

City Hospitals Sunderland NHS Foundation Trust Sunderland Royal Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Good



Medical care

Requires improvement



Surgery

Good



Critical care

Good



Maternity and gynaecology

Good



Services for children and young people

Good



End of life care

Good



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Sunderland Royal Hospital is one of two acute hospitals forming City Hospitals Sunderland NHS Foundation Trust. The trust provides acute hospital services to a population of around 350,000 people across the Tyne and Wear and Durham area. In total, the trust has 855 beds across two hospitals and employs around 4,923 staff. Sunderland Royal Hospital has 833 beds.

Sunderland Royal Hospital provides medical, surgical, critical care, maternity, children's and young people's services for people across the Tyne and Wear and Durham area. The hospital also provides accident and emergency (A&E) and outpatient services.

We inspected Sunderland Royal Hospital as part of the comprehensive inspection of City Hospitals Sunderland NHS Foundation Trust, which includes this hospital and Sunderland Eye Infirmary. We inspected Sunderland Royal Hospital on 17, 18 and 19 September and 2 October 2014.

We carried out this comprehensive inspection because the Care Quality Commission (CQC) had placed City Hospitals Sunderland NHS Foundation Trust in risk band 2 in the CQC's Intelligent Monitoring system.

Overall, we rated Sunderland Royal Hospital as requires improvement. We rated it good for being effective, caring and well-led, but it requires improvement in providing safe and responsive care.

We rated A&E, surgical services, critical care, maternity, services for young people, end of life care and outpatient services as good, with medical care as requiring improvement.

Our key findings were as follows:

- Arrangements were in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found that all areas we visited were clean. Rates of Methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C. difficile) were within an acceptable range for the size of the trust.
- Patients were able to access suitable nutrition and hydration, including special diets. Patients reported that, on the whole, they were content with the quality and quantity of food.
- Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs.
- There was effective communication and collaboration between multidisciplinary teams.
- There were staff shortages, particularly on the medical wards, mainly due to vacancies for nursing and medical staff. The trust was actively recruiting following a review of nursing establishments. In the meantime, bank and locum staff were being used to fill any deficits in staff numbers.
- The trust had an overall elevated risk for the Hospital Standardised Mortality Ratio, which was higher than expected for weekend mortality as well as for weekday mortality. It was working with other trusts in the region and with NHS England to improve its mortality rates.

We saw several areas of outstanding practice, including:

- Close collaborative working between the directorate of paediatrics and emergency medicine, which had developed a shared medical consultant staffing approach that included consultant staff qualified in paediatric emergency medicine.
- The directorate of paediatrics had facilitated the inspection of the service by a team of young people.
- The use of telehealth in maternity services. This system enabled women to monitor their blood glucose levels and blood pressure in their own homes, avoiding unnecessary visits to hospital.

Summary of findings

- The compassion shown to families if their family member died while on critical care. Nurses placed a locket of hair and the rings of the patient in a small silver bag, and handed a printed card to the family expressing sympathy from the staff on the critical care unit.

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

Importantly, the trust must:

- Ensure that there are sufficient qualified, skilled and experienced nursing and medical staff, particularly on medical wards, including provision of staff out of hours, on bank holidays and at weekends.
- Ensure that staff are suitably skilled and supported through the completion of mandatory training and appraisals, particularly in the A&E department.
- Ensure that medicines are managed appropriately. Medicines were not always started promptly when a patient was admitted at the weekend, and controlled drugs incidents were not appropriately investigated and reported within the hospital.
- Ensure that there is appropriate pharmacist support to ward and units, including with the reconciliation of medication.
- Ensure that patients are placed on the most appropriate ward to meet their needs.
- Ensure that the hospital fully complies with the four-hour wait standard in accident and emergency (A&E) and meets the standard that ambulance patients should be handed over within 15 minutes of arrival in the department.
- Continue to review and reduce the mortality outliers for the Summary Hospital-level Mortality Indicator (SHMI) within the trust.
- Ensure that 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders are signed by the appropriate medical professionals, and that discussions with patients or family members are recorded.
- Ensure that patient observation and monitoring charts for nutrition and hydration are fully and appropriately completed on medical wards.

However, we found that there was an area of poor practice that was a trust-wide issue resulting in a compliance action at trust level. This is reported in the trust provider report, which states:

The trust must:

- Ensure that patient group directions (PGDs), which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment, are updated and monitored in line with trust policy

In addition, the trust should:

- Review the training of competency of staff who care for patients being discharged to the community with syringe drivers in place. This will ensure that patients are not taken off one piece of equipment before discharge and then connected to the other equipment used in the community.
- Provide training on the grading of incidents and ensure that there are effective incident feedback mechanisms in place so that lessons can be learnt.
- Review the arrangements over the storage and supply of surgical instruments to ensure that there is appropriate provision of equipment.
- Review the storage and provision of linen in ward areas so that staff are assured that it is clean before use.
- Review staffing in the specialist palliative care team in accordance with commissioning guidance.
- Have in place assurance that training, supervision, appraisals and revalidation are monitored for the specialist palliative care team, who are employed by a different trust.
- Collect and monitor information regarding patients dying in their preferred place of death.

Summary of findings

- Have mechanisms in place for reviewing and, if necessary, updating patient information, particularly in the outpatient department.
- Introduce patient surveys specific to the outpatient department.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

Overall, we rated accident and emergency (A&E) as good. A&E was good in the 'safe', 'effective', 'caring' and 'well-led' domains, however required improvement in the 'responsive' domain. Systems were in place for investigating incidents, learning and sharing lessons learnt. Levels of nursing staff were good.

We found that the design of the department made it difficult for staff in the 'majors' area to fully observe patients when the department was busy. The resuscitation area was also cramped when it was full with patients. The general design of the department also prevented a fully effective flow of patients. However, the trust was aware of these issues and is addressing them by building a new department with fully developed flows and co-located diagnostic services.

We found poor levels of compliance with mandatory training, especially among medical staff. We found a significant amount of clinical auditing, which was complemented by auditing of performance measures. The service took part in the nationally recognised Trauma Audit & Research Network (TARN) and College of Emergency Medicine (CEM) audits.

The department used nurse practitioners in an effective way to manage minor injuries and illness, and more serious cases in the 'majors' area. An example of effective multidisciplinary working was the rapid assessment, interface and discharge (RAID) initiative, which had been implemented in coordination with the local mental health trust; this involved providing a 24-hour service for patients with mental health conditions.

The majority of patients told us that they found staff to be caring and compassionate. Patients told us that both medical and nursing staff fully involved them in the decision-making process.

Between 2013 and 2014 the trust had not been able to fully comply with the four-hour wait standard or to meet the standard that ambulance patients should be handed over within 15 minutes of arrival. In 2013/14 and the first quarter of 2014/15, the trust

Summary of findings

failed to meet the standard for 95% of patients to be admitted, transferred or discharged from A&E within four hours. It was evident that the trust had taken action in an attempt to address these deficiencies. These actions included improving access to mental health professionals, and creating a neurology 'hot clinic'. However, these continuing pieces of work have not yet addressed the breaches of the four-hour or ambulance handover wait standards.

The trust had a fully developed long term strategy for creating a new A&E department, which would be ready in 2016. In addition, the July 2014 A&E performance and quality report showed that service planning was taking place in an attempt to improve the care being offered in the department. We found good communication between management and staff. However, we found little evidence of the involvement of the public in the day-to-day running of the A&E department.

Medical care

Requires improvement



Overall, we rated medical care as requiring improvement. The medical division required improvement across the 'safe', 'effective', 'responsive' and 'well-led' domains; however, 'caring' was found to be good.

Staffing levels did not meet those in the National Institute for Health and Care Excellence (NICE) guidance for staffing levels. The medical division was addressing some of the concerns regarding staffing levels and skill mix; staff recruitment was in progress to fill vacancies. We found that staff were very busy, and many reported doing extra hours to cover staffing shortfalls.

Medicines were not always managed appropriately. We found that medicines were not always started promptly when a patient was admitted over the weekend, due to lack of pharmacy staff at weekends. Controlled drugs incidents were not appropriately investigated and reported within the service.

Systems were in place to ensure that all people were monitored effectively; however, some documentation was poorly completed. Care was provided in line with national best practice guidelines. The trust was identified as having mortality outliers for the Summary

Summary of findings

Hospital-level Mortality Indicator (SHMI) and the Risk-adjusted Mortality Index (RAMI) for some medical conditions. It was working with other trusts in the region and with NHS England to improve its mortality rates. There were good arrangements for multidisciplinary working within the medical division.

The hospital was meeting national waiting time targets. However, we found that bed management was not always well organised across the hospital, which meant that although patients often felt well looked after, they were not always placed on the most appropriate ward for their needs.

There were good arrangements for multidisciplinary working within the medical division.

Patients reported being treated with dignity and respect. We observed staff being polite to patients and involving them in their care.

Surgery

Good



We rated surgery as good.

Effective arrangements were in place for reporting patient and staff incidents.

Staffing establishments and the skill mix were regularly reviewed to maintain optimum staffing levels.

Arrangements were in place for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment in the daily checks for anaesthetic equipment. Care records were completed accurately and clearly.

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

Surgical services participated in national clinical audits and reviews to improve patient outcomes.

Mortality indicators were within expected ranges.

Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams.

We observed positive, kind and caring interactions on the wards and between staff and patients.

Patients spoke positively about the standard of care they had received.

Summary of findings

Services were available to support patients, particularly those who lacked capacity to access the services they needed.

Staff felt supported and had seen positive changes to improve patient care.

Systems were in place to plan and deliver services to meet the needs of local people. The service recognised the importance of the views of patients and the public, and mechanisms were in place to hear and act on their feedback.

Critical care

Good



We rated critical care as good. The critical care service was safe, effective, caring, responsive and well-led. The ratings for each of these varied, but in terms of patient outcomes and quality of care these were particularly strong areas.

The unit had a positive safety culture, responded well to incidents and ensured that practice continually improved and developed in line with best practice guidance. The unit, with its innovative design, provided a modern environment in which to deliver intensive and high dependency care.

The effectiveness of the service was shown by the positive outcome data for patients, and the unit performed well in comparison with other similar units. The skills and expertise of the medical and nursing team were to a high standard, and all consultants were trained in intensive care medicine. The size of the nursing team had recently been increased, this had negatively affected the skill mix as there was an increased proportion of nurses who had not yet achieved competence in ICCU specialist skills.

The healthcare team was caring and compassionate, as proved through our observations and speaking with patients and relatives. Excellent support services were available for patients and relatives, and the views of patients and relatives were effectively gathered in a variety of ways.

The service was able to effectively respond to changes in service demand. This was partly due to the ability of the unit to easily flex between intensive and high dependency care provision, and

Summary of findings

the responsiveness of the staff. Delays for patients in accessing critical care were minimal, but delayed discharges from the unit to the ward were becoming an increasing problem.

The culture within the service was open and transparent and there was a tangible drive to provide the best high standards of care. Staff spoke positively about the leadership team and the open communication. Engagement with both staff and the public was good, and there were good examples of where feedback about the service had altered practice for the better.

Maternity and gynaecology

Good



We rated maternity services as good. The maternity department provided safe and effective care in accordance with recommended practices. Arrangements were in place to manage and monitor infection control, medicines and safeguarding procedures.

The maternity service used national evidence-based guidelines to determine the care and treatment it provided. There was a multidisciplinary approach that involved a range of providers across healthcare systems to enable services to respond to the needs of women. The service participated in national and local audits. Resources, including equipment and staffing, were sufficient to meet the needs of women, although the ratio of midwives to women in labour was slightly lower than nationally recommended levels. Additional midwives were being recruited to address the staffing shortfalls. Medical staffing was in line national recommendations.

There were occasions where capacity interrupted the provision of services in antenatal care and access to theatre for elective caesarean sections. This meant that women experienced longer waiting times or their operations were delayed. The maternity service had carried out service reviews, and plans were in place to improve these areas. The individual needs of women were taken into account in planning the level of support throughout their pregnancies. Feedback from women about the standard of care they received was positive.

The service was well-led. There was an open and transparent culture that encouraged reporting and learning from adverse events. Staff showed a strong

Summary of findings

commitment to patient care and treatment. There was evidence of public and staff engagement, and action had been taken following real-time feedback from women and staff. The service had been nominated for a number of awards in innovation and service improvement.

Services for children and young people

Good



We rated services for children and young people as good. In the areas of safety, effectiveness, caring, and responsive, services for children and young people were good, and in 'well-led' they were outstanding.

The children's services actively monitored safety, risk and cleanliness. Nurse staffing levels did not meet nationally recognised guidelines, although this did not have a negative impact on patient care. There were challenges regarding some medical staffing levels, but these were being managed. Children's services made improvements to care and treatment where these had been identified using programmes of assessment or in response to national guidelines. Children, young people and parents told us they received compassionate care with good emotional support. They felt they were fully informed and involved in decisions relating to the patient's treatment and care.

We found that the children's service provided good access to and flow within its services. This was achieved in part through close collaborative working between the directorate of paediatrics and emergency medicine, which had developed a shared medical consultant staffing approach that included consultant staff qualified in paediatric emergency medicine. We also found that the service had a range of facilities and approaches to ensure that the needs of local families were met. The service had a clear vision and strategy and was led by a strong management team who worked together. The service regularly implemented innovative improvements with the aim of constantly improving the delivery of care for children and families. The service had facilitated the inspection of services by a team of young inspectors, which was excellent practice.

Summary of findings

We found a positive, open and friendly culture at the service. Staff placed the child and the family at the centre of care delivery, and this was seen as a priority and everyone's responsibility.

End of life care

Good



Overall, we rated end of life care as good. Care and treatment received by patients at the end of their lives was effective, caring and well-led. Patients and relatives were happy with the care being given and found it to be caring and compassionate. Staff were well trained and supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm, because policies were in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

Syringe drivers used in the hospital were not compatible with those used in the community. This sometimes led to delays in treatment as not all ward staff were not trained in the community equipment used. There had been no incidents reported in relation to this.

Patients were, on the whole, protected from receiving unsafe care, because medical records were available. There was, however, some room for improvement in the standard of record keeping in relation to 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders, because some of the records reviewed were not fully completed.

The services offered were delivered in an innovative way to respond to patients' needs and ensure that the department worked effectively and efficiently.

Outpatients and diagnostic imaging

Good



We rated outpatients as good. The care and treatment received by patients in the outpatient departments within the hospital was safe, effective, caring, responsive and well-led. Patients were happy with the care they received and found the service to be caring and compassionate.

Staff were well trained and supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm, because policies and procedures were in place to ensure that this was managed appropriately.

Summary of findings

Patients were given follow-up appointments when they should receive them. Staff were listened to, and patients were engaged with and their opinions actively sought.

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

Requires improvement 

Sunderland Royal Hospital

Detailed findings

Services we looked at

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

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Detailed findings

Background to Sunderland Royal Hospital

Sunderland Royal Hospital is one of two acute hospitals forming City Hospitals Sunderland NHS Foundation Trust. City Hospitals Sunderland was established as an NHS trust in April 1994. Under the Health and Social Care (Community Health and Standards) Act 2003 the trust became an NHS foundation trust in July 2004. The trust provides acute hospital services to a population of around 350,000 people across the Tyne and Wear and Durham area. In total, the trust has 855 beds across two hospitals and employs around 4,923 staff. Sunderland Royal Hospital has 833 beds.

We carried out this comprehensive inspection because the Care Quality Commission (CQC) placed City Hospitals Sunderland NHS Foundation Trust in risk band 2 in CQC's Intelligent Monitoring system.

Sunderland Royal Hospital provides medical, surgical, critical care, maternity, and children's and young people's services for people across the Tyne and Wear and Durham area. The hospital also provides accident and emergency (A&E) and outpatient services. The A&E department is a consultant-led 24-hour service; 92,880 people attended in 2013. The A&E department is divided into different treatment areas, which include children's A&E, an urgent care centre is located very near to the main department.

Sunderland Royal Hospital has 405 beds for medical care services. The medical services include a number of different specialties, including general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology, haematology, neurology, and stroke care. The trust had 31,678 admissions between April 2013 and March 2014.

The hospital provides elective and non-elective treatments for breast surgery, colorectal surgery, ear, nose and throat (ENT) surgery, oral surgery, trauma and orthopaedics, urology and vascular surgery.

The hospital's one integrated critical care unit (ICCU) falls under the theatres directorate. The unit is a relatively new and modern facility for the care of critically ill patients, including those who are immunocompromised or highly infective. The unit covers a catchment population of around 350,000.

The maternity service provided a 'labour, delivery, recovery and postnatal' model of care, which enables women to remain in the same room throughout their birthing experience. Five teams of community midwives deliver antenatal and postnatal care in women's homes, clinics and GP locations across the city. The service delivered approximately 3,228 babies in 2013/14.

Services for children and young people include three children's wards, the Niall Quinn children's centre (children's outpatient department) and a neonatal unit that includes eight intensive/high dependency cots, two mother and baby rooms, two cubicles and 12 special care baby cots. The directorate also provides community paediatric services.

End of life care services are provided throughout the hospital. Patients requiring end of life care are cared for depending upon their underlying condition. There is no specific palliative care ward within the hospital, although there is a specialist palliative care team of nurses and doctors.

Sunderland Royal Hospital has a large outpatient department where a number of different specialties hold clinics. Other outpatient areas across the hospital site are associated with specific specialties such as urology, trauma and orthopaedics, and children's services.

Our inspection team

Our inspection team was led by:

Chair: Doctor J Ahluwalia, Medical Director

Head of Hospital Inspections: Julie Walton, CQC

The team included CQC inspectors and a variety of specialists: consultant in emergency medicine,

Detailed findings

consultant paediatrician, consultant clinical oncologist, consultant obstetrician and gynaecologist, consultant

anaesthetist, consultant in palliative medicine, surgical registrar, ophthalmic registrar, junior doctor, clinical nurse specialist, senior nurses, emergency nurse practitioner, student nurses and experts by experience.

How we carried out this inspection

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

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

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

- A&E
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning group, local area team, Monitor, Health Education England and Healthwatch.

We carried out announced visit between 17 and 19 September 2014. During the visits we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, critical care, outpatients, maternity and A&E departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We completed an unannounced visit on the night of 2 October 2014.

We held a listening event on 16 September 2014 in Sunderland 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.

Facts and data about Sunderland Royal Hospital

Sunderland Royal Hospital provides services to a local community of 350,000 residents and is starting to provide more specialised services to a wider population.

The A&E department at Sunderland Royal Hospital saw 92,880 people last year. The A&E department had seen an increase in the number of attendances per month since 2011/12. The average number of attendances per month

in 2011/12 was 9,974, while in 2012/13 it was 10,449. There was a slight decrease to 10,430 in 2012/13, although in the first quarter of the financial year 2014/15 attendances have risen again to 10,589.

The hospital had approximately 58,698 inpatient admissions during 2012/13. Last year the outpatient departments had approximately 623,789 attendances for both consultant- and nurse-led clinics. The hospital carried out approximately 28,000 outpatient procedures in 2013.

Detailed findings

Sunderland Royal Hospital serves a children and young person population of 80,351, which accounts for 17% of the area's population. There were 3,500 non-elective and 500 elective paediatric medicine admissions within the last 12 months. In addition, there were 2,072 paediatric surgical admission (all specialties). The outpatient department saw 4,500 new attendances along with 10,000 follow-up review attendances. The service delivered approximately 3,228 babies in 2013/14.

Sunderland is the 44th most deprived area in England out of 326 local authorities. Local health profiles show that, in a number of areas, the health of people in Sunderland is significantly worse than expected, with all children's and young peoples' health being significantly worse than expected.

Detailed findings

Our ratings for this hospital


Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for A&E and outpatients.

Urgent and emergency services

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

Information about the service

The A&E department at Sunderland Royal Hospital saw 92,880 people last year (during the 12 months from the week of 21 January 2013). Out of this number 19,526 were admitted to the hospital. A total of 1,283 people left the department without being seen, or refused to be treated. The A&E department has seen an increase in the number of attendances per month since 2011/12. The average number of attendances per month in 2011/12 was 9,974, while in 2012/13 it was 10,449. There was a slight decrease to 10,430 in 2012/13, although in the first quarter of the financial year 2014/15 the number has risen again to 10,589.

The department is divided into different treatment areas. There is a resuscitation area for the treatment of critically ill patients and those who have suffered major trauma. This area is located next to the ambulance entrance, which also accesses the 'majors' area used for the treatment of patients with serious medical or surgical conditions or those who require a trolley before assessment. An area called the green zone is used for the treatment of patients with complex minor injuries.

A facility called the Pallion urgent care centre is located five minutes' walk from the A&E department. This is part of the trust and is used for the treatment of patients with minor medical and surgical conditions. It is staffed by nurse practitioners and a GP, and is open from 10am to 10pm. Patients are assessed by a nurse based on the A&E reception desk who sends appropriate patients to the Pallion centre.

A children's A&E department, adjacent to the main department, is open 24 hours a day, seven days a week. There is also a children's short-stay assessment unit, which is open from 9am to 10pm. The children's A&E department is led by Paediatric Emergency Medicine consultants with support from the paediatric consultants from the main hospital. It is also staffed by paediatric-trained A&E nurses.

There are plans to build a new A&E department, with work due to start at the end of 2014 and expected to be completed in 2016.

We spoke with 25 patients and relatives and 38 members of staff. We observed care being undertaken and viewed the clinical records of patients on the department's electronic patient record system. We also inspected the environment and amenities.

Urgent and emergency services

Summary of findings

Overall, we rated accident and emergency (A&E) as good. A&E was good in the 'safe', 'caring' and 'well-led' domains, however required improvement in the 'responsive' domain. We inspected but did not rate the effectiveness domain. Systems were in place for investigating incidents, learning and sharing lessons learnt. Levels of nursing staff were good.

We found that the design of the department made it difficult for staff in the 'majors' area to fully observe patients when the department was busy. The resuscitation area was also cramped when it was full with patients. The general design of the department also prevented a fully effective flow of patients. However, the trust was aware of these issues and is addressing them by building a new department with fully developed flows and co-located diagnostic services.

We found poor levels of compliance with mandatory training, especially among medical staff.

We found a significant amount of clinical auditing, which was complemented by auditing of performance measures. The service took part in the nationally recognised Trauma Audit & Research Network (TARN) and College of Emergency Medicine (CEM) audits.

The department used nurse practitioners in an effective way to manage minor injuries and illness, and more serious cases in the 'majors' area. An example of effective multidisciplinary working was the rapid assessment, interface and discharge (RAID) initiative, which had been implemented in coordination with the local mental health trust; this involved providing a 24-hour service for patients with mental health conditions.

The majority of patients told us that they found staff to be caring and compassionate. Patients told us that both medical and nursing staff fully involved them in the decision-making process.

Between 2013 and 2014 the trust had not been able to fully comply with the four-hour wait standard or to meet the standard that ambulance patients should be handed over within 15 minutes of arrival. In 2013/14 and

the first quarter of 2014/15, the trust failed to meet the standard for 95% of patients to be admitted, transferred or discharged from A&E within four hours. It was evident that the trust had taken action in an attempt to address these deficiencies. These actions included improving access to mental health professionals, and creating a neurology 'hot clinic'. However, these continuing pieces of work have not yet addressed the breaches of the four-hour or ambulance handover wait standards.

The trust had a fully developed long term strategy for creating a new A&E department, which would be ready in 2016. In addition, the July 2014 A&E performance and quality report showed that service planning was taking place in an attempt to improve the care being offered in the department.

We found good communication between management and staff. However, we found little evidence of the involvement of the public in the day-to-day running of the A&E department.

Urgent and emergency services

Are urgent and emergency services safe?

Good



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

The service used nursing staff in an effective way to manage the flow of patients through the department. However, we found that the design of the department made it difficult for staff in the 'majors' area to fully observe patients when the department was busy. The resuscitation area was also cramped when it was full with patients. The general design of the department also prevented a fully effective flow of patients. However, the trust was aware of these issues and is addressing them by building a new department with fully developed flows and co-located diagnostic services.

Levels of nursing staff were good. However, staff we spoke with were concerned that insufficient training and non-training grades were working at the middle level between the junior trainees and the consultants. However, the service had developed nurse practitioners with the advanced skills necessary to practise in the 'majors' area and treat serious minor injuries; this was in addition to their role in treating minor injuries and illness.

We found that patient group directions (PGDs) were out of date. The chief pharmacist told us that this was flagged up on the risk register in January 2014 and should be resolved by December 2014.

We also found poor levels of compliance with mandatory training, especially among medical staff.

Incidents

- The Strategic Executive Information System (STEIS) 2013/14 reported three serious incidents involving the A&E department. Two were ambulance waits of over two hours, while the other was a clinical incident.
- The A&E incident report showed two incidents with a reported severity of major harm
- A failure to appropriately prioritise a patient who had suffered a myocardial infarction (heart attack) was reported. Another similar incident was reported as being

of moderate harm. In response to these incidents, clear instructions were communicated to staff about the correct management and prioritisation of patients who had suffered myocardial infarctions.

- There were three incidents with a reported severity of moderate harm, in the September 2014 A&E Incident Report. All reports included a section detailing "action taken following incident" and "outcome of investigation". For example, -one incident included details of a patient who tried to self-harm; the "incident report" showed there was an immediate response by A&E and the mental health team to this incident.
- Root cause analysis (RCA) investigations were undertaken into serious incidents. We reviewed an RCA investigation, undertaken in July 2014, into a patient who was found after transfer to the ward to have suffered a fractured neck of the femur (hip fracture), which had not been diagnosed in A&E.
- Lessons learned from this incident included the need to raise the clinical knowledge of staff in the management of suspected hip fractures. These lessons were encapsulated in an action plan, which showed that, among other things, training sessions and case presentations had been delivered to clinical staff within set timeframes. Also, the lead consultant for clinical governance sent an email to all clinical staff by advising them of the lessons learned from the investigation.
- We found that incidents were a set agenda item in the A&E clinical governance meetings. The minutes of a meeting of July 2014 which we reviewed also stated that all junior doctors were to undertake 'human factors' training. ('Human factors' training allows trainees to gain an understanding of the human factors involved where serious errors have occurred, and therefore to respond effectively to prevent the errors from occurring in their own practice.)
- Mortality and morbidity was also a standing agenda item. The minutes of the July 2014 meeting included a discussion of 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. (These forms are completed when it would not be in the patient's best interests to attempt cardiopulmonary resuscitation.) The meeting noted that some forms were not being completed correctly, and that the lead clinicians should ensure this was addressed. This was actioned appropriately.
- We found there was an A&E consultant who led on clinical governance. As part of the role, the clinical

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governance lead communicated with staff so they learned the lessons of errors and incidents. We reviewed an email sent by this person, in April 2014, to remind all A&E clinical staff that the drug Parvolex should always be given without delay to patients who have taken a Paracetamol overdose. This drug can help to prevent liver damage in such cases.

- There was also a nurse who led on the investigation of incidents.

Cleanliness, infection control and hygiene

- Although the department was old, it was kept clean. We observed a cleaner working in the department throughout the time we were there.
- Hand hygiene dispensers were located throughout the department, which we observed staff using.
- Audits of cleanliness, infection control and hygiene were regularly carried out. These showed good staff compliance with 'bare below the elbows' policies and in the practice of aseptic techniques before undertaking patient treatments.
- The department also had a nurse who led on infection control.

Environment and equipment

- The entrance from the ambulance bay was clear and wide, allowing patients to be brought into the resuscitation area without delay.
- Although children used the same entrance to access the department, they were directed to the children's waiting area in the adjacent children's A&E department.
- There were five treatment bays in the resuscitation area, one of which was used for children. The area was small and seemed cramped when all the bays were in use.
- The 'majors' area consisted of a long corridor with 12 treatment rooms. An annexe on one side contained four trolleys. We observed that when the department was busy, staff found it difficult to keep all the patients under observation.
- The 12 single rooms each had their own door with an observation window that could be closed off by a blind. If the patient was considered to be at risk, the doors were kept open and only closed when the patient received care or treatment. We were also told that the doors were closed and the blinds drawn when relatives were in the room. This exacerbated the observation problems created by the design of the area.

- We found the lay out of the department to be confusing, although the staff were well aware of the flow within the department.
- We found that resuscitation equipment, including defibrillators, was readily available, and was regularly checked and maintained.
- In the adjacent children's A&E, there was no defibrillator although other resuscitation equipment was available. The policy was that in an emergency the child was taken to the resuscitation area of the main A&E, where there was a dedicated paediatric bay.
- Other clinical equipment was also readily available, regularly checked and ready for use.
- The department had a nurse who led on medical devices.

Medicines

- There was an area for the storage of drugs with an Omnicell system that only allowed access to those staff for whom the fingerprint of one of their digits was recorded on the system. This prevented unauthorised access.
- We found a drugs fridge for which there were no records to show that the temperatures had been checked. (It is necessary to record the temperatures of drugs fridges on a regular basis to ensure medicines are kept at a safe temperature.)
- We also found two entries in the controlled drugs record for March 2014 that were not fully completed. (It is a legal requirement that controlled drugs registers are fully completed.) However, these were the only entries we found that were not fully completed. On being informed, a senior member of the nursing staff acknowledged the error and said they would take action to prevent it happening again.
- There was a system of patient group directions (PGDs), which allowed appropriately trained nurses to prescribe medicines to patients.
- There was a policy for 'the administration of homely remedies to adults' that had a review date of June 2012. There was no evidence that this policy had been reviewed since this date. (Medicines policies must be regularly reviewed in the interests of safety.)
- It is a requirement of PGDs that they are regularly reviewed. However, we found that they were often not reviewed. In one case, we found a PGD for Paracetamol that stated that it 'must NOT be used beyond the review-by date' (highlighting in original text), which was

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June 2012. There was no evidence that the PGD had been reviewed beyond this date, although it was still being used. The chief pharmacist told us that this was flagged up on the risk register in January 2014 and should be resolved by December 2014.

Records

- We found that patient records were entered onto an electronic database. Although some staff we spoke with told us there had been initial problems implementing the new system, other staff found it beneficial.
- The national early warning score (NEWS), which records the acuity of patients' medical conditions, could also be entered onto the electronic patient record and regularly updated.
- Workstations were located throughout the department, in addition to mobile workstations that staff could wheel to where the patient was being treated, for direct input of information.
- We observed some staff jotting down information on notepads, although they would then go to the nearest workstation to input it onto the database.
- The electronic record system allows results/discharge communication to be accessed by GPs. Staff cannot access the GP record in line with other organisations at this point in time.
- The department had a team that led on the electronic medical records system. The team included nurses, a nurse practitioner and a consultant.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that clinical staff obtained consent before undertaking clinical procedures.
- Consultant staff informed us that for patients who underwent an invasive procedure such as the manipulation of a dislocation, the insertion of a chest drain, or any procedure under sedation, written consent using a trust consent form was obtained before the procedure. This was in accordance with the accepted standards of the emergency medicine specialty and of the trust.
- We spoke with eight patients in the adult A&E department, who told us they gave verbal consent to tests and treatments. Six of the eight patients also told

us they were given options as to the different tests and treatments available to them. The two people who were not offered choices told us this was because of the condition for which they were receiving care.

- The A&E matron told us that the most senior clinician on duty undertook Mental Capacity Act 2005 assessments. In such cases and where it was necessary to invoke Deprivation of Liberty Safeguards, the trust's dementia and delirium team would be contacted, who are available on a 24-hour basis. If the patient was found not to have capacity, the team would be able to obtain an independent mental capacity advocate to represent the patient's interests.
- Staff underwent training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Safeguarding

- Selected paediatric nursing staff could interrogate an electronic link to the local authority child protection register on a 24-hour basis. As well as viewing the register, they could alert the children's safeguarding authority to any concerns regarding a child. This system allowed them access to social services support in such cases.
- The trust expected clinical staff to undertake safeguarding children and young people training up to Level 3.
- A meeting of the A&E department's senior nurses, held in July 2014, stated that between 70% and 80% of staff had undergone child protection training at Level 3, which was part of their mandatory training. This was a rise from the 59% who had completed it up to March 2014. The trust standard was that 80% of staff should have undertaken their mandatory training by March 2014. From April 2014, this was raised to 90%.
- In order to ensure that staff attended child protection training, a 'communication update' for March 2014 reminded them that they would not receive any pay increments if they were not up to date with all their mandatory training.
- The trust expected clinical staff to undertake safeguarding adults training up to Level 1. Over 80% of staff had completed this training, except in the case of medical staff, of which 73% had completed the training.
- The adult A&E department had a nurse who leads on children's safeguarding.

Mandatory training

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- We looked at the percentage of staff who had completed their mandatory training for the period up to March 2014. The trust target for this period was that 80% of the staff group should have undertaken mandatory training. This was not being achieved in Accident and Emergency department.
- For nursing staff, this 80% target had not been achieved in seven of the 14 subject areas. These included 'violence and aggression: conflict resolution', where as of March 2014 only 58% of nursing staff had completed the training. In addition, only 10% had undertaken venous thromboembolism training, 39% had undertaken inoculation incident training and 60% had undergone manual handling training.
- For medical staff, the 80% standard had not been achieved in any of the 11 subject areas that were mandatory for this staff group.
- A staff 'communication update' for March 2014 reminded staff that they would not receive any pay increments if they were not up to date with all their mandatory training.
- Apart from the staff 'communication update', we found no other evidence of work being done to increase the number of staff undertaking mandatory training.
- The department had a nurse who led on education and training.

Assessing and responding to patient risk

- At the reception desk, a qualified nurse worked as a navigator. This nurse's role was to perform an initial assessment and then stream patients before further triage. We observed the navigator advising patients with minor injuries to go to the Pallion urgent care centre. The navigator told us that 60 to 70 patients a day are streamed to the Pallion centre.
- The 'navigator' post was shortlisted for the 'Pioneering Emergency Nurse' category in the Pioneers of Care Award 2014. (This award was organised by Welch Allyn, a medical equipment manufacturer.)
- The hospital had also introduced a 'flow facilitator' – a senior nurse who worked in a non-clinical capacity checking on results, bed availability and overall flow within the department. In order to ensure that they can concentrate on the role, these nurses do not wear a nursing uniform.
- A senior nurse acted as a coordinator to manage the nursing staff within the department.

- In order to help prevent breaching the maximum four-hour wait standard for patients, the department used an algorithm to identify when the general level of patients' waiting times reached three hours. The actions then involved paging specific staff to assist the department, including junior medical and surgical staff. Consultants are paged based on clinical need of patients. This would be followed by contacting the duty senior nurse, who would provide extra nursing staff to assist in the department. They would also contact the on-call A&E consultant to assist in the department.
- The department used the nationally recognised national early warning score (NEWS) clinical algorithm to monitor patients' changing acuity levels.

Nursing staffing

- Staff numbers were based on a workforce plan for the A&E department drawn up in February 2013. The numbers required in this plan were based on an increased patient-attendance rate and the requirements of the proposed new A&E department. There is no evidence that the hospital used a recognised staffing acuity tool when developing this plan.
- We reviewed the trust's staffing data for August 2014, which showed that it was up to its establishment of 117 whole-time equivalent (WTE) qualified and unqualified nursing staff. These numbers included 21 WTE nurse practitioners. The data showed the department was increasing its numbers to recruit eight more staff in bands 1 to 8, band 8 being the most senior band.
- The number of staff included 21 WTE paediatric-qualified A&E nurses who worked in the children's A&E department. Of this number 20 WTE were paediatric qualified, while one nurse had a degree in child health.
- These included 5 WTE paediatric-qualified nurse practitioners.
- Between 14.30pm and 10pm four qualified nurses were always on duty, between 7.30am and 14.30pm three were on duty, and between 10pm and 7.30am two were on duty.
- In the children's short-stay assessment unit there was one paediatric-qualified A&E nurse and a healthcare assistant.
- Nursing staff we spoke with thought there were sufficient numbers of staff to be able to do their job safely.

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- The matron told us they were able to cover sickness by using existing A&E staff or other trust staff with A&E experience.

Medical staffing

- There were 9 A&E consultants, two of whom had subspecialty qualification in paediatric emergency medicine, and four paediatricians with subspecialty qualification in paediatric emergency medicine consultants. There was one associate specialist who worked on the consultant rota with on-call consultant support. This provided 8.6 WTE to the adult department.
- We reviewed medical staffing rotas, which showed there was on-call consultant cover for 24 hours every day throughout the year.
- At weekends there was consultant cover 0900 to midnight. Weekday nights are covered as a minimum to 2100 hours and on average, until 2230 hours, depending upon clinical need. Two consultants were present until 2100 on a proportion of Monday nights, where the workload was predictably greater.
- A paediatric consultant covered the children's A&E between 9am and 5pm. This consultant was also assisted by paediatric consultants from the main hospital's paediatric department.
- Also, six higher specialist trainees in emergency medicine worked in the adult A&E department, and two in children's A&E. This was in addition to one staff and associate specialist (SAS) middle-grade doctor. This was the area of the rota that staff we spoke with considered required an increase in staff numbers.
- Also working in the department were foundation year trainees, senior house officers and GP trainees.

Major incident awareness and training

- There was a major incident chemical, biological, radiation, nuclear (CBRN) plan that covered all relevant areas.
- A manager was responsible for coordinating the major incident plan, as well as a lead A&E consultant for major incident planning.
- A 'table-top' exercise had been undertaken in the last year, while a 'live' exercise had taken place within the last three years. This is in accordance with time frames for exercises for major incident plans.

- There were two rooms for storing major incident equipment. One room was for equipment used during an incident involving casualties who had suffered multiple injuries and trauma. The second room was for the equipment used during CBRN incidents.
- Medical and nursing staff were aware of the major incident plan and their role in it. We spoke with an A&E consultant, who was not the major incident lead, who told us that the system of action cards allowed all staff to quickly understand their roles during an incident.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We found a significant amount of clinical auditing, which was complemented by auditing of performance measures. The service took part in the nationally recognised Trauma Audit & Research Network (TARN) and College of Emergency Medicine (CEM) audits.

The department used nurse practitioners in an effective way to manage minor injuries and illness, and more serious cases in the 'majors' area. An example of effective multidisciplinary working was the rapid assessment, interface and discharge (RAID) initiative, which had been implemented in coordination with the local mental health trust; this involved providing a 24-hour service for patients with mental health conditions.

We found that although nursing staff checked on patients' nutrition and hydration and their general comfort levels, this was not recorded in detail in the patient record. We also observed that during busy times, these checks were less frequent.

Evidence-based care and treatment

- We found that the service followed National Institute for Health and Care Excellence (NICE) guidelines as part of its practice and protocols. These guidelines were discussed at regular clinical governance meetings.
- The department used the nationally recognised national early warning score (NEWS) system to assess patient's acuity of illness and to measure any deterioration in their clinical condition.

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- Clinical audits, which are discussed below, were reflected in clinical practice. In the case of the management of neutropaenic sepsis, audits showed that the department complied with the 'acute oncology measures 2011' by administering antibiotics to patients within one hour of presentation.

Pain relief

- The department took part in the College of Emergency Medicine (CEM) 2011/12 audit of pain management in children. Among other things, the audit monitored how promptly after the arrival of patients in severe pain analgesia (pain relief medication) was provided. It showed that the department met the standard that 50% of patients should receive medication within 20 minutes. However, it should be noted that this audit was undertaken in 2011.
- During our inspection we observed clinical staff giving pain relief in an appropriate and timely manner.
- A nurse in the department led on pain management.

Nutrition and hydration

- The A&E matron told us that patients on trolleys in the A&E department were checked once an hour to assess their comfort levels. This check would involve ordering them hot or cold drinks and/or hot or cold food.
- We observed these checks taking place, although we did not see any record being made of them.
- We also observed that the checks became more infrequent at times when the department became busy with queues of ambulance trolleys forming.

Patient outcomes

- Clinical audits were undertaken in the department. These included cardiopulmonary resuscitation (CPR) audits. Among other things, these audits found that the first clinician seeing the patient in the majority of cases was of a middle grade (specialist registrar, or staff and associate specialist) or a consultant.
- Another audit was carried out into neutropaenic sepsis. In accordance with the 'acute oncology measures 2011', trusts are required to audit the timeliness of antibiotic administration in this patient group. This audit was carried out over a six-month period, and the A&E department was measured against eight other similar services. The July 2014 A&E performance and quality

report showed that over a six-month period the department achieved the highest proportion of patients receiving antibiotics within one hour of presentation, as well as the shortest door-to-needle time.

- The department also took part in the national Trauma Audit and Research Network (TARN) audit. This examines performance in the management of trauma. The results published in the March 2014 report showed that the department performed better than expected, having 1.95 extra survivors than expected out of every 100 patients.
- The department took part in a College of Emergency Medicine (CEM) audit in February 2013. This audit was reported on in the July 2014 A&E performance and quality report. It found that 24% of discharged patients and 23% of all admitted patients were assessed by a consultant. This compared with national figures of 14% and 13% respectively. Senior clinician involvement in care, especially in the most serious cases, has been seen to improve patient outcomes.
- The July 2014 A&E performance and quality report also reported that the trust had established a process to monitor consultants' 'sign-off' performance. This showed that a consultant signed off 85% of chest pain patients over 17 and 73% of febrile under one-year-olds. Sign-off ensured that where consultants did not see patients themselves, they could quality-assure the treatments given by their teams.
- CEM audits were undertaken in 2012 into feverish children and fractured neck of femur and renal colic patients. Although these audits show that the department took part in nationally recognised audits, they cannot be used as a barometer of the clinical service offered in 2014.
- Nursing staff undertook audits into the measurement of blood glucose levels.
- Also, a nurse led on audits of the NEWS national early warning system.
- In the year up to September 2014, the average re-attendance rate was 8.32%. (The re-attendance rate is the percentage of patients who came to the department more than once during this period.)

Competent staff

- Nursing staff told us they received regular yearly appraisals and regular supervision.

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- Data provided by the trust showed that rates of appraisal for nursing staff in A&E were 74% for the financial year 2012/13, and 50% for the financial year 2013/14. In the period between April 2014 and July 2014 the rate was 56%.
- In a 'communication update' from March 2014, staff were reminded that staff who were not up to date with their yearly appraisals would not qualify for a yearly pay increment.
- Nursing supervision took the form of monthly departmental supervision for all staff, in addition to regular or ad-hoc supervision dependent on the assessed needs of the member of staff.
- In the case of new staff, there was weekly individual supervision.
- Nurse practitioners told us they were supported in their development.
- To treat patients attending with minor illnesses or injuries in the urgent care centre and the main department's 'green zone', which dealt with complex minor illness and injury, the department used nurse practitioners in advanced clinical roles. In addition, nurse practitioners managed patients in the 'majors' area with more serious medical conditions.
- Some training was provided in house. A number of the nurse practitioners had completed masters degrees and also independent prescribing course. They had also undertaken clinical skills training accredited through the local university.
- There was a revalidation process for consultant staff, and junior medical staff were satisfied with the support and supervision they received.
- Trust records showed that the appraisal rates for medical staff stood at 100% between April 2012 and July 2014.
- Junior medical staff rotated to the children's A&E department to gain specific experience in paediatric emergencies.
- Both nursing and medical staff told us that training in the diagnosis and management of patients with mental health conditions who attended A&E was good.
- We viewed a series of emails that gave details of staff who had attended specialist mental health training up to July 2014. The emails also showed that staff had been booked on these courses up until September 2015.
- We also spoke with mental health practitioners from the local mental health trust who worked in A&E. They told

us that they undertook practical training of nursing and medical staff. This involved undertaking patient interviews and assessments with A&E staff, which allowed them to gain a practical understanding of the management of patients with mental health conditions.

- A nurse led on the training of new nurses in the department.

Multidisciplinary working

- We saw evidence of multidisciplinary working with various agencies. Examples included a joint initiative with the local mental health trust – Northumberland, Tyne and Wear NHS Foundation Trust. This involved implementing the rapid assessment, interface and discharge (RAID) model. The objective was to reduce the time from a patient being referred to mental health services to being assessed, as well as to reduce admissions. Following a trial period, this initiative was introduced on a 24-hour basis.
- We spoke with members of the RAID mental health team who, like the A&E clinical staff we spoke with, found the service to be a positive development.
- The RAID mental health team showed us how, from their base near the A&E department, they used the A&E database to monitor patient attendances and pick out patients with a mental health condition. Team members recognised attendees by name, so could identify patients even before they had been assessed by A&E, and could attend the department before they were requested to by A&E.
- The room in which the A&E database was located also contained the mental health trust's clinical database, which allowed the RAID team to cross-reference clinical information to obtain a full picture of patients' histories.
- We reviewed the minutes of meetings, which showed that regular joint management meetings took place between the mental health trust and the City Hospitals Sunderland trust to discuss the progress of this work. These meetings were complemented by regular joint clinical meetings between senior A&E clinicians and mental health trust practitioners.
- We also spoke with staff from the alcohol and drugs' charity Turning Point. They told us they visited the A&E department to discuss with patients their options for referral to structured treatment programmes to help address their alcohol and/or drug use.

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- Turning Point staff also told us they liaised regularly with the trust's alcohol specialist nurse, who could place patients on clinical pathways to manage the symptoms of chronic alcohol and drug use.

Are urgent and emergency services caring?

Good



Patients we spoke with told us that they found staff to be caring and compassionate. We also observed staff behaving towards patients in a kind and compassionate way. Patients told us that both medical and nursing staff fully involved them in the decision-making process.

Compassionate care

- We spoke with 17 patients in the adult A&E department and the Pallion urgent care centre, who told us they were treated with dignity and respect and that the care they received was compassionate.
- We spoke with the relatives of five children in the children's A&E department. They told us that the staff were approachable, had a caring manner and gained the confidence of their children.
- The July 2014 A&E performance and quality report stated that Friends and Family tests in the department had been higher than the national average and roughly in line with the regional average for north east England.
- In terms of patient satisfaction, the trust performed better than both the national and regional average. This included performing better than other A&E departments. These findings were in line with the views of patients and relatives we spoke with.
- A nurse in the department led on the Friends and Family tests.
- Although the care we saw being provided to patients was compassionate, in one instance we found this not to be the case. However, after we reported this to a more senior nurse in the department, immediate action was taken to rectify the situation.

Patient understanding and involvement

- We spoke with eight patients in the adult A&E department, who told us they gave verbal consent to tests and treatment. Six of the eight patients

also told us they were given options as to the different tests and treatments available to them. The two people who were not offered choices told us this was because of the condition for which they were receiving care.

- We also spoke with the relatives of five children in the children's A&E department, who told us they felt they were given enough information to give informed consent.
- We observed clinical staff communicating with patients and explaining the treatments available to them throughout the A&E departments and urgent care centre.

Emotional support

- The A&E matron told us that patients could access a multifaith chaplaincy service, and in the department's viewing room we found a notice explaining how this service could be accessed.
- There were two rooms next to the resuscitation department where relatives or partners of people being resuscitated could wait, so as to be near their loved ones. These rooms allowed staff to give emotional support in a private environment.

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

Requires improvement



Between 2013 and 2014, the trust had not been able to fully comply with the four-hour wait standard or to meet the standard that ambulance patients should be handed over within 15 minutes of arrival. In 2013/14 and the first quarter of 2014/15, the trust failed to meet the standard for 95% of patients to be admitted, transferred or discharged from A&E within four hours. It was evident that the trust had taken action in an attempt to address these deficiencies. These actions included improving access to mental health professionals and creating a neurology 'hot clinic'. However, these continuing pieces of work had not yet addressed the breaches of the four-hour or ambulance handover wait standards. The trust had plans to build a new department in 2016. It is clear from the design of the department that any substantial change

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which may improve access and flow will not be seen until this A&E renovation is completed, and the linked changes in systems and processes have had an opportunity to become embedded.

The service had made improvements that led to the RAID model improving the department's responsiveness to the needs of people with a mental health condition. Systems were also in place to provide a translation service for people whose first language is not English. There was also a service for people who require sign language interpretation, although this was not as comprehensive as that provided for people who required translation support.

A children's A&E department, adjacent to the main department, was open 24 hours a day, seven days a week. There was also a children's short-stay assessment unit that was open from 9am to 10pm. The children's A&E department was led by A&E paediatric consultants and paediatric consultants from the main hospital. It was also staffed by paediatric-trained A&E nurses.

Service planning and delivery to meet the needs of local people

- In order to improve the service provided by the A&E department, the trust was building a new department, with completion expected in 2016.
- The design of the department would include the co-location of services such as diagnostics and the urgent care centre.
- The design would also seek to address deficiencies in the present 'majors' and resuscitation areas.

Access and flow

- Since the financial year 2011/12, average monthly A&E attendances had risen from an average of 9,974 to 10,589 in the first quarter of the 2014/15 financial year.
- In 2013/14 and the first quarter of 2014/15 the trust failed to meet the standard for 95% of patients to be admitted, transferred or discharged from A&E within four hours.
- The main reason for breaching the four-hour target, given in the trust's summary of performance for the week ending 3 August 2014, was the time patients waited to be seen, which accounted for 40% of breaches. The time waiting for a bed was seen as the reason for 25% of breaches. In discussions with senior staff in the A&E department, it became clear that these

two reasons were connected, a lack of beds leading to patients not leaving the department in good time, and delaying the time it took clinicians to treat new attendees.

- During a busy time in the department, we observed the effect of patient numbers on the number of ambulance crews waiting to handover patients. The standard states that 98% of patients should be handed over to A&E staff within 15 minutes. It was clear that bed pressures created a backlog that led to the 15-minute-wait period being breached.
- The trust's summary of performance for the week ending 3 August 2014 stated that 89% of patients were handed over within 15 minutes.
- In its July 2014 A&E performance and quality report, the trust accepted that it had problems meeting the 15-minute-wait standard. As a result of this problem the trust had suffered financial consequences, based on its 2013/14 contract with its commissioners.
- The department had a direct electronic link with the ambulance service's computer-aided dispatch (CAD) system, which showed how many ambulances were bound for A&E and when they would arrive.
- An electronic tracker system showed where every patient was in the department and at what stage their treatment was. This was managed by the flow facilitator.
- There was evidence that the trust treated this as a whole-systems problem and not only an issue for A&E. A four-hour escalation protocol included contacting medical and surgical teams to come to A&E to assist with the through flow of patients. This allowed patients to be moved to other departments in a timely way to maintain the flow within the department.
- The actions the trust has taken have included, in 2012, asking the independent Emergency Care Intensive Support Team (ECIST) to provide advice.
- Following the ECIST visit the trust initiated the "safe and sustainable emergency care programme," part of which is the trust's A&E renovation plan. The trust's "operational plan" for 2014-16 states that this rebuild of the department is designed to improve the flow of patients through the hospital, reduce inappropriate admissions, eliminate waiting times, and improve patient pathways. The A&E renovation is due to be completed in 2016.

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- This was also explained to us by the emergency care clinical director, and the A&E senior management team, when we met with them as part of the inspection programme.
- As part of the trust's improvement programme for A&E there are other ongoing initiatives which have been implemented or are being trialled, some of which are described below.
- They have instituted initiatives such as the rapid assessment, interface and discharge (RAID) mental health model, in partnership with Northumberland, Tyne and Wear NHS Foundation Trust. (This is also discussed above, in the 'Are accident and emergency services effective?' section.
- The July 2014 accident and emergency (A&E) performance and quality report referred to an audit of RAID that found that 98% of mental health referrals were seen within the 60-minute response time. The audit also showed that 28 patient admissions per week had been avoided. This equated to a 68% rate of avoided admissions over a three-month period.
- We reviewed regular audits by the mental health trust, which in the period June to August 2014 saw 92% of patients within the one-hour response time; on average, the admission of 26 patients was avoided. This was in line with, and therefore corroborated, the audit undertaken by the trust and reported in its July 2014 performance report.
- The trust also trialled, between February and May 2014, a joint post with the North East Ambulance Service NHS Trust, which involved basing a hospital ambulance liaison officer (HALO) within the A&E department to facilitate efficient handovers. The trust is awaiting the full analytical report on this trial, although data and anecdotal evidence have tended to show a beneficial effect.
- The trust has used a community geriatrician to provide rapid access to outpatient clinics for the frail elderly, and to provide proactive input to care homes. The effects of this initiative were being analysed, so the effect on waiting times was not yet known.
- The trust has created an acute neurology 'hot clinic' to provide specialist rapid access and diagnosis. The effects of this initiative were being analysed, so the effect on waiting times was not yet known.
- Although the trust has provided evidence of managing access and flow using whole systems approaches, and making changes to practice this has not yet been reflected in improvement in their achievement of the four hour wait standard.
- It is clear from the design of the department that any substantial change which may improve access and flow will not be seen until the A&E renovation is completed in 2016, and the linked changes in systems and processes have had an opportunity to become embedded.

Meeting people's individual needs

- The A&E department had a separate entrance for people walking in with minor injuries and illnesses from that for those arriving by ambulance.
- The main patient waiting area for adults was open and spacious with refreshment facilities and toilets.
- Two rooms adjacent to the resuscitation room, one of them furnished with a leather sofa, were used as interview rooms for people with suspected mental health conditions, as well as for the relatives and friends of patients being treated in the resuscitation area.
- There was a viewing room for people whose relatives or friends had died in the department. The room was tastefully decorated and contained religious symbols that could be used when required. There was also information about how the trust's multifaith chaplaincy service could be contacted. The viewing room was located next to another room where people could sit before viewing their loved one. This room was fully furnished and decorated and contained a telephone that could be used for people to make calls in private. These rooms were located in a quiet part of the department away from the main acute working areas.
- The children's A&E department contained a waiting area, treatment areas, and beds and cots.
- A play area contained a selection of toys, which were clean. A children's A&E department, adjacent to the main department, was open 24 hours a day, seven days a week. There was also a children's short-stay assessment unit that was open from 9am to 10pm.
- The children's A&E department was led by A&E paediatric consultants and paediatric consultants from the main hospital. It was also staffed by paediatric-trained A&E nurses.
- We found that the A&E service responded to the needs of people with a mental health condition by having

Urgent and emergency services

access to a 24-hour service provided by mental health care professionals. As well as assessing people without delay, this service offered practical training to other clinicians in A&E.

- We found that the A&E service responded to the needs of people with dementia and confusion through the provision within the trust of a 24-hour service provided by a delirium and dementia team.
- The department had access to a trust lead for learning disabilities. The A&E matron explained that the A&E department was a difficult environment for people with dementia. The electronic medical record allows critical care information and individual patient needs to be flagged and available to all professionals accessing the patient record. This is used to flag where patients had individual care plans within the patient record.
- The trust lead for learning disabilities spoke with senior nurses at a meeting in April 2014. Following this meeting, further training in learning disabilities was arranged for nursing staff.
- Access to translation services was available for people whose first language is not English. The A&E matron told us that translation services were normally provided through face-to-face contact, although a telephone service was also available if face-to-face contact was not possible. Nursing staff we spoke with in the department told us it was easy to obtain translation support.
- Access to sign language interpretation services was available for people who are profoundly deaf and use sign language. However, this service was not as comprehensive as that provided for people who require translation support.
- The Pallion Urgent Care Centre was located five minutes' walk from the main department, although transport could be provided if required. The trust informed us that the intention was to move this to an area much closer to the main A&E department. The Pallion centre was new and well furnished with a waiting and reception area, treatment rooms, and a diagnostic room where x-rays were undertaken.

Learning from complaints and concerns

- The July 2014 A&E performance and quality report stated that 51 complaints had been made over the last 12 months. The report also found that the volume of complaints was low given the number of patients attending the department, and equated to less than 0.05% of attendees.

- A nurse led on complaints.
- Complaints were discussed at both nursing and medical staff meetings.
- Complaints were a standing agenda item on the agenda of the A&E clinical governance meeting. At the meeting held in July 2014 six complaints were discussed, and it was noted that nine compliments had been received from patients or their relatives. There was no evidence of the learning from complaints being discussed at these meetings.
- Patients and relatives we spoke with told us they would know how to make a complaint if they needed to do so.

Are urgent and emergency services well-led?

Good



The trust had a fully developed long term strategy for creating a new A&E department, which would be ready in 2016. The July 2014 A&E performance and quality report showed that service planning was taking place in an attempt to improve the care being offered in the department. There were links between the clinical leadership and the general corporate leadership of the trust in the triumvirate model of leadership, which involved a general manager, a consultant lead and a nursing lead.

We found good communication between management and staff. However, we found little evidence of the involvement of the public in the day-to-day running of the A&E department.

Vision and strategy for this service

- We spoke with the senior management team – both general managers and clinicians – who described their vision as focusing on quality and safety.
- They saw their vision being achieved through separating emergency and elective care.
- The long term strategy for the service was based on plans for constructing and building a new A&E department. This new A&E department was due to open in 2016, with building work starting in 2015.

Governance, risk management and quality measurement

Urgent and emergency services

- Governance, risk management and quality measurement was evidenced through clinical governance meetings, thorough incident investigation processes and extensive clinical audit.
- Complaints, incidents, audits and quality improvement were discussed at divisional monthly meetings.
- Feedback from these meetings was given at department weekly meetings.
- A & E department had a risk register in place. This had controls and assurance in place to mitigate risk. It was regularly reviewed.

Leadership of service

- The A&E department was fully linked into the structures of the trust through a directorate general manager and a clinical director, for emergency care. The emergency care directorate covered acute medicine, emergency medicine (A&E) and cardiology. The clinical director was a consultant cardiologist who also had an interest in acute medicine.
- The A&E department was led by a directorate general manager, a lead consultant and a matron.
- We found that the general managers were fully aware of the needs of the A&E service and had developed a plan to manage the pressures, including addressing the trust's failure to meet the four-hour wait standard.
- Although the central strategy was to create a new A&E department, the July 2014 A&E performance and quality report showed the A&E department was intent on finding immediate solutions to its present-day pressures.
- We found that the nursing and medical leads worked well together and leadership roles in different aspects of care and performance were shared out among consultant and nursing teams.

- We found that both general managers attended the department in order to liaise with the clinical staff.
- The general managers were represented on the area's multi-agency urgent care board responsible for coordinating and managing urgent care in the Sunderland area.
- The clinical director did not sit on the area's multi-agency urgent care board. Also, no A&E clinicians attended. The divisional general manager told us that the clinicians sat on another group that fed into the Urgent Care board. However, the clinical director told us, when we met the senior management team, that he thought it would be beneficial to have a clinician for A&E on the board.







Culture within the service

- Nurses and medical staff we spoke with on the floor had a positive attitude to the provision of care and the development of the service.
- We noted a good working relationship between the A&E matron and the matron responsible for the medical wards onto which a large number of the A&E patients were admitted.
- During a time when the department was busy we found that the divisional general manager was in the department assisting clinical staff with getting patients admitted to wards in the main hospital.

Public and staff engagement

- Meetings were held within the department that involved all staff groups.
- There was little evidence of the involvement of the public in the day-to-day running of the A&E department.

Medical care (including older people's care)

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

Information about the service

Sunderland Royal Hospital has 405 beds for medical care services. The medical services include a number of different specialties, such as general internal medicine, renal medicine, neurorehabilitation, care of the elderly, cardiology, respiratory medicine, gastroenterology, haematology, neurology and stroke care. The trust had 31,678 admissions between April 2013 and March 2014.

We spoke with 34 patients and their relatives over the course of the inspection, and reviewed information from interviews and discussions as well as listening to patients' accounts during a listening event held in the local community. We also reviewed 37 sets of patients' notes, including treatment charts.

We spoke with 46 staff in different roles and at different grades across the medical wards. We observed care and treatment and looked at care records. We also reviewed the trust's performance data.

Summary of findings

The medical directorate requires improvement across the 'safe', 'effective', 'responsive' and well led domains; however, 'caring' was found to be good.

Staffing levels did not meet those in the National Institute for Health and Care Excellence (NICE) guidance. The medical directorate was addressing some of the concerns regarding staffing levels and skill mix; staff recruitment was in progress to fill vacancies. We found that staff were very busy, and many reported doing extra hours to cover staffing shortfalls.

Medicines were not always managed appropriately. We found that medicines were not always started promptly when a patient was admitted over the weekend, due to a lack of pharmacy staff at weekends. Controlled drugs incidents were not appropriately investigated and reported within the service.

The trust was identified as having mortality outliers for the Summary Hospital-level Mortality Indicator (SHMI). It was working with other trusts in the region and with NHS England to improve its mortality rates.

Systems were in place to ensure that all people were monitored effectively; however, some documentation was poorly completed.

The hospital was meeting national waiting time targets. However, we found that patient flow management was

Medical care (including older people's care)

not always well organised across the hospital, which meant that although patients often felt well looked after, they were not always placed on the most appropriate ward for their needs.

There was comprehensive multidisciplinary team working in patient care, on ward rounds and in ward meetings. Care was provided in line with national best practice guidelines. Arrangements for multidisciplinary working within the directorate were good.

Patients reported being treated with dignity and respect. We observed staff being polite to patients and involving them in their care.

Are medical care services safe?

Requires improvement



All wards had introduced systems for sharing information about the ward's performance with staff and visitors. Incidents were reported, but staff told us they did not always receive feedback from incidents. Systems were in place to ensure that all people were monitored effectively; however, some documentation was poorly completed.

We found the medical care wards clean and well maintained. Staffing levels did not always meet those in the National Institute for Health and Care Excellence (NICE) guidance on general medical wards. On elderly medical wards, the Trust had established the levels of Registered Nurse staffing at a higher number than recommended by NICE but had been unable to recruit to full establishment so the percentage fill range appears lower than would be expected.

The medical directorate was addressing some of the concerns regarding staffing levels and skill mix; staff were being recruited to fill vacancies. Incidents were reported; however, some staff felt that learning from incidents was not shared.

Medicines were not always managed appropriately. We also found that medicines were not always started promptly when a patient was admitted over the weekend, due to lack of pharmacy staff at weekends.

Incidents

- The medical care services reported the highest number of reported patient safety incidents within the hospital. (This was expected, because medical services comprise the largest inpatient service within the trust.) The medical directorate had reported 55 serious incidents, with 18 related to slips, trips and falls (source: Strategic Executive Information System (STEIS) 2013/2014).
- Staff were encouraged to report incidents. Staff were made aware of learning from incidents. However, some staff commented that they only received feedback if the incident was very serious. Staff told us that incidents were sometimes re-graded by the safeguard risk management team, and that they did not always get feedback about why a specific incident had been re-graded.

Medical care (including older people's care)

- The majority of staff we spoke with felt that improvements were needed in feeding back from incidents that occurred on the medical wards.
- Staff told us that 'safety huddles' (where small groups of a clinical team meet and exchange information and discuss key issues on one specific topic) took place every morning.
- Regular mortality and morbidity meetings were held.
- The medical care service had identified issues with the data coding for mortality rates and had implemented changes to improve coding.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. Safety thermometer information was displayed on each ward we visited. Information about the last time a patient had a fall on the ward, or had developed a pressure ulcer was displayed.
- The directorate had an average percentage of 98.6% for VTE and were achieving the performance targets for VTE.
- From May 2013 to May 2014, falls had remained low, except for small peaks in December and April. Since April 2014, the number had reduced to well below that of previous months.
- The trust had put a new falls initiative in place. The medical directorate had a falls specialist nurse who had developed a falls information template for staff to complete to review all aspects of care and reflect on what improvements can be made. For example, it had been identified that the slippers provided by the trust could lead to falls. The falls specialist reviewed the slippers and new, more appropriate and safe slippers had been supplied to all wards.
- Catheter UTIs had remained consistently low during this period.

Cleanliness, infection control and hygiene

- We found the medical wards visibly clean and well maintained. Side rooms were available for patients who required treatment in isolation to prevent cross-infection.
- Equipment was appropriately checked and cleaned regularly, in the areas we visited.

- On two wards, we observed that chest drains were on the floor and not hung from the bed. We brought this to the attention of the trust, which confirmed that chest drains should not be on the floor.
- All the wards displayed information about how long they had been free of Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile) infections. These timescales varied from a few days to over one year. Between April and June 2014, the medical directorate had two cases of MRSA, six cases of C. difficile and one case of Methicillin-sensitive Staphylococcus aureus (MSSA). This was within expected range.
- Staff adhered to 'bare below the elbows' policies. ('Bare below the elbows' is an initiative that aims to improve the effectiveness of hand hygiene practices performed by healthcare workers.) We saw no staff wearing inappropriate jewellery.
- Personal protective equipment (PPE) and alcohol hand gels were available throughout the wards.
- We saw that some patients on the wards were being barrier nursed. (Barrier nursing is used to ensure that cross-infection is eliminated by the use of PPE such as gloves, aprons and isolation procedures.) Patients were cared for in side rooms or allocated bays.
- Staff were observed using PPE and hand gels when they entered and left patient areas. However, we observed two occasions when staff did not discard PPE aprons before they left a patient area. We brought this to the attention of the nurse in charge of the ward.
- Infection control audits were completed. We reviewed the audits completed; most wards were compliant. Ward E53 had achieved 92% in April 2014. Improvements needed were identified; for example, the ward needed to reinforce the used linen procedure with nursing staff, particularly the segregation of clean and dirty linen.

Environment and equipment

- Staff told us that they had good access on all wards to equipment and facilities for repairs and maintenance.
- There was 24-hour access to pressure-relieving equipment, including specialist beds.
- Staff told us there was sufficient equipment to meet their needs, and that additional equipment was made available when needed.

Medical care (including older people's care)

- Resuscitation equipment was available and accessible on the wards. This was checked regularly, and records of the checks were kept.

Medicines

- We found on the acute medical unit (AMU) that, when patients were admitted over a weekend, some medicines were not promptly started. We looked at records for all four people admitted to the ward on the weekend before our visit, and found that two people missed regular medicines for three days. These were restarted after review by the pharmacist.
- The National Patient Safety Agency (NPSA) recommends that pharmacists are involved in medicines reconciliation as soon as possible after a patient's admission. The trust had identified issues with medicine reconciliation at weekends and Bank Holidays due to the 'limited availability of appropriately trained staff, and Monday to Friday working hours'. There were plans for the pharmacist service to move to a seven day working pattern in 2015 to address this issue. Nurses reported that they valued the ward pharmacy service, but a regular service was not extended to all wards. Pharmacists we asked said that the omissions (referred to in the bullet above) would not be recorded on the electronic prescribing systems as missed doses; therefore this information will not be evaluated in trust audits.
- Medicines were kept safely; however, we observed one incident where medicines were stored in a fridge at a temperature higher than recommended, and on two other wards incomplete records were kept. We also saw that no record of room temperature was kept on any of the wards we visited. Nursing staff could show no evidence of any recent audit around storage of medicines.
- Controlled drugs incidents were not appropriately investigated and reported within the service. The trust told us that there was a process of six-monthly ward audits by pharmacy technicians; however, we saw that 10 wards listed on the audit report had not had an audit in the last six months.

Records

- Patient records were kept securely and could be located promptly when needed.

- Records were held in paper and electronic format. The 33 paper records we reviewed were mostly legible and were signed and dated correctly. The consistency of record keeping varied within ward areas and across the medical wards we visited.
- Admission checklists and patient safety checks were consistently completed, and risks around falls, venous thromboembolisms, and moving and handling were consistently assessed. These were mainly fully documented.
- We looked at the observation charts for patients. In six records we found that the observation checks should have been completed four-hourly. However, we found that observations were not completed during the night. We spoke with the nurse in charge, who told us they didn't make the observations during the night because patients were asleep. Nothing documented in the notes confirmed that observations did not need to be completed during the night. There was no evidence that there was an impact on patient care.
- We looked at monitoring charts for weight and nutrition, and found that some were incomplete. We also found that monitoring charts for nutrition were not updated consistently. For example, we found that fluid charts were blank and food charts did not document what extra food/ snacks patients were given. We spoke with the nurse in charge, who told us staff did not always have time to complete the paperwork.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During our inspection, most staff showed sufficient awareness of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Some staff told us they had not had MCA and DoLS training.
- Staff were able to tell us how many patients had a DoLS in place and the reasoning for the DoLS.
- Assessment of mental capacity was not consistently recorded within the medical directorate, and it was unclear from the records whether assessments had been carried out.
- Mental health liaison nurses from the local mental health trust worked with the hospital.

Safeguarding

Medical care (including older people's care)

- There were safeguarding procedures and protocols, and staff were aware of these.
- The patient safety lead is responsible for adult safeguarding. We saw posters with contact details and an outline of the role around the hospital during our visit.
- We looked at staff safeguarding training records. The trust had a target of 80% of staff in the medical directorate achieving compliance. Within the 20 medical care areas, 16 had achieved compliance of between 100% and 80% with safeguarding adults and safeguarding children at Levels 1 and 2. For the other four areas, compliance was below 80%, with the lowest figure being 68.4%.
- Nursing staff achieved the compliance rate for safeguarding training; however medical staff in general internal medicine and elderly medicine did not achieve 80% compliance for adult safeguarding or safeguarding children and young people Level 1 training.

Mandatory training

- We looked at records of staff mandatory training. The trust had a target of 80% of staff in the medical directorate achieving compliance. The medical directorate had achieved all of its targets. Nursing staff had achieved 100% and medical staff had achieved 95% for infection control training. Nursing staff had achieved above 90% for slips, trips and falls training and medical staff had achieved over 80% for resuscitation training.
- Staff told us they were up to date with their mandatory training. An induction programme for new staff included mandatory training.
- Staff we spoke with confirmed that they were up to date with their mandatory and statutory training.

Assessing and responding to patient risk

- The service managed patient risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections, which are highlighted by the NHS Safety Thermometer assessment tool. (The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to give a snapshot of avoidable harms once a month.) The trust monitored these indicators and displayed information on the ward performance boards.
- The trust used the national early warning score (NEWS) tool, which was designed to identify patients whose condition was deteriorating. The tool was designed to

be more sensitive to physiological changes in the patient's condition and alerted staff by the use of a trigger score. Staff could then call for appropriate support. The chart incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained personnel. We found that this tool was in use and staff understood how to use the tool.

- Every morning on the medical wards the multidisciplinary team attended a board round. This allowed clinical problems or potential delays to be highlighted and addressed promptly.
- On the wards, magnetic symbols were used to identify patients at risk of pressure ulcers and falls, and patients living with dementia. On most wards, the symbols were being used to identify vulnerable patients.

Nursing staffing

- Staffing levels regularly fell below those required to meet patients' needs and shifts did not include the full range of staff skills needed.
- The staffing establishment and actual staffing levels were displayed on a noticeboard in the corridor on each ward. On the days we inspected the wards; almost all staffing levels were lower than the establishment staffing levels.
- Staff told us that although staffing establishments were improved by using bank staff, there were sometimes problems with the skill mix of staff, so that staff could not always perform all of the tasks required of them. There were 19 incident forms completed for unsafe environment and staffing levels for August 2014 relating to poor staffing levels. For example three incident forms were completed because there were only two preceptorship nurses working for 13 hours shift without experienced staff available to provide support. Another incident form was completed for B26, which stated IV antibiotics were delayed because there were not enough staff on duty.
- Staff were very busy, and many reported doing extra hours to cover staffing shortfalls.
- We looked at incident reports from May 2014 to August 2014, and there were 78 incidents relating to staff shortages.
- We reviewed the incident forms and they documented that some care was not given because of staff shortages. For example, comments included that: staff were unable

Medical care (including older people's care)

to appropriately check skin integrity; there were delays in giving pain relief; chemotherapy was given late due to only two qualified staff being on duty; and patients requiring one to one nursing were unable to receive it. One patient who was identified as being at a high risk of falls was unable to have one-to-one care, and it is documented that the patient had a fall and sustained a fracture.

- During May, June and July 2014, overall the average qualified nursing levels were below 80% during the day, and they were under 85% during the night. Ward levels across the medical directorate in July ranged from 58% to 94% for qualified nurses. The trust provided more care staff on the wards with reduced numbers of qualified nurses; therefore the actual ratio of qualified nurses were lower than planned. This meant that some wards did not meet the staffing ratio of one registered nurse to eight patients through the day. During May, June and August all wards had below the planned numbers during the day. During May 2014 there were 10 wards that did not meet the planned levels of qualified staff during the night; during June 2014 there were 12 wards, and in July 2014 nine wards. On elderly medical wards, the Trust had established the levels of Registered Nurse staffing at a higher number than recommended by NICE but had been unable to recruit to full establishment so the percentage fill range appears lower than would be expected.
- Incident forms we looked at confirmed that sometimes staff were unable to perform tasks when staff had been transferred to cover shortages on other wards. For example, an incident form was completed for ward B28 that stated that due to staff shortage, "one staff nurse was moved to another ward. This had a great impact on chemotherapy which was given late due to their only being two staff nurses trained in chemotherapy and one preceptor working on the haematology side of the ward. In all there were three separate chemotherapies to be given and this impacted on patient care with medications being delayed."
- Staff told us that while staffing levels had been reviewed in many ward areas, concerns still remained about the skill mix, because staff could not always perform all the tasks required.
- Staff told us that the trust was recruiting for vacant nursing posts, and staffing establishments were

improving. Staff reported that wards were often understaffed, and that vacancies were filled with bank staff wherever possible. However, staff told us, "We're too busy to have time to care."

- We observed nursing handovers, which happened three times a day and were comprehensive; they were well run, and concise, relevant information was given about each patient.
- The trust used its own staffing bank for managing staff shortages on the wards. However, the trust is moving to using an external NHS provider of temporary staff to cover shortages on the wards.

Medical staffing

- From 9am to 5pm, Monday to Friday, all medical wards had consultant presence as well as middle grade and junior doctors. All patients were seen daily by either a consultant or registrar.
- There were a number of medical staff vacancies at all grades, including middle and consultant level. Staff turnover between April 2013 and March 2014 was 37% for elderly medicine and 150% for general medicine due to scheduled junior medical staff rotation. The trust reported a 0% staff vacancy rate within the medical directorate. The sickness rate for rehabilitation and elderly medicine was recorded as 0% for April 2013 to March 2014.
- Junior doctors felt they were well supported within the medical directorate. They reported they were always able to access senior doctors for support and advice.
- There was consultant cover seven days a week, which includes on call out of hours. Staff confirmed this and stated that they were accessible when required. There was appropriate junior doctor cover at weekends and out of hours.

Major incident awareness and training

- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff who may be called upon to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.
- The service had a plan to manage winter pressures, which, at the time of the inspection, was being ratified and agreed by the trust board.

Medical care (including older people's care)

Are medical care services effective?

Requires improvement



The trust had an overall elevated risk for the Hospital Standardised Mortality Ratio, which was higher than expected for weekend mortality as well as for weekday mortality. It was working with other trusts in the region and with NHS England to improve its mortality rates.

Care was provided in line with national best practice guidelines. There were good arrangements for multidisciplinary working within the medical directorate.

Staff were able to access a dietician and speech and language therapists. Meetings of the medical multidisciplinary team (MDT), which included allied health professionals, took place daily on the medical wards.

Evidence-based care and treatment

- The medical department used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to determine treatment it provided. These guidelines were used to develop policies and clinical guidelines for use across the medical directorate.
- The acute medical unit (AMU) completed an audit of all the elderly patients admitted to the hospital during April 2014 to review whether a nursing dementia screening assessment had been completed for the patients. Sixty patients were reviewed, and of the 60 patients, only two did not have a completed nursing dementia screening assessment. However, these patients had valid exclusion criteria; one was in an unresponsive state and the other had expressive dysphasia. Actions from the audit were identified; for example, more standardised and universal training is required to recognise and manage patients with dementia and acute changes to cognition, i.e. delirium, for all staff working in AMU, as well as in other departments.

Pain relief

- Ward staff monitored and treated patients who were in pain.
- Patients told us they were given pain relief when they needed it.

- All medical wards completed a pain audit, and the wards displayed the results for patients to see. For example, ward B21 scored 100%, E54 scored 83% and E52 scored 94% for the pain audit in August 2014.

Nutrition and hydration

- The trust participated in patient-led assessments of the care environment (PLACE). The hospital scored highly for food in the 2014 PLACE results, with a score of 96.4% against a national average of 88.7%..
- Patients were weighed and screened for malnutrition using the malnutrition universal screening tool (MUST) on admission. Where concerns were identified, a referral to a dietician was made.
- We looked at patient records and found inconsistent record keeping, particularly regarding people's fluid intake; therefore there was a risk that effective care was not provided, because accurate records were not kept to ensure that staff were able to monitor people's condition.
- Special diets and puréed meals were available to patients who needed them. Staff were able to access a dietician and speech and language therapists. Meetings of the medical multidisciplinary team (MDT), which included allied health professionals, took place daily on the medical wards.

Patient outcomes

- The trust had an overall elevated risk for the Hospital Standardised Mortality Ratio, which was higher than expected for weekend mortality as well as for weekday mortality. Additionally, two mortality outlier alerts had been raised with the trust from CQC and Dr Foster analysis that showed higher mortality for Pneumonia and for Pulmonary Heart Disease. These alerts were pursued with the trust and have now been closed following the inspection. The inspection team was satisfied that the trust has taken sufficient actions to reduce the risks to patients in relation to issues identified by the trust's review of these alerts.
- The trust had also identified specific areas through internal monitoring where their mortality was higher than expected based upon the average for England.
- The trust had implemented a mortality review group to review the mortality issues raised. The trust investigated

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the reasons for its high mortality rates in this area and identified required improvements. The group had reviewed and implemented an action plan to improve its mortality rates.

- NHS England visited the trust in August 2014. The trust outlined the significant work and analysis done to review and improve its mortality rates. The trust focused on the quality of record keeping and the recording of consultant reviews within the notes, and the involvement in death certification, but action also taking place in a range of clinical areas, such as the response to deterioration in national early warning scores (NEWS).
- The trust was collaborating with other trusts within the north east and with the North East Quality Observatory System (NEQOS) to improve the delivery and quality of clinical care.
- We saw a summary of the clinical audits undertaken, including the Myocardial Ischaemia National Audit Project (MINAP), Sentinel Stroke National Audit Programme (SSNAP) and the National Diabetes Inpatient Audit (NaDIA). Learning and actions from these audits were still being identified.
- The trust scored in the worst category for six of the 20 SSNAP indicators. Overall, the trust was rated as D. The service had regular SSNAP meetings with the ward manager and stroke specialist, and the matron disseminated the minutes from the meeting to all staff.
- The trust performed better than the England median for 11 of the NaDIA questions. NaDIA is a snapshot audit of diabetes inpatient care.
- MINAP audit data for 2012/13 indicated that 99% of patients with non-ST-elevation infarction (NSTEMI) were seen by a cardiologist or member of the team and 95% were admitted to a cardiac unit or ward.
- The Heart failure audit confirmed that 100% of patients have input from specialists.
- The average length of stay for patients on a medical ward is seven days for non-elective care and two days for elective care. The bed occupancy rate is 80% for 2013/14.

The readmission rates for medicine for April to June 2014 were between 34% (medical specialties) and 8% (medicine – other). The directorate had high readmission rates for medical specialties, this included planned readmissions for chemotherapy and other ongoing treatment.

Competent staff

- Staff have specific stroke training on the stroke ward for stroke and transient ischaemic attack assessment training; dysphagia and in house stroke training.
- The trust reported that the medical directorate had completed 100% of appraisals. Nursing staff we spoke with confirmed they had received an appraisal within the last year.
- Among consultants and staff and associate specialist (SAS) doctors for the trust, 99% completed the appraisal process by 1 October 2013. Following disciplinary investigations, the three outstanding appraisals were completed by 29th November 2013.
- The medical directorate had achieved 100% revalidation rates for medical staff.
- An established foundation programme forum, held within the foundation programme, allowed the foundation doctors to express their opinions and discuss issues of concern.
- There was a meeting with trainees in acute medicine to review their training experience and gain feedback for the department. Follow-up meetings were arranged with foundation trainees by the associate foundation tutor.

Multidisciplinary working

- Multidisciplinary teams worked well together to ensure coordinated care for patients. Patient records we saw showed patients were usually assessed and reviewed by physiotherapists and dieticians when they needed to be.
- There was clear evidence of multidisciplinary team (MDT) working on the ward. There was regular input from physiotherapists, occupational therapists and other allied health professionals, when required. Each ward we visited had a dedicated MDT office, which was used by the MDT for ward round meetings.
- There was evidence that the trust worked with external agencies such as the local authority when planning discharges for patients.
- The trust was implementing a readmissions avoidance collaboration (RAC) project. The RAC project is funded by the Sunderland Clinical Commissioning Group (CCG) and involves staff from a number of different teams working together. The staff/teams involved include: community nurse – care coordinator (South Tyneside Foundation Trust); complex discharge sisters (City Hospitals Sunderland (CHS)); community rehabilitation team (Sunderland City Council (SCC)); hospital social

Medical care (including older people's care)

workers (SCC); pharmacists (CHS); telehealth/tele care (SCC); Age UK; rapid response home care (Sunderland Care and Support). This project was implemented in September 2014; therefore it had not been reviewed for impact as yet.

Seven-day services

- There was consultant cover seven days a week. Some consultants were on call out of hours. Staff confirmed this and stated that they were accessible when required.
- On the stroke ward, scanning is available seven days a week. At weekends, scanning requested by the consultant is completed in the A&E department. Staff told us this was not a problem.
- Occupational therapists and physiotherapists were not available at weekends. Pharmacy was not available on all wards at weekends.
- The consultant on the stroke ward used a SMOT camera to review patients remotely out of hours for potential thrombolysis patients.

Are medical care services caring?

Good



Patients told us that the staff were caring and respected their wishes. We saw that the staff's interactions with people were person-centred and unhurried. Staff were kind and caring to people and treated them with respect and dignity. Most people we spoke to during the inspection were complimentary about the staff looking after them. The data from the hospital's patient satisfaction survey, the Friends and Family test, showed that the medical care wards performed above the NHS England average.

Compassionate care

- Overall, patients we spoke with were content with the level of care they received from staff, although a number commented that staff did the best they could despite how busy they were and the pressure they were under.
- Patients told us they were treated with dignity and respect. One patient told us that "communication flows easily. The staff took me for a shower, and there was no embarrassment. We had a good laugh."
- We observed staff being polite to patients. Most patients thought staff were thought polite, patient and caring.

- Patients and the relatives we spoke with told us that staff were caring, kind and compassionate. They told us that medical staff were approachable. We observed medical and nursing staff treating patients sensitively and discreetly.
- The trust scored a 36% response rate for the NHS Family and Friends test, which is 6% above the England average. (The Family and Friends test is a single-question survey that asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.) Two of the medical wards surveyed on the Family and Friends test for June 2013 to June 2014 scored below the trust's average.
- The trust actively sought the views of patients and their families. There were suggestion boxes on each of the wards we visited.
- Patients told us the food was poor, but that if they did not like the food when it arrived staff would provide alternatives. Patients told us they were offered plenty of drinks.
- Patients commented that nursing and care staff were, "Pleasant, polite, friendly and really helpful." One patient said, "The staff are polite and pleasant and treat you like a human being." Another patient said, "I can't fault the staff."
- Most patients said the staff communicated well and thought that they explained everything.

Patient understanding and involvement

- Patients we talked with told us they felt involved in their care and knew what was happening from day to day. They told us that staff listened to them and explained their care.
- Staff delivered care in a way that took into account the wishes of the patient. For example, four patients told us how the staff had listened to their concerns about their care and treatment and how they were given alternative choices.
- The majority of patients we spoke with said that they had been involved in making decisions about their care and treatments, and that they had been given advice and information. Although some patients said they were not really involved in planning their care, they were happy to ask questions and were confident in the treatment and support they were receiving.

Emotional support

Medical care (including older people's care)

- Patients' emotional wellbeing, including their anxiety and depression, were assessed on admission to each ward area, and appropriate referrals for specialist support were made where required.
- The patients and relatives we spoke with told us that they received emotional support from nursing and medical staff.

Are medical care services responsive?

Requires improvement



Support was available for patients living with dementia or who had a learning disability. A specialist dementia and delirium outreach team worked across the hospital.

Problems with patient flow were highlighted across the medical directorate by both staff and other people we spoke with. The trust took measures to maintain the flow of patients throughout the hospital; however, we found that patients were not always cared for on appropriate wards. The trust worked with the clinical site team to develop the trust's escalation plan; however, not all staff were able to tell us how the plan worked.

The hospital was meeting national waiting time targets. However, we found that patient flow management was not well organised across the medical directorate, which meant that although patients often felt well looked after, they were not always placed on the most appropriate ward for their needs.

Service planning and delivery to meet the needs of local people

- The trust had implemented a community geriatric team with three consultants and advanced nurse practitioners. Staff refer to the team on discharge to try and avoid readmission and maintain patients in their own homes.
- The trust was recruiting six allied health professionals to be allocated across the trust.
- The trust had a cardiac catheter lab that was fully staffed by physiologists, doctors and radiographers, and was integrated with the rest of the cardiology services. The trust opened a second catheter lab in January 2014.

Access and flow

- The trust took measures to maintain the flow of patients throughout the hospital. The trust worked with the clinical site team to develop the trust's escalation plan; however, not all staff were able to tell us how the plan worked.
- Daily ward rounds were undertaken during the week with physiotherapists and occupational therapists attending, in order to review patients' progress and expedite discharge planning.
- The trust had implemented admissions avoidance measures including readmissions avoidance collaboration (RAC) project funded by the Sunderland Clinical Commissioning Group (CCG) and involving staff from a number of different teams working together. The staff/teams involved include: community nurse – care coordinator (South Tyneside Foundation Trust); complex discharge sisters (City Hospitals Sunderland (CHS); community rehabilitation team (Sunderland City Council (SCC)); hospital social workers (SCC); pharmacists (CHS); telehealth/tele care (SCC); Age UK; rapid response home care (Sunderland Care and Support).
- The trust had a discharge lounge, which we visited. Staff told us they discharged three to 20 inpatients a day through the lounge. Staff told us they had no concerns about how the flow of patients for discharge to the lounge was managed. The discharge lounge had four ambulances allocated to it so that patients did not have long waits before being discharged. Looking at the discharge information for patients, we saw that patients did not have long waits before going home. In October 2014, however, ambulances will no longer be allocated to the discharge lounge. Staff reported that they would then have to book ambulances either the day before or when patients arrived in the discharge lounge. The service had trialled the new system in September, and patients had experienced delays of two to three hours waiting for transport.
- The trust had opened a nurse-led discharge ward to manage and facilitate the discharge of patients with complex needs, to increase bed capacity in the rest of the medical directorate.
- The referral-to-treatment percentage within 18 weeks were above the England average.
- The trust's average length of stay was two days under the England average for elective stays and nine days over the England average for non-elective stays by two days.

Medical care (including older people's care)

- Referral-to-treatment percentage rates within 18 weeks were above the England average of 92%. For cardiology, gastroenterology and rheumatology, referral-to-treatment rates were above 98%.
- During the inspection we found that patients were not always cared for on the appropriate medical ward for their diagnosis and age. For example, staff told us that, on a care of the elderly ward in the last month, they had cared for medical patients in their 20s and 30s. We also visited a 40-bed stroke ward and found 17 patients being cared for who did not have a diagnosis of stroke. This meant that patients may not have their needs met appropriately.
- There was no evidence of transfers at night; staff told us they did not transfer from the wards after 7pm at night.
- The majority of patients and relatives we spoke with during our visit told us that they did not have any complaints about their care and treatment.
- Staff were aware of the trust's complaints system and how to advise patients and relatives to make a complaint if they wanted to do so.
- The medical directorate had received 128 complaints between June 2013 and June 2014. Twenty-two complaints were resolved within 60 days, and 39 complaints remain unresolved.
- Learning from complaints was shared with staff at team meetings. Following a complaint, the stroke unit was developing a visual prompt for patients who have memory/communication problems to use the call bell.

Meeting people's individual needs

- Support was available for patients living with dementia or who had a learning disability.
- A specialist dementia and delirium outreach team worked across the hospital. It was responsible for assessing and referring for appropriate treatment patients living with delirium and dementia.
- To ensure that people with a diagnosis of dementia got the right care and support, the medical directorate used the Butterfly Scheme. Under this scheme, a butterfly symbol informs staff when a patient is living with dementia, so that staff can give appropriate help and support.
- The trust had introduced 'This is me' on all wards admitting people with dementia. All of the medical wards used the trust's 'This is me' document, which was completed by the patient's carer at admission and recorded information about their life, likes, dislikes and interests. It enabled health and social care professionals to see the patient as an individual and deliver person-centred care that was tailored specifically to the person's needs.
- Mental health assessments were completed and reviewed weekly by staff from the local mental health trust.
- The medical directorate had access to interpreting services. Staff told us that information could be made available in different languages. Staff were also able to access signing services for patients and relatives with a hearing impairment.

Learning from complaints and concerns

Are medical care services well-led?

Requires improvement



Staff felt well supported locally, however they were unclear about trust responses to capacity pressures within the medical directorate. Staff were concerned about how increasing workloads would be managed and how standards of care would be maintained. They were sometimes unable to have monthly team meetings because of the low numbers of staff on the wards. Some staff also felt that the managers of the medical directorate did not always consult with and inform staff about what was happening with nurse staffing levels.

There were regular governance meetings; however, most junior staff we spoke with were unsure of how clinical governance worked to improve patients' care

Lessons from complaints, incidents, audits and quality improvement projects were discussed at clinical governance meetings.

Medical and nursing staff spoke highly of each other and reported that working relationships were effective and supportive. Staff worked well together, and there was obvious respect, not only between the specialties, but also across disciplines.

Vision and strategy for this service

- The matron and ward managers within medicine were clear about their roles and responsibilities.

Medical care (including older people's care)

- Some staff within the medical directorate were unclear what actions were being taken in response to capacity pressures and relating to the recruitment of nursing and medical staff across the trust.
- Staff were concerned about how increasing workloads would be managed and how standards of care would be maintained.

Governance, risk management and quality measurement

- Monthly ward manager meetings were held with the matron for medical care. Safety, risk and audit results were discussed and action plans developed. Each ward manager then cascaded important information to other staff at ward meetings.
- Staff told us they were sometimes unable to have monthly team meetings because of the low numbers of staff on the wards.
- There were regular governance meetings; however, most junior staff we spoke with were unsure of how clinical governance worked to improve patients' care. The meetings covered areas of concern, complaints, nursing indicators and plans for improvements in the safe delivery of patient care.
- The cardiology department reviewed the quality of its services and shared the audit with staff in the cardiology department.
- The medical directorate had developed local risk registers, and these were monitored in local governance meetings; risks that scored 15 or above were escalated to the corporate risk register. For example, haematology had escalated chemotherapy prescribing because there was no electronic record of prescribing, there were no audit trails, there was no failsafe mechanism to document changes, and there was a failure to meet safety standards. Non-compliance with chemotherapy measures without EP and a permanent treatment record. Controls and actions had been put in place to reduce the risk, and it was reviewed and monitored by the trust corporate risk and governance group until it was reduced.

Leadership of service

- We observed that matrons and ward managers were highly visible on the wards and departments we visited.
- Staff we spoke with told us they felt supported and that their managers were approachable and accessible.

However, some staff felt that the managers of the medical directorate did not always consult with and inform staff about what was happening with nurse staffing levels.

- Medical and nursing staff spoke highly of each other and reported that working relationships were effective and supportive.

Culture within the service

- Many of the staff told us that despite all the negative feeling surrounding the trust regarding staffing levels, they were proud to work there.
- Staff told us that they felt dedicated to doing the best for their patients, and valued their colleagues.
- Staff worked well together, and there was obvious respect, not only between the specialties, but also across disciplines.
- Medical and nursing staff said that they felt supported by their immediate line managers.

Public and staff engagement

- The trust took part in the Friends and Family test, and the results were favourable; the overall response rates for the trust were 36%.
- The Patient Advice and Liaison Service was situated in the main entrance, and was visible.
- Further information about the Patient Advice and Liaison Service was displayed in public areas.
- Patients were not routinely provided with information about how to make a complaint.
- Seventy-five per cent of staff would recommend the organisation as a place to be treated, and 68% of staff would recommend it as a place to work.

Innovation, improvement and sustainability

- Staff within the directorate spoke positively about the service they provided for patients, despite all staff describing staff shortages.
- The directorate had a falls specialist nurse who had reviewed the management of falls. There had been a reduction in the number of falls on the wards.
- The trust was implementing a readmissions avoidance collaboration (RAC) project. The RAC project is funded by the Sunderland Clinical Commissioning Group (CCG) and involves staff from a number of different teams working together.

Medical care (including older people's care)

- The trust was working with other trusts within the north east and the North East Quality Observatory System (NEQOS) to improve the delivery and quality of clinical care.

Surgery

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

Information about the service

Sunderland Royal Hospital provides a range of surgical services for the population of Sunderland and the immediate surrounding area, and also serves the population of the north east of England.

The hospital provides elective and non-elective treatments for breast surgery, colorectal surgery, ear, nose and throat (ENT) surgery, oral and maxillofacial surgery, trauma and orthopaedics, urology, vascular, upper gastrointestinal, and bariatric surgery.

During this inspection we visited general surgical wards C30, C31, C33, as well as wards D42, D43 and D48 (trauma and orthopaedics), D46 (urology) and D47 (gynaecology, breast and GUI) and the surgical assessment unit. We visited theatres on C, D, E and F floors and observed care being given and surgical procedures being undertaken.

We spoke with 92 patients and relatives and 42 members of staff. We observed care and treatment and looked at care records for 32 people. We also reviewed performance information from and about this hospital.

Summary of findings

Effective arrangements were in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance, and staff were encouraged to report incidents.

Staffing establishments and the skill mix were regularly reviewed to maintain optimum staffing levels.

Arrangements were in place for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment in the daily checks for anaesthetic equipment. Care records were completed accurately and clearly.

Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges.

Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams.

We observed positive, kind and caring interactions on the wards and between staff and patients. Patients spoke positively about the standard of care they had received, and most felt they understood their care options and that they were given enough information about their condition.

Surgery

Services were available to support patients, particularly those who lacked capacity to access the services they needed.

Information about the trust's complaints procedure was available for patients and their relatives. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

The trust's vision, values and strategy had been cascaded to wards and departments, and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities, and ward leadership was good. Staff felt supported and had seen positive changes to improve patient care.

Systems were in place to plan and deliver services to meet the needs of local people. Identified issues relating to waiting times were continuously monitored, and waiting list initiatives were implemented and planned.

The service recognised the importance of the views of patients and the public, and mechanisms were in place to hear and act on patient feedback. Staff were encouraged and knew how to identify risks and suggest improvements.

Are surgery services safe?

Good



Effective arrangements were in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff were encouraged to report incidents, and most received feedback on what had happened as a result.

Staffing establishments and the skill mix were regularly reviewed to maintain optimum staffing levels at all times of day and night. Effective handovers took place between staff shifts and included daily safety briefings to ensure continuity and safety of care.

Arrangements were in place for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment in the daily checks for anaesthetic equipment. Care records were completed accurately and clearly.

Incidents

- Staff were aware of the process for investigating when things had gone wrong. Staff said they were encouraged to report incidents and were aware how to complete this process. Feedback was given to ward managers, who confirmed that themes from incidents were discussed at staff meetings and displayed in staff rooms.
- Staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic system (Ullyses), and were encouraged to do so.
- Two Never Events had been reported at this hospital – one surgical error and one wrong-site surgery. We saw that these had been fully investigated by the trust, which had identified the root causes of the error and the actions needed to stop recurrence.
- These actions included changes to current procedures, lessons learnt disseminated throughout the surgical division and increased vigilance with World Health Organization (WHO) checklist requirements.
- Within surgery, 24 serious incidents had been reported in the last 12 months. The reporting of serious incidents was in line with that expected for the size of the hospital.

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

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Information was clearly displayed on boards on all wards and theatre areas that we visited.
- Safety thermometer information included information about all new harms, falls with harm, and new pressure ulcers. Between May 2013 and May 2014 pressure ulcer rates varied between 4 per month to nil, falls and catheter acquired urinary tract infections remained low when compared with the England average.
- Data showed that 100% of inpatients had received a venous thromboembolism risk assessment on admission to hospital.
- Risk assessments for the above were being appropriately completed on admission.

Cleanliness, infection control and hygiene

- All wards and patient areas were clean, and we saw staff wash their hands and use hand gel between patients; 'bare below the elbows' policies were adhered to.
- Infection control information was visible in all ward and patient areas.
- All elective patients undergoing surgery were screened for Methicillin-resistant Staphylococcus aureus (MRSA). Policies were in place to isolate patients, when appropriate, in accordance with infection control policies. The numbers of cases of MRSA and Clostridium difficile (C. difficile) for the surgical wards had varied across the previous 12 months. Trust-wide data showed that MRSA is based on a very small number of cases..
- Clinical waste bins were covered, with foot-operated opening controls. Appropriate signage was used for the disposal of clinical waste.
- Separate hand-washing basins, hand wash and sanitiser were available on the wards and in the theatre and patient areas. We observed staff using this equipment appropriately.
- Records of a recent environmental audit showed that the service was 100% compliant with infection control procedures.

- Nursing staff had received training in aseptic non-touch techniques. This encompassed the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- The division participated in the ongoing surgical site infection (SSI) audits run by Public Health England. Reports from the department of microbiology identified SSI rates across all specialties running at between 0.6% and 2.0%. Each case of SSI was identified and then discussed at formal meetings, with actions identified to avoid a repetition.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene.
- Swab, pack surgical instrument and sharp count audits were completed, and identified areas of non-compliance. These were discussed at divisional meetings and actions identified.
- We saw extensive contact between the primary nurses and consultants during surgery.
- Pre-assessment of patients was in accordance with the guidelines of the British Association of Day Surgery.

Environment and equipment

- We observed that checks for emergency equipment, including equipment used for resuscitation, were carried out on a daily basis.
- Records showed that equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- All freestanding equipment in theatres was noted to be covered and dated when cleaned. Equipment was appropriately checked and cleaned regularly.
- There was adequate equipment in the wards to ensure safe care.
- In 2010 the supplier of instruments had identified that 75% of the stock of theatre instruments was in need of repair, replacement or refurbishment and the potential risk of patient cancellation due to equipment non-availability had been included on the division's risk register. Cancellations had not yet happened due to the non-availability of equipment. There was an ongoing programme of audit in relation to this.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge

Surgery

temperatures were checked. There was an exception on Ward C30, where the medicines fridge was showing a high temperature (8.8 degrees), and temperatures were not being recorded.

- We observed that the preparation and administration of controlled drugs was subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Some second signatures were missing from documentation on Ward C30.

Records

- Care pathways were in use, including enhanced recovery, for example, for fractured neck of femur.
- All wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure that patient confidentiality was maintained.
- Children's records reviewed included pre-assessments, medical notes, consent forms (written in detail and signed/dated), completed pre-operation checklist, anaesthetic record, medication administration record (MAR) chart, discharge checklist, and discharge letter and prescription.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that consent had been obtained appropriately for all patients; this was in line with the trust's policy and Department of Health guidelines.
- Staff told us that mental capacity assessments were undertaken by the consultant responsible for the patient's care, and Deprivation of Liberty Safeguards were referred to the trust's safeguarding team.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trust's whistleblowing procedures and the action to take.

- Compliance with adult and children's safeguarding Level 1 training was 100% across all surgical areas. We confirmed staff working with children had completed Level 3 safeguarding training.

Mandatory training

- The performance report showed that staff in the division of surgery were up to date with their mandatory training. For example, 100% of staff had attended consent training, 92% had attended infection prevention and control training, and 84% had attended resuscitation training during 2013 and 2014. These figures were against a trust attendance target of 80%.
- Staff we spoke with confirmed that they were up to date with mandatory training, and this included attending annual cardiac and pulmonary resuscitation training.

Assessing and responding to patient risk

- All wards used the national early warning score (NEWS), a recognised early warning tool for the management of deteriorating patients.
- Clear directions for escalation were printed on the observation charts, and staff we spoke to were aware of the appropriate action to take if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and that repeat observations were taken within the necessary time frames.
- We observed that theatre staff practised the 'five steps to safer surgery' of the World Health Organization (WHO). Audits across all specialties showed a very high level of compliance between May 2014 and July 2014.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool. The trust had recently undertaken work to reassess the staffing levels on wards. This was to ensure that staffing establishments reflected the acuity of patients.
- There was a safe staffing and escalation protocol to follow if staffing levels for a shift fell below the agreed roster.
- We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels were compliant with the required establishment and skill mix.

Surgery

- The average 'fill rates' both for nurse and care staff between May 2014 and July 2014 showed a high level of compliance across all specialties.
- Limited use was made of bank staff. Staff told us that they were asked to cover staff shortages. The trust's use of bank and agency staff was 1.3% during 2014, against an England average of 6.1%.

Surgical staffing

- Surgical consultants from all specialties were on call for a 24-hour period. Arrangements were in place for effective handovers between medical staff.
- There were a number of vacancies in anaesthetic junior rotas due to a national reduction in the number of trainee posts.
- We discussed this with the divisional management team, who were aware of the risks of meeting waiting times and care pathways. Locum posts had been agreed as a short-term measure and substantive appointments were actively being pursued.
- Patients requiring unscheduled inpatient surgical care are under the direct daily supervision of a consultant surgeon. The hospital publishes a rota 12 months in advance for the provision of general surgical emergency care.
- The general surgical on-call team comprises the consultant general and a consultant vascular surgeon.

Major incident awareness and training

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

Are surgery services effective?

Good



Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges.

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

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists of Great Britain and Ireland, and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients. The role of the primary nurse had been introduced to provide a nurse to escort the patient through the care pathways and follow up each patient, ensuring continuing care.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments, and these were in line with best practice.
- The surgery departments took part in all the national clinical audits that they were eligible for. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- We looked at examples of local audits completed during 2014 relating to infection control, checking of controlled drugs and use of personal protective clothing in theatres and recovery; these showed 100% compliance.
- The introduction of a day of surgery admissions unit had speeded up patient flow for urology patients and was positively commented upon by both patients and staff.

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Pain relief

- Planned pain relief was administered for ophthalmic patients who were on the enhanced recovery pathway.
- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels. All patients reported that their pain management needs had been met.

Nutrition and hydration

- Patients were screened using the malnutrition universal screening tool (MUST). Where necessary, patients at risk of malnutrition were referred to the dietician.
- Records showed that patients were advised of what time they would need to fast from. Fasting times varied depending on whether the surgery was in the morning or afternoon.
- Patient-led assessments of the care environment (PLACE) scored the wards at Sunderland Royal Hospital between 60 and 82% for food during August 2014. The trust's average score was 96.4%, higher than the national score of 88.7%.

Patient outcomes

- There were no current Care Quality Commission (CQC) mortality outliers relevant to surgery at Sunderland Royal Hospital. This indicated that there had been no more deaths than expected for patients undergoing surgery at the hospital.
- The percentage of surgery performed as day case surgery was above the national expectation in trauma and orthopaedics (93%) but below expectation for all other specialties (breast surgery, 84%; ear, nose and throat (ENT), 88%; general surgery, 53%; urology, 73%; vascular surgery, 51%). (The British Association of Day Surgery recommends that 90% of certain surgeries are completed as day cases.)
- Readmission rates for surgical patients at Sunderland Royal Hospital were 2% between July 2013 and June 2014. This was below the average for the trust at 6%.
- The trust contributed to all national surgical audits for which it was eligible. The National Bowel Cancer Audit showed better-than-England-average results for multidisciplinary team discussion, clinical nurse specialist involvement and scans undertaken. Of patients undergoing major surgery, 74% stayed in the

hospital for an average of more than five days (higher than the England average of 69%). Mortality rates were below the England average at 30-day, 90-day and two-year measures.

- The trust participated in the National Hip Fracture Audit. Findings from the 2013/14 report showed the trust was better than the England average in areas such as patients being admitted to orthopaedic care within four hours (66%) and surgery within 48 hours (91%, against the national target of 87%) and falls assessment (100%).
- The trust was worse than the England average for patients receiving a bone health medication assessment (77%), pre-operative assessment by a geriatrician (42% against an England average of 53%), and the mean total length of stay (21.5 days against 20 days).

Competent staff

- We spoke to staff and observed from the training matrix that appraisals were undertaken annually. Records for 2014 showed that 88% staff in surgery had received an appraisal.
- Staff could request informal one-to-one meetings. Monthly staff meetings took place.
- Most junior doctors told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- The General Medical Council (GMC) national training survey 2013 identified no risks in these areas, and all outcomes were within expectations.
- Revalidation and clinician outcomes were assessed and monitored by the deanery.

Multidisciplinary working

- Nursing documentation was kept at the end of each bed and centrally within the wards, and was completed appropriately.
- Therapists worked closely with the nursing teams on the ward where appropriate. Daily handovers were carried out with members of the multidisciplinary team.
- There was pharmacy input on the wards during weekdays.
- Staff explained that the wards worked with local authority services as part of discharge planning.

Seven-day services

Surgery

- Consultants were available on call out of hours and would attend when required to see patients at weekends.
- Daily ward rounds were arranged for all patients. New patients were seen at weekends when necessary.
- Access to diagnostic services – for example, x-rays – was available seven days a week.
- An on-call pharmacist was available out of hours. Pharmacy staff were available on site during the week.

Are surgery services caring?

Good



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

Patients we spoke with felt they understood their care options and were given enough information about their condition. Services were provided to ensure that patients received appropriate emotional support.

Compassionate care

- Throughout our inspection at Sunderland Royal Hospital we observed patients being treated with compassion, dignity and respect. We saw that patients were spoken to and listened to promptly; patients told us: “This is a brilliant hospital!” and “Nothing is too much trouble; the buzzer response is excellent,” and “The place is clean, well maintained and the food is excellent.”
- Staff were very attentive to the comfort needs of patients. Patients and relatives were positive about the care and treatment that patients had received.
- All patients commented positively on the dedication and professionalism of staff and the high quality of care and treatment received.
- Patients were complimentary about the staff in the service, and felt informed about and involved in their care and treatment. We observed patients being kept informed throughout their time within the anaesthetic room and theatres.
- We saw doctors introduced themselves appropriately. Curtains were drawn to maintain patients’ dignity.

- The hospital’s response rate for the Friends and Family test was slightly lower (at 32%) than the England average (33%) between June 2013 and June 2014. Scores, however, were consistently higher across all areas than the England average during that period.

Patient understanding and involvement

- Patients and relatives felt involved in the patient’s care and had been given the opportunity to speak with the consultant looking after the patient.
- Ward managers were available on the wards so that relatives and patients could speak with them.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- All the patients we spoke with had been made fully aware of the surgery that they were going to have; this had been explained to them.

Emotional support

- Patients felt able to talk to ward staff about any concerns – either about their care, or in general. Patients did not raise any concerns during our inspection.
- Information was included within care plans to highlight whether people had emotional or mental health problems.
- Patients were able to access counselling services, psychologists and the mental health team.
- Assessments for anxiety and depression were done at the pre-assessment stage. Nursing staff provided extra emotional support for patients both pre- and post-operatively.

Are surgery services responsive?

Good



Systems were in place to plan and deliver services to meet the needs of local people. Staff were responsive to people’s individual needs. Identified issues relating to waiting times were continuously monitored, and waiting list initiatives were implemented to meet demand.

Services were available to support patients, particularly those who lack capacity to access the services they need.

Surgery

Information about the trust's complaints procedure was available for patients and their relatives. There was evidence that the service reviewed complaints and acted on information about the quality of care.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation and surge policy and procedure to deal with busy times.
- Meetings were held to monitor the availability of beds in the hospital; staff reviewed data on planned patient discharge to assess the future availability of beds.
- When patient numbers and demand were high, elective patients were reviewed and placed in an order of priority for cancellation to prevent urgent patients, including cancer patients, being cancelled.
- The hospital had developed a business case to introduce a managed service to replace, repair or refurbish theatre instruments as required.

Access and flow

- A pre-assessment meeting was held with each patient before the surgery date. Any issues concerning discharge planning or other patient needs were discussed at this stage.
- Patients requiring assistance from social services upon discharge were identified at pre-assessment, and plans were continuously reviewed during the discharge planning process.
- The average length of stay was at or below the England average for both elective and non-elective patients, except for non-elective general surgery (six days; England average five days).
- No patients had their operations cancelled and not treated within 28 days.
- Enhanced recovery pathways were used for patients; this was viewed by staff and patients as an effective model, with the primary nurse facilitating the progress of patients through their treatment.
- The role of the primary nurse had been introduced to provide a nurse to escort patients through the care pathway and follow up on each cataract patient. Patients were accompanied throughout their journey within the hospital from admission through anaesthesia, the procedure and discharge.
- The introduction of a 'block room' within theatres to increase the flow of patients and advance the planning of procedures was particularly effective.

- Data showed that 570 procedures were cancelled across specialties between April and July 2014. These rates are comparatively low against the England Average. The main reasons given for these were cancellation by patients (50), patients medically unfit (79) and non-attendance of patients (92). The hospital had plans in place to manage these cancellations.
- The trust was better than the England average for the percentage of patients receiving surgery for fractured neck of femur within 48 hours (90%).

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse who could provide advice about and support in caring for people with these needs.
- Suitable information leaflets were available in a pictorial and easy-read format and described what to expect when undergoing surgery and post-operative care.
- Wards had access to an interpreter as required. Requests for interpreter services were identified at the pre-assessment meeting.
- Access was available to an independent mental capacity advocate for when best-interest decision meetings were required.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service and the mechanisms for making a formal complaint. We saw leaflets available throughout the hospital informing patients and relatives about the complaints process.
- Complaints were handled in line with the trust's policy. Information was given to patients about how to make a comment, compliment or complaint. Processes were in place for dealing with complaints at ward level and through the trust's Patient Advice and Liaison Service.
- Complaints and concerns were discussed at monthly staff meetings, where training needs and learning were identified as appropriate

Surgery

- For patients or their relatives who might need help with making a complaint, contact details for the Independent Complaints Advocacy Service were visible in the ward and throughout the hospital.

Are surgery services well-led?

Good



The trust's vision, values and strategy had been cascaded to wards and departments, and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities, and ward leadership was good. Staff felt supported and had seen positive changes to improve patient care.

The service recognised the importance of the views of patients and the public, and mechanisms were in place to hear and act on patient feedback. Staff were encouraged and knew how to identify risks and suggest improvements.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation, with clear aims and objectives. The trust's values and objectives had been cascaded across the surgical ward and were visible in ward areas.
- Surgical services had a local vision which was understood by staff.
- Staff had a clear understanding of what these involved and were able to repeat the vision and discuss its meaning with us at focus groups and during individual conversations.

Governance, risk management and quality measurement

- Clinical governance meetings were held each month. The minutes of meetings showed that complaints, incidents, audits and quality improvement projects were discussed and action taken where required, including giving feedback to staff about their individual practice.
- We saw that action plans for Never Events were monitored across the division, and sub-groups were tasked with implementing elements of the action plan where appropriate.

Leadership of service

- Staff told us that leadership of the service was good. They said staff morale was good and they felt supported at ward level.
- Each of the surgical specialties had a clinical director lead; there was also a directorate management lead.
- Staff spoke positively about the service they provided for patients. They emphasised that quality and the patient experience are a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers, although we were told that one-to-one meetings and appraisals were irregular.
- Medical staff stated that they were supported by their consultants and confirmed that they received feedback from governance and action planning meetings.
- We held discussions with the management team for the surgical division. They explained their understanding of the reasons for not meeting the 18-week target to treatment for some specialties (urology and oral surgery), actions planned and taken, and anticipated improvements.

Culture within the service

- Staff worked well together and there was respect not only between the specialties, but also across disciplines. We saw good team working on the ward between staff of different disciplines and grades.
- Staff were well engaged with the rest of the hospital and reported an open and transparent culture on the wards. They reported good engagement at ward level and felt that they were able to raise concerns and that these would be acted on.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority.

Public and staff engagement

- The trust had a target Friends and Family test response rate of 25%. The response rates for wards within the surgery division varied between 25% and 92%, and all showed scores higher than 66.
- The NHS staff survey data showed that the trust scored as expected in 22 out of 30 areas and better than expected in seven areas. One negative finding was the percentage of staff having equality and diversity training in the last 12 months. The trust requirement is three yearly so not all staff will receive this annually, hence the lower percentage uptake for this.

Surgery

Innovation, improvement and sustainability

- Systems were in place to enable learning and improve performance, which included the collection of national data, audits, and learning from incidents, complaints and accidents.
- Evidence showed that staff were encouraged to focus on improvement and learning. We saw examples of innovation, such as the development of the primary nurse role and specific care pathways.

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

Information about the service

City Hospitals Sunderland NHS Foundation Trust has one integrated critical care unit (ICCU), which falls under the theatres directorate. The unit is a relatively new and modern facility for the care of critically ill patients, including those who are immunocompromised or highly infective. The unit covers a catchment population of around 350,000.

The unit has 18 individual glass-walled rooms. It cares for acutely ill patients requiring intensive level 3 care and/or level 2 high dependency care. The maximum number of level 3 patients that can be accommodated at any one time is 10. An additional high dependency area in the maternity unit delivery suite includes two high dependency beds situated in the post-delivery recovery room; these beds are overseen by the obstetrics team with support from the critical care team.

We visited the ICCU and spoke with a range of staff, four patients and the family of a patient who had recently been discharged; we also visited the delivery suite recovery area. In addition, we observed care and reviewed documentation, including policies, audits and some patient records.

Summary of findings

The critical care service was safe, effective, caring, responsive and well-led. The ratings for each of were good, in terms of patient outcomes and quality of care these were particularly strong areas.

The unit had a positive safety culture, responded well to incidents and ensured that practice continually improved and developed in line with best practice guidance. The unit, with its innovative design, provided a modern environment in which to deliver intensive and high dependency care.

The effectiveness of the service was shown by the positive outcome data for patients and the unit performed well in comparison with other similar units. The skills and expertise of the medical and nursing team were to a high standard, and all consultants were trained in intensive care medicine. The size of the nursing team had recently been increased, this had negatively affected the skill mix as there was an increased proportion of nurses who had not yet achieved competence in ICCU specialist skills.

The healthcare team was caring and compassionate, as proved through our observations and speaking with patients and relatives. Excellent support services were available for patients and relatives, and the views of patients and relatives were effectively gathered in a variety of ways.

The service was able to effectively respond to changes in service demand. This was partly due to the ability of

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the unit to easily flex between intensive and high dependency care provision, and the responsiveness of the staff. Delays for patients in accessing critical care were minimal, but delayed discharges from the unit to the ward were becoming an increasing problem.

In terms of leadership of the unit, it was evident that the culture within the service was open and transparent, and there was a tangible drive to provide the best high standards of care. Staff spoke positively about the leadership team and the open communication. Engagement with both staff and the public was good, and there were good examples of where feedback about the service had altered practice for the better.

Are critical care services safe?

Good



The unit had a positive incident-reporting culture and had several mechanisms in place that promoted learning from incidents and near misses. The environment and design of the unit was to a high standard, and patients spoke positively about their experiences on the unit. However, the separate rooms made it difficult, on occasion, to maintain a good line of sight to the patients.

The medical team was well staffed, and medical cover for the unit, including out of hours, was effectively managed. Nurse staff levels were below the ideal, but care remained safe because the unit was not running at full capacity. This issue was recognised, and mechanisms were in place to ensure adequate nursing levels for when activity on the unit increased.

Incidents

- Between April 2014 and August 2014, the Integrated Critical Care Unit (ICCU) did not record any Never Events. Between April 2013 and March 2014 the one Never Event was a misplaced nasogastric tube (NGT).
- The NGT Never Event was comprehensively investigated and action taken to reduce the likelihood of such an event occurring again; this included revising the policy for NGT placement, additional training and NGT placement audits.
- The NGT incident showed how the unit was able to analyse incidents and effectively disseminate learning to unit staff and wider staff groups.
- Nursing and medical staff on the ICCU described an open reporting culture and how safety and learning from incidents were key priorities.
- Nursing and medical staff confidently described how they would report incidents and were clear about their accountabilities and who to escalate concerns to. Staff accurately stated that they would report incidents using an electronic incident-reporting system.
- Staff also described how they received feedback about incidents that had been reported; this was mainly through team briefs and at shift handovers. We

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observed a team brief at which pressure sores and slips, trips and falls were discussed. Such discussions supported that finding that there was a learning culture within the unit.

- We reviewed the ICCU's recorded incidents for a three-month period between May and August 2014. There were a total of 64 incidents: 36 no harm/near miss, 25 minor harm, three moderate harm and zero severe harm. All three moderate harm incidents had been investigated. One of the three moderate harm incidents required additional scrutiny, and we saw the full incident report and analysis.
- The review of incidents formed one part of the unit's safety culture. Other sources of data were also used to drive up standards; these included patient feedback, analysis of complaints, clinical audit and observation of practice.
- During 2013 there were concerns with the number of reported pressure sores on the unit; this prompted a detailed review of the incidents and related causes. Equipment, particularly mattresses, was seen as a key contributory factor.
- The unit invested in new mattresses and revised some clinical practice; this resulted in a dramatic reduction in the number of preventable pressure sores, particularly grade 3 and 4. The unit was shortlisted for an award by the trust's reward and recognition scheme.
- Mortality and morbidity (M&M) meetings were held on a Friday morning once a month; the meetings started at 9am and finished at lunchtime. The M&M meetings were open for all staff on the ICCU to attend, but the majority of attendees was medical staff, including non-consultant-grade doctors.
- As a result of the M&M meetings, a change in practice occurred in the treatment of patients with pneumonia, which resulted in improved survival rates.
- The ICCU team also participated in multispecialty M&M meetings, for example with accident and emergency (A&E); this was to promote shared learning.
- Due to the high staff turnover in acute medicine, multispecialty meetings have not continued within that specialty. This was recognised as an issue, particularly because the ICCU received a significant number of patients from A&E and the acute medical unit.
- The M&M meetings were used to provide staff with the opportunity to discuss errors and adverse incidents in an open manner, review care standards, and makes changes if required.

- Some concerns were raised during the inspection about how the critical care outreach team received feedback from reported incidents. The critical care outreach team had submitted a number of incidents where patient outcomes had been negatively affected; no feedback had been provided about investigations, outcomes and/or requirements to change practice. The outreach team had also never been asked for additional information or to provide statements.
- Other concerns were raised about the regrading of incidents, including incidents reported by the critical care outreach team. We observed how incidents reported at levels 4 or 5 were almost always downgraded to level 0, 1 or 2. (Incidents graded at below level 4 did not require feedback to the reporter, according to the trust's policy.)
- There were several examples of where patients had suffered harm as a result of an incident, and the re-graded incident score suggested there had been 'no harm'. As staff had not received feedback regarding this re-grading there was no learning or clarity on the process. The trust had recognised there was further development needed in relation to the reporting and investigation process. As this was a trust wide issue it is dealt with in the provider report.

Safety thermometer

- We observed the unit's safety thermometer display, which was in the family room; this meant it was clearly visible. Included in the display was data on infection prevention and control and patient safety.
- The information for the month of August 2014 showed zero patients with Methicillin-resistant *Staphylococcus aureus* (MRSA) in their blood and/or *Clostridium difficile* (C. difficile) infection. Also, for the month of August 2014, zero patients had fallen and/or had developed a pressure ulcer.

Cleanliness, infection control and hygiene

- The ICCU is a modern unit that was purpose-built in 2011. It was evident that its design had been carefully thought through with a focus on attention to detail.
- The unit provides 18 single rooms made from sound-proofed glass with an innovative mechanism to frost the glass when privacy is required. The glass is easily cleaned and there were no curtains or blinds; this meant there was less material for germs to settle on.

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- The equipment in and general environment of the ICCU was visibly clean, including horizontal surfaces and high-contact surfaces and equipment touched by staff and patients, for example bedrails.
- Each room has a bespoke waste management system; three bins were situated against the back of each room, and waste bags were collected through a corridor running along the back of the unit. This reduced the movement of staff within the rooms, which had a positive impact on reducing the chances of cross-infection and promoting patient privacy and dignity.
- We observed staff, particularly nurses and doctors, clean their hands when required using either soap and water or alcohol hand rub; this was usually before and after contact with a patient and/or the patient's immediate environment.
- All staff followed the trust's uniform policy in clinical areas and had rolled-up sleeves or wore a short-sleeved top; staff did not wear wrist watches.
- We also observed staff avoiding the use of alcohol hand rub when it was necessary and using soap and water instead; this was usually when a patient had a known infection such as *C. difficile*, because soap and water is seen as a more effective way of removing certain germs from hands.
- Staff were observed wearing an apron and gloves for all patient contact.
- We observed staff, including nurses and designated cleaning staff, clean areas of the wards, including patient rooms. A standard process was used for cleaning patient rooms, which included cleaning every item within the room, including the insides of all drawers. A chlorine-based product was used for cleaning and disinfection when required.
- There was suitable provision of, and access to, hand-wash basins. One hand-wash basin was situated at the entrance to the unit and a further three were situated along the main corridor of the unit. Each patient room had a designated hand-wash basin and a separate sluice sink for emptying fluids down, not including body fluids. This was a positive finding, because it ensured that the hand-wash sink was used solely for hand-washing and that staff could easily wash their hands before patient contact and whenever necessary.
- Alcohol hand rub was accessible throughout the unit. The alcohol hand rub provided extra opportunities for staff to clean their hands if washing with soap and running water was not required.
- Data on unit-acquired infection from the Intensive Care National Audit and Research Centre for the period between 1 October and 30 December 2013 showed no concerning trends in terms of *C. difficile* infections or MRSA bloodstream infections.
- At the time of the inspection, the last MRSA bloodstream infection on the ICCU was in August 2013. Cases of *C. difficile* were confirmed in February, March, April and September 2014. There was concern that some of the cases were linked, but this turned out not to be the case.
- The unit had one Methicillin-sensitive *Staphylococcus aureus* (MSSA) bloodstream infection in the previous year, and the case was fully reviewed.
- For ventilator-associated pneumonia (VAP), four cases were confirmed between May 2012 and May 2013. VAP rates were running at around 2.3%, which is an acceptable level.
- We spoke with a band 6 staff nurse on the unit, who described audit activity for infection control. Hand hygiene audits were completed on a monthly basis. Audits regularly involved staff from other areas conducting the observations, which helped reduce the potential for bias.
- We reviewed the minutes of recent clinical governance update meetings for the ICCU; such meetings included audit and infection control as standing items on the agenda. The minutes of the June 2014 meeting showed hand hygiene audits at 100% compliance and compliance with cleaning nebulisers at 90%.

Environment and equipment

- The environment was in a good state of repair and designed in line with relevant Health Building Note specifications, including HBN57 (2003).
- A significant proportion of equipment was relatively new, including monitors, bed frames, mattresses and ceiling lifting hoists. Ten new beds were delivered in October 2013.
- Many of the syringe drivers in use were 14 years old; they were adequately maintained, but staff felt they were a risk because of their potential to fail mechanically.

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- The age of the ventilators was variable, but some were obsolete and parts were difficult to source. Staff expressed concern about the ageing ventilators and the risk of them failing mechanically
- Syringe drivers and ventilators were on the risk register and business cases had been submitted for the purchase of such equipment.
- The unit was spacious and had ample storage facilities.
- A specific equipment-replacement programme had been devised, but senior nursing staff thought that the required investment in equipment for the unit was not always suitably supported.
- Resuscitation equipment was easily accessible within all patient rooms, and there was one resuscitation trolley with a defibrillator for the whole unit. Staff said that one resuscitation trolley was adequate and it that was checked daily.

Medicines

- The unit used an electronic prescribing and dispensing system, which staff spoke positively about. We observed the system in use, and it was accurate and efficient.
- For controlled drugs, the electronic system had a thumb-print recognition system as a security measure. There was no need for a paper-based controlled drugs book.
- The unit did not have a dedicated pharmacist, but a business case had been submitted requesting one. Core Standards for Intensive Care Units (2013) recommends there should be at least 0.1 whole-time equivalent (WTE) band 8a specialist clinical pharmacist for each level 3 bed and for every two level 2 beds.

Records

- The trust was in the process of transitioning from paper-based healthcare records to an electronic patient record system; this had not yet been fully embedded into critical care.
- Healthcare staff, mainly nurses, were required to duplicate the vast majority of their records onto paper and onto the electronic patient record system. Nursing staff found it very time-consuming to duplicate records, which meant unnecessary time being taken away from direct patient care.
- We reviewed a proportionate range of patient records and found them to be comprehensive, adequately detailed and fully completed.

- We also reviewed communication records from multidisciplinary team meetings; they were comprehensive and detailed.
- The bedside green observation charts on the unit were completed accurately. We noted that staff visiting the unit also completed their sections on the chart as required.
- We reviewed the risk assessments used on the unit, and they included assessments around falls, nutrition, pressure sores and confusion. We found that such assessments were completed accurately and fully.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Opportunities for gaining written and/or verbal consent from patients on the ICCU were limited due to the severity of some patients' conditions and the fact that many patients were sedated or unconscious.
- Staff reported that much of the care provided to patients was in their best interests, and how for some medical interventions the patient's family and/or friends would be consulted.
- We observed examples where specific consent had been gained from a person's family; this related to fitting a tracheostomy.
- In relation to Deprivation of Liberty Safeguards and mental capacity, nurses we spoke with accurately explained the process for providing care where these issues needed to be considered. For example, patients sometimes attempted to pull out medical devices attached to them, which was not safe; in some circumstances, special mittens were placed on patients' hands to help prevent this.
- The unit's policy on 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders was easily accessible and contained specific questions to ask as a guide for staff in assessing someone's mental capacity.
- Nursing staff accurately described the process for applying mittens, and this included discussions with the multidisciplinary team (MDT) and family and friends, and documenting best-interest decisions in the patient's records.
- Confusion assessment method forms was also completed daily; confusion assessments were part of the unit's delirium pathway.

Safeguarding

Critical care

- Nursing staff we spoke with on the unit were able to accurately describe the procedure for reporting concerns around safeguarding. Staff knew where to access hospital procedures in relation to safeguarding and how to escalate concerns.
- The policy on safeguarding was easily accessible on the trust's intranet. Staff thought that the training they had received was sufficient to meet their needs.
- The name of the safeguarding lead on duty at a particular time could be found on the trust's intranet site.
- Staff described some examples of where they had liaised with safeguarding services to good effect.

Mandatory training

- For consultants, compliance with mandatory training was 100%. Compliance among trainee doctors was only slightly less.
- Medical staff could not apply for study days or incremental awards if they were not up to date with their mandatory and statutory training.
- The percentages for compliance with mandatory training for nurses were between 80% and 99%. The highest compliance figures were for infection control, safeguarding adults and falls. The compliance level for safeguarding children training was 88% and safeguarding adults training was 93%.
- The lowest training figures related to epidurals and patient-controlled analgesia, at 66 and 54% respectively. Compliance with resuscitation training was 75%. Maintaining high training percentages had been challenging, because the unit had recently employed 15 new staff.
- Four members of the critical care staff had recently been trained to provide resuscitation training in-house, which made the training more accessible.
- Mandatory training was a mixture of in-house face-to-face training and e-learning.
- The unit used one of its patient rooms as a dedicated simulation room where staff could develop their clinical skills and receive updates to their mandatory training.

Assessing and responding to patient risk

- In order to develop and monitor action plans in relation to deteriorating patients, a deteriorating patient group

was set up; the group was led by an ICCU medical consultant. The group was set up in response to concerns that patients were deteriorating on wards but not being managed effectively enough.

- If there were delays in responding to a deteriorating patient, the corresponding ward completed an incident form. If no harm had been caused to the patient, the incidents were downgraded; this meant that detailed analysis and feedback about such incidents was being missed.
- The unit used an emergency alarm system to enable staff to be promptly alerted if a patient required immediate attention; all nurses carried small alarms around their necks that were triggered in an emergency.
- The deteriorating patient group monitored the recording of early warning scores reported by ward staff, and how often they occurred, and also assessed how effectively early warning scores were responded to and acted upon. This work helped ensure that deteriorating patients on the ward were more effectively managed.
- Critical care had a trust-wide outreach team based in the unit. The service was available 24 hours a day, seven days a week. The outreach team responded to patients across the trust who had high early warning scores and supported ward staff in the management of such patients.
- The outreach team also reviewed, at least once, all patients who were discharged from ICCU back onto the ward.
- Obstetric patients on the delivery suite requiring post-operative level 2 high dependency care were effectively cared for on the delivery suite. The occurrence of obstetric patients requiring such care was, we were told, about once every four to six weeks.
- Obstetric patients requiring post-operative level 2 high dependency care were overseen by an obstetric consultant who linked in with the critical care medical team.
- Midwives were trained in providing level 2 critical care, but such care was not required on a frequent basis. There was a risk that the critical care skills of the midwives could have been affected because they were not applying them on a frequent basis.
- The obstetric department did not input data to a national audit programme such as that of the Intensive Care National Audit & Research Centre (ICNARC) for its critical care level 2 patients. We were informed that this was under review.

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- The critical care management team had no ongoing concerns with the set-up of the two Level 2 beds on the delivery suite. It was recognised that all level 2 patients, wherever they were located within the trust, should receive the same high standard of care as patients on a dedicated critical care unit; this concept is supported by national guidance from the Maternal Critical Care Working Group (2011).

Nursing staffing

- We reviewed nurse staffing levels, taking into account national core standards, the unit's acuity tool, the number of level 2 and 3 beds, and the views of staff. It was acknowledged that the unit was short of nurses; this was on the directorate's risk register.
- The staffing issue on the risk register stated that there was insufficient staff to operate 18 ICCU beds safely. Some of the surrounding issues were that the turnover of staff during 2013 was disproportionate and the staffing budget was insufficient. The staff budget had been reviewed as part of six monthly reviews and is not based on full occupancy.
- Since the staffing concern had been placed on to the risk register, some improvements had been made: five extra band 5 junior nurses had recently been recruited, along with two band 2 critical care support workers. Extra senior nurses had also been recruited to enable at least one band 6 or band 7 nurse to be working on each shift.
- The recruitment of the band 5 nurses had affected the staff skill mix, and there were a reduced number of fully competent and experienced critical care nurses. This was being managed, and an experienced nurse, the majority of the time, was on the unit actively overseeing and supporting the junior nurses.
- In addition, educational input for the junior nurses had been increased with the aim of building up their knowledge and competencies more swiftly.
- We were informed that band 6 nurses were always part of the staffing numbers required to provide hands-on care, and any supernumerary time was ad hoc; this wasn't always ideal, particularly when the junior nurses would have benefited from extra support. National core standards for intensive care units recommend that for units with between 11 and 20 beds, there should be at least one additional supernumerary nurse in addition to the clinical supervisor; a business case had been submitted to enable senior nurses to have some supernumerary time.
- The ICCU was not running at full capacity: it had been running at around 70 to 80% capacity for the previous three years.
- The safety of patients did not seem to be compromised by the existing staffing levels, and it was evident that progress was being made in terms of recruiting nurses.
- Because of the layout of the unit, and the separate rooms, we noted how the line of sight to patients was sometimes compromised if staff were supporting patients in their own rooms. If all nursing staff were supporting patients in their own rooms at the same time, other patients were not always being observed as closely as they should be. This was discussed with the some nursing staff, and it had been suggested that extra critical care support staff could be employed to support staff in observing patients on a more frequent and structured basis.
- There was a trust-wide staffing acuity tool in use, and the ICCU used a local system that the unit manager had developed. Patient dependency scores were completed each every shift, to include the number of nurses required for manager the dependency of the patients and the actual total for each shift; this information was used to populate the 'safe staffing' board in the visitors' area.
- On the days of our inspection, the number of nurses and healthcare support staff that the unit should have had did match the actual numbers of staff on duty. The main issue was whether the unit could be fully staff if and when running at full capacity.
- The number of agency nurses used was low. The last time an agency nurse was used was in February 2014.
- There was no staff bank of healthcare staff for the ICCU, but the unit had its own texting system whereby text alerts were sent to staff if extra shifts needed covering. Staff said that the texting system worked well.
- We observed how the staff team worked together, including observing nurse handovers.
- Three nurse handovers took place each day, which included the senior nurse from the existing shift handing over to all staff coming on duty. The handover included basic information about each patient and a team brief.

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- The handover between senior nursing staff was more detailed and included information about staffing issues, bed availability and other key issues.
- Handovers were comprehensive and were documented using specific handover sheets. Additional check sheets were used for unit safety issues such as cleanliness.

Medical staffing

- The complement of medical staff and the skill mix of the medical team were suitable and were in line with national guidance.
- There were eleven consultant grade doctors, with a 12th recently been appointed. There were six trainee doctors.
- The number of more junior trainee doctors varied; the ones we spoke with spoke positively of their learning and development on the unit.
- We observed medical handovers, including those led by a consultant; they were sufficiently detailed and comprehensive.
- Consultants worked in five-day blocks, which is in line with national recommendations and supports continuity of care. This is positive for both patients and nursing staff.
- There was dedicated overlap time between the day and night rota to allow for a detailed handover.
- We were informed that there was no formal handover system for tracking of at-risk patients not on the ICCU.
- The general hospital handover system was ad hoc: there was no formalised method (either electronic or paper based) of ensuring that those patients who were most unwell were reviewed over the weekend or out of hours.
- Patients were reviewed by a consultant within 12 hours of admission to the unit, including at weekends. Patients were then medically reviewed by a consultant at appropriate intervals, again including at weekends.
- The non-consultant-grade doctors and the nurses we spoke with felt that the cover arrangements and working patterns of the medical team were suitable; this included the access to a consultant out of hours, including at weekends.
- The consultant-to-patient ratio was in line with that recommend in national guidance. The unit did not use any locum doctors.

Major incident awareness and training

- Unit policies to manage major incidents and for business continuity were easily accessible to staff on the unit's intranet site.

- Staff we spoke with were aware of the above policies, how to access them and how to escalate issues during emergency situations.
- Staff confirmed they had received adequate training in relation to major incidents and business continuity.
- The unit took part in regular major incident scenarios and desktop planning with other local healthcare trusts; this provided invaluable opportunities to test the unit's policy and related protocols.

Are critical care services effective?

Good



The unit performed well in comparison with other similar units in terms of patient outcomes, and there were no concerning patient outcome figures. Nursing and medical practice was based on nationally recognised guidance, and best-practice methods were consistently applied.

The expertise of the medical and nursing team was evident. Excellent training and support processes were in place. The skill mix of the nursing team had changed as a consequence of a recent junior nurse recruitment drive; this was seen as an area for development, and work was underway to address it.

The input from the multidisciplinary team, and the way in which the team worked together, was outstanding; this included the way in which staff engaged with healthcare colleagues outside the unit.

Evidence-based care and treatment

- We reviewed a selection of policies on the unit's intranet site and out on the unit; they were based on up-to-date evidence, including guidance from the National Institute for Health and Care Excellence (NICE), relevant royal colleges and core standards for intensive care units.
- Some policies had not been reviewed within the necessary timescales. The process that ensured policies were reviewed was not effective.
- There were a number of examples where practice was supported by evidence-based guidance. Examples included how patients were rehabilitated (which was in line with NICE guideline 83, Rehabilitation after critical illness), the use of care bundles and Matching Michigan, which is a quality improvement project to reduce bloodstream infections.

Critical care

- The unit also used a relatively uncommon approach in the management of patients with acute renal failure and consequent renal replacement therapy. The unit and renal team used sustained low-efficacy dialysis instead of the more commonly used continuous venovenous haemofiltration; this had proven improved outcomes for certain patients.
- In monitoring adherence to local policies and procedures, we saw evidence of local audits for pressure sores, central lines, nutrition and blood transfusion.
- We saw evidence of changes in practice because of audit activity. For example, blood transfusion audits highlighted a need for change with the barcode reader, and the incidence of pressure sores had been reduced as a result of changes to practice.
- We noted some intermittent use of weaning plans, with some apparent variance in the weaning strategy for different patients.
- On patient charts, we noted which care bundles were ticked as having been considered by medical staff, and these included sepsis, deep-vein thrombosis prophylaxis, sedation holds, family updates, lines review, head elevation, weaning plans, resuscitation status review, glycaemic control and analgesia.
- The unit had exceptional results in relation to organ retrieval and was among the best in the region; the organ retrieval team had not missed an opportunity to approach a patient where organ donation was a possibility.

Pain relief

- The trust-wide acute pain team had input into the care of patients on the ICCU on a 'referred in' basis.
- In addition, a band 7 critical care nurse had 0.5 whole-time equivalent (WTE) of their role as a pain specialist for the unit, and provided extra support and advice.
- We reviewed a selection of patient charts and noted that pain scores were appropriately recorded.
- We also witnessed pain scores being discussed during ward rounds and staff handovers.

Nutrition and hydration

- In our review of patient records we noted accurate and up-to-date nutritional assessments using the Malnutrition Universal Screening Tool (MUST).
- National guidance recommends that for critical care there should be 0.05 to 0.1 WTE dietician per bed. The

ICCU went beyond this recommendation and had a full time dietician who was funded from the savings made from changes to practice, for example with total parenteral nutrition.

- The unit's dietician had made a positive impact on patient care, through close monitoring of patients' nutritional intake.
- Some innovative practice had been introduced. For example, some patients going to the operating theatre continued having nutritional therapy during their operations; this is currently not common practice.

Patient outcomes

- The unit contributed to the Intensive Care National Audit & Research Centre (ICNARC) case mix programme. The latest 'cleansed' data available went up to the end of March 2014.
- There were no significant outliers in relation to patient outcomes for recent data, but there had been for unit percentage mortality for much of 2012 for ventilated admissions. However, the figure was much improved for 2013, with the last figure for the fourth quarter of 2013 being below the average for other similar units.
- Unit mortality percentages for admissions with pneumonia were consistently above the average figures for other similar units during 2010, 2011 and 2012, but recent data showed that this had dropped below the average for other similar units for the fourth quarter of 2013, continuing the downward trend seen from quarter two of 2013.
- Early readmission and late readmission data showed no concerning trends. Post-unit hospital deaths in the latest figures (third and fourth quarters of 2013) were slightly below the average for other similar units.
- The trends in crude mortality for the unit closely matched that of the hospital's acute mortality. Mortality ratio data showed the unit's mortality rate as below that of similar units from the first quarter of 2013 to 2014 (for both ICNARC and APACHE II data), which was a positive outcome.

Competent staff

- Due to a number of experienced nursing staff who left the unit approximately 18 months ago, there was a disruption to the skill mix of the nursing team.

Critical care

- Relatively recently, there had been a recruitment programme for critical care nurses, and several band 5 nurses had started work on the unit. This had put additional pressure on existing experienced staff and educational staff, but good progress was being made.
- The educational lead described the education programme that was accessible to staff and the process that new starters followed. New band 5 nurses, for example, had four to six weeks working on the unit in a supernumerary capacity alongside an allocated mentor/preceptor.
- The nurses followed a specific critical care competency package that was a national training package. The nurses then continued with a foundation course in acute critical care, which was an in-house course, and then on to a university-based critical care course for between 1.5 and 2 years.
- There was slight concern about the status of and focus on new staff and the impact this was having on more senior staff and their own development.
- For critical care healthcare assistants, effective educational programmes were in place, including study days and educational sessions on the unit.
- Nurses we spoke with, including junior nurses, felt the education provided on the unit was suitable and they felt appropriately supported.
- Nurses described how senior staff, including the unit manager, were approachable and supportive.
- Nurses' annual appraisals were up to date. Staff described opportunities for clinical supervision, which included reflecting on practice and discussing issues at team meetings and team briefings.
- For medical staff, all the consultants were specifically trained in intensive critical care medicine under the Faculty of Intensive Care Medicine.
- There were six trainee doctors, all training specifically in anaesthesia and intensive critical care medicine.
- Consultants' appraisals were completed using an electronic system. All education, mandatory training and reflective work were entered into a pro forma.
- All critical care consultants had up-to-date appraisals and all had, or were undergoing, revalidation.
- Newly appointed consultants were not part of the medical on-call rota for their first month, and all were required to complete the trust's induction programme.
- New consultants were not required to work autonomously for their first month.

- All the critical care consultants employed at the time of the inspection had worked at the trust as senior trainees.

Multidisciplinary working

- We observed good multidisciplinary team (MDT) working; the unit had positive input from a range of healthcare professionals including doctors, nurses, physiotherapists, a dietician, pain nurses and a microbiologist.
- The above healthcare professionals were present during ward rounds, which meant the approach to patient care was holistic.
- We saw some positive examples of teamwork between disciplines; for example, renal physicians came to assess renal patients on the ICCU, and renal nurse specialists supported patients requiring renal replacement therapy on the unit.
- MDT governance update meetings were held on a monthly basis.
- All patients discharged from the unit to the ward had at least one follow-up visit from the critical care outreach team.
- The outreach team was accessible 24 hours a day, seven days a week, and worked closely with ward staff and the critical care team.

Seven-day services

- The amount of consultant presence on the unit in daytime met the recommended levels of intensive care medicine programmed activities.
- Both in- and out-of-hours junior doctor cover was at safe levels. The skill mix was suitable to cover emergencies, including airway emergencies.
- Out-of-hours cover during the week was provided by a consultant with sufficient intensive-care medicine experience, as per core skills requirements; the on-call consultant had no other clinical commitments.
- Staff, including nurses and trainee-grade doctors, said that on-call consultants were approachable and would come in from home if necessary.
- There was access to out-of-hours x-ray computed tomography (CT); the service was provided by the trust up until 6pm during weekdays and until 2pm at weekends. After those times, an external company provided the out-of-hours CT service.

Critical care

- There was access to magnetic resonance imaging (MRI) out of hours, including at weekends. Out-of-hours MRI facilities for patients under general anaesthetic were not available, but would be available in 2015.
- Access to x-ray facilities was available 24 hours a day, seven days a week.
- Physiotherapy was available through an on-call rota at weekends, as were pharmacy services.

Are critical care services caring?

Good



The team working on the unit were caring, patient-focused and compassionate; this was clear from our observations and from speaking with staff, relatives and patients.

Patients and relatives had good opportunities to provide feedback and influence the running of the service, in order to develop the experience of patients and relatives.

The support services available to both staff and patients were excellent and included access to psychology services and complementary therapies.

Compassionate care

- We observed a number of interactions between staff and patients or relatives, and staff were always polite, respectful and professional in their approach.
- We spoke with two patients during the inspection; both felt well informed about their care and treatment, and both described their care as excellent. Patients expressed no concerns about the care provided, and they felt staff were caring in their approach.
- We noted the compassion expressed to families if their family member died while in critical care. For example, nurses placed a locket of hair and the rings of the patient in a small silver bag, and handed a printed card to the family with sympathy from the staff on the unit.

Patient understanding and involvement

- Patients were invited to meetings in the unit to give their stories and provide feedback about their experiences.
- We observed examples on a noticeboard in the unit of 'you said, we did'. For example, patients said that

telephones on the unit were too noisy; this led to all nurses holding a cordless phone, which was individually assigned to patient rooms; the phone vibrated, which kept noise to a minimum.

Emotional support

- There was a specific team for rehabilitation of critically ill patients, and there were designated follow-up clinics for patients who had been on the ICCU. The rehabilitation team was able to signpost people to support services and other related health and wellbeing services.
- Complementary therapies were available to patients and relatives, including non-invasive acupuncture provided by a cancer charity.
- There was access to psychology and counselling services.
- Chaplaincy services were available, and the service also provided counselling services for staff.
- All critical care patients had a delirium score and were placed on a specific delirium care pathway if required; we observed this pathway in use during the inspection.

Are critical care services responsive?

Good



The unit was an integrated critical care unit, which meant it could easily flex between level 2 and 3 beds depending on demand. The staff group were also responsive to the changing needs of patients and worked effectively to manage the workload.

Delays for patients needing an intensive and high dependency care bed were minimal. The unit faced challenges with discharges back to the wards, however; this was because the hospital was frequently running at full capacity.

The outreach team was responsive to patient needs, both on the unit and across the trust, and worked well to support and educate staff.

Service planning and delivery to meet the needs of local people

Critical care

- The ICCU had been running at under full capacity for over a year. The availability of beds during busy periods was manageable; this was particularly so because the unit could easily flex level 3 beds up or down.
- Staffing the unit during busy periods had been a challenge. A text-message system had been introduced to help manage any shortfalls in staffing without the need to use agency staff.
- Consideration was being given to expanding the bed availability and occupancy of the ICCU, even though enough beds were available to meet demand at the time of the inspection.
- The outreach team was assessing more effective ways of identifying patients who would benefit from care on the ICCU rather than staying on a hospital ward and receiving outreach care; this had the potential to provide better outcomes for some patients and increase capacity on the unit.
- Patients with epidurals stayed overnight on the ICCU; there was potential to free up critical care capacity by enabling such patients to be managed on the ward.
- There were planned increases for vascular surgery at the trust, which would increase the demand for critical care beds; this was the main reason for increasing the unit's bed base in the future.
- The number of discharges from the unit during August 2014 was 62, and, for the same month, the number of delayed discharges was 36; well over half of all discharges were delayed, because there were no available ward beds in the hospital to discharge patients to.
- Some issues with delayed discharge were observed during the inspection, and one patient was discharged directly home and a second was delayed from returning to a ward for over two days. Critical care is not the ideal environment for patients who no longer require close healthcare intervention, and it can be a distressing environment to be in when fully alert and able to fully understand and see the care being provided to acutely unwell patients. However, because the pressure to admit patients to the unit wasn't significant, to keep some patients on the unit and not create upset by transferring patients was sometimes seen as an acceptable option and in the best interests of the patient.
- No elective surgical operations had been cancelled in the previous year due to capacity issues on the ICCU.

Meeting people's individual needs

- We spoke with two critical care nurses about how patients with complex needs were supported; this included people with specific learning needs or dementia. The nurses described how, in such instances, patients' carers and/or family members were valued in supporting the nurses in providing care and support.
- The nurses described how the unit was flexible, in many cases, with visiting times, especially when a patient needed a significant amount of extra support.
- The unit provided good facilities for patients' families and/or friends, and people could sleep overnight if required.
- Translation services were easily accessible, and staff were able to accurately describe the process for accessing such services.
- There was a large reception and waiting area for relatives, with two adjacent interview rooms. The area was staffed between 9am and 8.30pm seven days a week. The interview rooms provided privacy for families when having discussions with the healthcare team.

Learning from complaints and concerns

Access and flow

- The ICCU, during 2013, ran consistently under 80% occupancy. Occupancy was as low as 40% during June and July 2013, and was its highest in February 2014 at just under 80%. For the month of August 2014, capacity was at 64%.
- Intensive Care National Audit & Research Centre (ICNARC) data showed no concerning outliers in terms of early discharges, out-of-hours discharges, out-of-hours discharges to the ward, delayed discharges (four-hour delay) and non-clinical transfers out.
- There were no reported concerns with delays in patients accessing critical care beds.
- Delayed discharges (four-hour delay) showed a distinct upward trend from the second quarter of 2009 through to the fourth quarter of 2013. The figures fluctuated over that period, but the trend remained upward.
- Recent raw data, described by the unit manager, showed that the upward trend continued into 2014. In the region of 40 to 60% of discharges to the ward over the past 12 months had been delayed by over four hours.

Critical care

- The ICCU had a very low number of complaints. The vast majority of complaints were managed at a local level without the need for issues to be formally escalated.
- Complaints were reported at the division of theatres' monthly clinical governance update meetings.
- Learning from complaints was disseminated to staff through team briefs, formal team meetings and through monthly divisional updates.

Are critical care services well-led?

Good



The culture of the service was open and transparent, and staff spoke positively about how the unit was managed. The management team was aware of future challenges, in the short and long term, and was often proactive in its approach.

Governance processes were embedded, and the processes for managing risk were suitable. Staff and the public were effectively engaged and involved in making decisions about service planning.

There were several examples of innovative practice, including in the design of the unit, rehabilitation services, research, renal replacement therapy and electronic dispensing.

Vision and strategy for this service

- We spoke formally with the leadership team, including the divisional general manager, directorate manager, matron, unit nurse manager and clinical director. It was acknowledged that some progress was yet to be made in relation to vision and values.
- Time had been set aside in the forthcoming weeks to discuss the strategic and long-term plans for the service, taking into account the planned increases in vascular surgery and the proactive work being undertaken by outreach to increase patient throughput on the unit.
- There was ambition within the senior team to strive forward and provide the best service possible with the available resources; this included aiming to be the third main critical care centre in the region.
- The more short-term strategy was around improving the staffing skill mix and having fewer empty beds.

Governance, risk management and quality measurement

- From our discussions with a range of staff within the ICCU and directorate, and having observed and understood the governance processes, we determined that risk was managed effectively and quality was very much at the heart of the service.
- Strong feedback mechanisms within the service covered a range of items including incidents, complaints, patient/relative feedback and performance.
- Information flow between frontline staff and the divisional management team was effective. However, concern was expressed because clinical directors did not attend trust board meetings, and it was felt this weakened the direct links between the directorate and the board. There were 3 Clinical Director representatives on the Operations Committee which was a formal sub committee of the Trust Board.

Leadership of service

- From our observations, from speaking with staff, including the management team, and assessing the systems and processes in place on the unit, it was apparent that the leadership on the unit was effective and seen positively by staff.
- Senior nurses, lead consultants and directorate managers had good presence and visibility on the unit and were well known by staff.
- The leadership team was approachable, open and proactive in its approach.

Culture within the service

- The management team described how, in relation to culture, there was a strong emphasis on team work. The culture was described as open, transparent and supportive. Staff we spoke with in the unit confirmed this, and people felt supported and listened to.
- The management team explained that there was a sense of pride on the unit and everyone worked hard to ensure the best outcomes for patients.

Public and staff engagement







- The senior management team had a number of effective ways of engaging with staff, including at formal staff meetings, team briefings, informal discussions at handover, and monthly clinical governance update meetings, and by having a strong presence on the unit.

Critical care

- The unit also arranged social activities to encourage team building, including an ICCU-specific sports day.
- Information about the unit, including details of incidents and minutes of meetings, were all easily accessible to staff on the unit. Information was openly shared and discussed between all levels of staff.
- There was a positive emphasis on public engagement, and the facilities provided on the unit for families and friends supported this.
- A system was in place, supported by volunteers, to enable patients to provide real-time feedback about their experiences of being a patient at the trust; this was done using a computer tablet.
- Patients were also invited to divisional meetings to provide direct feedback about their care on the ICCU.
- The changes implemented as a result of patient feedback were displayed publically on the ICCU in the form of 'you said, we did'.
- There were several examples of innovative practice, including the design of the unit, rehabilitation services, research, renal replacement therapy and electronic dispensing.
- From a point of having no research portfolio two years ago, the ICCU recently became involved in national trials on the National Institute for Health Research portfolio.
- The research team was preparing to embark on a further two portfolio trials and one commercial phase-two drug trial.
- The unit was shortlisted in the 'best acute design' category of the Building Better Healthcare Awards.
- The leadership team and all staff, were focused on providing high quality care. Performance was closely monitored in a number of ways, including through patient feedback and more quantitative data.
- Sustaining a high quality service, and striving for excellence, was a key focus. Change was implemented where necessary to ensure the unit met the ever-changing demands being placed on it.

Innovation, improvement and sustainability

Maternity and gynaecology

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

Information about the service

The maternity service at Sunderland Royal Hospital delivered approximately 3,228 babies in 2013/14.

The service provides a 'labour, delivery, recovery and postnatal' model of care, which enables women to remain in the same room throughout their birthing experience. Five teams of community midwives deliver antenatal and postnatal care in women's homes, clinics, children's centres and GP locations across the city.

We visited the antenatal clinics, labour, delivery, recovery and postnatal wards, the obstetric theatre, high dependency unit and early pregnancy assessment unit. We spoke with 10 women and 39 staff including midwives, midwifery support workers, doctors, consultants and senior managers. We observed care and treatment and looked at five care records. We also reviewed the trust's performance data.

Summary of findings

Overall, we rated maternity services as good. The maternity department provided safe and effective care in accordance with recommended practices. Arrangements were in place to manage and monitor infection control, medicines and safeguarding procedures.

The maternity service used national evidence-based guidelines to determine the care and treatment it provided. There was a multidisciplinary approach that involved a range of providers across healthcare systems to enable services to respond to the needs of women. The service participated in national and local audits.

Resources, including equipment and staffing, were sufficient to meet the needs of women, although the ratio of midwives to women in labour was slightly lower than nationally recommended levels due to recent vacancies. Additional midwives were being recruited to address the staffing shortfalls. Medical staffing was in line with national recommendations.

There were occasions when capacity interrupted the provision of services in antenatal care and access to theatre for elective caesarean sections. This meant that women experienced longer waiting times or their operations were delayed. The maternity service had carried out service reviews, and plans were in place to improve these areas.

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The individual needs of women were taken into account in planning the level of support throughout their pregnancies. Feedback from women about the standard of care they received was positive.

The service was well-led. There was an open and transparent culture that encouraged reporting and learning from adverse events. Staff showed a strong commitment to patient care and treatment. There was evidence of public and staff engagement, and action had been taken following real-time feedback from women and staff. The service had been nominated for a number of awards in innovation and service improvement.

Are maternity and gynaecology services safe?

Good



The service was safe. Effective systems were in place for reporting, investigating and acting on adverse events. Midwifery staffing levels were below those nationally recommended, and additional midwives were being recruited. Medical staffing was in line with national recommendations.

Arrangements were in place to manage and monitor infection control, medicines and safeguarding procedures. Compliance was good for the number of staff completing mandatory training.

Incidents

- The trust's policies on reporting incidents, near misses and adverse events were embedded in the maternity services. All staff told us they were encouraged to report incidents.
- No Never Events were reported as having occurred in maternity services.
- Eight serious incidents had been reported for 2013/14, which were within the expected range for this size of service. These related to unexpected neonatal death, a medication incident, and intrapartum and intrauterine death.
- We looked at two root cause analysis investigation reports in response to serious incidents. The reports were comprehensive and in line with risk management procedures. The action plans showed that recommendations following the root cause analysis had been fully implemented.
- We saw a list of other incidents that were classified as causing no harm, or minor or moderate harm. These incidents were reported through the incident reporting system and included details of the investigation of the incident and the follow-up actions.
- The unit used a national trigger tool to identify and report incidents specific to maternity care. We observed one of the morning safety meetings, held each day and open to all clinical and managerial staff in the

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department. All antenatal intrapartum or postnatal cases triggering an alert on the trigger list were discussed. The meetings provided staff with an opportunity for learning and for sharing good practice.

- Monthly perinatal mortality and morbidity meetings were held. All serious cases, including stillbirths and neonatal deaths, were reviewed by a peer group. Minutes for April to June 2014 showed that recommendations to improve practice had included changes to clinical guidelines, training and documentation.
- A monthly newsletter for maternity services included lessons learned from incidents, complaints and claims, and this was actively disseminated to all staff.

Safety thermometer

- There was no evidence of the use of the safety thermometer in clinical areas. We discussed this with the directorate's manager, who told us that the unit was developing a safety thermometer specific to maternity risks to measure patient harms and harm-free care. The maternity service was piloting the national maternity safety thermometer. The directorate's manager told us that there had been no patient harms in the last six months.
- The performance report for obstetrics and gynaecology showed that between April and June 2014, 90 to 94% of women had received a venous thromboembolism assessment against a trust target of 95%. The sample of records we looked at showed that risk assessments for venous thromboembolism had been completed correctly.

Cleanliness, infection control and hygiene

- All areas in the maternity unit were visibly clean and well maintained. Cleaning schedules were in place, and there were clear processes for checking the cleanliness of the environment and for decontamination of equipment.
- Hand hygiene gel was available, and we observed staff washing their hands and adhering to the 'bare below the elbows' policy. An audit for June 2014 showed the directorate was 100% compliant in these areas.
- Records showed that 94% of midwifery staff had received infection prevention and control training against a trust target of 80%.

- There were no cases of methicillin-resistant *Staphylococcus aureus* (MRSA) bacterial infections or *Clostridium difficile* infections detected in the last six months in maternity services.
- All women received MRSA screening before undergoing elective caesarean section. Failsafe systems were also in place to identify women for hepatitis B and HIV at booking to ensure that they were managed on the correct care pathways.

Environment and equipment

- There was adequate equipment in the wards to ensure safe care (specifically, cardiotocography (CTG) and resuscitation equipment). Staff confirmed they had sufficient equipment to meet needs. A business case was in progress to purchase a central station for foetal monitoring, analysing and archiving, which would allow real-time review of CTGs.
- Wall-mounted resuscitaires did not have facilities for blended oxygen; however, staff confirmed that they would use portable resuscitaires for preterm babies of less than 32 weeks' gestation, which was in line with guidance from the Newborn Life Support Resuscitation Council (UK) (2010).
- Records for checking the functionality of equipment were correct in most areas; however, we found that the airway rescue trolley, which should be checked weekly, was last checked 10 days earlier.
- The service had made appropriate adjustments to ensure that women with a disability had appropriate access to facilities. This included adaptations to bathroom and toilet areas.

Medicines

- Medicines were stored correctly and appropriate checks were carried out. Records showed that the administration of controlled drugs was subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- We found that appropriate checks were carried out for epidural infusion pumps; however, epidural wastage was not being recorded in the controlled drugs book and staff were discarding epidural wastage in the sink. We discussed this with the operating department practitioner who told us that advice about disposal had been obtained from the trust's pharmacy department.

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- Fridge temperatures were checked in all clinical areas, and medication was stored within the correct temperature range.
- All midwives were practising under patient group directions (PGDs). (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicine(s) to a predefined group of patients without them having to see a doctor.) Records showed midwife exemptions were up to date and the PDGs we reviewed were in date until February 2016. There were signatures of all midwives competent to prescribe under a PGD.

Records

- Clinical records were completed to a good standard. Each record we looked at contained a clear pathway of care that described what women should expect at each stage of labour. When not in use, records were kept safely in line with the data protection policy.
- Due to the layout of the unit, there was a risk of breach of patient confidentiality because computers were outward facing on the delivery suite. To minimise the risk, VDU privacy screens had been purchased and staff were reminded to ensure that computers were not left on or unattended.
- Risk assessments had been conducted and identified any potential or actual risks.
- The child's health record (RED book) was completed correctly and given to parents before discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was obtained from patients appropriately and correctly. Records showed that women were given choices about their care, and that the risks, benefits and alternative options were discussed. The consent process was supported by written information.
- A consultant obstetrician and head of midwifery were identified as leads for mental capacity and Deprivation of Liberty Safeguards. Staff told us they had received training in these areas and would obtain further advice and support from the trust's mental health team.

Safeguarding

- Staff had a good understanding of the need to ensure that vulnerable people were safeguarded in maternity services. Also, staff understood their responsibilities for identifying and reporting any concerns.

- The head of midwifery was the named midwife for safeguarding; however, the service had identified that insufficient dedicated time was provided. Following a gap analysis, additional midwifery hours had been identified to support safeguarding processes.
- Safeguarding training was mandatory staff. We saw from training records 92% of midwifery staff and 85% of medical staff had received level 3 safeguarding children and young people training up to the end of March 2014.

Mandatory training

- Staff received protected time to attend mandatory training over a three day period. The training covered a number of topics which included obstetric emergency skills training, adult and neonatal resuscitation.
- Compliance with mandatory training was good. There was a dedicated practice development midwife who monitored attendance and organised training sessions. Training records for July 2014 showed that over 90% of staff were up to date with their mandatory training. This was against a trust target of 80%.
- Midwives who were newly qualified undertook a period of preceptorship. During this time they had access to extra support and training.

Assessing and responding to patient risk

- The service used the Modified Early Obstetric Warning Score (MEOWS). This assessment tool enabled staff to identify and respond to the need for additional medical support if required. The MEOWS identified directions for escalation, and staff were aware of the appropriate action to take if patients scored higher than expected. We looked at completed charts and saw that staff had escalated correctly and repeat observations were taken within the necessary time frames.
- Arrangements were in place to ensure that checks were made before, during and after surgical procedures in accordance with best-practice principles. This included completing the 'five steps to safer surgery' World Health Organization (WHO) surgical safety checklist in operating theatres. We observed the use of the checklist in obstetric theatres and found that all five stages were completed correctly. . A retrospective case note audit carried out on 10 sets of records 1 April – 30 June 2014

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showed that most areas of the checklist were completed. However, action had been identified to improve areas relating to 'time out' before skin incision took place.

- Maternity had three high dependency unit beds providing up to level 2 care, which were staffed by registered nurses and midwives with input from anaesthetic medical staff. Risk assessment tools were used to ensure timely referral to the high dependency unit beds for women developing a critical illness during or after pregnancy. Midwives at band 7 and some of the core band 6 midwives had received training in the foundations for critical care to manage women with complex, high risk needs.
- The unit used the 'fresh eyes approach', a system that required two members of staff to review foetal heart tracings; this reduced the risk of misinterpretation.

Midwifery staffing

- The births to midwives ratio was 1:30 against a nationally recommended ratio of 1:29. The service was recruiting additional midwives to address the staffing vacancies.
- There was a safe staffing and escalation protocol to follow if staffing levels per shift fell below those in the agreed roster. There were also daily reviews of staffing levels and monthly staffing establishment meetings.
- The service aimed to provide 100% one-to-one care for women in labour; however, staff told us that this was not always achieved. During the inspection, we did not receive details of any concerns from women, who confirmed that they had received one-to-one care throughout their labour.
- Staff reported good cross-department working, and any gaps in the rota were filled with internal bank staff. The unit did not use agency staff.
- The ideal and actual staffing numbers were not displayed on the unit. Staff told us that transparency boards were on order.
- Verbal handovers took place to the oncoming team at the change of each shift. There was also a one-to-one handover from the midwife who had provided care to the midwife taking over. This occurred at the woman's bedside.
- There was a lack of formal handover of care for interdepartmental and intradepartmental transfers using formal handover tools such as Situation, Background, Assessment, Recommendation (SBAR).

Clinical information was discussed informally between staff and documented in the clinical notes. The service had identified this as a risk and planned to pilot the implementation of the SBAR tool.

Medical staffing

- Consultants were present on the labour ward for 66 hours a week, which was in line with national recommendations according to the number of babies delivered on the unit per year. Consultants were present from 8.30am to 8.30pm Monday to Friday and from 9am and 12midday over the weekend. Consultants were on call outside the hours when they were present on the unit.
- The unit was not overly reliant on locum medical staff and only used locums who had previously worked in the unit.
- There was 24-hour anaesthetics cover.
- The results for the General Medical Council's national training scheme survey 2013 showed that junior doctor's workloads and overall satisfaction were 'within expectations' for this trust. No concerns were raised regarding junior doctors' rotas, and robust systems were in place to monitor junior doctors' working hours.

The college tutor told us that maternity services had scored the highest in the region for junior doctors' training in 2014.

- We observed a medical handover from the night team to the day team. The handover was attended by the consultant and junior medical staff and also included the midwifery coordinator and gynaecology medical staff. The handover was comprehensive and included feedback regarding postnatal women, women receiving midwifery-led care and gynaecology patients.

Major incident awareness and training

- Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were clear escalation processes to activate plans during a major incident or internal critical incidents such as shortfalls in staffing levels or bed shortages.
- The trust had major incident action cards to support the emergency planning and preparedness policy, which staff in maternity services were aware of.

Maternity and gynaecology

Are maternity and gynaecology services effective?

Good



The maternity service used national evidence-based guidelines to determine the care and treatment it provided. A multidisciplinary approach to care and treatment involved a range of providers across healthcare systems to enable services to respond to the needs of women. The service participated in national and local audits.

A process was in place to identify the learning and development needs of staff. Staff had received appraisals and there was a proactive approach to midwifery supervision. Patient outcomes were in line with national expectations.

Evidence-based care and treatment

- The delivery of care and treatment was based on guidance issued by professional and expert bodies: the maternity services used a combination of National Institute for Health and Care Excellence (NICE) guidelines (for example, QS22, QS32 and QS37) and Royal College of Obstetricians and Gynaecologists guidelines (for example, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) to determine the treatment they provided.
- Local policies were written and reviewed in line with national guidance and monitored through the maternity guidelines group; however, we found that some guidelines on the intranet were not the most up-to-date versions.
- The service participated in national and local clinical audits. The audit lead told us that staff were encouraged to put forward their own ideas for audit. An annual audit programme included topics such as care of women with diabetes, antenatal care of women with previous caesarean sections, and postnatal review of women with perineal problems. Audit monitoring reports showed that recommendations had been made, such as improved access to clinics and changes to guidelines and documentation.
- There was an active research programme: the trust had a team of six research midwives. Two research midwives coordinated national obstetric clinical trials, working

closely with the universities and the clinical research network. Ten trials were in progress. Information about the studies were presented in antenatal areas and information leaflets.

Pain relief

- Women were given information about the pain relief options available to them.
- Various forms of pain relief were available for women giving birth; options included drug-free methods, for example use of the birthing pool.
- There was a 24-hour epidural service.

Nutrition and hydration

- Women had a choice of meals, which took account of their individual preferences, including religious and cultural requirements; for example, menus included halal options.
- Meal times were protected but there was flexibility to obtain food outside set times for postnatal women attending the neonatal unit or for unexpected admissions.
- A public health midwifery specialist and a team of peer support workers at the hospital and in the community provided advice and support for women who chose to breastfeed. The service had achieved level 2 UNICEF Baby Friendly accreditation and was working towards level 3. (The UNICEF Baby Friendly initiative is a worldwide programme that encourages maternity hospitals to support women to breastfeed.) Figures showed that breastfeeding initiation rates had increased from 29% to 54%.

Patient outcomes

- In the last 12 months there had been 3,228 deliveries at this hospital.
- Normal delivery rates were higher than those reported nationally.
- The trust had lower rates of caesarean sections compared with national figures.
- No risks were identified for the number of maternal readmission rates, neonatal readmissions and puerperal sepsis.
- The service participated in the Royal College of Obstetricians and Gynaecologists' 11 maternity quality indicators. There were no areas of concern in relation to performance against all 11 quality indicators.

Maternity and gynaecology

- The proportions of delivery methods were mostly in line with national expectations.
- There were 51 incident forms completed for unplanned admissions to the neonatal intensive care unit (April 2013 to March 2014).
- There was one maternal unplanned admission to the intensive therapy unit (April 2013 to March 2014).

Competent staff

- Staff received support to develop and maintain the skills needed to provide safe and effective care.
- The North East Local Supervising Authority's annual report to the Nursing and Midwifery Council for 2013/14 indicated that the range of caseloads held by supervisors was from nine to 13 midwives, which was in line with the recommended ratio of 15 midwives for each supervisor. All midwives had 24-hour access to supervisors. Eighty per cent of annual supervisory reviews were reported on the local supervising authority's database, and an action plan was in place to achieve 100%.
- Supervision was positively evaluated by midwives, who said they were able to contact supervisors at any time for guidance and support. Student midwives also told us they received good support from their supervisors and had the opportunity to become involved in the care of women to develop their skills while under the supervision of a midwife.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They told us they had good ward-based teaching, were well supported by the ward team and could approach their seniors at any time if they had concerns.
- Staff told us they received annual appraisals. Figures for April to June 2014 showed that 86% of midwifery and 100% of medical staff had received an appraisal.
- The unit participated in the UK National Screening Committee's antenatal and newborn screening education audit. Figures showed that blood testing rates for newborns had been above the national average; the screening coordinator had addressed this, and told us that avoidable repeat rates had reduced from 4.9% to 2.1%.

Multidisciplinary working

- Close and effective integrated working was evident between hospital- and community-based midwives. Community midwives rotated between the community and hospital birthing unit one day a week.
- There were clear processes for multidisciplinary working if a woman in labour was transferred by ambulance or transferred from a home birth to hospital, or for postnatal transfers to another unit.
- The postnatal ward had no transitional-care cots for babies requiring additional support; however, staff worked closely with the neonatal unit to care for babies who required additional clinical interventions such as administration of intravenous antibiotics.
- Obstetric staff said they received excellent support from the neonatal unit and could obtain advice at any time.
- There was a good communication and referral process between the hospital and GPs,

Seven-day services

- There was sufficient medical cover out of hours. At weekends, consultants were present on the labour ward from 9am to 2pm.
- The antenatal day unit had extended its opening times to provide a six-day service. Access to the early pregnancy assessment unit, which is a 7 day service, includes facilities for urgent scans out of hours.
- There was a rota to provide a theatre team for obstetrics 24 hours a day.
- Access was available to pharmacy and diagnostic services.
- A designated physiotherapist for women's health was present on the unit and routinely saw all women following caesarean sections and third and fourth degree tears.

Are maternity and gynaecology services caring?

Good



Maternity and family planning services were caring. Women spoke positively about their treatment by clinical staff and about the standard of care they had received. Staff interacted with women in a respectful way and provided compassionate care.

Maternity and gynaecology

Women were involved in their birth plans and had a named midwife.

Compassionate care

- In the Care Quality Commission (CQC) maternity services survey 2013, 133 women who delivered their babies at Sunderland Royal Hospital responded. (The response rate was 46% nationally.) The results showed that, in answering the majority of questions relating to antenatal care, labour, birth and postnatal care, respondents rated Sunderland Royal Hospital about the same as the results for other trusts, with the hospital performing better than other trusts in areas relating to information given to women and staff introducing themselves.
- Response rates to Friends and Family tests for antenatal, birth and postnatal experiences were above the England average. Results of the Friends and Family test for July 2014 showed that the majority of women were 'extremely likely' or 'likely' to recommend the service to their family or friends.
- All women spoke positively about their treatment by clinical staff and the standard of care they had received.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful manner. Arrangements were in place to ensure privacy and dignity.

Patient understanding and involvement

- Women told us they were involved in developing their birth plans and had received sufficient information to enable them to make choices about their care and treatment during labour.
- Staff told us they discussed birthing options with women at the time of booking and would accommodate requests where possible, following a risk assessment. We noted that the rate for home births was low (0.8%). The matron told us improvements had been made to ensure women were aware of the choice about place of birth. This included a dedicated section in the handheld records to prompt questions about birth options, along with a promotional DVD available on the internet to inform women about their birth choices.
- Women had access to their paper records throughout their pregnancy.
- All women had a named midwife.

- Women said they felt well supported and cared for by staff, and that their care was delivered in a professional way.

Emotional support

- Staff held debriefing and resolution meetings with women to discuss any concerns relating to their care and treatment, and referrals were made to counselling or other specialist services where required.
- The unit had no dedicated bereavement facility, although there was one single room that could be used if required. The trust is looking at options to reconfigure an existing facility to accommodate a dedicated bereavement suite.

Are maternity and gynaecology services responsive?

Good



The service was aware of the risks to ensure that services were planned and delivered to meet increasing demands. There were occasions where capacity interrupted the provision of services in antenatal care and access to theatre for elective caesarean sections; this meant that women experienced longer waiting times or their operations were delayed.

The service responded to the needs of vulnerable patients. Specialist midwives provided support.

Complaints were handled in line with the trust's policy. There was learning from complaints and concerns, and action was taken to improve services where required.

Service planning and delivery to meet the needs of local people

- The service was aware of its risks to ensure that services were planned and delivered to meet the increasing demands of the local and wider community. It worked with local commissioners of the service, the local authority, other providers, GPs and service users to coordinate and integrate pathways of care.
- Service specifications were in place that detailed the aims, objectives and expected outcomes for women;

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these were monitored against national and local performance indicators. Outcomes showed that women were, on the whole, receiving a good quality maternity service.

Access and flow

- Bed occupancy rates in maternity services between April and June 2014 were at 58%, which was similar to the England average of 59%.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests required.
- Midwives were available on call 24 hours a day for advice. Community midwives were integrated within the service.
- GPs were informed of a woman's discharge from postnatal care, which are currently printed to send to the GP.
- Sunderland offered a 'labour, delivery, recovery and postnatal' care model facilitated by multidisciplinary teams (MDTs). Women were assigned to a particular team and received all their care within the labour, delivery, recovery and postnatal area, which ensured continuity of care.
- We visited the antenatal day unit and found that capacity and demand sometimes affected women's access to and flow within the unit. One woman said she had been waiting for over an hour to see the doctor. We discussed this with the unit manager, who told us that the antenatal day unit consistently over performed with regard to expected patient attendances. The unit manager had undertaken a six-month review of workload, patient to staff ratios, analysis of clinical referral criteria and use of the day unit, which had been sent to the senior management team for approval.
- The unit had access to one emergency obstetric theatre, which meant that women admitted for elective caesarean sections might be delayed or lists deferred due to emergency admissions. Staff told us that this happened approximately once a month; however, the unit did not collate data on the number of times this occurred. During the inspection, we found that the elective caesarean section list had been deferred until the following day. We discussed this with the clinical director, who told us that a business case for a second theatre was almost completed and the theatre would be

incorporated as part of the trust-wide strategy for reconfiguring maternity services. The need for a second theatre was included on the obstetric risk register, which indicated that plans and costings had been received.

- Of pregnant women accessing antenatal care, 68.8% were seen within 10 weeks and 94% seen within 20 weeks. Performance was monitored through the corporate dashboard, which indicated a key performance indicator that 90% of patients should have access to midwifery care within 12 weeks and six days. Each month, the directorate monitored and validated patients who did not appear to have been seen within 12 weeks and six days to determine whether this was due to accessibility of midwives or to patient choice/genuine late bookings. The service confirmed that monthly validation (plus feedback from the community teams) did not suggest capacity issues, and that patients were either choosing to book at their convenience or did not find out they were pregnant until a later date. One objective of the service was to support women in accessing antenatal care, ideally within 10 weeks, and the trust was working towards this.
- The unit did not have to close in 2013/14 due to overcapacity.

Meeting people's individual needs

A range of information leaflets were available in clinical areas including tests and screening, breastfeeding and sources of support. The service responded to the needs of vulnerable women. A number of specialist midwives provided support in areas such as teenage pregnancy, substance misuse and domestic violence. The service offered a holistic approach by developing an enhanced care pathway based on individual needs, in partnership with community midwives.

- There was no specialist perinatal mental health midwife; however, the service had good access to a recently appointed psychiatrist with a special interest in perinatal mental health, and staff attended perinatal mental health training as part of their mandatory training programme.
- The team of midwifery supervisors led on the normality agenda for women and actively promoted normal births through the normal birth champion group, supporting women and midwives with normality initiatives.

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- Smoking cessation clinics were led by a public health midwife and had seen a reduction of smoking from 43% to 17%. Smoking cessation pathways were in place, and baby clear CO2 assessments were undertaken in the antenatal clinic.
- Women identified with high risk needs were referred to specialist MDT clinics such as epilepsy and diabetes.
- Staff told us they had good access to the trust's learning disability team, who provided advice and support where required. Processes were in place to identify women with learning disabilities using a vulnerability assessment protocol. Staff encouraged family and key workers to be involved in the care pathway, and extra time was allocated for clinic appointments.
- There was access to a telephone translation service, and interpreters could be booked for face-to-face consultations.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Information was given to women about how to make a comment, compliment or complaint. Processes were in place for dealing with complaints at ward level or through the trust's Patient Advice and Liaison Service.
- The directorate manager of obstetrics and gynaecology told us that the number of complaints for obstetrics and gynaecology had reduced from 50 in 2012/13 last year to 25 in 2013/14.
- The July 2014 board performance report showed that maternity was an outlier for responding to complaints within 90 days. We discussed this with the manager of the directorate, who told us that action had been taken to reduce the backlog.
- Learning from complaints and concerns was discussed at monthly and weekly governance and risk management meetings. Action taken following complaints included changes to the environment, training in customer care and the development of a new early pregnancy assessment pathway.

Are maternity and gynaecology services well-led?

Good



The service was well-led. Management structures showed clear lines of accountability. There were effective

governance and risk management procedures to ensure that poor quality care was reported and improved. An open and honest culture encouraged reporting of and learning from incidents and adverse events.

Staff showed a strong commitment to patient care and treatment. There was evidence of public and staff engagement, and action had been taken following real-time feedback from women and staff. The service had been nominated for awards in innovation and service improvement.

Vision and strategy for this service

- The strategy for obstetrics and gynaecology services aligned with the trust's strategic planning process for 2014/17. The strategy was part of the trust's 'Accelerating the Bigger Picture' strategy, which included a programme to expand maternity services, ante-natal clinic, and a second theatre to accommodate medium and high risk births from South Tyneside. The senior management team told us the board supported this vision and its business priorities.
- Staff were aware and engaged with this vision and strategy.

Governance, risk management and quality measurement

- The maternity risk management strategy set out clear guidance for reporting and managing risk. It detailed the roles and responsibilities of staff at all levels to ensure that poor quality of care was reported and improved.
- A maternity risk register was in use and monitored on a monthly basis. Processes were in place for escalating risks to the trust's board when required.
- Monthly governance meetings were held where incidents, complaints, claims, audits and guidance were discussed. Two dedicated risk management midwives reviewed and responded to risks on a daily basis. Staff were kept up to date with this information through newsletters, staff meetings and team briefings. Most of the staff we spoke with had a good understanding of the areas of risk within their areas.
- The service used a data collection tool to identify and benchmark risks against national indicators; however this wasn't integrated into a maternity dashboard as recommended by the Royal College of Obstetricians and Gynaecologists as good practice. (The dashboard is a clinical performance and governance score card and

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helps to identify patient safety issues in advance.) The clinical director told us that there were problems with extracting and accessing data from the existing systems to populate the dashboard, and that action was being taken to rectify this.

- The risk management midwife had organised a separate debriefing meeting to provide staff with support following an adverse event. Junior doctors were also encouraged to seek support from their allocated educational supervisor.

Leadership of service

- **The service ran with a triumvirate directorate management structure consisting of the clinical director, lead midwife, and matron overseen by a divisional manager. Quarterly management reviews were in place to monitor quality and performance.**
- Staff were aware of their roles and responsibilities. Management structures showed clear lines of accountability. We noted that the head of midwifery's job title was 'lead midwife'; we were told that there were plans to change this to 'head of midwifery', which would clarify managerial roles and responsibilities.
- Trainee doctors told us they received good support from senior staff and felt the department was well run, organised and friendly.
- Most staff told us that the chief executive and director of nursing were visible and had carried out safety walkabouts on the wards.

Culture within the service

- We observed strong team working, with medical staff and midwives working cooperatively and with respect for each other's roles. They told us the trust was a good place to work.
- Staff reported that managers operated an 'open door' policy for them to raise any issues or concerns. Staff felt confident that these would be acted on.
- Staff sickness levels were within expected numbers.
- We saw a strong commitment to patient care and treatment.

Public and staff engagement

- The service obtained real-time feedback from women. Most comments showed a high level of satisfaction with the service. The unit had acted on feedback; for example, improvements had been made to the environment to enable partners to stay overnight post-delivery, and a birthing pool had been introduced.
- The service had links with teenage pregnancy groups and worked closely with the children's centres.
- The service took account of the views of women and their families through the maternity liaison services committee, a multidisciplinary forum where comments and experiences from women were used to improve standards of maternity care. Minutes of the meeting in August 2014 showed that a launch event was being organised to encourage parents of children aged two years and under and pregnant women to attend. Issues from the maternity liaison services committee were fed back through the clinical governance group up to the board.

Innovation, improvement and sustainability

- Evidence showed that staff were encouraged to focus on improvement and learning. For example, midwifery staff were currently reviewing the 'labour, delivery, recovery and postnatal' model of care, and reconfiguration of the unit's layout to improve the environment and patients' access and flow.
- We saw areas of innovative practice. The antenatal services manager and members of the clinical team had project-managed the use of a telehealth system (the delivery of health information using telecommunications technology). This system enabled women to monitor their blood glucose levels and blood pressure in their own homes, avoiding unnecessary visits to the clinic. The project had been nominated for an innovation award.
- The service had been shortlisted as a finalist for the CHKS Excellence in Maternity Care Award 2014.

Services for children and young people

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Good	●
Well-led	Outstanding	☆
Overall	Good	●

Information about the service

The directorate of paediatrics and child health is responsible for services for children and young people at City Hospitals Sunderland. Services include three children's wards: F63, a 26-bed ward for children receiving elective and emergency surgery; F64, a 22-bed ward for paediatric medical admissions aged two years and over; and F65, a 12-bed cubicle-based ward for babies from birth to two years of age. The service includes the Niall Quinn children's centre (children's outpatient department) and the neonatal unit, which includes eight intensive/high dependency cots, two mother and baby rooms, two cubicles and 12 special care baby cots. The directorate also provides community paediatric services and hosts statutory safeguarding children posts.

The hospital serves a population of 80,351 children and young people, which accounts for 17% of the area's population.

There were 3,500 non-elective and 500 elective paediatric medicine admissions within the last 12 months. In addition, there were 2,072 paediatric surgical admissions (all specialties). The outpatient department saw 4,500 new attendances along with 10,000 follow-up review attendances.

During our inspection we visited all clinical areas where children were either admitted or which they attended on an outpatient basis, including the neonatal unit, wards F63, F64 and F65, the Niall Quinn children's centre and the children's emergency department and short-stay

assessment unit. We talked with 30 medical staff and 30 nursing and allied healthcare professionals, and examined 15 medical/nursing records. We spoke with 24 children and parents.

Services for children and young people

Summary of findings

We rated the areas of 'safety', 'effectiveness', 'caring' and responsive as good, with 'well-led' as outstanding.

The children's services actively monitored safety, risk and cleanliness.

The levels of nursing staff did not meet nationally recognised guidelines, although this did not have a negative impact on patient care. There were challenges regarding the numbers of some medical staff, but these were being managed.

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

Children, young people and parents told us they received compassionate care with good emotional support. They felt fully informed about and involved in decisions relating to the patient's treatment and care.

We found that the children's service provided good access to and flow within its services. This was achieved in part through close collaborative working between the directorates of paediatrics and emergency medicine, which had developed a shared medical consultant staffing approach that included consultant staff qualified in paediatric emergency medicine. We also found that the service had a range of facilities and approaches to ensure that the needs of local families were met.

The leadership was outstanding and the service was extremely well-led. There was a clear vision and strategy for the service, which was led by a strong management team who worked together. They were clear on how they wanted to develop the service and staff were engaged and enthusiastic about this. The service regularly implemented innovative improvements with the aim of constantly improving the delivery of care for children and families. The service had facilitated the inspection of services by a team of young inspectors, which was excellent practice.

We found a positive, open and friendly culture at the service. Staff placed the child and the family at the centre of care delivery, and this was seen as a priority and everyone's responsibility.

Services for children and young people

Are services for children and young people safe?

Good



Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms. Staff told us that they received feedback about incidents they had reported to the trust.

We found that risks were regularly assessed and monitored, and control measures put in place. We found that all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. Medicines were stored and administered correctly. Medical records were handled safely and protected. Managers and staff demonstrated a clear awareness of the referral processes they must follow if a safeguarding concern arose.

Members of staff of all grades confirmed that they received a range of mandatory training. The service's ability to recruit suitably qualified staff was good. Sickness rates were low. During 2014 levels of nursing staff sometimes fell below nationally recognised guidelines, but we did not identify evidence to demonstrate that this had a negative impact on nursing care. The trust faced challenges regarding specialty trainee doctor staffing but had plans in progress to manage this issue.

Incidents

- Staff demonstrated an awareness of how to report incidents using the trust's reporting mechanisms. The management team and ward managers in all clinical areas felt their staff were good at reporting incidents. Staff in children's services told us that they received feedback about incidents they had reported to the trust.
- Minutes of meetings of the directorate of paediatrics and child health governance committee showed a standing agenda item for discussing incidents. The ward manager from ward F64 collated a quarterly incidents and risks report on behalf of the clinical areas; this included an outline of the incident along with the investigation and learning that had taken place. Minutes of directorate meetings demonstrated that reports had been fed back and discussed at governance meetings.
- We reviewed submitted incident data for the children's services for the period from May to July 2014. A total of

101 incidents had been reported. The severity of the incidents had been rated as minor harm (32), no harm (66) or moderate harm (3). The three incidents assessed as moderate harm had been appropriately investigated.

- The matron gave examples of how learning had taken place following incident investigations. For example, following an incident involving the use of restraint, a learning event had been arranged at which the police talked about their role in the use of restraint.

Cleanliness, infection control and hygiene

- We found that the children's wards (F63, F64, F65), Niall Quinn children's centre (children's outpatients) and the neonatal unit were kept very clean and tidy. Various infection-prevention measures were in place, such as multiple wall-mounted hand gel dispensers and hand-wash sinks.
- We observed, during our inspection of all clinical areas, members of medical, nursing and other staff regularly performing hand hygiene measures.
- Regular hand-hygiene audits and infection-control audits were undertaken in the clinical areas. For example, we reviewed a completed infection prevention audit tool for ward F64, completed on 1 July 2014, which demonstrated that a thorough audit had been undertaken and recommendations made where required. The audit showed an overall compliance rating of 93% and actions included the identification of some 'dusty' areas and the repair of a freezer door in the parents' room. The neonatal unit also held evidence of regular cleaning checks and other audits.
- Minutes of the directorate's clinical governance meetings included regular feedback regarding infection control and prevention.
- Each area in the service had nominated members of nursing staff who acted as infection control link nurses. The infection control link nurses shared information at staff meetings and ensured that staff maintained correct infection control procedures.

Environment and equipment

- We saw and staff told us that all clinical areas had a wide range of clinical and other equipment to assist them in providing care for children and young people. Records showed that the trust's electronic bureau medical equipment department regularly tested and serviced equipment.

Services for children and young people

- We reviewed records that demonstrated that members of staff had received training in the use of new medical equipment.
- All the children's clinical areas we visited had suitable resuscitation equipment available, which had been checked regularly by members of staff.
- The matron explained how learning had taken place regarding the use and management of equipment. For example, a plastic cable tie on a particular piece of equipment tubing had scratched a baby. The incident was reported to the manufacturer, who, as a result, has changed the cable tie to soft Velcro across all hospitals where the equipment was in use.
- We found the children's wards to be spacious, well lit and uncluttered. The area had various facilities for children, young people and families. For example, there was a large play area.
- Additional facilities had been developed to meet the individual needs of children; for example, there were nominated areas and bed spaces for adolescents on ward F64.

Medicines

- We reviewed a sample of electronic treatment records on the children's wards and neonatal unit and observed the administration of medications. We found that medicines had been appropriately stored, checked and administered in the clinical areas where children received inpatient care.
- Minutes of the directorate's clinical governance meetings showed that any medicines management incidents were investigated and discussed.
- The controlled drugs register had been appropriately completed according to the hospital's policy.
- The matron explained how a drug matrix was completed whenever a drug incident was reported. This document reviewed what had happened and how it might be avoided in the future. A rating was recorded that would tell the matron how to manage learning and actions from the incident; for example, the score might suggest an interview with the nurse followed by training.

Records

- Each of the clinical areas we visited had a ward clerk/administrative staff, who we observed carefully

managing clinical records. We found that records were stored securely during our inspection. For example, medical records were securely sealed in a special notes bag to move them around the hospital.

- We found that the respective paediatricians and surgeons had appropriately completed paper-based medical records.
- Nursing documentation was completed electronically and included an assessment of the child or young person's daily activities, which had been individualised where needed to reflect the child's and family's needs.
- Nurses maintained detailed evaluation records in the medical notes by for each span of duty. This meant that the nursing evaluation and each medical review entry were written at the same time, alongside each other, so that it was clear what treatment and care the child had received and what the child required.

Consent

- The children's service included a dedicated surgical ward (F63) for a range of specialties, including general surgery, orthopaedics, dental, and ear, nose and throat.
- The surgical ward held pre-assessment clinics for the majority of elective surgery, which meant that consent was most commonly recorded before the day of surgery. The parent and child (who can understand the proposed surgery) therefore had sufficient time to weigh up the benefits and risks of surgery.
- We reviewed a sample of five records where consent had been obtained before surgery, and found that these had been appropriately completed, dated and signed by the doctor/surgeon and parent. We also observed that consent already obtained was confirmed on the day of surgery.
- Staff we talked with showed that they understood the Gillick competency standard surrounding consent for children. Staff explained that the consent process completed by surgeons actively encouraged young people to be involved in decisions about their proposed treatment.

Safeguarding

- Managers and members of staff within children's services demonstrated a clear awareness of the referral processes they must follow if a safeguarding concern arose.

Services for children and young people

- The hospital's intranet home page included a clear hyperlink in red that took the member of staff to the safeguarding policy and other documents, including an electronic referral form.
- The named nurse for safeguarding children told us that all staff who worked with children should be trained to the level 3 safeguarding children standard.
- Training records submitted by the trust before the inspection showed that over 80% of staff groups within the children's directorate had received level 3 training. For example, 86.7% of nursing staff had received level 3 training.
- Training records held locally by each ward/department manager in the children's directorate confirmed high levels of attendance. For example, the training record for ward F65 showed that 100% of staff had received level 3 safeguarding training within the trust's expected timespan of every three years. The matron explained that staff members also had regular safeguarding awareness updates.
- The trust had the necessary statutory people in post, including the named nurse and designated doctor. The executive director of nursing was the nominated executive lead for safeguarding.
- We reviewed documents which showed that the trust audited the effectiveness of its safeguarding processes. Governance minutes included regular discussion regarding safeguarding matters.

Mandatory training

- Members of staff of all grades, included staff from wards F63, F64, F65, the Niall Quinn children's centre and the neonatal unit, confirmed that they received a range of mandatory training. This covered subjects such as fire, information governance, infection prevention, moving and handling, safeguarding, blood transfusion and resuscitation. Records of mandatory training, submitted before the inspection, confirmed that staff uptake of mandatory training was maintained to a good standard.
- The trust used an electronic monitoring/management system for mandatory training and personal development. The system encouraged staff to take mandatory training because, in part, it assisted the line manager in determining staff member's yearly incremental pay rise.
- We reviewed a sample of individual electronic training records within each clinical area, which confirmed high levels of compliance with mandatory training.

Compliance rates were as follows. Fire safety: medical staff, 91.6%; nursing staff, 94.4%. Moving and handling: medical staff, 87.5%; nursing staff, 80.5%. Resuscitation: medical staff, 83.3%; nursing staff, 87.96%. Infection prevention and control: medical staff, 95.83%; nursing staff, 97.22%.

Assessing and responding to patient risk

- The electronic care records system included individualised clinical risk assessments, which were completed on admission and reviewed regularly. These risk assessments included areas such as infection prevention and a children's skin assessment tool. The neonatal clinical risk assessment included additional areas such as aspiration.
- The children's clinical areas used an early warning assessment/clinical observation tool based on the Brighton Paediatric Early Warning Score (PEWS) tool. The tool included a clinical observation chart, coma scale and additional information such as the pain score, along with an assessment table to assist clinical staff in determining the action that should be taken. It was explained that the chart assisted with determining whether a child required transfer to a tertiary centre for children, such as Newcastle.

Nursing staffing

- The matron explained that recruitment and retention were good within the children's clinical areas, so vacancy rates were very low. The directorate's clinical governance meetings received regular human resources updates from a divisional human resources manager, which confirmed low vacancy rates.
- Sickness absence rates within the directorate were reported to be within reasonable levels. Minutes of the clinical governance meeting for 24 June 2014 noted that sickness was 3.33% for March 2014, 3.30% for April 2014 and 4.31% for June 2014.
- We found a mixed picture regarding staffing across the children's wards and neonatal unit. Overall, few staff raised concerns over staffing levels on the children's wards, although some were unhappy about being moved to work on other clinical areas, including adult wards, at times.
- We did not identify any evidence during our inspection to suggest that levels of nursing staff were not adequate to meet children's and families' needs and there had been no incidents in relation to staffing at this time.

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However, the current staffing establishment for each of the children's wards did fall below recommended minimum staffing levels for children's wards set out by the Royal College of Nursing (RCN). For example, on ward F64, which had 22 beds, RCN guidance suggests a minimum number of 5.5 registered nurses for each span of duty for a fully occupied ward (one registered children's nurse per four children). The actual average number of staff was approximately four nurses during the daytime, with one healthcare assistant in support, and at night three nurses on duty.

- The matron explained that a staffing level acuity tool was not currently used on the children's wards and neonatal unit. The trust was in the process of introducing a tool. The matron explained that they had been provided with the acuity tool developed and used by Sheffield Children's NHS Foundation Trust, and this had shown that a small increase in staffing establishment might be required.
- Staffing on the neonatal unit varied depending on the number of babies on the unit and the level of care they required. We reviewed staffing on the neonatal unit in detail and found that there was limited flexibility in the establishment to cover busy periods.
- The ward manager, staff and matron in the neonatal unit told us that the unit did not currently meet nationally recognised standards set out by the British Association of Perinatal Medicine (BAPM). These standards set out minimum staffing levels for the three levels of dependency used to describe neonatal care – including level 1 (intensive care), which required registered nurses/midwives who had undertaken a specialist neonatal course.
- Statistics collated by the Northern neonatal network for quarter one (April to June 2014) showed that staffing (a comparison of staffing in relation to bed occupancy and level of care required) met BAPM standards on only 18% of days.
- We did not identify any evidence to demonstrate that staffing levels on the neonatal unit had an adverse impact on the care of babies. Despite the neonatal unit not meeting the BAPM staffing standards, staff we talked with were generally positive about staffing on the unit. This was due to a positive, caring culture shown by members of staff towards families and each other, along with clear positive working relationships with the

neonatal medical team. We were informed by the management team and by neonatal staff that few incident reports were submitted to the trust about staffing issues relating to the neonatal unit.

Medical staffing

- The trust employed 23 consultant paediatricians. The clinical director explained that recruitment of new consultant staff had been good, due to the positive reputation the directorate had for teaching and support.
- Medical staffing of specialty trainee doctors (middle grades) was complex within the children's and neonatal service. Due to national shortages of specialty trainees, the number available to complete placements at the hospital had reduced. This had caused a particular shortage within the neonatal unit.
- In response to the shortage of specialty trainee doctors within the neonatal unit, the directorate had developed the role of the advanced neonatal nurse practitioner (ANNP) – nurses who were qualified and skilled to cover duty rotas for specialty trainee medical staff. There were also four neonatal nurse practitioners to cover foundation trainee doctors' hours. Three senior ANNPs covered specialty doctors out of hours (night duty) three weeks out of four. One week in four, a middle grade doctor covered the neonatal unit, although this doctor also formed part of the general paediatric on-call rota and was required to cover the children's wards. This meant that immediate cover might not always be available on the unit for that particular week. The clinical director explained the directorate was assured that neonatal consultant staff provided adequate cover during these periods.
- The directorate's management team explained that a medical staffing strategy was in progress to develop staffing in a safe and sustainable way as the availability of specialty trainee doctors reduced. We were told that plans, soon to be implemented, would see consultant staff being available 24 hours per day.
- We talked with a number of medical staff who did not raise any particular issues regarding medical staffing. Nursing staff did not raise any concerns over medical staffing and felt well supported. Foundation and specialist trainee doctors were very complimentary about the level of training and support they received from paediatric consultant staff.
- There was a consultant-led formal handover each morning for paediatric medicine, followed by an

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evening handover on the wards. We attended one handover meeting that was well attended by nine trainee doctors, two consultants and two children's nurses. The handover was well structured and included discussions of x-rays, blood tests and other reports, which were presented on a large screen within the privacy of a seminar room; this promoted clinical discussion and decision making.

Major incident awareness and training

- The trust had a major incident plan in place that set out actions to be taken for major incidents and other similar events. The management team we talked with demonstrated awareness of the plan, although they did not recall the children's service being involved in any exercise for the last two years. None of the training records we reviewed showed that there had been any specific training in the use of the major incident plan.

Are services for children and young people effective?

Good



Children's services made improvements to care and treatment where these had been identified using programmes of assessment or in response to national guidelines. The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance.

Children and young people had access to a range of pain relief if needed. The services for children and young people used evidence-based pain-scoring tools to assess the impact of pain. The inpatient ward areas had access to play specialists and a range of distraction tools. We reviewed information that demonstrated that children's services participated in national audits that monitored patient outcomes when these were applicable.

Staff had received an annual appraisal and received good levels of support and personal development. Members of staff gave positive feedback about the individual support they received regarding their personal development. There was clear evidence of multidisciplinary working across various disciplines and specialties.

Evidence-based care and treatment

- The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. One of the paediatricians acted as the service lead for the review of guidance and steered its incorporation into protocols where required. The matron explained how guidance was disseminated to all groups of staff.
- The clinical director explained how some guidance led to additional audits and regional networking. For example, previous NICE guidance relating to urinary tract infection in children led to regional audits that confirmed that existing protocols for managing urinary infections exceeded NICE guidance.
- The service's clinical governance meetings included a standing agenda item for national guidance and included discussion of recently released guidance and other benchmarking documents. For example, minutes of the meeting on 29 April 2014 set out how a national benchmarking tool for orthopaedics had recently been used to assess current practice within the children's clinical areas. The minutes stated that the tool had shown that "in general the assessment of care was, in most cases, very good and met the criteria for good practice." Areas for improvement had been identified, including the update and review of patient literature.
- Discussion with members of staff and reviews of documentation showed that clinical practice was regularly audited. National audits were undertaken, such as in diabetes and asthma, and local audits had been completed, for example a nasogastric feeding audit and a head injury audit. Other audits completed checked the effectiveness of evidence-based tools; for example the Paediatric Early Warning Score (PEWS) observation charts were audited regularly to check that they were completed and used correctly. The early warning score audit we reviewed (dated 2 July 2014), which audited a sample of 10 records, demonstrated good levels of completion by members of staff with most categories assessed scoring 10 / 10. The lowest score 7 / 10 related to their being a monitoring plan in place.

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- The clinical director explained that the hospital's library department within the education centre provided a prompt same-day service when a consultant or other staff member required a literature search to inform a child's evidenced-based treatment plan.

Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia and patient-controlled analgesics.
- The service used evidence-based pain scoring tools to assess the impact of pain. Three pain-scoring tools were incorporated into the PEWS assessment tool that members of staff completed. We reviewed a sample of pain score ratings, which showed members of staff regularly assessed pain when required.
- The children's ward and children's centre had access to play specialists and a range of distraction tools when required as an alternative means to lessen the impact of pain, discomfort or distress.
- Discussion with neonatal staff and review of the electronic care records system showed that members of staff considered pain in neonatal babies.

Nutrition and hydration

- Children's likes and dislikes regarding food were identified and recorded as part of the nursing assessment of the child's daily activities. The nursing team used a dedicated nutritional assessment tool for children known as the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP).
- Children were able to choose their food from the daily menu with the support of parents and staff. Children could eat food from the adult menu or have a children's meal. Snacks and drinks were available in between meals, either through members of staff or from a snack trolley available on ward F64.
- Parents and children we talked with gave positive feedback about the food available. In response to the question "How would you rate the hospital food provided to your child?" in the real-time feedback surveys for August 2014 for ward F63, seven out of nine respondents rated the food as good or very good. Similar results were noted for ward F64 in its August 2014 feedback report.

Patient outcomes

- We reviewed information that demonstrated that children's services participated in national audits that monitored patient outcomes when this was applicable to the service. For example, we reviewed data and information relating to the National Neonatal Audit Programme (NNAP) along with national Commissioning for Quality and Innovation (CQUIN) data for neonatal outcomes. Data submitted by the trust for NNAP showed reasonably good compliance with expected standards. In the period January to August 2014, 100% (NNAP expected standard 98 – 100%) of babies had their temperature taken within an hour of birth. In the same period 50% (expected standard 58%) babies <33+0 weeks gestation at birth had received any of their mother's milk when discharged from the neonatal unit.
- We discussed with the clinical director and the directorate's management team other examples of participation in national audits, such as for asthma and diabetes; for example, in the national diabetes audit, the service was found to have a number of positive outcomes for children, such as low HbA1c (average blood sugar over previous weeks) rates in comparison with those in other services. The clinical director explained that the audit showed that the hospital also had low DKA (diabetic ketoacidosis) rates for children in the north east region. We were told that the diabetes service attracted the best practice tariff.
- Clinical areas in children's services also submitted ongoing data (where applicable to children) that contributed to the patient safety thermometer monitoring dashboard. Data showed that all participating children's clinical areas were scored as 100% harm-free.

Competent staff

- Formal processes were in place to ensure staff had received training and an annual performance development review (appraisal).
- Electronic records showed that staff members received an annual appraisal. Members of staff we talked with confirmed they had received an appraisal.
- Members of staff in all clinical areas gave positive feedback about the individual support they received regarding their personal development.

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- In the neonatal unit, more-junior nursing staff were well supported to develop intensive care skills and were promptly identified and supported to attend formal neonatal intensive and special neonatal care courses.
- We talked with student nurses in a focus group, who told us they received very good support during placements on the children's wards. Support included mentors ensuring that student nurses were able to access a range of experiences to develop nursing skills and competence.

Multidisciplinary working

- Medical and nursing staff gave positive examples of multidisciplinary working. We were told that the paediatricians and nursing teams worked closely together and also worked closely with other allied health professionals such as dietitians, occupational therapists and physiotherapists.
- Staff also told us that children's services worked closely with surgeons and doctors in specialties such as emergency medicine, ear, nose and throat surgery, orthopaedics, general surgery and anaesthetics.
- The clinical director for paediatrics and the clinical director for emergency medicine told us how the two departments had worked closely together for a number of years to develop medical staffing within the children's emergency department. This close working had resulted in joint consultant cover within the department by consultants with specialist skills in paediatric emergency medicine.
- Similarly, staff from the neonatal unit and staff from maternity services told us how these two clinical areas worked closely together to ensure newborn babies and mothers received the care they needed.

Seven-day services

- The children's inpatient services accessed diagnostic services such as the x-ray department, pharmacy and laboratory during the weekend. Staff did not raise concerns over accessing these services.
- We were told there were sometimes delays when accessing local social services, particularly at the weekend. However, the service was working with the local authority using joint meetings on ways of improving access out of hours.
- During weekdays, consultant paediatricians completed two formal ward rounds per day, with one at weekends.

Trainee doctors working out of hours and at weekends told us they felt well supported by consultant staff, who were on call. The clinical director explained how the consultants are available seven days a week.

Are services for children and young people caring?

Good



Children, young people and parents told us they received compassionate care with good emotional support. They felt they were fully informed about and involved in decisions relating to treatment and care. We spoke with 24 children and parents who provided examples of how they had been provided with supportive care centred on their personal needs. We saw that staff were responsive to and supportive of children's and parents' emotional needs.

Compassionate care

- Throughout our inspection, we observed members of medical and nursing staff who provided compassionate and sensitive care that met the needs of children, young people and parents.
- We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with children and parents.
- The environment was warm and welcoming on the children's wards, in the Niall Quinn children's centre and on the neonatal unit, which promoted family-centred care. Facilities were available to help staff ensure that children's and families' needs for privacy and dignity were met; for example, there were breastfeeding screens in the neonatal unit.
- We spoke with 24 parents and children across all children's inpatient and outpatient areas. The parents provided examples of how they had received supportive care. For example, parents explained how well different groups of staff worked together to ensure their children's needs were met. A number of parents described their care children's care as "fantastic".
- We were told that the children's services did not participate in the NHS Friends and Family test as this had not yet been rolled out nationally. Parents had completed 'real-time feedback' surveys each month for the three children's wards, and reports compiled. For

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question 1 in August 2014 ward reports, “During your child’s stay were they treated with compassion by hospital staff?” wards F63, F64 and F65 scored 100% based on a sample of 10 parent responses on each of the respective wards.

Patient understanding and involvement

- We observed members of staff who talked with children and young people used language appropriate to their age-related level of understanding. We spoke with one young person who said the staff really knew how to talk with them in a way they understood.
- A number of children, young people and parents/carers told us they had felt fully involved in the planning and decisions relating to the patient’s care.
- Question 3 of the monthly real-time feedback surveys asked parents, “Were you involved as much as you wanted to be about decisions about your child’s care and treatment?” Each ward scored 100% based on a sample of 10 responses from parents.
- Parents and children talked positively about the information they had received. Families also explained how they had been given sufficient information to make an informed choice about their children’s care.
- Information leaflets about various treatments and other care were available within the hospital. Leaflets at this trust were written in English. Members of staff explained that they could get leaflets translated when required.

Emotional support

- Parents and children told us they had been well supported during their visits to the children’s areas.
- We observed that the play specialists and other staff were responsive to and supportive of children’s emotional needs.
- Parents we talked with gave examples of how staff supported their children. For example, one parent and young person explained how supportive staff had been in various situations regarding the management of the child’s complex illness.
- Parents also made clear when talking to us and through the real-time surveys that they could talk to a member of staff when they felt concerned or anxious during their children’s stay in hospital. Parents’ comments were positive about the care and emotional support they had received within all the children’s clinical areas.

Are services for children and young people responsive?

Good



The children’s service provided good access to and flow within its services. This was due in part to the close collaborative working between the directorates of paediatrics and emergency medicine, which had developed a shared medical consultant staffing approach that included consultant staff qualified in paediatric emergency medicine.

The children’s service actively planned and delivered services to meet the needs of local children and parents. We also found that the service had a range of facilities and approaches to ensure that the needs of local families were met.

Service planning and delivery to meet the needs of local people

- A range of evidence was available that demonstrated how the children’s service engaged with the trust, commissioners, the local authority and other providers to address the needs of the local population – for example, business cases for reconfiguring children’s services.
- Recent reconfiguration of children’s acute services had taken place as part of what was known as the ‘south of Tyne and Wear bigger picture’. The reconfiguration has seen Sunderland become the main provider of longer stay inpatient facilities for children living south of the Tyne river and north of Durham. Documents reviewed showed how planning had been undertaken along with the preparation of business cases to employ additional staff to ensure that more children could be adequately managed.
- The management team for the children’s service explained that children’s short stay assessment units continued to exist at Gateshead NHS Foundation Trust and South Tyneside NHS Foundation Trust, and the increase in patient numbers at Sunderland Royal Hospital had not had an adverse impact on the hospital’s delivery of services.
- We reviewed documents that demonstrated that the trust had been preparing business cases along with completing other work in preparation for a review of

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neonatal intensive care/high dependency care providers within the Northern Neonatal Network region. City Hospitals Sunderland NHS Foundation Trust was one of four neonatal intensive care providers within the north east region.

Access and flow

- The children's service at Sunderland Royal Hospital provided good access to and flow within its services. A dedicated emergency department for children was located next to the adult department. A children's short-stay assessment unit was located adjacent to the children's emergency department. Following assessment, children were either discharged, referred to other primary services or admitted to wards F63, F64 and F65.
- The emergency department was staffed by registered children's nurses. The children's service and emergency department had developed an outstanding shared medical staffing model for the children's emergency department. The children's service provided two consultant paediatricians specifically qualified in paediatric emergency medicine. Although based within the emergency department, these consultants also worked as general paediatricians, which facilitated cohesive continuity of care between these services.
- The emergency department also provided consultants in emergency medicine who were trained in paediatric emergency medicine. The clinical directors for children's services and emergency medicine both explained how this approach had led to "excellent quality care for children" and facilitated expert clinical decision-making for children.
- Paediatric emergency medicine clinics were held on some weekday mornings that accepted referrals either from the emergency department or general practice. Also, a rapid-access clinic was held in the Niall Quinn children's centre. Referrals to these clinics adhered to specific criteria.
- The three children's inpatient wards were also configured to facilitate access to and flow between age ranges and between specialties. Ward F63 cared for children who were undergoing emergency or elective surgery, F64 cared for children over two years of age with medical conditions, and F65 cared for children under two years of age with medical conditions.
- To assist with the flow of patients, consultant paediatricians completed two handovers/reviews each

weekday. A review of care records showed that discharge planning began on admission, including on the neonatal unit. The service had developed nurse-led discharge for some conditions within paediatric medicine. The surgical ward had established nurse-led discharge for some specialties such as ear, nose and throat surgery. Nurse-led discharge meant that children could be discharged promptly without waiting for review by a member of medical staff.

- The children's service used an early warning clinical observation system known as the Paediatric Early Warning Score (PEWS) that helped staff to identify children who were becoming ill more promptly so that transfer arrangements could be made to a regional centre such as in Newcastle when required.

Meeting people's individual needs

- Staff told us that interpreting services were available when they needed them, and that they did not normally have any issues when accessing these services.
- The Niall Quinn children's centre provided spacious outpatient facilities for children within a separate building opposite the main entrance to F block (where the children's wards were located). Facilities available within the outpatient department were focused around the needs of children and young people and included equipment to help distract patients during potentially distressing procedures such as the taking of blood samples by members of the nursing team.
- The centre provided a spacious and suitably designed and decorated outpatient suite dedicated to children. Clinic rooms were clean, well lit, large and suitably decorated. A large central nurse station area facilitated the organisation of multiple clinic sessions.
- The centre also included a spacious waiting area, which was described by the staff as a play room.
- The treatment room where blood samples were taken and other minor procedures undertaken was brightly decorated with a mural covering the walls; a range of positive distraction tools were available, such as portable sensory equipment.
- The neonatal unit lacked space in some rooms. For example, the nominated intensive/high dependency room included eight incubator units plus equipment such as monitoring and infusion devices for each cot space. This meant that space around each cot for staff and parents very limited. Neonatal staff told us that the room had not been designed for eight cot spaces.

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- There were limited facilities available for parents, including two small 'mother and baby' rooms and basic facilities for making hot drinks. The neonatal unit had recently completed the Bliss Baby Charter Audit, which had identified that the unit lacked a dedicated play area for siblings and a parents' rest room where they could relax away from the intensive/special care area.
- The children's ward areas had a full range of facilities to ensure family-centred care. For example, parents had access to a relaxation room that included hot drink facilities, microwave, refrigerator and television. There was also a large, well-equipped playroom/school room for children.
- We saw that the children's wards took account of adolescents' needs. Ward F64 had dedicated bed spaces for adolescents. A well-equipped adolescent room was also accessible to teenagers on ward F63 and ward F64.
- Formal adolescent transition arrangements were in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty, including jointly run clinics with the adult team. Other specialties, including epilepsy and neuro-disability conditions, had some form of transitional arrangements being further developed. We saw documents which showed that protocols and guidelines had recently been developed and established for adolescent transitional care in the management of diabetes.
- There was no overarching policy statement regarding the coordinated development of adolescent services for children, and there was no formally nominated lead member of staff to develop adolescent services. However, we found that the clinical director, management team and staff had a positive approach and showed commitment to the development of adolescent care and transitional arrangements; this was demonstrated by the development of sub-specialty transition arrangements and by discussions recorded in minutes of directorate meetings.
- Babies discharged from the neonatal unit received their early follow-up appointments (up to six months of age) with the neonatologist within clinic rooms in the neonatal unit. This approach allowed parents and babies to be seen by known nursing and medical staff within a familiar environment until care was either transferred to the community or to paediatricians in the Niall Quinn children's centre.

- We saw that the service had established processes in place to provide end of life care for children and young people with life-limiting conditions. There was a nominated lead for end of life care, and there were regional links with various organisations, including local children's hospices. Children were cared for in the community within their own homes, with support from community nurses and other agencies.

Learning from complaints and concerns

- The children's management team explained that few formal complaints were received within the children's service. Six formal complaints had been received in the last six months through the Patient Advice and Liaison Service (PALS). No clear themes had been identified in the complaints received.
- Staff and ward managers confirmed that few complaints were received and that any verbal complaints were usually resolved straight away. The ward manager on ward F64 talked through an example of a complaint made by a parent that led to a formal night nurse ward round being introduced to update staff on care changes during the night.
- Meetings of the clinical governance committee included a standing agenda item for complaints, and minutes showed that these meetings reviewed and discussed complaints.

Are services for children and young people well-led?

Outstanding



The leadership was outstanding and the service was extremely well-led. There was a clear vision and strategy for the service, which was led by a strong management team who worked together. They were clear on how they wanted to develop the service and staff were engaged and enthusiastic about this. Robust governance and risk management arrangements were in place which fed into the wider trust governance systems. The service regularly implemented innovative improvements with the aim of constantly improving the delivery of care for children and families. We found that staff understood their leadership structures and felt well supported by line management. The executive director of nursing explained that a non executive director had a keen interest in children's services

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and that there was no formally nominated non-executive director for children's services, although the executive director of nursing explained that the nomination of a director would be facilitated promptly.

The service had excellent and innovative approaches to receiving feedback. It engaged with people who used the service through a range of methods. The service involved children and families in decisions regarding the service and facilitated a range of support groups. The service had facilitated the inspection of the service by a team of young inspectors, which was outstanding practice.

We observed excellent examples of clinical innovation for example, one of the consultant paediatricians, had devised and developed a traffic light tool for use in paediatric disability review clinics held within the hospital and community settings. The tool was described as empowering families to bring their issues forwards and to ensure that everything that matters for the family is adequately addressed in the most efficient and effective way possible.

We found a positive, open and friendly culture at the service. Staff placed the child and the family at the centre of care delivery, and this was seen as a priority and everyone's responsibility.

Vision and strategy for this service

- The paediatric directorate had a strategy and vision for the future of service provision in the City Hospitals Sunderland NHS Foundation Trust. The trust's operational strategy included a strategic planning process document for the period 2014/15 to 2016/17 for children's services. This document centred on the trust's vision and values and was populated with the services initiatives and measures to achieve the strategy's objectives and goals. For example, within the 'improve patient safety' goal, one initiative documented was to "address deficit on ward nursing levels in relation to RCN/BAPM guidelines", and the measure was to write a business case.
- We reviewed evidence which showed that action was taken to take forward initiatives stated in the strategy and other documents. For example, we saw that a business case for the neonatal unit was currently under review.
- Other documents presented the review of current service requirements and how these requirements

might be met in the future. For example, the document "Review of Training and Service Requirements (Paediatrics and Child Health)" set out various options for maintaining adequate medical staffing in the future as the number of specialty trainee doctors (middle grade registrars) fell.

- During our interview with the clinical director, divisional general manager, divisional directorate manager and matron we were able to establish that the management team held a clear vision for the future of children's and neonatal service. They were also clear on how they wanted to develop parts of the service such as adolescent transitional care.

Governance, risk management and quality measurement

- The paediatric directorate had an active risk register that was reviewed regularly. Nine risks were listed for children's services. We reviewed the risks and saw that none were identified as significant risks. The risks identified had measures in place to manage them appropriately, and they were regularly discussed within governance meetings.
- The ward manager from ward F64 collated a quarterly report that included a review of current risks. This collated report was discussed in the minutes of clinical governance meetings.
- The paediatric directorate held its own clinical governance meetings on alternate months from when the more business-focused general directorate meetings were held. Clinical governance meetings included members of the children's leadership team at ward and unit level along with the children's management team, including the clinical director, divisional general manager, matron and directorate manager. One of the consultant paediatricians took a lead role in all matters relating to governance and risk.
- The minutes of clinical governance meetings included a standing agenda item for discussing risks, and these reflected the risks recorded on the directorate's risk register.
- The governance committee met bi-monthly. We reviewed a sample of minutes of meetings on 28 January, 29 April and 24 June 2014, and saw that the meetings had a number of standing agenda items covering areas such as safeguarding, infection control, risks/incidents, policies, national guidance, and local

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quality assurance. The minutes recorded discussions at the meetings that demonstrated that actions were being undertaken to address identified areas, for example to review identified risks logged on the risk register.

- The minutes of meetings of governance and directorate meetings were well organised and detailed. Meetings of both the governance committee and directorate included regular updates from the nominated divisional human resources manager and finance officer.
- The ward and unit managers told us they had held staff meetings, although these were sometimes difficult to arrange due to duty rotas. Staff members we talked with confirmed that meetings were held and that information was regularly shared with them.

Leadership of service

- The directorate of paediatrics had a clear structure set out within an organisational chart. The divisional general manager reported to acting Director of Operations. Other members of the management team included a directorate manager, matron and clinical director.
- The matron was supported by experienced band 7 ward managers on wards F63, F64 and F65 and the neonatal unit. In these areas, the band 7 ward managers were supported by experienced band 6 sisters. The Niall Quinn children's centre was managed by a band 6 sister who reported to the matron. All the clinical leadership team told us they felt well supported by both the matron and the clinical director. One ward manager felt "empowered" by the matron to develop the ward.
- We saw that the consultant paediatricians were a well-led group of medical staff who worked proactively together to manage their workload. We were invited to a well-attended consultant meeting which demonstrated how the consultant team was committed to continuing professional development. The consultant team ensured business continuity for patients by planning annual leave cover for school holiday periods.
- Children did not have representation at the trust's board level. There was an executive board lead for safeguarding children (the executive director of nursing). The executive director of nursing confirmed that there was no formal board-level non-executive director to promote children's rights and views as required by the National Service Framework for Children standard for hospital services. However, the executive

director of nursing explained that one non-executive director regularly spoke on behalf of children in an informal capacity, and subject to discussion proposed to progress the formal nomination of the non-executive director as a formal lead for children.

Culture within the service

- We found a culture of openness and flexibility among all medical, nursing and allied health professional staff we met within the children's service. Staff spoke positively about the care they provided for children, young people and parents. We saw how staff placed the child and the family at the centre of care delivery, and how this was seen as a priority and everyone's responsibility.
- We saw that staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children, such as the emergency department.
- The management team demonstrated how they were proud of their service. For example, the clinical director was particularly proud of the diabetes service for children and of the joint working to develop paediatric emergency medicine. We also saw examples of where leaders praised staff when they had contributed to the success of the service.
- The chief executive, through a presentation, showed that the executive team was aware of the strengths of the children's service within City Hospitals Sunderland NHS Foundation Trust.

Public and staff engagement

- We found that people's experiences of the service were regularly sought. A system had been set up to gain the views of children, young people and families about their experiences, known as 'real-time feedback'. A formal survey was undertaken each month on each ward, which asked a sample of parents/children their views about their experiences using 18 questions. These surveys resulted in a monthly report that was made available for parents and families to review.
- Other simple written feedback slips were regularly left in children's bed areas. These were frequently completed by parents and children. The comments were collated, and we were given examples of how parents' views had contributed to change.
- The children's service either facilitated or was involved in various support groups that had been set up for

Services for children and young people







parents and children, for example the diabetes support group and epilepsy support group. The ward manager for the neonatal unit explained that a neonatal support group met every six weeks. This group was facilitated by one of the staff nurses. Drinks and snacks were provided, along with toys for siblings. The meeting allowed parents to ask each other questions and meet older babies and young children who had previously been patients on the neonatal unit.

- The children's service also attended other multi-agency groups such as the inter-agency strategic partnership for disabled children. This group included parents and carers, along with other interested parties.
 - Sunderland City Council facilitated a team of young inspectors who inspect services for children and young people using a recognised approach known as the 15-step audit. The team of young inspectors visited wards F63, F64 and F65 on 24 April 2014 and produced a report on their findings for each ward area. The reports were positive in their respective findings and made some recommendations, which the management team was considering.
 - The matron explained that the hospital planned to invite the young inspectors to audit outpatients (Niall Quinn children's centre) and the children's emergency department later in the year. This process of using young inspectors was good practice, because it not only involved the public in the audit of service provision but also involved young people who may access these services.
 - The management team and some members of staff told us that senior trust-wide leaders visited the children's clinical areas and engaged with staff. For example, the chief executive had previously visited ward F64 and attended the children's Christmas party. The chief executive also held six-monthly ward manager band 7 forums, which ward managers felt were informative and useful.
- The clinical director explained how the service for babies with 'tongue tie' had improved by developing a commissioned service in Sunderland. This had improved outcomes for babies, because of reduced waiting times for surgery, which therefore removed associated problems with tongue tie such as feeding difficulties.
 - Another example of innovation involved one of the consultant paediatricians, who had devised and developed a traffic light tool for use in paediatric disability review clinics held within the hospital and community settings. The tool was described as "[empowering] families to bring their issues forwards and to ensure that everything that matters for the family is adequately addressed in the most efficient and effective way possible". The tool had been developed with involvement from disabled young people and parents. The assessment involved the families writing down causes for celebration and recording what may improve the child's participation in everyday activities, followed by a traffic light assessment of functioning, health issues, and areas where there may be barriers to participation or quality of life. A review noted that the tool had improved the focus of consultations.
 - Other evidence of improvement was the introduction of a locally designed emergency health care plan for children with disabilities. This document included key information about the child's condition, details of decisions in relation to end of life care, and a flag referral form for the North East Ambulance Service.
 - In the neonatal unit, a developmental care group had introduced measures relating to sensory care of the neonatal baby.
 - Other local innovation had involved setting up the Sunderland community anaphylactic service, developed by a paediatrician in partnership with others with the aim of helping school and nursery staff provide emergency care for children with a history of severe allergic reaction. Principal tools for the programme included an anaphylaxis management plan template (individualised for every child at risk), one type of adrenaline auto-injector, training for designated teachers, update training, and the maintenance and monitoring of a database. A review document noted that this programme "provides confidence to parents that their children will be safe at the place of education".

Innovation, improvement and sustainability

- The paediatric directorate, its consultant paediatricians and other staff had introduced innovative ideas along with other measures to improve service provision and sustainability for children and families who used the service.

End of life care

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

Information about the service

End of life care services were provided throughout the hospital. Patients requiring end of life care were cared for depending upon their underlying condition. There was no specific palliative care ward within the hospital, although there was a specialist palliative care team of nurses and doctors. The team consisted of two full-time nurses and two part-time doctors who worked a total of 0.6 whole-time equivalent hours each week. Care was provided by a multi-professional team who had undergone recognised specialist palliative care training. The aim of the care was to provide physical, psychological, social and spiritual support nearing the end of their life. Between April 2013 and March 2014 the service attended to 357 patients. There were 1502 face to face contacts with patients, 885 with carers and 2306 with other health professionals. The majority of patients referred to the team had cancer however 16% had other conditions.

In 2013-14 the consultants also attended to 140 patients, had face to face contact with 328 patients, 63 carers and 332 professionals

During the inspection we visited the stroke unit, general medical wards, the bereavement office and the general office, and looked at family rooms in accident and emergency (A&E) and facilities for supporting families when a baby died.

We spoke with nine patients, three relatives, 20 nurses, one consultant, three healthcare assistants, five ward managers, two domestic staff and two volunteers. We also spoke with two mortuary staff and staff from the chaplaincy.

We looked at the records of 22 patients who had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order in place, some of whom were at the ends of their lives due to illness. We also looked at information given to us about end of life care in the trust and at national data.

End of life care

Summary of findings

Overall, the care and treatment patients received at the end of their lives was effective, caring and well-led. Patients and relatives were happy with the care being given and found it to be caring and compassionate. Staff were well trained, well supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because policies were in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

We found that there was an issue over the transfer of care of some patients to the community who were fitted with a syringe driver (for the continuous administration of medicine). Not all staff had been trained in its use which necessitated a change of equipment at discharge and could lead to the interruption in access to some medication. There had been no incidents reported in relation to this.

Patients were, on the whole, protected from receiving unsafe care because medical records were available. There was, however, some room for improvement in the standard of record keeping in relation to 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders, as some of the records were not fully completed.

The services offered were delivered in an innovative way to respond to patients' needs and ensure that the department worked effectively and efficiently.

Are end of life care services safe?

Requires Improvement



Patients were, on the whole, protected from receiving unsafe care, because medical records were available. There was, however, some room for improvement in the standard of record keeping in relation to 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders, as some of the records reviewed were not fully completed.

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Incidents were reported and investigated and lessons learned. Cleanliness and hygiene in the wards was within acceptable standards and sufficient personal protective equipment was available to protect patients and staff from cross-infection and contamination. There was sufficient clean and well maintained equipment to ensure that patients received the treatment they needed in a safe way.

Staff were aware of the various policies in place to protect vulnerable adults or those with additional support needs. Patients were asked for their consent before care and treatment was given. Staff knew what action to take if a patient's health began to deteriorate. Although the specialist palliative care team was understaffed according to national commissioning guidance this did not affect the safety of patient care.

Staff across all of the departments we visited demonstrated that they were aware of their responsibilities in the light of major incidents.

Incidents

- Staff from the palliative care team told us that they rarely reported incidents, but would report concerns to the particular ward managers for them to make the reports.

End of life care

- There were ten incidents that related to end of life, or palliative care between April 2014 and August 2014. Four were graded as no harm, five as minor harm and one as moderate harm.
- We looked at incidents reported by the mortuary and found that there had been four incidents reported about identity bracelets or body tags between 28 April and 31 August 2014. Action was being taken to increase awareness of staff about the importance of identity bracelets and tags through governance meetings and ward meetings.
- There had been seven incidents reported under the heading 'Bereavement'. Six were classified as 'minor harm' and one was classified as 'no harm/near misses'.

Medicines

- Staff told us that they were able to access medication for patients who were at the end of life when needed. We saw within some records that 'anticipatory drugs' that is, drugs that may be needed by a person at the end of their life, had been prescribed.
- Wards had supplies of controlled drugs that could be used to alleviate the symptoms and pain levels of patients at the ends of their lives.
- The palliative care team gave advice on anticipatory prescribing and checked to ensure it was used appropriately.
- The National Care of the Dying Audit 2012/13 showed that the trust's score was better than the England average for as-required medication for the five key symptoms that may develop during the dying phase.

Records

- We looked at the 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms of 22 patients. Of these, 11 had been completed correctly and fully, three were missing countersignatures for a consultant, and seven did not document that either the patient or relatives had been involved. One further order had been cancelled but was still at the front of the file with only a line through it; it had not been moved to the back of the file. There was a risk that, in an emergency situation, this could be misread.
- Within one set of care records we saw that the patient had been started on the end of life care pathway, but the record did not show that the patient had been reviewed every four hours as best practice states.

- In medicine services, we looked at 12 'do not attempt cardiopulmonary resuscitation' (DNACPR) records that had been completed. Four of the records we looked at were not completed fully. For example, the forms did not document that the doctor had discussed the DNACPR with the family; however, there was a record of the discussion with the patient and/or their relatives in the patient's medical records.
- In critical care services (ICCU), we observed that DNACPR forms were in place for some patients. The forms were accurately completed and were assessed on a daily basis.
- The ICCU had its own resuscitation status form. The document was used in conjunction with the trust's overarching DNACPR form and the Mental Capacity Act 2005. The ICCU DNACPR form had specific sections for documenting discussions with family and friends, the patient's mental capacity and the reasons for the resuscitation status decision.
- In addition, the ICCU DNACPR form listed the specific therapies that could or could not be performed, including cardiopulmonary resuscitation, giving oxygen, dialysis and use of certain intensive care drugs.

Equipment

- Access to equipment to support patients with specific needs at the end of their life such as pressure relieving equipment.
- There were problems with the transfer into the community of some patients who were using syringe drivers. This problem was because the trust used a different type of equipment than was used in the community setting. Not all ward staff were competent to use the type of equipment used in the community. Some patients had to be taken off one piece of equipment before discharge and given a dose of medication (usually for pain relief and nausea) to last until they could be connected to the equipment used in the community. This was not best practice and meant there could be a risk that patients would suffer breakthrough pain and other problems associated with their conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

End of life care

- Staff we spoke with were aware of the Mental Capacity Act 2005. One record that we saw recorded that a patient lacked capacity after an assessment had been carried out.
- The staff we spoke with about lasting power of attorney understood that there were two different types, only one of which meant that a designated person could make decisions about the patient's care and treatment.

Safeguarding

- There were no specific issues about safeguarding in relation to end of life care.
- The trust's level of safeguarding training for vulnerable adults was approximately 89%.
- There was no specific information relating to members of the palliative care team, who were employed by another trust and worked at City Hospitals Sunderland on honorary contracts; they received all training from the trust they were employed by. According to the director of nursing, the trust had no formal assurance system in place to make sure that members of the specialist palliative care team were up to date with their mandatory training, supervisions and appraisals.
- Staff we spoke with in the specialist palliative care team were aware of the policies and procedure in relation to safeguarding. They were aware that there was a safeguarding team within the trust.

Mandatory training

- There was no information about the palliative care team's level of mandatory training, because team members were employed by another trust and worked at City Hospitals Sunderland on honorary contracts.
- Members of the specialist palliative care team confirmed that they had completed mandatory training with the trust they were employed by.
- End of life care was not part of mandatory training for staff employed by the trust. There is a wide range of end of life training in areas such as nurse preceptorship, healthcare assistant programme and medical staff training.

Assessing and responding to patient risk

- Staff on the wards told us that they used the early warning score system to identify patients who were at risk of deterioration.

- When patients deteriorated at the end of life, staff told us they were able to access support from colleagues, as well as from the specialist palliative care team if the patient developed complex needs.

Nursing staffing

- Two full-time nurses worked at the trust in the palliative care team. They were employed on honorary contracts. According to commissioning guidance for specialist palliative care, a trust the size of City Hospitals Sunderland NHS Foundation Trust requires three nursing staff. (This is based on one full-time nurse for each 250 beds.) This means that the specialist palliative care team employed fewer than the expected number of nursing staff to meet the needs of patients. Staff told us that patient care was maintained; however, other aspects of their role, such as training other staff about how to support patients at the end of life, did not happen due to lack of capacity.
- The trust also employed a 1 WTE End of Life Modernisation Facilitator whose role was to develop protocols, deliver training and supervision for end of life care alongside the specialist palliative care team.
- There was access to the specialist palliative care team 24 hours a day, seven days a week. Out-of-hours cover was initially by telephone.
- Staff who worked in the mortuary told us sufficient staff were available to cope with the workload.

Medical staffing

- The trust employed two consultants from another trust in the region on honorary contracts. In total, the doctors were employed for 0.6 whole-time equivalent (WTE) per week. According to commissioning guidance for specialist palliative care, the number of doctors expected to be employed by a trust this size is three. (This is based on one WTE consultant or associate specialist for each 250 beds.) According to national commissioning guidelines, the trust did not have enough medical staff in the specialist palliative care team. However, there was no evidence to indicate that this affected patient care.
- There was access to cover from the specialist palliative care team doctors 24 hours a day, seven days week, through an on-call agreement with other trusts in the local area. There was a consultant in the trust each day from Monday to Friday, and telephone and on-call cover at other times.

End of life care

Major incident awareness and training

- The mortuary technicians told us that contingency plans were in place should the mortuary become full; however, they told us that the mortuary had 100 fridges and freezers, but the greatest number of bodies they had ever had at one time was 70.
- Mortuary technicians were aware of how to deal with the bodies of deceased patients that posed an infection risk to others.
- Standard operating procedures and policies were in place to support staff in the event of a major incident.

Are end of life care services effective?

Good



The end of life care delivered by City Hospitals Sunderland was evidence based and followed a region-wide initiative called Deciding Right. This meant that patients were protected from inappropriate care and support. The trust took part in national and local audits of practice to ensure that care being delivered met expected standards. Action was taken if care did not meet expected standards.

Patients were able to access pain relief in a timely manner. Their nutrition and hydration needs were met.

There was evidence of multidisciplinary working and access to specialist support seven day a week.

Evidence-based care and treatment

- Specialist palliative care nurses told us that local policies and procedures were based on national guidance from the National Institute for Health and Care Excellence (NICE), best practice and local guidance in the 'Deciding Right' information. We saw a booklet that the specialist palliative care nurses based their care and advice upon, which was underpinned by this guidance.
- The trust followed the region-wide initiative called Deciding Right. We met the palliative care modernisation facilitator, who told us how they worked with the specialist palliative care nurses, and were involved in rolling out training about the initiative.
- The trust had removed the Liverpool Care Pathway from use. This had been replaced by an electronic records system and contained the necessary information to

deliver care for patients at the end of their life. Staff followed guidance from the Northern England Strategic Clinical Network entitled 'Guidance for care of patients who are ill enough to die'.

- The trust carried out some clinical audits, such as an audit of 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders. The audit showed that some work needed to be done to improve the standard of record keeping in relation to DNACPR.
- Specialist palliative care staff told us that, other than the national audit, they did not carry out clinical audits specific to end of life care.

Pain relief

- The specialist palliative care team had advanced knowledge about how to manage people's pain at end of life. They were accessible either in person or by telephone 24 hours a day.
- Patients and relatives we spoke with told us that pain was monitored and additional medication given if patients had breakthrough pain.
- Appropriate medication was available in the ward areas. There were examples to show that anticipatory prescribing was being managed.

Nutrition and hydration

- In the record we looked at for a patient who was at the end of life, there were prompts to remind staff to carry out mouth care; however, there was no record that mouth care was carried out.
- Palliative care patients were able to receive nutrition and hydration that met their needs, for example one person was being given a soft diet. Staff told us that they could also support people's nutrition and hydration needs using a drip if necessary.

Patient outcomes

- The trust participated in the National Care of the dying Audit in 2012/2013. In the 10 key performance indicators for clinical performance the trust scored worse than the England total for 8 of these. For the organisational KPI's the trust scored better or the same for 5 out of 7.
- The trust had undertaken a clinical audit of DNACPR recording in the critical care unit. The audit found that, in this unit, patients and relatives were included in discussions and informed about the patient's prognosis.
- In A & E department audited the completion of do not attempt cardiopulmonary resuscitation (DNACPR)

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forms. The July 2014 A&E performance and quality report noted that the audit showed that full completion of these forms had dropped to 73%. Action had been taken and the senior available clinician was made responsible for completing these forms.

Competent staff

- The staff who worked as part of the specialist palliative care team were employed by another trust and worked at City Hospitals Sunderland NHS Foundation Trust on honorary contracts. The trust had no formal mechanism in place for ensuring that these staff were up to date with their supervisions, appraisals or revalidation.
- The specialist palliative care team confirmed that they received appraisals and supervision from the trust they were employed by.
- The palliative care team had not been able to deliver bespoke training on end of life care to individual wards due to capacity issues.
- The trust employed a 1 WTE End of Life Modernisation Facilitator whose role was to develop protocols, deliver training and supervision for end of life care alongside the specialist palliative care team.

Multidisciplinary working

- There was clear evidence of multidisciplinary team (MDT) working on the wards.
- The specialist palliative care team worked in a collaborative and multidisciplinary manner. The service included spiritual support from the chaplaincy team and bereavement support from specialist palliative care nurses.
- There were regular clinical review meetings to discuss patients' care, and there were good links with the palliative care services in the community. For example, a system was in place to enable patients to be discharged quickly so that they could die in their preferred place, such as at home. Staff told us that, on the whole, this system worked well.
- The nurses described how they had good relationships with the local hospice, because the specialist palliative care consultants worked jointly at the trust and in the local hospice.
- We did not see any electronic palliative care coordination system in use.

Seven-day services

- The specialist palliative care team was available from 9am to 5pm, Monday to Friday, and patients were usually referred by telephone, followed by fax. Out-of-hours cover was available by telephone initially, but in person if necessary.
- The chaplaincy provided cover and support 24 hours a day, seven days a week, for patients and their relatives.

Are end of life care services caring?

Good



The treatment and support that patients and their relatives received at the end of life was caring and compassionate. Patients were treated with dignity and respect.

Where appropriate, family members were involved in and kept up to date with their family member's progress. Patients felt that staff were open and honest with family members and gave them bad news in an informative but sensitive way. Patients and relatives were given opportunities to ask questions.

Support services were available to patients and relatives who were having difficulty coming to terms with the fact that the patient was at the end of life. Patients reported that they were offered support from a number of sources, such as the chaplaincy and others.

Compassionate care

- Patients and relatives we spoke with about end of life care told us that staff were very caring; they were very positive in their comments. Relatives spoke of staff noticing when patients were uncomfortable or distressed.
- During our inspection, on the whole we witnessed patients being treated with dignity and respect.
- Patients who were at the ends of their lives were placed in side rooms, away from the busy ward environment, whenever possible. Curtains were closed when treatment or care was being given.
- Staff and relatives told us that normal visiting times were suspended when patients were approaching the end of life, meaning that relatives were able to visit the ward at any time, night or day.
- Volunteers worked in the trust to support patients at the ends of their lives by sitting with them, supporting them and reading to them, for example.

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- According to the Cancer Patient Experience Survey, the trust was within the top 60% of trusts and in some cases the top 20% of trusts in relation to cancer care. In some areas the trust's performance had dropped from the previous year, notably by 7% (from 69% to 62%) in relation to whether patients thought there were always/nearly always enough staff on duty.
- According to patient-led assessments of the care environment (PLACE), the trust was performing better than the England average for cleanliness, food, and privacy and dignity.

Patient understanding and involvement

- One patient told us that they had asked staff to be open and honest about their condition and health care. They reported that staff had been kind and caring in their explanations and had given the patient choices about where they wanted to spend their time – at home, in a care home, or in a hospice.
- Relatives told us that staff had told them clearly but kindly how their loved one was progressing; relatives felt reassured that, when the time came, staff would inform them of changes and deterioration.
- Staff we spoke with told us that they encouraged patients to involve their families, but understood that some patients did not want their families to know how unwell they were. Staff understood that they must respect this decision.
- Specialist palliative care nurses told us about a new initiative they had introduced to support patients and their relatives. Each patient at the end of life was given a booklet containing information, with a section for patients and relatives to make notes or write down any questions about care, equipment or any aspect of the admission. Specialist nurses visited patients every day and could answer the questions in person, explain any areas of confusion, and quickly allay fears and worries. This improved the experience not only for the patient, but for family members too.
- The trust took part in the National Care of the Dying Audit. The result showed that 63% of records reviewed gave evidence that discussions with patients and relatives had taken place.
- According to the inpatient survey, the trust was among the worst-performing trusts for staff answering questions about operations and procedures; however,

the trust performed as expected for involvement in decisions about care and treatment, emotional support, addressing worries and fears, and nurses answering questions in a way that patients could understand.

- During our inspection we visited the mortuary and spoke with staff. They were able to demonstrate compassion, respect and an understanding of the importance of preserving the dignity of the deceased. The explained how the viewing rooms were prepared and how they supported visiting relatives.

Emotional support

- Specialist palliative care staff, as well as staff on the wards, were able to offer emotional support to patients and relatives. When the specialist palliative care team had been involved, they then visited bereaved relatives up to three times to offer emotional support before signposting them to other agencies for support.
- The chaplaincy was available to offer spiritual support to patients and their friends and family.
- Staff on the wards told us that they would monitor the mood of patients who had received a poor prognosis or had been given bad news to see whether they needed extra support.
- The trust had a counselling service available to staff and patients, called Listening Ear.
- In maternity services, bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; these were facilitated by the chaplaincy service, which offered support to families following bereavement. A specialist midwife was responsible for coordinating this and ensuring paperwork was accurately completed, and for cascading bereavement training to staff; however, no dedicated time was allocated for this role.

Are end of life care services responsive?

Good



The trust was able to respond to the needs of patients and their relatives. Appropriate arrangements were in place for relatives to visit deceased patients. Support was available to relatives through counsellors and chaplaincy staff. The

End of life care

trust was able to accommodate the cultural and religious needs of patients and their relatives and worked hard to ensure that these were met, for example to release bodies quickly to comply with religious burial customs.

In the majority of cases, patients were able to have a side room for their last days.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team was available from Monday to Friday, from 9am to 5pm, and out of hours through a mobile telephone number. They told us they aimed to see urgent referrals within one working day and non-urgent referrals within two working days.
- Chaplaincy support was available 24 hours every day, in person during office hours, and by telephone initially out of hours.
- Staff collected and analysed information about the gender and age of patients, reasons for referral, type of medical condition patients had and where they were discharged to in order to help them provide a service that was most appropriate and tailored to people's needs.
- Staff from the specialist palliative care team told us that their role involved not only the care of patients, but giving advice and training to other staff employed by the trust on the wards. They told us that, when demand for their support and input was high, patient care remained their priority but they could not fulfil other aspects of their role.
- The trust did not collect information about whether patients were dying in their preferred place of death.

Access and flow

- Patients requiring specialist palliative support were referred by the ward teams. Referral was supposed to be in writing, but staff told us they usually made a telephone call first and then followed up the referral with a fax.
- The specialist team told us they supported approximately 450 to 500 patients each year and provided telephone advice and support to staff for many other patients.
- We saw some patients who were at the end of life. They had been moved from the main ward to a side room so that they and their family had privacy in their final days.

- Staff on the wards told us that due to pressure on beds, they occasionally had to move patients at the end of life out of side rooms or onto different wards. We reviewed the incidents from January to July 2014 and found that there was one incident reported where this had happened and one where this was proposed but did not happen. The patient, who was moved, was moved out of a side room because the room was needed for someone who presented with an infection control risk.
- The specialist palliative care team told us they followed patients around the hospital to ensure that their end of life care needs were planned appropriately.

Meeting people's individual needs

- Where possible, side rooms were prioritised for patients at the end of life. In the accident and emergency department, there was a relative's room and a room in which to place deceased patients, which relatives could enter. This was good practice.
- Staff we spoke with about end of life care on the wards told us that due to staffing levels, particularly if the ward was busy, sometimes it was difficult to give patients at the end of life all the attention and support they needed.
- Staff told us that they always tried to accommodate patients' wishes about their preferred place of death and worked with community staff to facilitate quick discharge. There was a rapid discharge policy and checklist in place to facilitate the process. The annual report from the service showed that 3% of patients were discharged using the rapid discharge process. A further 12% of patients had been discharged to a hospice. This was a 100% increase on the previous year. .
- Translation and interpreting services were available to patients and their relatives, and leaflets were available in different languages. We did, however, meet with one patient with very poor vision who told us that they had not been offered any information in a format suitable for people with reduced vision.
- There were several different places where relatives could visit deceased family members, such as in accident and emergency, within the maternity service and in the mortuary. These places were decorated sympathetically and provided a good environment for relatives.

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- Information leaflets were available to patients and relatives leading up to a patient's death, and for relatives after a patient's death. These were clearly written and gave practical advice.

Learning from complaints and concerns

- The trust had mechanisms in place to feed back to staff information about complaints and concerns received from patients and their relatives.
- The specialist palliative care team told us they received feedback about complaints that related to end of life care, but did not have a record of how many complaints had been made within the last 12 months. They told us that they would check whether any learning from complaints could be shared across wards. Where there was learning, if the specialist palliative care team had capacity to do so, they would work with the specific ward in question initially and then with other wards.
- In the six months from October 2013 to March 2014, the trust received 52 complaints about end of life care. Of these, 28 related to aspects of care, six to admission, discharge or transfer, 14 to communication, two to delayed appointments and two to property.

Are end of life care services well-led?

Good



The end of life care services delivered by the trust were well-led. There was an end of life strategy and a modernisation facilitator in place to make sure the strategy was implemented.

Governance and risk management mechanisms were in place. There was learning from incidents, concerns and complaints.

Staff felt supported. There was an open and supportive patient-focused culture within the service.

The trust took part in national audits and had undertaken some local audits of practice. Staff were innovative in their approach and some initiatives were being piloted to improve patients' experiences.

Vision and strategy for this service

- The trust had an end of life strategy in place and employed a modernisation facilitator to ensure that the

strategy was implemented. Additionally, when we spoke with one of the consultants and the two specialist nurses, they were clear about how they wanted to develop the service to meet the needs of future patients.

- Staff we spoke with on the wards were aware of the challenges faced by the trust, such as financial pressures.
- The annual report for the service identified the priorities for the team in the coming year and there was an action plan in place to support this.

Governance, risk management and quality measurement

- Audit about 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders had taken place and the results had been disseminated across the trust. The audit included 11 wards and 215 patients, 53 of whom had DNACPR decisions. Areas where standards were not met included; 19 patient records did not have relevant documentation stapled to the front of the clinical record, 30 patients with a decision made by a junior doctor had not had the decision reviewed by a consultant, 34 patients did not have the communication section of documentation completed, only 9 patients had documented evidence that discussions with patients and/or their relatives had taken place, 18 patients did not have the decision recorded on the electronic patient record system in use. The audit showed that recommendations had been made to educate staff and carry out a re-audit. This was being actioned by the trust.
- From the DNACPR records we looked at, we could see that there had been some improvements. For example, all relevant documentation was stapled to the front of the medical record, consultant counter signatures were in place more often and discussions with patients and relatives were documented more frequently.
- The specialist palliative care team had governance arrangements in place through the trust they were employed by rather than through City Hospitals Sunderland. However, the End of Life steering group attended by the specialist team ensured that there were close links with the clinical governance structures in place within City Hospitals Sunderland.

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- The lead consultant worked closely with the complaints team. The specialist team met regularly to discuss complaints and incidents, and how to improve the quality of the care provided to patients and training and support of staff.
- Information relating to drug alerts and safety bulletins was communicated to the staff via their employing trust.
- According to the National Care of the Dying Audit, the trust had achieved the key performance indicator of having trust board representation and planning for care of the dying.

Leadership of service

- The palliative care consultant provided leadership to the specialist team, who told us they felt supported in their roles.
- Although the staff were not directly employed by the trust, they told us they felt part of the trust and had worked in their roles for many years.
- Staff expressed some frustration that there were not more staff in the team, which would give them capacity to improve training for other staff.

Culture within the service

- Staff told us they provided good care and they were proud to work at the hospital.
- The palliative care team, the mortuary staff and the chaplains were very proud of the difference they made to patients, their relatives and friends.
- Staff worked well together and there was obvious cooperation across disciplines.
- Staff were committed to providing patients at the end of life with high quality care.







Public and staff engagement

- The Patient Advice and Liaison Service (PALS) was visible. Patients and relatives we spoke with knew how to raise any concerns.
- Patients and relatives we spoke with knew how to make a complaint if they needed to. None of the people we spoke with had needed to make formal complaints; they were happy to raise any concerns on the ward without fear of repercussions.
- We saw some information for patients on how to raise complaints displayed around the hospital.
- The trust took part in the Friends and Family test, although there was no specific information relating to the specialist palliative care team.

Innovation, improvement and sustainability

- The specialist palliative care team expressed their frustration that due to staffing pressures they had not been able to develop the service as much as they wanted to.
- A system was in place called the rapid access patient alert (RAPA) system to identify when any patient receiving chemotherapy was admitted to the hospital. This was due to be rolled out to the accident and emergency department.
- The service was working with the intensive and critical care unit in supporting them to get patients home to die with home extubation.
- The service worked with the chemotherapy department to offer chemotherapy at home service to patients.

Outpatients and diagnostic imaging

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

Information about the service

Sunderland Royal Hospital has a large outpatient department where a number of different specialties hold clinics. Other outpatient areas across the hospital site are associated with specific specialties such as urology, trauma and orthopaedics, and children's services. In 2013 approximately 623,789 people attended consultant- and nurse-led clinics in the outpatient departments, and the hospital carried out approximately 28,000 outpatient procedures.

During the inspection we visited the main outpatient department plus three other areas where outpatient clinics were held, including urology, head and neck, and trauma and orthopaedics.

We spoke with 37 patients, 10 nurses, one consultant, six support staff, four relatives, two medical technicians and five healthcare assistants. We observed the outpatient environment, checked equipment and looked at patient information. We also reviewed performance information from the trust.

Summary of findings

Overall, the care and treatment received by patients in the outpatient departments within the hospital was safe, effective, caring, responsive and well-led. Patients were happy with the care they received and found the service to be caring and compassionate.

Staff were well trained and supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm, because policies and procedures were in place to ensure that this was managed appropriately.

Patients were given follow-up appointments when they should receive them. Staff were listened to, and patients were engaged with and their opinions actively sought.

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

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



Care and treatment delivered by the outpatient service was safe. Incidents were reported, investigated and lessons learned. The cleanliness and hygiene in the department was within acceptable standards. Sufficient personal protective equipment was available to protect patients and staff from cross-infection and contamination. There was sufficient clean and well maintained equipment to ensure that patients received the treatment they needed in a safe way.

Staff were aware of the various policies in place to protect vulnerable adults or those with additional support needs. Patients were asked for their consent before care and treatment was given. There were sufficient well trained and competent nursing and medical staff within the department to ensure that patients were treated safely. Staff also told us that they were aware of their responsibilities in the light of major incidents.

Patients were, on the whole, protected from receiving unsafe care, because medical records were available for outpatient clinics, with only very few exceptions, and electronic records were being introduced.

Incidents

- There had been two serious incidents in 2013/2014 relating to radiology and a patient death.
- In all of the areas we visited, staff told us that they were learning from incidents and having team meetings.
- Staff told us they were able to access the incident reporting system and could report serious incidents; however, minor events such as missing clinic notes were not always reported as incidents.

Cleanliness, infection control and hygiene

- We observed that clinic areas were clean and tidy. However, one patient reported noting the same stain on the floor in the oncology department on two consecutive days.

- Hand gel was available in treatment rooms and in some public areas where the dispensers could be observed. (Hand gel dispensers were only placed in public areas that could be monitored, because some patients had tried to drink the alcohol gel.)
- We observed staff cleaning their hands and changing personal protective equipment appropriately between patients.
- Hand-washing audits were carried out regularly in all outpatient departments. We saw reports received by some managers to show that staff were fully compliant.

Environment and equipment

- Staff told us, and we observed that specialist equipment such as hoists and slings were available within the department. Staff confirmed that they had been trained to use this specialist equipment.
- A supply of wheelchairs was available to assist patients with mobility problems. We observed that these were clean and in good condition.
- Where there was specialist equipment in some outpatient departments, such as in cardiology and urology, maintenance contracts were in place to ensure that equipment was maintained regularly and fixed quickly.
- We carried out general observations to make sure equipment had received a portable appliance test (PAT). One fridge had an out-of-date PAT test. Other equipment we checked had up-to-date PAT tests.
- Staff told us that equipment was regularly calibrated to make sure that accurate readings were given.
- We saw that resuscitation trolleys were in place around the department. Staff told us that these were checked regularly before clinics started. We looked at one and saw that it had been checked that day.

Medicines

- We noted that fridge temperatures had been checked and documented in some but not all areas of the outpatient department.
- Some cancer drugs in the outpatient department required that two signatures be given before they were administered. The documentation we looked at showed that this was taking place.
- Drugs were stored appropriately in all areas.
- There were no controlled drugs in any of the outpatient areas we looked at.

Outpatients and diagnostic imaging

Records

- Staff showed us that records were stored securely. We saw that on reception, staff made sure to keep clinical records out of sight of patients.
- Staff told us that records were generally available for outpatient clinics. They confirmed that electronic records were being used, which meant that even when paper records were not available, information about patients was available to staff.
- In some clinics, dual recording in paper records and electronic records takes place. This is because some staff did not like to work from electronic records. Some staff told us that this increases the time it takes them to complete records, increases pressure on them and can cause delays in clinics. It was confirmed that the electronic and paper records were the same.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about how they gained consent from patients to carry out interventions such as taking blood and measuring height and weight. Staff told us that such consent was not formally documented. Staff told us that if they told a person they needed to take blood and the person offered their arm, they would understand that the patient had consented. Staff confirmed that if at any point people withdrew their arms, they would understand that consent had been withdrawn.
- We spoke with a number of staff about their understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. On the whole, staff were able to explain what each involved; however, some staff confused deprivation of liberty with safeguarding vulnerable adults.
- From the training information the trust gave us, we could see that consent was part of mandatory training only for some staff, and none of these worked in the outpatient department.
- The trust was able to show that one person from the rheumatology outpatient department and six people from the chest clinic outpatient department had attended Deciding Rights training. The trust could not demonstrate that any staff from outpatient departments had attended training about mental capacity or Deprivation of Liberty Safeguards.

Safeguarding

- The trust had policies and procedures in place about how to deal with safeguarding situations for both children and adults.
- On the whole, staff we spoke with had an understanding about safeguarding, and knew what possible signs of abuse might be and where to access support if they had any concerns that someone was being abused. They were confident about how to escalate concerns to the safeguarding team.
- Of outpatient staff, 95% had completed training in safeguarding vulnerable adults, 95% had completed Level 1 and 2 training in safeguarding children, and 100% had completed level 3 training in safeguarding children.

Mandatory training

- Staff reported that they were able to access mandatory training.
- The trust gave us information about the different mandatory training people received in the outpatient department. Some staff required more mandatory training than others, for example in the use of syringe drivers or other medical devices, because of the area of the outpatient department they worked in.
- The overall level of completion of mandatory training across all staff for all types of training was 92%. This was above the trust's requirement of 80%. Specifically, fire training was at 90%, slips, trips and falls training was at 96%, moving and handling of people was 79%, infection control level 1 was 98% and level 2 was 98%.

Assessing and responding to patient risk

- Staff told us that the outpatient department had good links with the accident and emergency department in case there were any concerns about deteriorating patients.
- There were resuscitation trolleys around the department in case patients needed urgent medical attention.

Nursing staffing

- Managers in the main outpatient department told us that there were some vacancies, but the department was able to use bank staff if it needed to. Recruitment had taken place to fill these vacancies, and pre-employment checks were underway. New staff were expected to start within the coming month.

Outpatients and diagnostic imaging

- The three managers we spoke with told us that the number of staff on duty was decided not only by the number of clinics running, but also the type of clinic, because some clinics needed more support staff than others. The particular specialty running the clinic decided the number of staff needed. Some clinics also had patients with higher dependency or needs.
- Some staff told us that on occasion they were under pressure, but they all told us they worked hard to ensure that there was no impact on patient care. Some staff felt that additional staff were needed on some clinics.
- Staff felt that the skill mix within the department was fit for purpose and that patients' needs were met.

Medical staffing

- Other departments provided medical staff on the specific days when they ran clinics.
- Medical staff undertaking the clinics were of all grades; however, we saw that consultants were always in the department when clinics were running.
- Medical staff told us that they were able to cover clinics for sick or absent colleagues. They told us that clinics were only rarely cancelled; this was confirmed by other staff within the department and by patients.
- Medical staff told us that only limited use was made of locums within the outpatient clinics, although some specialist clinics had a shortage of technical staff which meant that locums were used. Senior clinicians told us they found these staff to be very competent.
- No specific information about locum staffing levels within the outpatient department was available.
- In 2013/2014, 3.57% of the staffing budget was spent on agency staff.

Major incident awareness and training

- There was a major incident policy, and staff were aware of their roles in the event of an incident.
- Managers told us that unannounced mock incidents took place in the trust to check the preparedness of staff.

Are outpatient and diagnostic imaging services effective?

We found that the services provided by the outpatient department were effective. Care and treatment was evidence based and patient outcomes were within

acceptable limits. Staff in the department were competent, and there was evidence of multidisciplinary working. When the number of patients waiting to be seen caused problems, action was taken to run extra clinics to meet demand.

Evidence-based care and treatment

- We saw that National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments within the hospital, with a lead clinician taking responsibility for ensuring that guidance was implemented within specific specialties. Nursing- and specialty-specific staff we spoke with were aware of the NICE and other guidance that affected their practice.
- We saw that the department was adhering to local policies and procedures. Staff we spoke with were aware of how the policies and procedures affected patient care.

Pain relief

- Staff told us that they were able to access pain relief for patients if this was required before, during or after outpatient treatment. Some patients occasionally needed controlled drugs; these were prescribed by clinicians and obtained from the pharmacy.
- None of the patients we spoke with had needed pain relief during their outpatient appointments.

Patient outcomes

- The outpatient departments we visited told us that they took part in local and trust-wide audits. For example, in the fracture clinic within the last 12 months there had been an audit of scaphoid fractures and of mallet finger. There were also examples of audits being carried out by the chest clinic, such as of electronic oxygen prescribing. Some of these audits were to be reported at national conferences. Staff involved in audits were aware of the audit cycle and the need for re-audit to ensure that positive changes happened as a result of changes in practice.

Competent staff

- Minutes of team meetings showed that they were held regularly and staff were able to contribute to them.
- Staff we spoke with confirmed that they had received appraisals in the last year, and that clinical supervision was available for individuals and groups.

Outpatients and diagnostic imaging

- Information sent to us showed that all doctors were up to date with their revalidation.
- As of June 2014, 38% of nursing and healthcare staff had undergone an annual appraisal. In the previous financial year from April 2013 to March 2014, 29% of staff underwent appraisal.

Multidisciplinary working

- We saw evidence of multidisciplinary working in a number of the outpatient departments we visited. For example, in the cardiology department, cardiographers worked alongside doctors and nurses. In the fracture clinic, nurses worked alongside radiographers and plaster technicians.
- Staff told us how they worked alongside therapists in some outpatient clinics when patients were receiving therapy, as well as attending outpatient clinics.

Seven-day services

- The outpatient department occasionally ran clinics at weekends; however, most activity within the outpatient department happened between Monday and Friday. On occasions, specific specialties ran clinics on Saturday morning, particularly if the waiting list was increasing or there was a risk of not meeting waiting time targets.

Are outpatient and diagnostic imaging services caring?

Good



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

Compassionate care

- The patients we spoke with in all the outpatient clinics we visited spoke highly of the care and treatment they received. There were no negative comments about the compassionate and caring aspects of the service.

- During our inspection we saw patients being treated respectfully by all staff. We also saw occasions when staff noticed that patients were nervous and reassured them.
- We saw that people's privacy was respected and that people were addressed and treated respectfully by all disciplines of staff.
- Staff made sure that patients were kept up to date with waiting times in clinics; patients told us that this meant they were able to take comfort breaks if they needed to. Patients also told us that they had been offered alternative appointments when clinic waiting times became long or if they were unable to stay.
- We saw that patients and staff had a good rapport and that staff put patients at ease. Some patients were regular attenders and knew the staff very well. Even new patients told us that they were put at ease and felt that staff were caring towards them.
- Staff were observed to knock on doors before entering. Curtains were drawn and doors closed when patients were in treatment areas.
- Staff told us that the trust had mechanisms for identifying patients with additional support needs, although we did not see any examples of this in the records we looked at in the department.

Patient understanding and involvement

- We spoke with 37 patients across all of the outpatient clinic areas within the Sunderland Royal Hospital site. Patients told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment. One patient told us, "The staff were straight with me and told me what I needed to know, but in a very kind way. I know my prognosis and I know how my illness will progress."
- Patients felt that they were given clear information and time to think about any decisions they had to make about different treatment options available. They also told us that the treatment options had been explained to them clearly with enough information about side effects and outcomes for them to make informed decisions.
- Relatives told us that they were able to go into clinics with their loved ones and that staff encouraged them to do so if this was in line with patients' wishes.

Emotional support

Outpatients and diagnostic imaging

- Patients told us that they felt supported by the staff in the clinic. They reported that if they had any concerns, they were given the time to ask questions. Staff made sure that people understood any information given to them before they left the clinic.
- Some patients told us that they were given time to take in news they had been given, and that staff had offered to speak with them over the telephone at any time if they had any concerns or questions.
- Staff told us that formal counselling support was available for patients and relatives who needed it if, for example, they had received bad news. Information was also displayed on noticeboards in some clinics about support networks available for patients, and patients could take leaflets about support groups.

Are outpatient and diagnostic imaging services responsive?

Good



We found that outpatient services were responsive to needs of patients. Waiting times were within acceptable timescales, with clinics only occasionally being cancelled. Patients were able to be seen quickly for urgent appointments, if required. Outreach clinics were run closer to patients' homes.

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

Service planning and delivery to meet the needs of local people

- Patients told us that some clinics started early for people who worked, to make sure they could attend and not miss any work.
- Staff told us that when clinics were expected to be busy, extra staff routinely worked to try to ease the pressure.
- When clinics were running late, some clinics, such as urology, offered patients alternative appointments.
- The trust informed us that it did not monitor when clinics started late or overran, and that the only way this

information was captured was if a member of staff reported an incident. When incidents were raised, divisional and service-manager-level managers addressed the issues.

- Occasionally, additional clinics were organised by some specialties, particularly if they were concerned about patients not being seen within waiting time targets.

Access and flow

- The average time for a patient to wait for a new appointment, from referral, across all specialties, was 46 days. Some patients had to wait longer to be seen in clinics such as endocrinology (62 days) and neurology (69 days), and for much less time in others such as general surgery (32 days) and geriatric medicine (32 days).
- The average time that patients had to wait once they arrived at the clinic, before being called in to their appointment, was two minutes; however, in haematology, the average wait was 32 minutes.
- Overall, in 2013/2014, the percentage of patients achieving the referral-to-treatment time of 18 weeks was above the England average and above the national standard of 95%.
- The percentage of people, across the trust, seen by a specialist within two weeks of urgent GP referral was slightly lower than the England average, although the percentage had risen towards the end of the year and was similar to the England average by the end of March 2014.
- The trust held outreach clinics in a number of locations around the region in premises owned by other organisations. These sites were staffed consistently by the same staff, supported and visited by the outpatient department's sister and its manager. Clinics were therefore more easily accessible to patients who could not access the main hospital easily.
- The 'did not attend' rate for the outpatient department was less than 1% across all specialties.
- Staff told us that clinics always had the capacity to see patients who were referred urgently, and that double booking two patients into one clinic slot happened only on rare occasions.
- The cancellation rate for clinics in the outpatient department from January to June 2014 ranged between 2% and 3%.
- Staff told us that some clinics were piloting a new initiative called Clinic in a Day. Before leaving the

Outpatients and diagnostic imaging

hospital after their appointments, patients were given information about their condition, and the dates and times of their next appointment and any appointments for investigations or tests such as x-rays. Any information for GPs was also printed and given to the patient.

- The trust was working with the local ambulance service to improve the experience of patients travelling by ambulance. The plan was for a member of staff from the ambulance trust to be on site to coordinate patients. Staff told us that currently there was telephone line direct to the ambulance bureau that patients could use.

Meeting people's individual needs

- Staff told us that they were able to access translation services if they needed to. On the whole, staff told us that they used translation services.
- We saw that the outpatient department provided information leaflets for patients; however, some of these leaflets were past their review dates, some by a number of years. Leaflets were available in different languages if needed.
- Staff told us that when patients with learning disabilities attended the department, staff tried to give the patients priority to be seen. Staff were aware of the support available within the trust, and also knew to allow carers to remain with the patient if this was what they wanted.
- Some staff told us they had attended training about dementia within the trust and were aware of how to support people at different stages of dementia. Staff told us that most patients living with dementia were accompanied by carers or relatives. Provisions were made to ensure that patients were seen quickly.
- A canteen was available for patients to use, and the outpatient department had access to food and drink for vulnerable patients and patients with conditions such as diabetes. A system was in place to make sure that patients who attended in wheelchairs and were waiting to return home were also able to access food and drink. If there were long delays for ambulance patients or vulnerable adults, patients were taken to the discharge lounge to await transport. Food and drink was available in the discharge lounge.
- The department was able to accommodate patients in wheelchairs or who need specialist equipment such as hoists. Staff told us that they had received training in how to use such equipment.

Learning from complaints and concerns

- Staff we spoke with were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the Patient Advice and Liaison Service (PALS) or make a complaint was available in waiting areas.
- Managers and staff all told us that complaints and concerns were discussed at local team meetings and any learning was shared across the department and fed back to particular specialties if relevant. The managers we spoke with told us that action plans were generated and monitored.
- The trust gave us information about the number of complaints received about outpatient departments. This showed that there were 327 complaints in 2013/14. The majority of complaints were about clinical care and treatment (210). There were also complaints about attitude and behaviour (21), communication (52), consent (1), environmental incidents (34), non-clinical care (2), protocols and procedures (3) and security incidents (1).
- Some of the patients we spoke with had complained in the past. They told us that they were happy with how their complaints had been dealt with.

Are outpatient and diagnostic imaging services well-led?

Good



The outpatient department of Sunderland Royal Hospital was well-led. Staff and managers had a vision for the future of the department and were aware of the risks and challenges faced by the department. Staff felt supported and were able to develop to improve their practice. There was an open and supportive culture where incidents and complaints were reported, lessons learned and practice changed. The department supported staff who wanted to be innovative and try new services and treatments.

There was little evidence that the trust engaged with patients who used the outpatient department, or actively sought their views about their care, since the Friends and Family test only applied to inpatients. There was no mechanism for reviewing patient information, updating it or checking its validity.

Vision and strategy for this service

Outpatients and diagnostic imaging

- The department managers we spoke with demonstrated a vision for the future of services. They were aware of the challenges faced by the departments they managed. They described how work was underway to look at the capacity of the services and at ways to manage increased demand through reorganising the way clinics were organised and run.
- Staff within the services we visited were aware of the challenges the organisation faced, for example the financial challenges. Most were aware that there is a strategy for the trust but were mostly interested in how their department is running.

Governance, risk management and quality measurement

- Strong governance arrangements are in place, which staff were aware of and participated in. The trust has regular clinical governance meetings. For example, staff were given feedback about incidents and lessons learned, and the trust regularly produced lessons-learned newsletters.
- The organisation had systems in place to appraise guidance from the National Institute for Health and Care Excellence (NICE) and ensure that any relevant guidance was implemented into practice. It was less clear whether clinical audits of implemented guidance took place.
- The trust had a number of risk registers in place that were specialty specific and trust wide. These were reviewed and updated regularly. We saw that action was being taken to manage, minimise or eliminate risks.
- A number of leaflets in the department were past their review date. This showed that the trust did not have a mechanism in place for reviewing information available to patients to ensure that it was still relevant.

Leadership of service

- Staff told us that they found the managers of the service to be approachable and supportive. All the staff we spoke with told us they were extremely happy in their roles. A number of staff had been in their posts for many years.
- Staff felt that managers communicated well with them and kept them informed about the running of the department. Some staff, however, expressed their frustration that sometimes although managers listened, changes and suggestions were not acted upon. For example, some staff had reported poor signage a

number of times; however the signage had not changed. Staff had also expressed concerns about double recording for some clinics; however, time allowances were not made and double recording continued.

- Staff were able to access training and education to further their personal development. Staff told us that they were encouraged to manage their own personal development. Two staff showed us their electronic staff records of all the training they had attended. For example, one nurse had attended a course at university about care and compassion; others were doing e-learning in subjects they were interested in. Also, the trust ran leadership courses for aspiring managers; none of the staff we spoke with had accessed these.

Culture within the service

- Staff and managers told us that the trust had an open culture. They felt empowered to express their opinions and felt that they were listened to.
- Staff were encouraged to report incidents and complaints, and felt that these would be investigated fairly.
- Managers told us that they felt well supported by the organisation.
- Managers told us that members of the board occasionally visited the department, and that the chief executive had regular meetings with senior nursing staff.
- All the staff we spoke with were very proud to work for the trust.

Public and staff engagement

- We saw that governance arrangements were in place and complaints and comments were discussed at team meetings.
- We asked the trust for results of patient satisfaction surveys conducted in the outpatient department. Staff were unaware of any patient satisfaction surveys having been carried out within the outpatient department. (The Friends and Family test related only to inpatients.)
- The staff survey contained no specific information relating to staff in the outpatient department. However, the trust as a whole performed within expectations or better than expectations in all but one element of the staff survey: the number of staff attending equality and diversity training.

Innovation, improvement and sustainability

Outpatients and diagnostic imaging

- Staff and managers reported that they were able to change the way the outpatient department is organised and run. We were given a number of examples of changes that had been made to the way the service was run that had improved the patient experience and made the clinics run more efficiently. For example, in the fracture clinic a consultant triage system was being piloted to improve patient flow and reduce waiting times.
- The main outpatient department was also working on a new way of running clinics, called Clinic on a Day. The aim was to make sure that before patients leave the clinic, they know when their next appointment or test will be.
- Of all staff within the trust who responded to the NHS staff survey, 72.9% felt they were able to contribute towards improvements at work. There was no specific information for the outpatient department as the NHS staff survey does not provide this breakdown.
- Outpatient clinics were organised in locations easily accessible to the community, such as in some local health centres.
- Trials of voice recognition software were underway in the outpatients department.
- The department was involved in discussions about larger developments to the site as a way of improving capacity, effectiveness and efficiency.

Outstanding practice and areas for improvement

Outstanding practice

There was close collaborative working between the directorates of paediatrics and emergency medicine, which had developed a shared medical consultant staffing approach that included consultant staff qualified in paediatric emergency medicine.

The directorate of paediatrics had facilitated the inspection of the service by a team of young inspectors.

The use of a telehealth system in maternity services enabled women to monitor their blood glucose levels and blood pressure in their own homes, avoiding unnecessary visits to hospital.

Staff expressed compassion to families if their family member died while in critical care. Nurses placed a locket of hair and the rings of the patient in a small silver bag, and handed a printed card to the family expressing sympathy from the staff on the critical care unit.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure that there are sufficient qualified, skilled and experienced nursing and medical staff, particularly on medical wards, including provision of staff out of hours, on bank holidays and at weekends.
- Ensure that staff are suitably skilled and supported through the completion of mandatory training and appraisals, particularly in the A&E department.
- Ensure that medicines are managed appropriately. Medicines were not always started promptly when a patient was admitted at the weekend, and controlled drugs incidents were not appropriately investigated and reported within the hospital.
- Ensure that there is appropriate pharmacist support to ward and units, including with the reconciliation of medication.
- Ensure that patients are placed on the most appropriate ward to meet their needs.
- Ensure that the hospital fully complies with the four-hour wait standard in accident and emergency (A&E) and meets the standard that ambulance patients should be handed over within 15 minutes of arrival in the department.
- Continue to review and reduce the mortality outliers for the Summary Hospital-level Mortality Indicator (SHMI) within the trust.

- Ensure that 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders are signed by the appropriate medical professionals, and that discussions with patients or family members are recorded.
- Ensure that patient observation and monitoring charts for nutrition and hydration are fully and appropriately completed on medical wards.

At Trust level the provider must:

- Ensure that patient group directives (PGDs), which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment, are updated and monitored in line with the trust's policy.

Action the hospital **SHOULD** take to improve

- Review the training of competency of staff who care for patients being discharged to the community with syringe drivers in place. This will ensure that patients are not taken off one piece of equipment before discharge and then connected to the other equipment used in the community.
- Provide training on the grading of incidents and ensure that there are effective incident feedback mechanisms in place so that lessons can be learnt.
- Review the arrangements over the storage and supply of surgical instruments to ensure that there is appropriate provision of equipment.

Outstanding practice and areas for improvement

- Review the storage and provision of linen in ward areas so that staff are assured that it is clean before use.
- Review staffing in the specialist palliative care team in accordance with commissioning guidance .
- Have in place assurance that training, supervision, appraisals and revalidation are monitored for the specialist palliative care team, who are employed by a different trust.
- Collected and monitor information regarding patients dying in their preferred place of death.
- Have mechanisms in place for reviewing and, if necessary, updating patient information, particularly in the outpatient department.
- Introduce patient surveys specific to the outpatient department.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations
2010 Staffing

Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to carry out the activity of TDDI on medical wards, including provision of staff out of hours, bank holidays and weekends, in order to safeguard the health safety and welfare of service users.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations
2010 Assessing and monitoring the quality of service provision

Ensure that the hospital fully complies with the four-hour wait standard in accident and emergency (A&E) and meets the standard that ambulance patients should be handed over within 15 minutes of arrival in the department.

Continue to review and reduce the mortality outliers for the Summary Hospital-level Mortality Indicator (SHMI) within the trust.

Ensure that patient group directives (PGDs), which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment, are updated and monitored in line with the trust's policy.

Review the available support by pharmacists and ensure that this meets the needs of wards and departments, including reconciliation of medication advice.

This section is primarily information for the provider

Compliance actions

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

Ensure that staff are suitably skilled and supported through the completion of mandatory training and appraisals, particularly in the A&E department.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Ensure that 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders are signed by the appropriate medical professionals, and that discussions with patients or family members are recorded.

Ensure that patients' records are maintained up to date including fluid balance and turning charts.