

# South Tees Hospitals NHS Foundation Trust

## Quality Report


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

## Ratings

### Overall rating for this trust

Requires improvement 

Are services at this trust safe?

Requires improvement 

Are services at this trust effective?

Requires improvement 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Good 

Are services at this trust well-led?

Good 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected the trust from 9 to 12 December 2014 and undertook an unannounced inspection on 16 December 2014. We carried out this comprehensive inspection as part of the CQC's comprehensive inspection programme.

We inspected the following core services:

- James Cook University Hospital – urgent and emergency care, medical care, surgical care, critical care, maternity care, children's and young people's services, end of life care, outpatient services and diagnostic imaging.
- The Friarage Hospital – urgent and emergency care, medical care, surgical care, critical care, maternity care, children's and young people's services, end of life care and outpatient services and diagnostic imaging.
- Community Health Services – including:
  - Community health inpatient services at Carter Bequest Primary Care Hospital, East Cleveland Primary Care Hospital, Guisborough Primary Care Hospital, Friary Community Hospital, Lambert Memorial Community Hospital and Redcar Primary Care Hospital.
  - Community end of life care
  - Community health services for children, young people and families
  - Urgent care centres at East Cleveland Primary Care Hospital, Guisborough Primary Care Hospital and Redcar Primary Care Hospital
  - Community health services for adults

Overall, the trust was rated as requires improvement. Safety and effectiveness were rated as requires improvement. Well led, responsiveness and caring were rated as good.

The trust leadership had generally been stable over the last few years; in 2013 the director of nursing, who had previously worked in the trust for a number of years, had been appointed to the post of Chief Executive. Some further changes were expected with the retirement of the medical director and appointments to additional roles to strengthen the delivery of quality and safety within the trust. The trust was working with staff groups, local stakeholders and consulting with the general public on the development of its services and where they were best located and how to improve the effectiveness of delivery.

The trust was in the process of reviewing its governance and reporting arrangements and many of the issues identified through the risk assessment of operational delivery or the impact of the transformation of services was still work in progress. The trust was facing a particularly challenging financial position with a deficit to address, entailing significant cost improvement plans. Staff were aware of the situation and had been consulted and informed of decisions about where saving should occur. Where there had been an identified risk to quality or safety, plans had been rejected or refined. It was too early to assess at the time of the inspection whether cost savings would impact on quality and safety in the next financial year. Consultation with staff was seen as a priority and work was in progress to improve on engagement with patients and the general public.

Our key findings were as follows:

- There was a transformation programme in place to reconfigure and re-structure services in order to operate more effectively, which entailed centralising and moving some services. The maternity, children's and young people services had been re-organised so that the main service delivery was located at James Cook University Hospital. This was an ongoing programme, which included reviewing the community services and the trust was engaging with staff, the local commissioners of services and local communities as part of its development.
- There were areas of excellent practice across the trust, particularly in the maternity services, where we found the leadership to be outstanding. The service was managed by a strong, cohesive leadership team who understood the challenges of providing good quality care and had identified effective strategies and actions needed to address these. This was particularly evident with the reconfiguration of services, which were well-developed and understood throughout the department.
- Staff felt engaged and were passionate about the quality of care given to patients. Staff reported pride at working in the trust and felt encouraged and able to introduce innovative ideas to improve service development and delivery.

# Summary of findings

- Care and treatment was delivered with compassion and patients reported that they felt treated with dignity and respect.
  - Across the acute hospitals and within the community services, 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 visibly clean. Rates of Methicillin-Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. difficile) were within an expected range for the size of the trust, although the trust was aware of and was taking action to address concerns over the increasing cases of C. difficile.
  - 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 across the acute services and within the community.
  - There were nursing staff shortages across wards and departments, particularly at the James Cook University Hospital and Friarage Hospital in urgent and emergency care and in children's services. The trust was actively recruiting following a review of nursing establishments. In the meantime, bank staff were being used to fill any deficits in staff numbers, and staff were working flexibly, including undertaking overtime.
  - The composite of the Hospital Standardised Mortality Ratio (HSMR) indicators was slightly higher than expected in this trust. The Summary Hospital-level Mortality Indicator (SHMI) was as expected. The trust actively reviewed mortality cases on an ongoing basis and held regular meeting with clinicians to identify issues when data was available.
  - The trust was performing worse than the national average for the development of pressure sores. The prevalence rate for grade 3/4 pressure ulcers was consistently above the national average accounting for 79% of all serious incidents reported, although there had been a steady decrease throughout the year.
  - There was still much more work to be done to ensure that the premises and the arrangements in place were suitable for the children's services.
  - Attendance at mandatory training and specific subject area training, particularly for safeguarding and mental capacity assessment, was low across some areas.
  - Not all records were consistently completed across the acute and the community services, including the updating of care records such as assessments, fluid balance charts, risk assessments and decisions over whether to attempt to resuscitate a patient. There were also concerns over the completion of safeguarding records, particularly in the see and treat area within the accident and emergency department.
- We saw several areas of outstanding practice including:
- For James Cook University Hospital:
- In medical care services, a team of therapeutic volunteers had been created which was led by a therapeutic nursing sister who had been in place for 18 months. The volunteers had mandatory and dementia training and were in operation 24 hours a day. The role of the volunteers was to support patients who may be living with dementia or other illnesses which affected their behaviour and level of supervision required. This included engaging with patients, such as playing board games or other interests patients may have. They also supported patients who required help with eating or wanted to explore their environment. This included supporting them overnight if they were disorientated. The volunteers predominantly worked on wards 10, 12 and 26. The team had been regionally recognised for its work.
  - We found examples of outstanding leadership within Maternity services.
  - In maternity services, the Families and Birth Forum was involved in the design of the induction of labour suite and championing the take-up of breastfeeding rates through the use of peer supporters, as well as improving information to raise awareness and promote the service to women when they had left the hospital.
  - In maternity services, lay representatives were actively involved in the patient experience rounds and 15 Steps Challenge – a series of toolkits used as part of the productive care work stream. The toolkits helped look at care in a variety of settings through the eyes of patients and service users, to help determine what good quality care looks, sounds and feels like.

# Summary of findings

- In maternity services, a 'baby buddy' mobile phone app was being piloted by the community midwives to inform women of pregnancy issues, common ailments and reasons to seek advice.
- We found outstanding areas of practice in the care and involvement of young people, including a young people's unit, participation and accreditation in the You're Welcome toolkit in four clinical areas, the development of a young person's advisory group, inspections of services by young people and the involvement of young people in staff interviews.

For The Friarage Hospital:

- We found examples of outstanding leadership within Maternity services
- In maternity services, the families and birth forum was involved in the design of the induction of labour suite and in championing the take-up of breastfeeding rates through the use of peer supporters, as well as improving information to raise awareness and promote the service to women when they had left the hospital.
- In maternity services, lay representatives were actively involved in the patient experience rounds and 15 Steps Challenge – a series of toolkits which are part of the productive care work stream. The toolkits help look at care in a variety of settings through the eyes of patients and service users, to help investigate what good quality care looks, sounds and feels like.

For the community services:

- Diabetes specialist nurses provided telephone support and advice and clinic sessions for patients with diabetes supported by a dietician and ran the DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) programme which was accessible to patients with diabetes or the risk of developing Type 2 diabetes to provide learning and support for the patient and the health care professionals involved with them

There were several areas of good practice in the community services:

- In community end of life services a Sources of Information and Support service directory had been developed by the Hambleton and Richmondshire Palliative Care Partnership, a health and wellbeing clinic was held at Redcar Primary Care Hospital,

community specialist palliative care nurses supported the National Gold Standard Framework coordination in GP practices and supported nursing and residential homes for people with cancer and other life-limiting conditions in the Middlesbrough, Redcar and Cleveland locality.

- Within community children's, young people's and families services a Baby Stars programme was in place to promote the social, emotional and physical development of infants, the school nursing service held weekly drop-ins for children and young people, there was a breastfeeding group with trained peer supporters and facilitators, there were good transition arrangements for young people transferring to adult services and services enabled good accessibility for children and young people by offering different clinics and opening times.
- Within the community services for adults, the community respiratory service focused proactively on preventing admissions through meeting patient's needs and reviewing the quality and cost effectiveness of the service through audit, the falls and osteoporosis service received an award for its inpatient work in community hospitals. The tissue viability service had developed several examples of innovative practice such as a chronic oedema project and leg ulcer collaborative to support prevention of these conditions and specialist and maintenance clinics were held for patients with lymphedema.

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

Importantly, the trust must:

For James Cook University Hospital:

- Ensure that there are sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical and surgical wards, children's wards and the paediatric intensive care unit (PICU).
- Ensure that staff have received an appraisal and appropriate supervision so that the trust can be assured they staff are competent to undertake their role.
- Ensure staff receive appropriate training, including the completion of mandatory training, particularly the

# Summary of findings

relevant level of safeguarding and mental capacity Act 2005/assessment training so that they are working to the latest up to date guidance and practices, with appropriate records maintained.

- Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are carried out and decisions made.
- Ensure that all patients' records are maintained up to date, including the recording of identification and stored confidentially in accordance with legislative requirements, particularly ensuring that paediatric care records are contemporaneous, appropriately completed and regularly audited to monitor staff compliance.
- Ensure that there are appropriate arrangements in place for the safe handling and administration of medication, including the reconciliation of patients' medications, that all controlled drugs are appropriately checked particularly on Coronary Care Unit and that medication omissions are monitored, investigated and reported in line with trust policy.
- Ensure that ward-based nursing staff are educated in the use of syringe drivers, including best practice in the use of continuous administration of medication for the management of key symptoms at the end of life.
- Ensure the paediatric environment in A&E is reviewed so it is fit for purpose; including a process to make sure that robust risk assessments are readily accessible and available to all staff in the department.
- Ensure all toys in A&E are cleaned regularly to reduce the risk of infection.
- Ensure that there are sufficient assisted bathing facilities and moving and handling aides within the children's and young people's ward areas.
- Ensure the timely completion of the refurbishment of the medical block, especially wards 10 and 12, to enable people living with dementia to be cared for in a safe environment.
- Ensure that the system for nurse calls is reviewed to ensure that there is no confusion over patients calling for assistance and the emergency alert for cardiac arrest potentially causing delays in treatment.
- Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.

- Review arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.
- Ensure robust monitoring of the safe use of syringe drivers, with sharing of results and learning from safety audits.
- Ensure that an appropriate concealment trolley is in use for the transfer of the deceased, that risks have been assessed, and that all staff using the trolleys are aware of safe moving and handling practices.
- Ensure that resuscitation equipment in surgical wards and in outpatients and diagnostic imaging areas is checked in accordance with trust policies and procedures and that this is monitored.

For The Friarage Hospital:

- Ensure that there is sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, and outpatients department.
- Ensure staff receive appropriate training and support through appraisal including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained.
- Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are being carried out and how decisions are made.
- Ensure that patients records are appropriately up dated and stored to ensure confidentially is maintain at all times in line with legislative requirements.
- Ensure that there are mechanisms in place for reviewing and, if necessary, updating patient information, particularly in the outpatients department.
- Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.

# Summary of findings

- Review arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.
- Ensure that there are mechanisms in place for reviewing and, if necessary, updating patient information, particularly in the outpatients department.
- Ensure that resuscitation equipment and medication fridge temperatures in the diagnostic and imaging department are checked in accordance with trust policies and procedures.

For the Urgent Care Centres services:

- Ensure that staff have attended mandatory training in accordance with trust policy.
- Review the quality monitoring arrangements within the urgent care centres, including patient outcomes.
- Review the provision of pain relief to ensure that there are no unnecessary delays when treating patients.
- Ensure that evidence-based guidance is available for staff working in urgent care centres and that policies are appropriately reviewed and up to date.

For the Community Inpatient Services the trust must:

- Ensure that the number of staff who received safeguarding children level 2 training and safeguarding adult level 1 training meets trust targets.
- Ensure that staff have received mandatory training.
- Ensure that patient records are accurate and complete, particularly fluid balance records, venous thromboembolism (VTE or blood clot) assessments and malnutrition universal screening tool (MUST) scores.
- Ensure that staff have received an annual appraisal.
- Ensure that hazardous substances are secured, particularly at Lambert Memorial Community Hospital.
- Ensure that staff follow the escalation policy when a patient's condition deteriorates.

In addition, the trust should consider other actions these are listed at the end of the report.

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

# Summary of findings

## Background to South Tees Hospitals NHS Foundation Trust

South Tees Hospital NHS Foundation Trust was granted foundation trust status in May 2009 having previously been made a trust in November 1991. The trust provided acute hospital services at James Cook University Hospital and The Friarage Hospital to the local population as well as delivering community health services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland. The trust also provided a range of specialist regional services to 1.5 million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria. It had a purpose-built academic centre with medical students, nursing and midwifery students undertaking their clinical placements on-site. In total, the trust had 1,351 beds across two hospitals and the community, and employed around 9,000 staff.

James Cook University Hospital provided services to 1.5 million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria. Between April 2013 and March 2014, the A&E department saw 102,870 patients, including 17,772 children. The trust anticipated that this figure would rise by 3% per annum. The department was originally established for the purpose of caring for and treating 78,000 patients and had currently seen 71,273 people since April 2014. The maternity services delivered about 5,247 babies in 2013/14. The hospital had around 186,172 inpatient and day case admissions during 2013/14. In 2013, the outpatient departments had around 486,091 attendances for both consultant- and nurse-led clinics.

The Friarage Hospital provided services to the local population as well as delivering community services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland and had 170 beds. Between April 2013 and March 2014, the A&E department saw 17,291 patients of which 5,855 were children. Following a re-configuration of children's services in the hospital in October 2014, the A&E department no longer treated children, apart from those who self-presented with injuries. The hospital served a population of 62,389 children in the NHS South Tees area and 30,468 children in the NHS Hambleton, Richmondshire and Whitby area. During the period April 2013 to October 2014 the hospital had 4,431 admissions, 602 of which were day case admissions. There were a

total of 124,971 outpatient appointments between April 2013 and March 2014. The hospital had one integrated intensive care unit (ITU). The unit covered a catchment population of around 430,500.

Following a reconfiguration of maternity services in October 2014, the maternity service at the Friarage Hospital became a separate, free-standing midwifery-led unit. It provided care for pregnant women who were medically fit, had a normal pregnancy and were at low risk of complications. Women identified as high risk were transferred to the James Cook University Hospital for consultant-led care. The maternity service had delivered around 1,300 babies in 2013/14.

Children's services included a dedicated short stay paediatric assessment unit (SSPAU), open between the hours of 10am and 10pm seven days per week, and a children's outpatient department. The SSPAU provided short stay assessment and treatment for children under the paediatric medicine specialty. Some short stay minor surgery was also performed every week at the unit, including plastic surgery, general surgery, oral surgery and community dental surgery.

The trust's specialist palliative care team comprised of one full-time palliative care consultant and one half-time respiratory consultant with an interest in palliative care. There was an end of life lead nurse and three additional palliative care nurses. The team worked as part of a wider multi-disciplinary palliative care team, that provided specialist palliative care support to patients at both acute hospitals and across two community regions.

Community health inpatient services were provided by six inpatient community hospitals. These were the Friary Community Hospital (18 beds), Lambert Memorial Community Hospital (14 beds), Guisborough Primary Care Hospital (18 beds), Redcar Primary Care Hospital (31 beds), Carter Bequest Primary Care Hospital (24 beds) and East Cleveland Primary Care Hospital (18 beds). There was also a day surgery unit at Redcar Primary Care Hospital. A total of 2,142 people were cared for in the community hospital beds during 2013/14.

# Summary of findings

There were proposals to change some of the service provision. The NHS South Tees Clinical Commissioning Group (CCG) had been working in partnership with the South Tees Hospitals NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation Trust and local authorities in Middlesbrough and Redcar and Cleveland to improve services for the vulnerable, elderly and those with long-term conditions. This included reconfiguring the bed base at the primary care hospitals. It was planned that the wards at Guisborough Primary Care Hospital and Carter Bequest Primary Care Hospital would close. This had been subject to a public consultation in 2014.

Urgent care facilities were provided and located at three of the community hospital locations: East Cleveland Primary Care Hospital, Guisborough Primary Care Hospital and Redcar Primary Care Hospital.

The urgent care centre at Redcar Primary Care Hospital was open 24 hours a day, 365 days per year, and provided immediate care for minor injuries and illnesses. At East Cleveland Primary Care Hospital and Guisborough Primary Care Hospital, there were urgent care centres which were open 9am to 5pm Monday to Friday and 8am to 8pm on weekends and bank holidays. There were plans to amalgamate all three of the urgent care centres to one location at Redcar Primary Care Hospital in March/April 2015. There were approximately around 500-550 attendances a week across the centres.

Community health services for children, young people and families were provided across Middlesbrough, Redcar and Cleveland by health visitors, school nurses and the looked after children team.

The trust provided a health visiting service to Middlesbrough and Redcar and Cleveland. The service was for children aged under five years and aimed to protect and promote the health and wellbeing of children in the early years in line with the Healthy Child Programme.

The trust provided school nursing services in Middlesbrough and Redcar and Cleveland. School nurses assessed child and family health needs in line with the Healthy Child Programme.

The looked after children team was commissioned by South Tees clinical commissioning group to provide initial health assessments and reviews for children looked after by either Middlesbrough or Redcar and Cleveland local authorities who were placed with carers within Teesside.

Community services for adults were aligned with clinical commissioning groups and the operational organisation of services followed a restructure in September 2014. Services operated from seven centres, which were aligned with acute medical wards.

The Integrated Medical Care Centre operated within three service groups which delivered community nursing services at locality level across the trust area covering Middlesbrough, Redcar, Cleveland, Richmondshire and Hambleton. The service operated from a number of community locations, including community hospitals, primary care centres and GP practices.

Community nursing services also operated through virtual wards in Richmondshire and Hambleton. Intermediate care was delivered through a rapid response and out of hour's service in Middlesbrough, Redcar, and Cleveland and in Richmondshire and Hambleton, through a fast response service. Within service groups, localities were divided into community nursing teams which were aligned with GP practices, or groups of practices. In Middlesbrough, three teams of district nurses operated from one location. In Redcar and Cleveland, three teams of district nurses operated from three locations. The out of hour's service covered the area for the six community teams. Community matrons and specialist services outreach teams also operated within the service group structure.

## Our inspection team

Our inspection team was led by:

Chair: Sandra Christie Director of Nursing, The Wirral Community NHS Trust

Head of Hospital Inspections: Julie Walton, Care Quality Commission



# Summary of findings

A team of 45 people included CQC inspectors and a variety of specialists including medical, paediatric and

surgical consultants, junior doctors, senior managers, nurses, midwives, a palliative care nurse specialist, a health visitor, children's nurses and experts by experience who had experience of using services.

## How we carried out this inspection

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

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

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

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatient services

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

- Community end of life
- Urgent care centres
- Community health services for children, young people and families

- Community in-patient services
- Community services for adults

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

organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committees and the local Healthwatch.

We held a listening event on 2 December 2014 in Middlesbrough to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 9 – 12 December 2014 and undertook an unannounced inspection in the evening on 16 December 2014.

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

The results of the CQC Inpatient Survey 2013 showed the trust performed around the same as other trusts.

The Cancer Patient Experience Survey results for 2012/2013 for inpatient stays showed the trust was in the top 20% for 18 out of 34 indicators with only one indicator in

# Summary of findings

the bottom 20%. This indicator was about whether a patient's health got better or remained about the same while waiting; the trust scored 77 for 2013/14 with the top 20% score for all trusts in 2012/13 being 83.

Results of the Patient-Led Assessments of the Environment (PLACE) 2013 showed that the trust scored

for cleanliness 99 (the England average was 96), food 86 (the England average was 87), privacy, dignity and wellbeing 89 (the England average was 87) and for facilities 94 (the England average was 88).


The local Healthwatch reported that the themes coming out of engagement with local people about the trust services were in the main positive.

## Facts and data about this trust

- Deprivation in South Tees was higher than average, with some areas of considerable deprivation on a par with the most deprived areas of the country. Significant numbers of children lived in poverty, with more than one in four children in Redcar and Cleveland and one in three children in Middlesbrough living in poverty (more than 18,000 children across South Tees).
- There was substantial variation in life expectancy between the most and least deprived areas of South Tees (12.5 years lower for men and 8.5 years lower for women in Redcar and Cleveland; 14 years lower for men and 9.3 years lower for women in Middlesbrough).
- The health of people in Middlesbrough is generally worse than the England average. The health of people in Redcar and Cleveland is mixed compared with the average for England
- Breastfeeding initiation and prevalence rates reflect the levels of deprivation in the Borough as being ranked as one of the five lowest in England.
- 11.7% of the population is estimated to be from the Black and Minority Ethnic (BME) community compared to the regional average of 8.2% making Middlesbrough one of the most diverse places to live in the north east.
- Children and young people under the age of 20 years make up 26.0% of the population of Middlesbrough. 21.0% of school children are from a minority ethnic group.
- The health and wellbeing of children in Middlesbrough is generally worse than the England average. Infant and child mortality rates are similar to the England average.
- The level of child poverty is worse than the England average with 34.3% of children aged less than 16 years living in poverty. The rate of family homelessness is better than the England average.
- Children in Middlesbrough have worse than average levels of obesity: 11.9% of children aged 4-5 years and 22.9% of children aged 10-11 years are classified as obese.
- In 2012/13, children were admitted for mental health conditions at a similar rate to that in England as a whole. The rate of inpatient admissions during the same period because of self-harm was higher than the England average.
- There were 360 children in care at 31 March 2013, which is a higher rate than the England average. A higher percentage of children in care are up-to-date with their immunisations compared to the England average for this group of children.
- Trust revenue - £550,750,000
- Full Cost - £555,135,000
- Deficit - £4,385,000

# Summary of findings

## Our judgements about each of our five key questions

	Rating
<p><b>Are services at this trust safe?</b></p> <p>There were systems and processes in place to promote a safety culture within the organisation. However, these were not fully embedded within the trust and there were areas where improvements were required, particularly around staffing levels in some areas, the checking of equipment, arrangements for dealing with some medication, record keeping, training and safeguarding.</p> <p>We found an open culture around safety, including the reporting of incidents. Staff were confident with reporting incidents and these were appropriately investigated. There had been four Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) between April 2013 and July 2014 at this trust; three relating to surgery and one relating to critical care services. Systems were in operation to understand what caused an incident and there was good sharing of the outcome to investigations to improve practices. We saw that incidents had been fully investigated, identifying the root causes of the errors, contributory factors, lessons learned, arrangements for sharing learning and actions needed to stop recurrence. All incidents relating to people living with dementia or with a learning disability were highlighted and sent to the dementia and safeguarding leads for the trust, where themes or trends were then reviewed. Staff were aware of the duty of candour and there were systems in place to ensure that patients were informed as soon as possible if there had been an incident that required the trust to give an explanation and apology. However, not all staff were aware of the change in legislation and the requirements placed upon the trust with the introduction of the new Duty of Candour Regulation (2014) or had received specific training on this subject. We were told that a paper had gone to the Trust Board addressing this issue.</p> <p>Wards across the trust monitored safety and ‘harm free’ care and used this information to benchmark where improvements were needed. We saw that concerns arising from the monitoring of the safety thermometer, such as complaints and serious incidents were discussed at the clinical centres’ governance meetings. Lessons learnt were identified, but there was some inconsistency in recording actions and outcomes to lessons learnt, for example in the integrated medical care centre, there had been no record of made of discussions regarding footwear on the impact of ulcers on morbidity</p>	<p><b>Requires improvement</b> </p>

# Summary of findings

on admission. We were told that the head of nursing for the integrated medical care team met with ward managers to check if actions had been completed. However, no local ward based action plans were evident to address the concerns raised.

Generally, arrangements ensured that equipment was checked and serviced according to trust policy and manufacturers guidance but there were inconsistency in practice in some areas, leading to potential risk and an indication that the trust's own monitoring and auditing programme was not always sufficiently robust. We found a few inconsistencies in the daily checking of some resuscitation equipment, drug fridges and some portable appliances for example some checks on equipment had not been carried out regularly in the imaging and the dermatology department at both acute hospitals. The trust took immediate action to address all issues raised to their attention.

There were plans in place for dedicated pharmacist support by 1 January 2015 in all clinical areas following a substantial investment in pharmacy staff. Syringe driver monitoring was inconsistent, with the required four-hourly checks not always being carried out, meaning that safety checks were not always conducted in line with trust policy. We observed four patients who were receiving medication to reduce their symptoms via a syringe driver; in all four cases, syringe driver monitoring was inconsistently recorded.

Patients' records and observations were mostly recorded appropriately and concerns were escalated in accordance with the trust guidance. However, across the trust we found examples of patient care records that were not fully completed or maintained up to date and in some cases were not stored to ensure that they remained confidential. We found this a particular concern in some A&E see and treat records in terms of children's safeguarding, where there was inconsistent recording of assessments. We also found that supportive documentation on some wards across the trust, such as fluid balance charts and risk assessments were not consistently completed in all cases.

Improvements were required in the recording of 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) decisions. Of the 31 forms across both acute hospitals we viewed, nine had not been signed by a consultant, eight did not include details of discussions with the patient or relatives, one was a photocopy and 13 did not include a date for review. We saw one patient whose condition had improved, yet a review of the DNA CPR decision had not been carried out. This meant that resuscitation decisions were not consistently being recorded in line with national guidance and trust policy. Patients identified as being in the last days of life were

# Summary of findings

commenced on the last days of life care pathway. While on many wards these were completed accurately and in full, we did view examples where the assessments were not always completed or signed by the assessing doctor and nurse. Of the 13 records we reviewed, we saw that eight included incomplete assessments.

Attendance at mandatory and safeguarding training was low on some specific wards. Members of staff of all grades confirmed that they received a range of mandatory training, although training records did not always accurately reflect training take-up. Compliance was low in some subject areas, which were labelled as “once only” mandatory training. For example, in the children’s services Mental Capacity Act 2005 awareness training attendance was 16% (23 out of 144 staff) and conflict resolution update 24% (37 out of 150 staff). Staff in community settings reported that non-compliance was due to a range of issues, including insufficient training places and practical difficulties in obtaining smart cards to access e-learning.

Children’s services had been reconfigured recently and this was still work in progress to adapt to the new changes in provision. The main care facility for children and young people had moved to the James Cook University Hospital site and the facilities were not yet fully fit for purpose in some areas such as the urgent and emergency care unit and the paediatric care unit.

## **Staffing**

We found that nurse staffing in some areas was a concern particularly at the two acute hospitals in the urgent and emergency care departments, medical wards and children’s services. In Accident and Emergency the trust had introduced a number of measures to improve access to skilled staff such as the recruitment of emergency nurse practitioners (ENP), advanced trained nurses able to see, treat and discharge certain categories of patients so that patients did not have to wait to see a doctor. ENPs were not counted in the shift nursing numbers due to their role being to assess, diagnose and treat patients. Three ENPs had recently been recruited and were undergoing training at the James Cook University Hospital.

The level of nursing staff fell below nationally recognised guidelines on the children’s wards and neonatal unit. The seven-bed paediatric intensive care/high dependency unit was only commissioned and staffed for four critical care beds. The current staffing establishment for each of the children’s wards fell below the recommended minimum staffing level for children’s wards set out by the Royal College of Nursing (RCN) staffing guidance. The ward manager explained that the staffing numbers roughly equated to

# Summary of findings

one registered nurse to seven children. Ratios set out by the RCN recommend one registered nurse to four children (over two years of age). Staffing on the neonatal unit had historically fallen below nationally recognised standards set out by the British Association of Perinatal Medicine (BAPM). These standards set out minimum staffing for the three levels of dependency used to describe neonatal care – including level 3 (intensive care), which required registered nurses/midwives who had undertaken a specialist neonatal course. This was a recorded risk on the risk register.

The neonatal unit had changed from October 2014 because an additional 10 cots had opened to accommodate the closure of the special care baby unit at Friarage Hospital. This had also led to an increase in staffing establishment, with a number of neonatal nursing staff who had moved to James Cook University Hospital. Staffing on the paediatric intensive care/high dependency unit was complex and historical in nature. The four intensive care beds were funded via a subcontract arrangement from Newcastle and formed part of the regional paediatric critical care network. The three high dependency beds had been developed and opened locally by the trust. The leadership team explained that the paediatric intensive care unit nurse staffing was funded for four beds and not the seven beds available. The ward manager on the neonatal unit explained that these additional staff, along with trust investment for an additional 5.5 neonatal qualified nurses, was already having a significant, positive impact on the staffing of the neonatal unit. Medical staffing had some gaps, but these were being managed and addressed. During the period 17 November to 7 December, at least one child requiring level 3 care was refused admission from another hospital because there were not enough staff on duty. There were also other events during the period that would have impacted on the nurse staffing on duty, such as withdrawal of care. The nurse management team told us that the commissioner of the services was currently reviewing how the service was funded.

Nursing staffing levels were also not always meeting nationally recommended guidance or the trust's own identified levels on some medical and surgical wards at both acute hospitals. The trust used the Safer Nursing Care Tool to determine the required levels of nurse staffing for each ward. Nursing acuity audits were started in the late spring/early summer 2014 and were completed for four weeks every quarter.

We reviewed the nurse staffing levels on surgical wards across the trust and in theatres and found that levels were not always compliant with the required establishment and skills mix. On surgical wards, the average 'fill rate' varied from 84% to 102.6% during the day and 77.1% to 106.6% at night. The 'fill rate' for

# Summary of findings

unregistered staff varied from 70.8% to 146.9% during the day and 93.4% to 173.2% at night. At James Cook University Hospital and the Friarage Hospital nurse staffing levels on some medical wards, especially overnight were concerning with levels of one nurse to 16, 14.5 and 13.5 patients. We were concerned about the nurse staffing levels overnight, especially on ward 2, ward 3, ward 10 and ward 12. The trust had already highlighted this as a concern and plans were in place to improve the ratios. This included moving to a model of three nurses on nights where there were more than 24 patients on a ward or if the acuity of patients required more nurses. This was noted in the minutes of the integrated medical care centre board meeting in September 2014. The proposals for wards 10 and 12 were to be implemented by the end of December 2014 and for wards 1 and 2 by the end of January 2015. Within the outpatients department, there were concerns that the low number of registered nurses meant that the skills mix of staff was not always able to support patients' needs.

Within community nursing, the service used an e-rostering tool to support the planning of staff workload. Staffing levels required to achieve safe staffing levels in community and specialist nursing teams reflected the skill mix of staff and miles travelled, as well as the number and needs of patients. Staffing levels were sufficient in most areas. However, in some community locations staffing levels including cover arrangements required review to ensure adequate staffing arrangements.

We found that planned staffing levels in the community hospitals were mostly met; where this was not the case senior staff took action such as using bank staff or temporarily reducing the number of beds to promote patients' safety.

## **Safeguarding**

Following a service review, the trust had recently introduced a new structure for managing safeguarding within the trust. We found that although there were arrangements in place for dealing with safeguarding concerns, that there were weaknesses within these that meant that responses to safeguarding issues could be delayed or inefficiently dealt with, particularly with those involving children. Currently, there remained some capacity concerns for the adult safeguarding arrangements and their ability to sustain the volume of activity required, particularly with incorporating issues raised with people living with dementia or a learning disability. Concerns over the capability of adult safeguarding services were on the trust risk register. The trust was taking action to make improvements such as up-skilling matrons and ensuring that policies and procedures were accessible.

# Summary of findings

In the urgent and emergency care department at James Cook University Hospital, when looking at the management of children's safeguarding concerns, we found that there were clear procedures to follow including an action flow chart, but there were gaps and inconsistencies in documenting safeguarding assessments. We reviewed 47 paediatric care records in the see and treat area of accident and emergency and found that, in the majority; the safeguarding tool was incomplete or had not been completed at all. We were informed by the trust that this safeguarding tool was a pilot that had only been introduced in the week of the inspection. When we spoke with managers they explained that due to sickness the typing of transcriptions from dictation machines had been behind schedule, which meant there was no contemporaneous record available of safeguarding assessments. The introduction of a new IT system was expected to resolve this problem in the future. Before we left the hospital, managers had already started to make improvements by formally instructing staff to document evidence of safeguarding assessments and implementing an audit process until compliance was assured.

Training uptake and completion was variable across the trust and within staff groups. Safeguarding adults and children training was part of the mandatory training programme. In the urgent and emergency care departments 61% of medical staff had completed the core initial level 3 training; and 41% had completed the safeguarding children level 3 core update. All medical staff had completed safeguarding children training at level 2. For nursing staff: 76% had completed the core initial level 3 training; 30% had completed the level 3 core update; 63% had completed safeguarding children training at level 2; and 21% had completed level 1 safeguarding training. There was a safeguarding adults training programme for April 2014 to March 2015, and 47% of medical staff and 80% of nursing staff had completed their training.

There was a Mental Capacity Act (2005) and Deprivation of Liberties Safeguarding (DoLS) policy in place, although this was in transition at the time of the inspection. The trust was submitting DoLS applications and had submitted 71 in October 2014. Only 53% of clinical staff had been trained on DoLS assessments.

We were told that a paper on a training strategy for safeguarding had been submitted to the next Trust Board meeting for consideration.

## **Infection Prevention and Control**

Across the acute hospitals and within the community services, 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



# Summary of findings

all areas we visited were visibly clean. Rates of Methicillin-Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. difficile) were within an acceptable range for the size of the trust, although concerns remained over the prevention and control of C.difficile infections. There had been two external reviews with concerns raised over the environment on wards 1 – 12. An improvement programme was in place to refurbish wards identified as a challenge for example ward 3.

In 2014/15 there were three cases of Methicillin-resistant Staphylococcus aureus (MRSA) attributed to the trust up to September 2014. Post infection reviews had been held with the commissioning groups and action plans implemented. The trust had not achieved its C. difficile target of having less than 39 cases in 2013/14. There were 57 cases reported. For 2014/15 there were six cases of C. difficile reported in October 2014, taking the total to 30, which was one above trajectory for a full year target of 49.

A monthly monitoring report prepared by the infectious diseases doctor was submitted to the Transformation Board, with weekly reporting to the Chief Executive and Chair. The report concentrated on antibiotic prescribing, communication, cleaning, hand hygiene and isolation. An infection prevention group sat monthly and reported through the patient safety sub group through to the quality assurance committee. Actions were identified to address issues, for example, for antibiotic prescribing a revised drug sheet had been introduced with a stop date included on the form.

The trust had a team dedicated to the management of infection prevention and control (IPC), comprising a board level director for Infection prevention and control (DIPC), a lead nurse and seven specialist nurses, who worked with staff across the trust and undertook training and auditing of practice. Audit results of ward practice were collated and displayed on each ward's dashboard. The microbiologist worked with medical staff to undertake audits, particularly on prescribing practice. Link practitioners from wards worked with the IPC team to support colleagues, but access to meetings and training was a challenge at times due to staff shortages. Training was mandatory for staff and provided at induction as well as through additional ad hoc training and e-Learning courses. A newsletter had been developed and was cascaded monthly to staff to aid in communicating updates in IPC issues. There was an external contract in place for the cleaning of wards and departments.

## Are services at this trust effective?

Policies and procedures for care and treatment were based on National Institute of Clinical Excellence, national and Royal College

Requires improvement



# Summary of findings

guidelines. These were accessible to staff across the trust, through the trust's intranet site. Staff were aware of the local policies and procedures and there were mechanisms in place to update policies as guidance changed. The trust had a system in place to audit its performance and participated in the national clinical audit programme. According to the trust's Quality Accounts there were 35 national clinical audits and five national confidential enquiries during 2013/2014, which covered relevant health services that the trust provided. During that period the trust participated in 97% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The hospital participated in national CEM audits so it could benchmark its practice and performance against best practice and other A&E departments. Although it was acknowledged these were not recent, they were the latest audit data available at the time of inspection. The trust was not meeting several patient outcomes.

Hospital Standardised Mortality Ratio compares number of deaths in a trust with number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2013/14 the Trust had a slightly higher figure of 108, this was lower than the previous year. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was as expected. The trust actively reviewed mortality cases on an ongoing basis and held regular meeting with clinicians to identify issues when data was available.

Audits were undertaken to monitor compliance with guidance, for example audits regarding the use of antibiotics, cardiac rehabilitation and Troponin testing, which measures the levels troponin proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack. These audits were discussed at clinical governance meetings. In addition, local auditing of practice took place across care treatments and also staff practices, with action plans developed for any issues identified for improvement.

The trust had also audited itself against the NICE guidance for dementia in 2013 and as a consequence put action plans in place. For example to deliver training to Foundation Year 1 and Foundation Year 2 doctors in the prescribing of medication for dementia. A further internal audit was completed in August 2014 against 48 standards, which highlighted the main issue as being poor pain

# Summary of findings

management. Each clinical centre developed an action plan. Actions taken included the development of a flow chart to seek mental health support and a pain assessment tool using Facial Location Assessment.

There were local policies and procedures in place which staff followed to ensure that patients received the right care and treatment, for example the multi-disciplinary integrated care pathway for deep vein thrombosis and the diagnostic pathway for a patient with suspected pulmonary embolism.

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. The Patient-led assessments of the Care Environment (PLACE) 2014 survey indicated that the trust (91%) was slightly better than the national average (90%) with regard to patient's comments on the food provided. However, we saw that the assessment of nutrition and hydration had been inconsistent in the acute hospitals for patients at the end of life, with documentation not always being adequately completed in its current format. Following the results of the National Care of the Dying Audit, nutrition and hydration had been addressed in the new guidance and plans were in place to develop training in this area.

Not all staff had received an appraisal or had access to supervision, where appropriate. For example, in the medical clinical centre 52% of staff had received an appraisal and approximately 60% of staff working within the integrated medical care centre had received staff development reviews.

Pain assessments were carried out and recorded. Pain scores were included on the medical assessment proforma. 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. However, we found that in the acute hospitals, there were concerns over the consistency of checking and recording of the of syringe drivers used to give continuous measured doses of pain relief, which could lead to gaps in patients' access to medication.

Staff across the trust reported very good working relationships within the multidisciplinary teams. There was internal multi-disciplinary working (MDT) both between specialities and with allied health professionals. For example, between medical cardiology and cardiothoracic surgery, stroke services and neuro-rehabilitation. There was an acute liaison psychiatry service which was provided by another local trust. The team was based at James Cook University Hospital and available 24hours a day by phone. There was a four hour referral agreement in place.

# Summary of findings

Medical staff reported positively about senior medical and consultant cover. Ward rounds were undertaken daily Monday - Friday. On some wards, such as the medical assessment units, CCU and gastroenterology there were daily consultant-led ward rounds. Multidisciplinary board rounds were undertaken at community hospitals. There was a hospital at night system in place, which co-ordinated the medical handovers and managed requests for support from the doctors working overnight. There was five day working for both physiotherapists and occupational therapists with limited allied health professional support for medical areas of the trust at weekends. There was 24 hour physiotherapy cover for acute respiratory patients; although it was reported at the consultant focus group that access to physiotherapy especially for rehabilitation treatment was limited at weekends. The stroke ward (ward 28) had some therapy services over weekends, with occupational therapists usually available both days. However, there was no other routine weekend or on call occupational therapy cover. Pharmacy services were available seven days a week, although there were limited operating hours on a weekend. X-rays and blood transfusion services were available 24 hours every day at the acute hospitals. There was also 24 hour access to CT scanning through agreement with the senior doctor.

## Are services at this trust caring?

We found that services provided at the trust were caring and compassionate. Patients confirmed that they were treated with dignity and respect, that they were involved in their care decisions and felt generally well informed. We found examples of outstanding practice delivered to adults receiving community healthcare.

Analysis of patient feedback and surveys showed that on the whole patients were satisfied with the care and treatment at the trust. The trust performed around the same as other trusts in relevant questions in the CQC's Inpatient Survey 2013, with the exception of one question. This was regarding whether patients felt they received enough emotional support during their stay.

The NHS Friends and Family Test response rate was consistent with the England average. The Friends and Family Test requires all patients, after discharge from hospital, to be asked: How likely are you to recommend our ward to friends and family if they needed similar care or treatment? Of those that responded in December 2014, 97% said they would be likely to recommend the hospitals compared with 95% nationally. The percentage of patients who would recommend the services was consistent with, or higher than, the national average in September 2014.

Good



# Summary of findings

The results of the 2014 CQC A&E patient experience survey put the trust among the best in the country. Responses to key questions asked about a safe, effective, caring, responsive and well-led service indicated that the trust's performance was better than expected when compared to other trusts.

The cancer patient experience survey results for 2013/2014 for inpatient stays showed the trust was in the top 20% nationally for 18 out of 34 questions with only one question in bottom 20% which was whether a patient's health got better or remained about the same whilst waiting for treatment, which was 77% for this trust compared to 83% nationally.

We observed positive, kind and caring interactions between staff and patients on wards, clinics and in patients' homes. We saw an example of outstanding practice regarding implementation of the DESMOND programme for patients with diabetes or the risk of developing Type 2 diabetes. Patients reported that they felt able to talk to staff about any concerns, either about their care, or in general. Patients were able to access counselling services, psychologists and the mental health team.

## Are services at this trust responsive?

The trust was generally responsive to the needs of patients and the local population. Work was in progress to transform services to improve on service delivery and identifying what service arrangement best met demand. The trust was working with staff groups, local commissioners of services, other health and social care providers in the region and consulting with the general public to develop service plans. On the whole, we found services were responsive to need, particularly in some specialties. For example following the re-configuration of maternity services, with the concentration of consultant-led care at the James Cook University Hospital and the formation of a midwifery-led service at the Friarage Hospital, patients were highly satisfied with the care and service received. We saw some excellent examples of collaborative working across sites, including the community to extend support for mothers before and after birth. For example, in response to the increased demand for uro-gynaecology services, steps had been taken to expand services, including the appointment of a consultant and nurse specialists and the introduction of telephone follow-up clinics.

Actions were being taken to improve the facilities and care given to patients living with dementia and a learning disability. Ward environments were being refurbished and adapted to make them more dementia friendly and suitable to meet patients' needs. We read a dementia audit, dated March 2014 which referenced the

Good



# Summary of findings

trust's aim to become a dementia-friendly organisation with environments and processes that caused no avoidable harm to patients living with dementia. The trust had a dementia care pathway and a relevant learning package for staff in place.

There was a small team of dementia educators within the trust. A new dedicated dementia educator funded by Hambleton, Richmondshire and Whitby clinical commissioning group had started in December 2014 to support staff in developing an understanding of dementia and how to provide appropriate care. To help support people living with dementia the trust operated a "Forget me not" scheme. This included a leaflet completed with the patient and/or their family which was kept near the patient for staff to use. It included information staff needed to know to care for patients such as food likes and dislikes, usual sleep routine and how to identify when someone was in pain. There was also a service level agreement with a local mental health trust to provide more specialised dementia care as required. Staff knew about the Hospital Passport document system for people with learning disabilities and how it was used at the trust. These passports set out people's specific needs and copies were taken and placed in the care record.

However, there was still work in progress on transforming the service configuration at the trust and this was particularly evident within children's services where the premises had yet to be developed to meet the needs of the children now being cared for at James Cook University Hospital.

There was a facilities improvement programme in place, which included the refurbishment of ward areas. However, we found that some areas had limitations, for example on ward 21; there was a lack of disabled facilities on Ward 21, which may carry risk regarding moving and handling. There was only one hoist available and we were told this was shared with other wards and clinical areas within children's services. The ward had no dedicated, adjustable assisted bath (there was one on ward 22) and no rooms with a roof-mounted hoist. We were told by the management team and some staff that this made caring for children with complex physical needs difficult at times.

The seven-bed paediatric day unit (PDU) was located along one corridor adjacent to Ward 21. We were told that the PDU environment did not always fully meet the needs of children and families due to capacity issues, which carried some risk. The PDU waiting area for families was very small. This sometimes meant families were left in the corridor for periods of time waiting for a bed space to become available. The waiting overspill area in the corridor

# Summary of findings

partially closed a door leading to a link corridor. The waiting area was not clearly observable by the PDU staff, which meant a waiting child may become poorly without staff being immediately aware. During our inspection we observed parents waiting in the corridor on more than one occasion, making it difficult to access the link corridor to other parts of the children's area.

In the James Cook University Hospital urgent and emergency care department, 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 adult patients. The children's waiting area was situated where adults were treated for minor complaints or injuries and conversations with adult patients could be overheard. The children's waiting area was small and only had nine chairs to seat families. We saw the area was crowded on several occasions. During our three-day inspection, we saw children sitting in the waiting area with adult patients, including an injured adult patient. We asked for the paediatric environment risk assessments but were told these were not readily available or accessible as they were on a member of staff's laptop and not backed-up to the hospital's hard drive.

From October 2014, some paediatric patients who were previously seen at the Friarage Hospital, Northallerton were treated in the department at James Cook University Hospital, (except those who self-referred at the Friarage with minor injuries). This meant there was a small increase of children being seen and treated in the department.

The trust was consistently meeting the national target for initial assessments or four hour waiting in the urgent and emergency care service. The national standard for patients who arrived by ambulance states they should receive an initial assessment by a registered healthcare professional within 15 minutes. We read departmental data (April to October 2014) that showed how patients within the 95th percentile who arrived by ambulance did receive an initial assessment within the 15-minute target. However, the longest time to initial assessment was recorded in July 2014 at about 158 minutes. Managers told us that the main issue with maintaining compliance with the four-hour target was patient flow, particularly related to patients who were waiting for beds. We saw staff working well together to monitor patient flow on an hourly basis and the escalation plan being implemented when necessary. Staff told us that the trust had started a project to look at patient flow across the hospital and there were plans to employ a project manager.

# Summary of findings

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 department had a rate of less than 3% of people who left without being seen by a doctor or a nurse (April to October 2014).

The trust was meeting the referral-to-treatment time targets for 90% of patients admitted for treatment from a waiting list within 18 weeks of referral. The referral-to-treatment times for patients admitted from a waiting list within 18 weeks was not met within trauma and orthopaedics (73.6%), urology (88.4%), ophthalmology (88.4%), oral surgery (73.1%) and cardiothoracic surgery (74.1%). The reasons for these shortfalls had been identified and additional recruitment to consultant posts undertaken and locum cover arranged to reduce the backlog of patients. The centre had also introduced 'three session' days in response to referral-to-treatment times.

Delays to discharge within the trust were caused mainly by patient or family choice (14.8%), waiting for further NHS non-acute care (23.9%) or completion of assessment (32.2%). These are all above the England average (13.8%, 21.2% and 18.7% respectively). The average length of stay was below the England average (three days) for all surgical patients (two days) and for general surgery (two days). Sixteen patients had their operations cancelled and were not treated within 28 days during 2014; this is higher than the England average during this period and represents a monthly average of 0.53% of elective patients between April and October 2014. The trust were taking action to address the delays to discharge for example the employment of discharge facilitators, access to 7 days a week rapid response teams and they had undertaken a bed utilisation review to identify those patients whose discharges were delayed.

Improvements were also required in the way care was planned for patients at the end of their life, including the assessment of spiritual needs and recording of the preferred place of death. We viewed an audit of the last days of life care pathway that had been carried out by the specialist palliative care team from January to April 2014. This audit highlighted that the assessment of spirituality needs and recording of the preferred place of death were not always consistently completed. Actions to be addressed from this audit included the need to liaise with community colleagues about advanced care planning for patients approaching the end of life.

## **Learning from complaints and concerns**

The trust had reviewed its complaint processes and had improved its response times. However, the number of complaints was increasing and the trust was not achieving its 25 day (meeting only



# Summary of findings

11%) target response due in the main to the complexity of the issues raised. Some responses took up to 100 days. The responsibility for ensuring that a complaint was investigated sat with the clinical matron, who then reported to the head of nursing the outcome and any actions required. There was an independent review panel in place.

The main general themes were around communication, information giving and the cancellation of appointments. Complaint reports go monthly to the patient experience sub group monthly and quarterly then to the Trust Board.

Across the trust staff reported that they were made aware of complaints within their areas, that these were discussed and actions taken to address issues identified.

## Are services at this trust well-led?

There was a clear vision, strategies and plans in place for service delivery and future development within the trust. Pivotal to this was the transformation programme, which set the road map for future service re-configuration and although this was still in development, progress had been made in some specialities and locations. The trust was working with staff groups, local stakeholders and consulting with the general public on the development of services, where they were best located and how to improve the effectiveness of delivery.

There was a visible leadership team, which engaged with staff groups across the trust. There had been some changes within the leadership team, and a governance review was being undertaken, which included the structure of the reporting processes to the Board, such as the sub-committee structures. There was an open safety culture within the trust, although this was not fully embedded and staff reported that they felt able to be honest when reporting incidents and concerns. There were mechanisms in place to identify risk, and much of the findings of this inspection had already been identified by the trust and highlighted on risk registers or within action plans, although not all. It was clear that dealing with many of the issues identified as part of the risk assessment of operational delivery or the impact of the transformation of services was still work in progress.

We identified examples of outstanding leadership within Maternity care.

The trust was facing a particularly challenging financial position with a deficit to address, entailing significant cost improvement plans. Staff were aware of the situation and had been consulted and informed in decisions on where saving should occur. Where there

Good



# Summary of findings

had been an identified risk to quality or safety, plans had been rejected or refined. Confidence in the impact assessments on cost improvements were reported by staff. It was too early to assess at the time of the inspection whether cost savings would impact on the quality and safety at the trust.

Consultation with staff was seen as a priority and work was in progress to improve on engagement with patients and the general public. Staff were encouraged, able to input ideas and were empowered to develop and implement solutions to provide a high-quality service.

## **Vision and strategy**

- There was a clear vision for the future of the trust and this involved the transformation of services to meet the changing needs of the population and demands on services. The trust's ambition was to improve access to health care and tailor services in appropriate locations to better meet the increasing demands, for example the Chief Executive stated that the vision for the Friarage Hospital was for this to be, "A beacon for rural health". It was recognised that the trust worked over two different communities with distinct needs and challenges, a rural community with long distances to travel and Middlesbrough, with a high level of deprivation and unemployment. The trust was working with external partners, including the commissioners of services and other health care providers in developing plans for the future of the trust.
- An ambition was to improve the community hospital stock, which required the movement of some services. There were plans to amalgamate the community-based urgent care centres and a public consultation regarding the community hospitals had been undertaken in 2014. There had been the recent move of the children's services and consultant led maternity services now concentrated at James Cook University Hospital rather than mirrored services across two acute sites. A second ambition was to increase care delivered closer to home, again in discussion with the local commissioners of services.
- There was an overall communication strategy in place which was to be updated in May 2015.
- The trust had a mission statement: Seamless, high quality, safe healthcare for all, with a strap line of - together we do the amazing.
- The trust's vision was, "To be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement."

# Summary of findings

- The Trust Strategy focussed on transformation or continuous improvement within four themes: quality, safety and patient experience, business sustainability, organisation capability and operational excellence. The trust had a clear aim to become a dementia friendly organisation - “with environments and processes that cause no avoidable harm to patients with dementia”. The trust had done a self-assessment, based on the markers of best practice from the National Dementia Audit-Royal College of Psychiatrists, of the environment. There was a strategy to further develop early supported discharge of stroke patients into community services, which was planned to be implemented by April 2015 and here was significant ongoing work, both strategically and locally on wards to improve the discharge of patients. However, it was acknowledged that a number of key strategies that would underpin the trust’s overall strategy were still being developed at the time of the inspection, including the clinical strategy for the Friarage Hospital, the nursing strategy and the communications strategy.
- There were five clear values at the heart of the Trust Strategy, which were – supporting, respecting and valuing each other; putting patients at the centre of everything we do; continuously improving quality; using our resources to the benefit of the wider community and financially strong to underpin quality, safety and improvement.
- Three quality priorities underpinned the Trust Strategy: Sign up to safety, Right care, right place, right time and At the heart of the matter.
- Sign up to safety had six areas identified for attention, the safe storage of medication, documentation, reducing infection, reducing pressure ulcers, the environment and staffing.
- Right care , right place, right time, focussed on the recognition/ treatment of the deteriorating patient, nutrition, no unnecessary waits and improving access to care.
- At the heart of the matter entailed improving the patient experience by ensuring that staff identify themselves, complaints and concerns were dealt with appropriately, personalised care, the trust’s vision and values and patient information.
- The trust had set itself thirteen objectives to achieve its strategic aims to drive continuous improvement in the delivery of services. These identified a range of areas including standards of excellence in patient safety and clinical quality; performance in access to treatment and resilience to winter pressures; the transformation of services, particularly for older patients; the sustainability of children’s services; increasing

# Summary of findings

income opportunities for specialised services; the better use of resources; improved staff engagement and enhanced working with external stakeholders, such as commissioners. Each objective had identified leads and a project plan. Collaborative working with external stakeholders and staff engagement was identified as a theme within the development of the trust's objectives, for example the assistant director of transformation was a jointly funded post with the commissioning group and another foundation trust in the region. Some plans and actions had been identified within each objective with a range of completion dates from May 2014 to March 2015. However, the majority centred on September to December months. It was not clear as to when the progress of each objective would be reviewed. Work was in progress with meeting the objectives and therefore it was too early to assess progress on these at the time of the inspection.

- Each strategic aim, with its underpinning objective was identified on the Board Assurance Framework (BAF), which identified known risks to meeting that aim for example, the objective - To set the national standard for excellence in patient safety and clinical quality by delivering care free from avoidable harm and continuously reducing the mortality rate, had the risk to complying with the C.difficile and MRSA targets highlighted with gaps in control, assurance processes and performance measures identified.
- The objectives developed to achieve specific strategic aims were linked from the BAF to the corporate risk register, demonstrating that the trust had a system in place to identify, monitor and escalate those risks at service level to its achieving its strategy.

## **Governance, risk management and quality measurement**

- The trust was undergoing a governance review of Board assurance, including a review of the committee structures; an external agency was due to report its findings, but this information was not available at the time of the inspection.
- The trust's present governance structure comprised of a Board of Directors, Council of Governors, an Audit Committee and a Nominations Committee. A Transformation Board monitored and ensured the operational delivery of the trust's key priorities and objectives, directly reported to the Board of Directors. There were two main sub committees, a remuneration committee and a quality assurance committee; the latter dealt with quality and safety governance for the trust.

# Summary of findings

- There were five sub groups reporting to the quality assurance committee, the patient experience sub group, the clinical standards sub group, the patient safety sub group and the workforce sub group.
- Each sub group to the quality assurance committee dealt with a range of operational as well as quality issues for the committee. The patient experience sub group oversaw matters around the patient experience within the trust, including complaints, the independent complaint review panel and the patient experience forum. The clinical standards sub group oversaw the clinical aspects of service including the clinical audit programme, safer medication, end of life care, mortality reviews, NICE guidance, infection prevention and control, critical care and the trauma care group. The patient safety group included matters such as serious incident review, health and safety and the human factor steering group. The workforce sub group dealt with the medical workforce strategy, the nursing and midwifery strategy, the clinical support workforce strategy, the equality and diversity group, staff experience and staff experience and wellbeing. Each of these had working or action groups, which had been delegated specific work to do on behalf of the sub group and involved a range of staff across the trust and some external stakeholders.
- In addition, there were three professional advisory groups, which dealt with the director of nursing team meetings, the medical staff meetings and the clinical professional practice group.
- The trust's management structure consisted of seven clinical centres: the trauma and theatres centre, the integrated medical care centre, the surgical services centre, the tertiary services centre, the speciality medicine centre, the clinical and diagnostic support centre and the women and children centre.
- Each clinical centre had a triumvirate leadership arrangement, which comprised of a lead clinician/chief of service, a head of nursing and a managing director. The leadership for community services was incorporated into the clinical centres with managers covering both acute and community services. Below this level sat clinical directorates, each with an identified clinical director lead. This structure enabled a clinically led service, which allowed for the greater involvement of clinicians in the management decisions within the trust. Staff reported that lines of reporting, responsibilities and performance management were clear within each of the clinical centres.
- The risk management arrangements were designed to underpin the BAF, which had at the heart of it a corporate risk register. Risks were rated from 1 to 25; any over 12 were brought

# Summary of findings

to the Board's attention via the corporate risk register. Each service within the trust had a risk register, from these, risks were escalated to the corporate risk register should they reach the threshold for consideration. We found that the risks identified on the local service register were generally known by the staff at the time of the inspection, who were able to discuss mitigating actions that had been put in place, or which had been escalated upwards. However, local clinical centre risk registers included most but not all the issues identified as risks during the inspection. We were told that the risk registers were not readily accessible for ward managers and some community teams.

- There was an action log for lessons learnt from pressure ulcers and complaints. We were told this was to be developed to include falls and medication incidents.
- There was no local ownership or leadership on ward 28 at James Cook University Hospital to ensure that the safety thermometer information was up to date. We were told this was due to sickness.

## Leadership of the trust

- The Chief Executive had been in post since January 2013, and had previously been the director of nursing at the trust since 2000. This allowed for some stability in the senior team, and continuity of experience within the trust.
- The medical director was due to retire in March 2015, he had been in post for nearly five years, but had worked at the trust, originally as a consultant surgeon since 1988.
- A newly appointed transformation director had been appointed to start in January 2015. There were plans in place to make a new appointment to the role of director of quality with the purpose of ensuring that quality would not be compromised at any level, and would include areas of responsibility such as complaints, litigation, patient safety and risk.
- The Chief Executive told us how important it was that she was visible within the trust and ensured that she engaged with staff at every opportunity. We were told that the Chief Executive took a week out twice a year, including a weekend and spent time going into wards and departments. Clinical staff confirmed at interview and within focus groups that they saw the Chief Executive regularly and were able to gain access to her, and other members of the senior team.
- In addition, the Chief Executive and the Chair spent time with groups of staff to have conversations about their experiences within the trust. Staff across the trust spoke of the good visibility of the leadership team.

# Summary of findings

- Leadership forums took place monthly, with video links across the different sites to foster good communication channels. Presentations were also shared using this method; an example of a recent one given was the clinical director for neurosurgery's presentation on the cancer strategy and another on the transformation programme. In addition, external speakers were invited to take part in such events, including members of the commissioning groups.
- Senior leaders across the organisation were invited to attend the Trust Board meetings with the director of nursing, with medical leaders shadowing the medical director. Different members of staff groups are encouraged to attend a Board meeting, including nursing students, so that they could see how the Board and ward connected.
- In addition leadership development was taking place, for example there was a medical leadership development programme and feedback from clinicians was positive about this.
- There had been some changes to the Board, with three new non-executives appointed, each with a distinct portfolio and skill set, covering areas such as IT, patient experience and workforce/human resources. Further changes were due to take place next year when two non-executives will leave.
- As a foundation trust there was a Council of Governors. It was unclear how much involvement there was of governors, particularly in offering challenge to plans and decisions. There was no strategic plan for the role of the governor. However, the Chair was ambitious for the role of the governor in the trust and spoke of plans to further develop this body for the future including increased training opportunities, and create potential for better using people's skills and experiences in improving services within the organisation.
- In November 2014, the Fit and Proper Person Regulation had come into force that placed a duty on NHS providers not to appoint a person or allow a person to continue to be an executive director or equivalent or non-executive director if they had not passed a fit and proper person test. There should be in place appropriate procedures to ensure that staff appointed to these roles had been checked to show they were fit for the role. Trusts should be able to demonstrate that they had been through a process and followed the necessary procedures including checking of previous convictions, concerns in previous employments and appropriate fitness for the role. We checked the trust's compliance with this regulation and found that there had been a process in place prior to the introduction to the new regulation; however, not all new

# Summary of findings

aspects had been captured for example the trust had not previously included bankruptcy or insolvency in their checking procedures. A paper had gone to the Board for approving the addition of these changes. The trust was introducing an annual self-declaration of all appropriate Board members as part of the Board assurance over continued compliance to this regulation.

- When discussing the issues that required attention by the trust, there was a general consensus amongst the board of directors of which areas required the greatest focus. There was general agreement that the trust should address concerns over staffing shortages, particularly overnight (including improving recruitment processes), the financial challenge ahead including a failure to deliver the cost improvement programme and more clinical aspects of care such as the prevention of pressure ulcers, reducing cases of C.difficile (there had been 57 cases in 2013/14 with a 37 target), failure to meet the 18 week referral to treatment backlog, and improving environmental shortfalls.
- Four main risks reported by members of the leadership team were winter pressure planning with the increase in emergency admissions, the pace of change with the transformation programme and possible impact on staff morale and the challenge of the trust's financial position. At the consultant focus group, seven day access to pharmacy and physiotherapy (particularly for rehabilitation) services were given as examples of where the trust was less responsive. There was some concern over patient flow and how this impacted on the lack of access to critical care and high dependency beds.
- The trust had a forecast deficit of £34.9 million for 2014/15 to increase to £52.3 million in 2015/16 and was to receive £82.9 million support from the Department of Health, but needed to show that it could remain solvent until March 2016. A financial recovery plan had been submitted to Monitor with a substantial cost improvement plan. The trust needed to save £91 million; this would entail doubling the cost improvements for this year and then doubling again for next year. The leadership team reported confidence in the strategy to deal with the financial challenges ahead, that a robust quality impact assessment had taken place for the cost improvement programme. An external agency had reviewed the system, which led to improvements and made it much more sophisticated. Clinicians were involved with each proposed cost improvement plan and a series of engage and challenge sessions had taken place. An example of challenge was given when cost improvements had been



# Summary of findings

identified over staffing, which had shown as a high risk, this had been rejected. Staff were aware of the financial challenges that the trust had of the local cost improvement programmes, to ensure sustainability, and what was required to achieve these.

- Concerns over the challenges over the mortality ratio for the orthopaedic service had also attracted much attention to understand underlying issues and identify what actions were needed to address any areas of concern. A review had taken place of the data and each patient's case notes had been examined, with no specific issues found. Further analysis was taking place at the time of the inspection.

## **Culture within the trust**

- A positive culture of openness and candour with a collective responsibility for quality, safety and service improvement was evident. We found that there was a culture of openness among all the staff and teams we met. Staff spoke positively about the services they provided.
- We observed staff working well together and there were positive relationships within the multidisciplinary team.
- Staff working across the organisation, including staff working in community settings, felt engaged with the wider organisation.

## **Public and staff engagement**

- There was a Patient Experience Strategy but this was in need of updating.
- There was a drive to improve the patient experience and a course on customer care had resulted from work undertaken in response to complaints. The trust was increasing engagement with patients and the public and involving people more in the development of strategy work, in patient groups for example in children's services and neurology.
- Patient experiences were being heard at the Trust Board meetings.
- Each month 20% of the patients who had attended the hospital and were diagnosed as living with dementia or their relatives were contacted and asked to complete a survey about the care they had received. A recent Trust Board report indicated that that there had been an increase from a base of 52% to 77% for above average or excellent care of the person living with dementia.
- On some wards, for example ward 3 at James Cook University Hospital, there were public display boards that included feedback to patients and the public "You said, we did" from previous questionnaires or surveys.

# Summary of findings

- The department sought views from the public through the NHS Friends and Family Test, the response rate was similar to the England average.
- The Chief Executive explained how there is a great deal of work being undertaken to communicate the changes within the trust with staff including the transformation programme and the challenges over the financial position. To aid this, the Chief Executive used social media as a tool for communication including a blog, which was reported to have received 40,000 hits per month. Staff were able to feedback their views through the blog, and there were over 3000 followers on tweets. It was reported that the Chief Executive had an open door policy so that staff could feel enabled to raise any issues with her in person.
- The NHS staff survey 2013 indicated that only three areas out of 29 scored worse than the national average. These were the percentage of staff receiving health and safety training in last 12 months; the percentage of staff feeling pressure in last 3 months to attend work when feeling unwell and; the staff motivation at work score. The overall staff engagement score, 3.74, was similar to other trusts nationally at 3.73. Staff were slightly more likely to recommend the trust as a place to work or receive treatment, when compared with other NHS organisations nationally.
- In the NHS staff survey the staff in the medicine speciality (73%) and acute medicine staff (69%) said they would recommend the organisation as a place to work which was higher than the trust-wide response of 64%. Also, 83% of acute medicine staff said that if a friend or relative needed treatment they would be happy with the standard of care provided by this organisation compared to the trust average of 75%.
- There were forums for staff for example, the specialist nurse forum who gathered together to share and hear good practice and a medical advisory committee, which was reported had an open, transparent culture; the board included staff side representatives and staff council members.
- The medical director met with the consultant body in the senior medical staff forum every two months, but this was not well attended with a consultant group of 375 and 170 associates, only 50 – 100 attended meetings. To supplement communication, emails were sent to clinicians regularly. The medical director also met with the chiefs of service weekly, assistant medical directors monthly.
- Consultants confirmed that consultation was taking place and that they were aware of the challenges faced by the trust and were able to engage in discussion about service development.

# Summary of findings

Consultants at the focus group acknowledged that there was access to study leave and a leadership development programme was in place. However, concerns were highlighted over the IT system and that this was impacting on the effectiveness of delivery, causing some frustration, including a lack of work stations within the theatre departments.

- Staff sickness levels stood at 4.3% compared to the regions sickness level of 4.7%. This put the trust at the third lowest amongst peers in the region.

## **Innovation, improvement and sustainability**

- Innovation was encouraged from all staff members and staff were able to give examples of practice that had changed as a result. Staff were encouraged, able to input ideas and were empowered to develop and implement solutions to provide a high-quality service.
- A number of initiatives had been instigated to try to keep people out of hospital and at home – for example, the trust was working closely with commissioners and local authorities on a whole-system approach to prevent hospital admissions, to improve patient flow and expedite patient discharge. Almost 50 discharge workshops had been held to embed the improvements made.
- Staff were encouraged to focus on improvement and learning. We saw examples of innovation, such as the development of the discharge lounge within the surgical assessment unit and the dedicated ‘one-stop’ clinic for patients experiencing haematuria. In the children’s service, consultant paediatricians and other staff had introduced innovative ideas to improve service provision and sustainability for children and families who used the service.
- A review of practice regarding medication administration led to the development of a systematic approach from policy known as the ‘10 steps to safer medication’. This process set out a clear process for staff to follow from prescription through to administration of medicines. Documentation showed that the new process led to a 46% reduction in medication incident reports for April 2010 to March 2011. Staff had received ongoing DVD information and workshop training and risk meeting minutes showed a continued review of medication incidents and management. This was good practice which demonstrated how medications management had been improved and sustained following formalised changes to practice.
- The children’s service demonstrated how it reviewed the latest evidence-based tools and took action to introduce them. For example, the children’s service had previously used the Braden

# Summary of findings

Q scale (adult-adapted children's pressure sore risk calculator). A review of pressure incidents from the period April 2011 to April 2014 showed there had been 14 grade 2 pressure ulcers and four grade 3 ulcers. Of these, 61% had occurred in children with disabilities with 55% of ulcers were directly caused by pressure from equipment. The team conducted a literature review and identified a more recently developed tool known as the Glamorgan risk assessment scale, which was found to be more accurate at identifying children with mobility issues at risk of pressure sores. The new scale had been recently introduced in the hospital.

- We found several areas of outstanding practice relating to the care and involvement of children and young people. The trust's children's service had proactively participated in the You're Welcome toolkit, which was a quality criteria for young people highlighted in the National Service Framework for Children. Ward 21, with the young people's unit, was the first inpatient unit to nationally achieve the You're Welcome award in 2010. Since then, accreditation had also been gained by ward 22, the children's outpatient department and the paediatric surgery day unit. The service planned to extend accreditation to the community with the school nursing service.
- The service had developed a young people's advisory group, which provided a forum for young people to give feedback on hospital care and to share their ideas about how services should be delivered. The matron, who we saw inspired the passion and drive for young people in the department, explained that the advisory group had suggested new service developments that had been introduced, such as a pregnancy advisory service room. The children's wards and children's outpatient department had also been periodically inspected by a group of young people who had reported back on positive issues and also areas they would like to see develop and improve. The clinical director explained how they involved and included young people on interview panels for people wanting to work within the children's services. We were told the last three consultant paediatrician appointments had included a young person sitting with the interview panels.
- Children and young people who were patients acted as inspectors to check members of staff adhered to 'bare below the elbows' hygiene guidance. This included the young inspectors issuing a 'certificate of achievement' to members of

# Summary of findings

staff if they were compliant. We were told this exercise was completed every around six months. This was good practice because it actively involved young people with the engagement and maintenance of good practice among members of staff.

- The neonatal unit provided a good practice example that helped contribute to ensuring positive patient outcomes. The unit utilised a simulation approach to test new equipment and clinical procedures. The neonatologists we talked with gave examples, including the testing of new neonatal resuscitation equipment.
- Other examples of innovation included good clinical practice that staff were proud of, for example the diabetes and epilepsy services, joint working with gynaecology consultants to provide a 'one-stop' paediatric/gynaecology clinic, and the service provided for children with eating disorders.
- A team of therapeutic volunteers had been created which was led by a therapeutic nursing sister who had been in place for 18 months. The volunteers had mandatory and dementia training and were in operation 24 hours a day. The role of the volunteers was to support patients who may be living with dementia or other illnesses which affected their behaviour and level of supervision required. This included engaging with patients, such as playing board games or other interests patients may have. They also supported patients who required help with eating or wanted to explore their environment. This included supporting them overnight if they were disorientated. The volunteers predominantly worked on wards 10, 12 and 26. The team had been regionally recognised for its work.
- Leadership in maternity and gynaecology services was outstanding. The service was managed by a strong, cohesive leadership team who understood the challenges of providing good quality care and had identified effective strategies and actions needed to address these. This was particularly evident with the reconfiguration of services which were well-developed and understood throughout the department.
- In community end of life services a Sources of Information and Support service directory had been developed by the Hambleton and Richmondshire Palliative Care Partnership, a health and wellbeing clinic was held at Redcar Primary Care Hospital, community specialist palliative care nurses supported the National Gold Standard Framework coordination in GP practices and supported nursing and residential homes for people with cancer and other life-limiting conditions in the Middlesbrough, Redcar and Cleveland locality.

# Summary of findings

- Within community children's, young people's and families services a Baby Stars programme was in place to promote the social, emotional and physical development of infants, the school nursing service held weekly drop-ins for children and young people, there was a breastfeeding group with trained peer supporters and facilitators, there were good transition arrangements for young people transferring to adult services and services enabled good accessibility for children and young people by offering different clinics and opening times.
- Within the community services for adults, the community respiratory service focused proactively on preventing admissions through meeting patient's needs and reviewing the quality and cost effectiveness of the service through audit, the falls and osteoporosis service received an award for its inpatient work in community hospitals, diabetes specialist nurses provided telephone support and advice and clinic sessions for patients with diabetes supported by a dietician and ran the DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) programme which was accessible to patients with diabetes or the risk of developing Type 2 diabetes to provide learning and support for the patient and the health care professionals involved with them, and the tissue viability service had developed several examples of innovative practice such as a chronic oedema project and leg ulcer collaborative to support prevention of these conditions and specialist and maintenance clinics were held for patients with lymphedema.

# Overview of ratings

## Our ratings for James Cook University Hospital

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

## Our ratings for The Friarage Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Requires improvement	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Outstanding	Good
Services for children and young people	Good	Good	Good	Good	Good	Good

# Overview of ratings

End of life care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
<b>Overall</b>	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

## Our ratings for Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
UCC	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Community inpatients	Requires improvement	Good	Good	Good	Good	Good
Children's, young people and families	Good	Good	Good	Good	Good	Good
Community adults	Good	Good	Outstanding	Good	Good	Good
Community EoLC	Good	Good	Good	Good	Good	Good
<b>Overall</b>	Good	Good	Good	Good	Good	Good

## Our ratings for South Tees Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Overall</b>	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

### Notes

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



# Outstanding practice and areas for improvement

## Outstanding practice

For James Cook University Hospital:

- In medical care services, a team of therapeutic volunteers had been created which was led by a therapeutic nursing sister who had been in place for 18 months. The volunteers had mandatory and dementia training and were in operation 24 hours a day. The role of the volunteers was to support patients who may be living with dementia or other illnesses which affected their behaviour and level of supervision required. This included engaging with patients, such as playing board games or other interests patients may have. They also supported patients who required help with eating or wanted to explore their environment. This included supporting them overnight if they were disorientated. The volunteers predominantly worked on wards 10, 12 and 26. The team had been regionally recognised for its work.
- In maternity services, the Families and Birth Forum was involved in the design of the induction of labour suite and championing the take-up of breastfeeding rates through the use of peer supporters, as well as improving information to raise awareness and promote the service to women when they had left the hospital.
- In maternity services, lay representatives were actively involved in the patient experience rounds and 15 Steps Challenge – a series of toolkits used as part of the productive care work stream. The toolkits helped look at care in a variety of settings through the eyes of patients and service users, to help determine what good quality care looks, sounds and feels like.
- In maternity services, a ‘baby buddy’ mobile phone app was being piloted by the community midwives to inform women of pregnancy issues, common ailments and reasons to seek advice.
- We found outstanding areas of practice in the care and involvement of young people, including a young people’s unit, participation and accreditation in the You’re Welcome toolkit in four clinical areas, the development of a young person’s advisory group, inspections of services by young people and the involvement of young people in staff interviews.

For The Friarage Hospital:

- In maternity services, the families and birth forum was involved in the design of the induction of labour suite and in championing the take-up of breastfeeding rates through the use of peer supporters, as well as improving information to raise awareness and promote the service to women when they had left the hospital.
- In maternity services, lay representatives were actively involved in the patient experience rounds and 15 Steps Challenge – a series of toolkits which are part of the productive care work stream. The toolkits help look at care in a variety of settings through the eyes of patients and service users, to help investigate what good quality care looks, sounds and feels like.

Community Health services for adults

- Diabetes specialist nurses provided telephone support and advice and clinic sessions for patients with diabetes supported by a dietician. The DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) programme was accessible to patients with diabetes or the risk of developing Type 2 diabetes to provide learning and support for the patient and the health care professionals involved with them

### Good Practice

Community End of Life Services

- The Sources of Information and Support service directory developed by the Hambleton and Richmondshire Palliative Care Partnership.
- Community specialist palliative care nurses support for the National Gold Standard Framework coordination in GP practices.
- The health and wellbeing clinic at Redcar Primary Care Hospital.
- Support for nursing and residential homes for people with cancer and other life-limiting conditions in the Middlesbrough, Redcar and Cleveland locality.

Community Children’s, young people’s and families

- A Baby Stars programme was in place to promote the social, emotional and physical development of infants.

# Outstanding practice and areas for improvement

- The school nursing service held weekly drop-ins for children and young people.
- There was a breastfeeding group with trained peer supporters and facilitators
- There were good transition arrangements for young people transferring to adult services.
- The services enabled good accessibility for children and young people by offering different clinics and opening times.

## Community Adult Inpatient Services

- We saw the use of stamps which detailed registered nurses names and personal identification numbers against their signature. This meant it was clear which staff member had made the record in patients' notes.

## Community Health services for adults

- Staff demonstrated a clear understanding of the Mental Capacity Act (2005), of their responsibilities under the Act and of Deprivation of Liberty Safeguards (DoLS) procedures.

- The respiratory service focused proactively on preventing admissions through meeting patient's needs and reviewing the quality and cost effectiveness of the service through audit.
- The falls and osteoporosis service received an award for its inpatient work in community hospitals. The service audited risk assessment tools twice per year using "focuses of the month" for example, lying, standing and blood pressure on admission. Education and protocols have been introduced in residential and nursing homes.
- The tissue viability service participated in the chronic oedema project and leg ulcer collaborative to support prevention of these conditions. Specialist and maintenance clinics were held for patients with lymphedema. The team leader for the service was a published writer and the service had been publicised through national conferences.

## Areas for improvement

### Action the trust MUST take to improve

#### Action the trust MUST take to improve

For James Cook University Hospital the trust must –

- Ensure that there is sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical and surgical wards, children's wards and the paediatric intensive care unit (PICU).
- Ensure that staff have received an appraisal and appropriate supervision so that the trust can be assured they staff are competent to undertake their role.
- Ensure staff receive appropriate training, including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity Act 2005/assessment training so that they are working to the latest up to date guidance and practices, with appropriate records maintained.
- Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are carried out and decisions made.
- Ensure that there are appropriate arrangements in place for the safe handling and administration of medication, including the reconciliation of patients' medications that all controlled drugs are appropriately checked particularly on Coronary Care Unit and that medication omissions are monitored, investigated and reported in line with trust policy.
- Ensure that ward-based nursing staff are educated in the use of syringe drivers, including best practice in the use of continuous administration of medication for the management of key symptoms at the end of life.
- Ensure the paediatric environment in A&E is reviewed so it is fit for purpose; including a process to make sure that robust risk assessments are readily accessible and available to all staff in the department.
- Ensure all toys in A&E are cleaned regularly to reduce the risk of infection.
- Ensure that there are sufficient assisted bathing facilities and moving and handling aides within the children's and young people's ward areas.

# Outstanding practice and areas for improvement

- Ensure the timely completion of the refurbishment of the medical block, especially wards 10 and 12, to enable people living with dementia to be cared for in a safe environment.
- Ensure that the system for nurse calls is reviewed to ensure that there is no confusion over patients calling for assistance and the emergency alert for cardiac arrest potentially causing delays in treatment.
- Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.
- Review arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.
- Ensure robust monitoring of the safe use of syringe drivers, with sharing of results and learning from safety audits.
- Ensure that an appropriate concealment trolley is in use for the transfer of the deceased, that risks have been assessed, and that all staff using the trolleys are aware of safe moving and handling practices.
- Ensure that resuscitation equipment in surgical wards and in outpatients and diagnostic imaging areas is checked in accordance with trust policies and procedures and that this is monitored.
- Ensure that there are mechanisms in place for reviewing and, if necessary, updating patient information, particularly in the outpatients department.
- Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.
- Review arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.
- Ensure that resuscitation equipment and medication fridge temperatures in the diagnostic and imaging department are checked in accordance with trust policies and procedures.

For the Urgent Care Services the trust must:

- Ensure that staff have attended mandatory training in accordance with trust policy.
- Review the quality monitoring arrangements within the urgent care centres including patient outcomes.
- Review the provision of pain relief to ensure that there are no unnecessary delays when treating patients.
- Ensure that evidence-based guidance is available for staff working in urgent care centres and that policies are appropriately reviewed and up to date.

For The Friarage Hospital:

- Ensure that there is sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, and outpatients department.
- Ensure staff receive appropriate training and support through appraisal including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained.
- Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are being carried out and how decisions are made.
- Ensure that patients records are appropriately up dated and stored to ensure confidentiality is maintain at all times in line with legislative requirements.

The Community Inpatient Services:

- Ensure that the number of staff who received safeguarding children Level 2 training and safeguarding adult Level 1 training meets trust targets.
- Ensure that staff have received mandatory training.
- Ensure that patient records are accurate and complete, particularly fluid balance records, venous thromboembolism (VTE or blood clot) assessments and malnutrition universal screening tool (MUST) scores.
- Ensure that staff have received an annual appraisal.
- Ensure that hazardous substances are secured, particularly at Lambert Memorial Community Hospital.
- Ensure that staff follow the escalation policy when a patient's condition deteriorates.

In addition the trust should:

For James Cook University Hospital:

# Outstanding practice and areas for improvement

- Review College of Emergency Medicine audit data to ensure that good patient outcomes are met.
- Continue to review and reduce the mortality outliers for the Hospital Standardised Mortality Ratio (HSMR).
- Consider the commencement of a restraint-training programme for staff in A&E.
- Introduce a formal toy-cleaning schedule in A&E.
- The trust should ensure that patients who are medically fit are discharged in a timely manner to the appropriate setting to reduce the number of delayed discharges.
- Identify a formal board-level director who can promote children's rights and views. This role should be separate from the executive safeguarding lead for children.
- Review the content and access of risk registers in medical care to ensure that these are robust to appropriately inform decision making regarding actions taken to mitigate any risk. Review the systems in place for learning lessons from complaints to improve the patient's experience.
- Review the progress of mitigating actions taken to prevent patient falls and the development of pressure ulcers, including ward based action plans, on medical care wards.
- Review the care of patients receiving non-invasive ventilation to ensure that care is delivered in line with national guidance, particularly nurse staffing ratios.
- Ensure that there are mechanisms for reviewing and, if necessary, updating patient information, particularly in the outpatients department.
- Introduce patient surveys specific to the outpatients department.

## For The Friarage Hospital:

- Review College of Emergency Medicine audit data to ensure that patient outcomes are met.
- Continue to review and reduce the mortality outliers for the Hospital Standardised Mortality Ratio (HSMR).
- The trust should ensure that patients who are medically fit are discharged in a timely manner to the appropriate setting to reduce the number of delayed discharges.
- The trust should ensure that medication omissions were monitored, investigated and reported in line with trust policy.

- Identify a formal board-level director who can promote children's rights and views. This role should be separate from the executive safeguarding lead for children.
- Consider the commencement of a restraint-training programme for staff in A&E.
- Incorporate the use of mental capacity assessments into the trust-wide audit of DNA CPR documentation.
- Introduce patient surveys specific to the outpatients department.

## For Community End of Life services:

- Consider a common patient record system and database to gather the minimum dataset and achieve a single electronic patient record.
- Review the referral system from the hospital which is by fax, which staff have to scan in to the community information system.

## For Urgent Care Centre Services:

- Ensure that all staff receive appropriate clinical supervision.

## For Community Children's, young people's and families:

- The service should ensure staff are aware of their responsibility around the Duty of Candour.
- The trust should review how they manage and measure caseloads for health visitors and school nurses.
- Continue to review compliance with the Family Nurse Partnership (FNP) targets.

## For the Community Inpatient Services:

- Continue to work with stakeholders to reduce the number of patients with delayed transfers of care.
- Engage with staff at Lambert Memorial Community Hospital regarding the longer-term vision and strategy for the service.
- Ensure that equipment, particularly mattresses and crash mats, at Lambert Memorial Community Hospital are used for the intended purpose.
- Collate information on readmissions to the acute hospitals as part of monitoring the effectiveness of the service at the community hospitals

## For Community Services for Adults:

# Outstanding practice and areas for improvement

- The trust should review arrangements to support adequate staffing of all community nursing teams to ensure patients are not placed at risk.
- The trust should review arrangements to support accessibility and staff understanding of the risk register.
- The trust should take steps to mitigate connectivity issues for staff working in rural locations.
- The trust should facilitate access to e-learning for staff working in rural locations.
- The trust should review training arrangements to support competencies of staff in the rapid response service and the relevance of training to community settings.
- The trust should review availability and access to information for patients whose first language is not English.
- The trust should review discharge liaison arrangements between the acute hospital and community settings.
- The trust should consider extending training for all clinical staff in caring for patients living with Dementia.
- The trust should review car parking arrangements at community locations for patients with restricted mobility.
- The trust should review guidance for referral to rapid response for the acute hospital and GP practices.
- The trust should review arrangements for clinical supervision in community nursing teams.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>The provider must:</b></p> <p>Ensure that resuscitation equipment in surgical wards and in outpatients and diagnostic imaging areas is checked in accordance with trust policies and procedures and that this is monitored.</p> <p>Ensure that there are mechanisms for reviewing and, if necessary, updating patient information, particularly in the outpatients department.</p> <p>Ensure that areas containing chemicals hazardous to health are properly secured and at Lambert Memorial hospital in accordance with legislative requirements.</p> <p>Ensure that there are appropriate arrangements in place for the safe handling and administration of medication, including the reconciliation of patients' medications that all controlled drugs are appropriately checked particularly on CCU and that medication omissions are monitored, investigated and reported in line with trust policy</p> <p>Review the quality monitoring arrangements within the urgent care centres including patient outcomes and the provision of pain relief to ensure that there are no unnecessary delays when treating patients.</p> <p>Ensure that evidence-based guidance is available for staff working in urgent care centres and that policies are appropriately reviewed and up to date.</p> <p>Ensure that staff follow the escalation policy when a patient's condition deteriorates.</p>

This section is primarily information for the provider

## Requirement notices

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider must:

Ensure that there are sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, surgical wards and children's wards, particularly the paediatric intensive care unit (PICU).

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider must:

Ensure staff receive appropriate training and support through appraisal including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained.

Ensure that ward-based nursing staff are educated in the use of syringe drivers, including best practice in the use of continuous administration of medication for the management of key symptoms at the end of life.

Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are carried out and decisions made.

This section is primarily information for the provider

## Requirement notices

This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must:

Ensure the paediatric environment in A&E is reviewed so it is fit for purpose; including a process to make sure that robust risk assessments are readily accessible and available to all staff in the department.

Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.

Review arrangements and improve arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.

Ensure that patient records are accurate and complete, particularly fluid balance records, venous thromboembolism (VTE or blood clot) assessments and malnutrition universal screening tool (MUST) scores.

This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.