them. They also told us that the treatment options had been explained to them clearly with enough information about side effects and outcomes for them to make informed decisions.
- Staff told us that they encouraged patients to involve their families and loved ones in their care, but that they respected the decisions of patients when they chose not to involve their loved ones.
- We saw patients and people close to them being consulted before radiology procedures and staff were attentive to the needs of the patients.
- There were no delays evident to patients' care and treatment during the course of our visit to the radiology department.

Emotional support

- Patients told us that they felt supported by the staff in the departments. They reported that if they had any concerns, they were given the time to ask questions. Staff made sure that people understood any information given to them before they left the departments.
- Formal and informal networks had been created by staff to link patients with people with similar conditions who were further along their patient journey. There were posters on the walls advertising these groups, for example for patients who had cancer, hearing loss, or who were losing their sight.
- There was formal counselling support available for patients who needed it.

Are outpatient and diagnostic imaging services responsive?

Good

We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Waiting times were within acceptable timescales with outpatient clinics only occasionally being cancelled at short notice. Patients were able to be seen quickly for urgent appointments if required.

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

Service planning and delivery to meet the needs of local people

- Staff were supported by colleagues within the wider department at busy times, or when there were absences. This made sure that clinics were only cancelled as a last resort.
- Additional outpatient clinics were run to meet extra demand to ensure that waiting time targets were met.
- The imaging department was able to provide a comprehensive service across the community, in local community hospitals as well as at the University Hospital of North Durham.
- Referrals for imaging, particularly CT, MRI and ultrasound were triaged and vetted by each modality and booked according to clinical need.
- The University Hospital of North Durham provided CT 24 hours a day, 7 days a week.
- MRI services operated from 8am to 6pm five days per week with occasional planned weekends dependent on demand. MRI scans out of hours were referred to Newcastle from Durham and to Middlesbrough from Darlington.
- Ultrasound services operated from 8.45am to 7pm five days per week and from 9am to 1pm Saturdays and Sundays.
- The imaging department had the capacity to deal with urgent referrals.

Access and flow

- Referral to treatment times (RTTs) were better than the England averages for non-admitted patients (98.5% against the 95% the England average) and incomplete pathway patients (95% against the England average of 92%).
- The trust was better than the England average for the 2-week cancer wait target (97% against an England average of 95%), 31-day wait from diagnosis to first definitive treatment (99% against the England average of 97%) and 62-day urgent GP referral to first definitive treatment (90% against the England average of 84%).
- All but one of the hospitals (Sedgefield) had a non-attendance rate worse than the England average of around 7%. The trust had recently introduced a text message reminder service in an attempt to reduce the levels of non-attendance across the trust. The rate for the University Hospital of North Durham between July 2013 and June 2014 was approximately 10%.
- The trust provided us with information which showed that between 1 May 2014 and 31 August 2014 390 paediatric outpatient clinics were cancelled and 1,699 general outpatient clinics were cancelled. This equates to less than10% of clinics being cancelled over this time period and is in line with similar trusts. This information was not split between the different sites that held outpatient clinics.
- Within the general outpatient departments, the most common reason (51%) why clinics were cancelled during this time was because of annual leave. The second most common reason (24%) was because staff were on call. Other reasons included clinical support, meetings, study leave and 'other'.
- The specialty that cancelled the most clinics was ophthalmology (185). We did not have enough information to show the number of ophthalmology clinics cancelled as a percentage of the total number of ophthalmology clinics due to run during that time period.
- The trust was better than the England average for diagnostic waiting times, but this sharply increased to worse than the England average in May 2014.
- The trust did not routinely collect information about the average waiting time for patients once they arrived at outpatient clinics and before being called in to their appointment.

- Staff told us that there was always capacity in clinics to see patients who were referred urgently and that double booking two patients in to one clinic slot happened occasionally to make sure that waiting time targets were met. Information about how often this happened was not routinely collected by the trust and therefore was not quantifiable.
- On the day of our visit, patients with appointment times in the radiology department were not left waiting for long periods of time.
- Patients arriving from outpatient clinics and inpatients were booked into time slots within the departments on an as-required basis and according to the clinical need of the referral.

Meeting people's individual needs

- Staff told us that they were able to access interpreting services if they needed to. We witnessed an interpreter attending with a patient.
- Staff told us there was a limited supply of patient information available in different languages. They told us that they would make sure any information patients needed, for example about aftercare, was explained to them by an interpreter and that the patient understood.
- We saw that the outpatient and imaging departments had leaflets for patients, but we noted that some of these leaflets were past their review date, some by a number of years.
- Staff were aware of the support that was available within the trust for people with learning disabilities, should it be needed. Staff told us they would allow a patient's carer stay with them if that was what the patient wished.
- Staff told us they were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly. Staff were keen to point out that they would be careful not to make people feel awkward or different if this would cause them distress.
- There was a canteen available for patients to use as well as a small shop for patients to buy refreshments at the entrance to the outpatient department. The department had access to food and drinks for vulnerable patients or

patients who had conditions such as diabetes. There was a system in place to make sure that patients who had attended by wheelchair and were waiting to return home were also able to access food and drinks.

- The departments were able to accommodate patients in wheelchairs or who needed specialist equipment as they were spacious.
- There was clear signage throughout the departments.

Learning from complaints and concerns

- There were 152 complaints about the outpatient department and radiology departments between November 2013 and October 2014. Fifteen were about the radiology department and 132 were about outpatient departments.
- For outpatient departments
 - 59 were about appointments
 - 8 were about staff attitudes
 - 16 were about communication
 - 24 were about delay in diagnosis/treatment
 - 7 were about missed diagnosis
 - 23 were about various other aspects of care and treatment.
- For the radiology department:
 - 5 were about appointments
 - 2 were about the attitude of staff
 - 3 were about communication
 - 1 were about confidentiality
 - 2 were about delays in diagnosis or treatment
 - 1 was about privacy
 - 1 was about funding of a diagnostic test.
- Staff we spoke with were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the Patient Advice and Liaison Service (PALS) or make a complaint was available within waiting areas.
- Managers and staff all told us that complaints and concerns were discussed at local team meetings and any learning was shared. We looked at two sets of team meeting minutes which confirmed this.
- The radiology manager kept local records of all complaints received. We looked at one recent complaint and saw the outcomes from the investigation were recorded and these had been discussed with the patient and an apology given.

- We also saw evidence through our review of the departmental communication processes of post-complaint feedback and learning points reviewed.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint. On the whole they were happy with the experience they received from the departments.

Are outpatient and diagnostic imaging services well-led?



Within the outpatient and imaging departments of this hospital, staff and managers had a vision for the futures of the departments and were aware of the risks and challenges faced. Staff felt supported by their line managers and were able to develop to improve their practice.

There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed. The departments were supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments.

Vision and strategy for this service

- The department managers, matron and senior managers we spoke with demonstrated vision for the future of the two services, outpatients and imaging. They were aware of the challenges faced by the departments and the trust as a whole.
- Staff within the services were aware of the challenges faced by the organisation, such as the financial challenges faced. Most told us they were aware that there was a strategy for the trust, but were mostly interested in the future of the University Hospital of North Durham.
- Throughout the departments, we saw information about the vision and strategy of the trust as well as information promoting the 'Six 'C's', a national initiative to improve the care and treatment patients receive.

Governance, risk management and quality measurement

- There were governance arrangements in place which staff were aware of and participated in. The departments had staff meetings where clinical governance topics were discussed.
- Staff were given feedback about incidents and lessons learned and the trust regularly produced lessons learned information that staff could access.
- The organisation had systems in place to appraise NICE guidance and ensure that any relevant guidance was implemented.
- The imaging department held bi-monthly meetings to discuss and review perception error incidents.
- Radiology reports were part outsourced with an external provider under contract. The managers told us that reliance on outsourcing reports was reducing.
- One of the medical staff we spoke with raised some concern in relation to the timeliness and quality of outsourced reports and the department's reliance on locum radiologists.
- We spoke with the managers and they told us of the systems and processes in place for monitoring the quality and tracking of radiology outsourced reports.
- Both outpatients and diagnostic imaging had risk registers in place. These were reviewed and updated regularly. They gave details about action being taken to manage, minimise or eliminate risks.

Leadership of service

- Staff told us that they found the managers of the service to be approachable and supportive. All the staff we spoke with told us they were content in their role. Many staff we spoke with told us that they had worked at the hospital for many years.
- The managers of the departments were seen as fair and flexible with staff.
- Radiology staff we spoke with reported that leadership at the local level was positive. All of the staff were aware of the trust leadership and could access the relevant information from the intranet.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development.
- Staff were able to access some training and development provided by the trust although this was not as easy as in the past due to staffing levels and

financial pressures. Some staff, such as in dermatology, were encouraged to develop their role and undergo additional training to enable them to perform more skilled tasks.

Culture within the service

- Staff told us that the chief executive was approachable and accessible if they had any concerns. Some told us that the chief executive occasionally visited the outpatient departments.
- Some staff were unsure about who the non-clinical managers and senior managers of the outpatient departments were, although all were aware of the matrons who oversaw the departments.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Staff were aware of their responsibilities in relation to 'Duty of candour'; to be open and honest with patients when incidents or accidents occurred and where appropriate to involve them in discussions and investigations.
- Managers told us that they felt well supported by the organisation.
- The radiology department had a positive 'can-do' attitude and the staff had confidence in the local leadership of the service.

Public and staff engagement

- We saw that governance arrangements were in place, and complaints and comments were discussed at team meetings.
- A Complaints, Litigation, Incidents and PALS (CLIP) report was produced every 3 months and presented to the board and senior staff. Any themes and trends were reported back to departments so the department could prepare action plans for improvement.
- The outpatient department had started to take part in the NHS Friends and Family Test (a survey that measures patients' satisfaction with the healthcare they have received).
- A cardiac rehabilitation patient questionnaire was undertaken between 2 December 2012 and 20 December 2013. Patients were asked for their experience of accessing the community CHD/HF service to enable service evaluation to take place, which could help shape and improve the services. The overall feedback was positive.

• There was no specific information from the staff survey relating to the outpatient and imaging departments, but the trust as a whole performed within expectations or better than expected in all but two elements of the staff survey: the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (which had fallen since the last survey in 2012), and the percentage of staff receiving job-relevant training, learning or development in last 12 months (which had improved since the last survey in 2012).

Innovation, improvement and sustainability

- Staff all told us that they were being encouraged to look at ways the trust could work more efficiently, make savings and improve the quality of care for patients. They told us about how they were encouraged to try changes and then evaluate them to make sure quality of care did not fall when money was saved.
- Staff and managers reported that they were able to influence changes in the way the outpatient and

imaging departments were organised and run. We were given examples of changes that had been made to the way the service was run which had improved the patient experience and made the clinics run more efficiently. For example, a coloured card scheme had been introduced to one of the outpatient clinics so that patients could easily tell which clinic they were attending and whether that particular clinic was running late. This had improved patient experience and made sure that patients were aware of specific waiting times.

- The trust had developed a regional radiology training centre, the only dedicated radiology training centre in the region.
- Seventy per cent of all staff within the trust who responded to the NHS staff survey felt they were able to contribute towards improvements at work. This was higher than the England average of 68%. There was no specific information for the outpatient or radiology departments.

Outstanding practice and areas for improvement

Outstanding practice

The CREST service, which provided early senior and multidisciplinary assessment for frail older people, facilitated safe, early supported discharge and managed patients with an anticipated short length of stay. The team also identified and transferred patients requiring longer stays to the appropriate specialist team. Providing early multidisciplinary assessment for frail older people and expediting early discharge is good practice, in line with 'Silver Book' and other national recommendations. The Silver Book is a set of quality standards for the emergency care of older people launched by the British Geriatrics Society.

Areas for improvement

Action the hospital MUST take to improve

- Review the achievements and actions taken to address the targets set nationally within accident and emergency (A&E) department.
- Review consultant levels against CEM guidance.
- Ensure the A&E department meets cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.
- Ensure all toys are cleaned properly to reduce the risk of infection within the A&E department.
- Ensure sharps bins are managed appropriately to reduce the risk of needle stick injury within the A&E department .
- Ensure that all resuscitation drugs and equipment within the A&E department are regularly checked, cleaned and in date. This should include all grab bags and anaphylaxis kits.
- Ensure that all relevant staff know where the difficult airway kit is kept.
- Ensure there are robust risk assessments in place for the paediatric environment within the A&E department. These must be readily accessible and available to all staff in the department. Risk mitigation must be outlined and an action plan to improve the area must be written.
- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance and taking into account patients' dependency levels on medical wards, particularly where patients are receiving non-invasive ventilation (NIV) and require Level 2 intervention.

- Undertake a review of current documentation relating to the care and management of patients receiving NIV to ensure that it is consistent across both the University Hospital of North Durham and Darlington Memorial Hospital.
- Have arrangements in place for patients who are in receipt of NIV that comply with the British Thoracic Society guidelines (2008) for the use of NIV for acute exacerbation of chronic obstructive pulmonary disease.
- Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and to the appropriate quality
- Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with best practice guidance.
- Ensure that patient records are maintained up to date, are patient-centred and contain the relevant information about their treatment and care, including patients awaiting discharge to eliminate unnecessary delays.
- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance and taking into account patients' dependency levels on medical wards, particularly where patients are receiving non-invasive ventilation (NIV) and require Level 2 intervention.

Outstanding practice and areas for improvement

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- Ensure that patient records are maintained up to date, are patient-centred and contain the relevant information about their treatment and care, including patients awaiting discharge to eliminate unnecessary delays.
- Ensure that staff are familiar with the syringe driver policy and carrying out/recording syringe driver checks in line with this policy.
- Add audits of syringe driver administration safety checks to the annual end of life audit programme.
- Ensure medical staff record mental capacity assessments for patients who are unable to participate in decisions about do not attempt cardiopulmonary resuscitation (DNACPR) forms.
- Ensure audits of mental capacity assessments are incorporated into audits of DNACPR forms.
- Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.
- Ensure data are available to identify and demonstrate the effectiveness of the service.

Action the hospital SHOULD take to improve

- Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcomes are met.
- Direct medical staff to check resuscitation equipment and drugs before the start of their shift even when nursing staff have completed the checks.

- Encourage all relevant staff to attend violence and aggression training within the A&E department.
- Ensure patients have their medicines reconciled in accordance with trust targets.
- Review access to patient information in languages other than English.
- Review dedicated management time allocated to ward managers.
- Review the patient flow of higher dependency patients throughout the hospital to ensure care was given in the most appropriate setting.
- Have an up-to-date standard operating procedure (SOP) which clearly sets out the management of patients admitted to both the University Hospital of North Durham who require NIV.
- Ensure that this guidance/SOP includes clarity on the setting/specific ward in which patients can be managed.
- Ensure that this guidance/SOP includes staffing to patient ratios that are in line with current guidance.
- Ensure that there is a training plan in place, which is delivered to all staff involved in the care of patients receiving NIV, and that it is competency-based and in sufficient detail to demonstrate competence in all aspects of NIV.
- Ensure that any guidance/SOP includes an escalation plan that includes action to be taken when a bed is unavailable in an appropriate setting and when patient numbers do not match agreed staffing ratios.
- Ensure that the intensive care unit has an outreach team to identify and monitor deteriorating patients.
- Ensure that there is clinical pharmacist input in the intensive care unit in line with core standards for intensive care guidelines.
- Consider ways of improving engagement between staff and managers within the care closer to home directorate with a view to achieving a joined up approach within maternity and gynaecology services. Also, consider ways of improving responsiveness and efficiency in respect to service level decisions within this service.
- Consider ways in which it can identify the required standards within the maternity service dashboard.
- Consider within the maternity and gynaecology services clinical and quality strategy for 2014–16 timelines for review and achievement.

Outstanding practice and areas for improvement

- Consider ways of developing a coherent plan for joint working on improvements in maternity and gynaecology services.
- The trust should consider ways of improving timely and responsive human resource management processes, including personnel issues that impact on service delivery maternity and gynaecology services.
- Ensure the paediatric high dependency unit room has specific standard operating procedures or protocols available to guide suitably trained staff.
- Ensure advanced paediatric nurse practitioners have a set of standard operating procedures available to guide their practice and care.
- Formally nominate an executive or non-executive director to represent children at board level which is separate from the safeguarding children executive lead role.
- Ensure actions against the National Care of the Dying Audit and other identified actions to develop the service are carried out in a planned and timely way with continued evaluation.

- Ensure systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.
- Ensure that any out of date medication is removed from stock cupboards once it has expired, in line with the trust's medication management policy, and have a process for monitoring this within the outpatient departments.
- Ensure that all fridge temperatures are checked daily and that there is a system in place to monitor that checks are taking place within the outpatient departments.
- Ensure that all resuscitation equipment is checked daily, stored securely and introduce a monitoring system to ensure that checks take place within outpatients.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good
	Review the achievements and take actions to address taken to address performance against the targets set nationally in A&E.
	Review consultant levels against CEM guidance.
	Ensure that staff regularly check all resuscitation drugs and equipment within the A&E department .
	Ensure medicine fridge temperatures are checked regularly within the A&E department; this will include the recording of maximum and minimum fridge temperatures.
	Ensure audits of mental capacity assessments are incorporated into audits of DNACPR forms.
	Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.
	Ensure data is available to identify and demonstrate the effectiveness of the end of life service.
	Undertake a review of current documentation relating to the care and management of patients receiving NIV to ensure that it is consistent across both the University Hospital of North Durham and Darlington Memorial Hospital.
	Have arrangements in place for patients who are in receipt of NIV that comply with the British Thoracic Society guidelines (2008) for the use of NIV for acute exacerbation of chronic obstructive pulmonary disease.
	Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and to the appropriate quality

Requirement notices

Ensure that staff are conversant with the syringe driver policy and carrying out/recording syringe driver checks in line with this policy.

Add audits of syringe driver administration safety checks to the annual end of life audit programme.

Regulated activity

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff on medical wards, in line with best practice and national guidance; taking into account patients' dependency levels, particularly where patients are receiving non-invasive ventilation (NIV) and require Level 2 intervention and that actual staffing levels meet planned staffing levels.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff, in line with best practice guidance.

Ensure that patient records are maintained and up to date, are patient centred and contain the relevant information about their treatment and care, including patients awaiting discharge to eliminate unnecessary delays.

Regulated activity

Regulation

Requirement notices

Treatment of disease, disorder or injury

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

Ensure the A&E department meets cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors.

Ensure the area outside the A&E decontamination facility is free from dirt, litter and debris.

Be able to demonstrate that all toys are cleaned properly to reduce the risk of infection within the A&E department.