

Review of compliance

Great Western Hospitals NHS Foundation Trust Great Western Hospital

Region:	South West
Location address:	Marlborough Road Swindon Wiltshire SN3 6BB
Type of service:	Acute services with overnight beds Diagnostic and/or screening service
Date of Publication:	January 2012
Overview of the service:	Great Western Hospital is situated on the eastern side of Swindon, close to Junction 15 of the M4. The hospital opened in 2002 and has over 600 beds. Over 30% of the beds are provided in single rooms. A range of services are provided, including emergency care, surgery, diagnostics, paediatrics and maternity.

Summary of our findings for the essential standards of quality and safety

Our current overall judgement

Great Western Hospital was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Great Western Hospital had made improvements in relation to:

- Outcome 01 - Respecting and involving people who use services
- Outcome 04 - Care and welfare of people who use services
- Outcome 05 - Meeting nutritional needs

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 8 December 2011, checked the provider's records, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We visited the hospital to look at the improvements made in connection with three main areas:

- The use of 'extra bed spaces'. These were additional beds which were being used, for example, to provide a fifth bed in a room designed for four people.
- The monitoring of fluid intake in relation to those patients who were at risk of dehydration if they did not receive the appropriate support.
- The occurrence of two 'never events'. Never events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'.

These areas were not directly related, but they were matters that the Trust had responded to by producing action plans with the aim of improving outcomes for patients.

We had heard adverse comments from patients about the extra bed spaces during our two previous visits to the hospital. The Trust has since carried out work to improve the facilities; however we were told that the use of extra bed spaces continued to cause difficulties for both patients and staff. Patients did not feel they were being treated on an equal basis and staff said that they received a lot of complaints.

We had been informed of two never events in recent months involving surgical procedures. One of these was a 'wrong site' event and the other involved the 'wrong implant' (a lens). During our visit we were told about the action being taken to reduce the risk of people being involved in surgery related never events. However, patients could not yet be confident that the appropriate preventative measures were being consistently implemented.

Patients' fluid intake was not always being well monitored when we visited the hospital in July 2011. There was a risk that some patients were not receiving the support they needed with hydration. We looked at this again during the visit on 8 December 2011. The staff we spoke to were aware of the importance of monitoring people's fluid balance, although there continued to be shortcomings in how this was being managed.

What we found about the standards we reviewed and how well Great Western Hospital was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People who occupy the extra bed spaces feel that they are not being treated equally and some patients' expectations in relation to privacy and dignity are not being met. Additional facilities have been provided, although the extra bed spaces continue to be a source of dissatisfaction and complaint for some people.

The extra bed spaces present difficulties for staff and there is a lack of good information and guidance about their intended use. This is important as there are risks associated with their use and they do not provide the higher standard of services and amenities that are usually available to patients.

Overall, we found that Great Western Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People have not been adequately protected from the risk of receiving unsafe treatment during surgical procedures. The Trust has identified measures to address this and is establishing new ways of working, however these have not yet been effectively implemented. Regulation 9 (1) (b) is not being met.

Overall, we found that improvements were needed for this essential standard.

Outcome 05: Food and drink should meet people's individual dietary needs

People who have needs in relation to fluid intake and hydration are being identified, so that staff know who requires support in this area.

There is a system in place for helping people to restore or maintain their fluid balance. However, there continue to be shortcomings in this area and not all patients are receiving the support that they require. In particular, patients' fluid balance is not monitored well

enough to ensure that their needs are met and they are not at risk.

Regulation 14 (1) is not being met - people are not being adequately protected from the risk of dehydration.

Overall, we found that improvements were needed for this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

In a previous review, we suggested that some improvements were made for the following essential standards:

- Outcome 11: People should be safe from harm from unsafe or unsuitable equipment
- Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills
- Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Please see previous reports for more information about previous reviews.

**What we found
for each essential standard of quality
and safety we reviewed**

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01: Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- * Understand the care, treatment and support choices available to them.
- * Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- * Have their privacy, dignity and independence respected.
- * Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

We had found on our two previous visits to the hospital that patients using the extra bed spaces did not experience the same degree of facilities, choice, and independence. Their privacy and dignity were being compromised.

We visited three wards during our visit on 8 December 2011 and saw extra bed spaces being used on each. The facilities had improved overall through the provision of lights, call points and cupboard spaces.

The use of extra bed spaces continued to have an adverse affect on patients' experiences. Relatives we spoke with mentioned a lack of privacy and not having a radio to listen to. One patient expressed their frustration at not having access to their own television; they watched the set that was installed above an adjacent bed.

On each ward staff said that they had received negative feedback from people occupying the extra bed spaces. This included "lots of complaints about a lack of space and privacy". We were told that some people felt aggrieved at not being treated equally; others complained that they could not access the entertainment system and became bored. Speaking on behalf of a patient, a relative said that they had not been told about the lack of some facilities and why this was the case.

Staff and a ward manager told us about the practical difficulties. The extra bed spaces were described as "claustrophobic" and "not good for privacy". One of the staff commented "none of the nurses like the extra beds as they restrict what we can do". We saw that the location of some extra bed spaces meant that the patient could only get out of bed on one side and the door to the room hit the end of their bed.

Curtains were providing privacy for patients, although there were shortcomings. The extra bed spaces we saw did not have sufficient curtain tracking to enable curtains be fully drawn around the bed; staff showed us portable curtains that could be used when privacy was needed. One of the staff described the use of the portable curtains to maintain privacy as "a bit tricky when doctors are doing procedures".

In some situations, a curtain could be drawn along one side, but it overhung the bed space. This meant that the curtain was up against the bed and we saw visitors sitting at the bedside in contact with the curtain. This compromised the efforts being made to reduce the risk of cross-infection.

Other evidence

The Trust had produced an action plan for improving the facilities in the extra bed spaces and the privacy provided to patients. All the spaces were to have call bells and lights fitted; full curtain rails and curtains were to be installed where possible.

The Trust told us that ceiling curtain rails were not possible in all areas, but mobile screens were available instead. Internal viewing windows in the corridors next to some extra bed spaces also had an impact on people's privacy. Staff said that curtains had been ordered for these windows. For the most part, we found that the plan had been implemented, although there were deficiencies, such as where we saw that a light or a call point had not been fitted. Staff on one ward said that one of the extra bed spaces was not being used as the call point was not working. In contrast, an extra bed space on another ward was being used without a call point having been installed. Staff told us that the patient was provided with a hand bell.

The Trust originally told us that the use of the extra bed spaces was a temporary measure and that staff had been told that the improved facilities did not mean that they were becoming permanent. Each ward we visited had four extra bed spaces, which staff said were being used regularly. The Trust confirmed that the extra bed spaces were only used in accordance with the Trust's escalation policy when there was an increased demand on bed capacity.

Staff said that consideration was being given to who used the extra bed spaces. We were told, for example, that they were used for the "fitter patients who were relatively independent". Staff on one ward said that people with mental health problems, learning disabilities, or people who required oxygen would not be deemed suitable. On another ward we were told that staff used their judgement and these beds would only be allocated to "people who did not require a lot of attention". Staff said that there were sometimes difficulties because patients assumed they would be able to transfer to another bed when one became available, but this was not always possible because of competing needs of new admissions. The Trust told us that, in accordance with the escalation policy, patients were allocated beds by the site manager 'as clinically appropriate and safe to do so'.

Staff told us that it was explained to people prior to using one of the extra bed spaces that they would not have the same facilities as other patients. This included a lack of equipment such as piped gasses and entertainment systems. We were told that these discussions had not been recorded and other information, for example about the criteria used and the risks to patients using the extra bed spaces, were not being documented.

Our judgement

People who occupy the extra bed spaces feel that they are not being treated equally and some patients' expectations in relation to privacy and dignity are not being met. Additional facilities have been provided, although the extra bed spaces continue to be a source of dissatisfaction and complaint for some people.

The extra bed spaces present difficulties for staff and there is a lack of good information and guidance about their intended use. This is important as there are risks associated with their use and they do not provide the higher standard of services and amenities that are usually available to patients.

Overall, we found that Great Western Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 04: Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

We had been informed of two never events in recent months involving surgical procedures. One of these was a 'wrong site' event and the other involved a 'wrong implant' (a lens).

Action was being taken to reduce the risk of people being involved in surgery related never events. Staff from another trust had offered advice and shared their experience about how changes and improvements could be made. Surgeons and anaesthetists had attended meetings and been informed of the never events. One surgeon commented: "things have got better since our team meeting". They said that communication was good, although we received mixed feedback from other staff. The overall feedback from staff at all levels was that changes had been made, but there was still "some way to go".

Staff said there had been a change in how the World Health Organisation (WHO) surgical safety checklist was being used. This checklist consists of safety checks which are done at various stages of a person's journey through the operating theatre, with the involvement of the theatre team. The checklist had been used by the Trust since 2009 and staff said a paper copy of the checklist was now being completed for each patient. This had been happening for about three weeks. The Trust confirmed that the checklist had been relaunched on 1 December 2011 in order to raise its profile. We were told that the paper checklists were collected centrally. The Trust confirmed that audits of the checklist had been in place on an 'ad hoc' basis since 2009 and the audit process was to be improved and relaunched as part of their action plan in response to the never

events.

The feedback from staff was that the checks were being more thoroughly completed, although some surgeons and anaesthetists were "better than others". The checks covered three main procedures called 'sign in', 'time out' and 'sign out'. These checks are expected to be 'clear, formal and read out loud'. We observed over 20 checks being carried out across several theatres. We saw checks being carried out in a clear and focused way and well organised checks which were being led by strong members of the team.

However, we saw that the WHO guidelines were not always being followed in a consistent way. A detailed 'sign in' check should be performed before the anaesthetic is given to the patient. The sign in checks were not done well; we saw anaesthetists doing them in isolation and occasions where the check was interrupted by staff, which meant that information could be missed. We saw an example where staff confirmed that the anaesthetic machine was functioning, although they had not been present in the anaesthetic room when the anaesthetist had checked it. The Trust told us that their standard practice was for anaesthetic machines to be checked by anaesthetic practitioners and documented (sometimes before the arrival of the anaesthetist).

Staff were aware of the shortcomings we found; some mentioned the need for a shift in culture and for staff to come together earlier in theatre to do the sign in. Staff also mentioned the importance of a person taking responsibility for ensuring that the checks were undertaken appropriately. They said that it had not always been happening.

The next check, 'time out' is carried out just before the operation begins. This was performed better overall, with the majority of checks being done in a clear and organised manner with the full team. However, one time out check was performed when the anaesthetist was not present. Another was conducted when a theatre support worker was not listening and later had to ask for information which had already been relayed during the time out check.

We saw that sign in and time out checks were performed in a sensitive and reassuring way when patients required local anaesthetic. Staff involved patients in these checks so that they were aware of what was happening. At the end of one procedure we heard a surgeon taking time to advise a patient about after care and how they could be contacted if the patient had any concerns.

Following the surgery there should be a 'sign out' check performed before any member of the operating team leaves theatre. Checks should be done to confirm that the name of the procedure has been recorded, that the swab and needle counts are correct and any specimens have been labelled. Instructions for the recovery period, including checks, specific to different types of surgery are also shared at this time. The majority of sign out checks we observed were performed in an organised way. However, one surgeon rushed the check and did not speak clearly and directly to the team.

The way swabs were collected and counted was consistent across the different theatres we saw. This meant that staff who moved from one theatre to another were familiar with each system and less likely to make mistakes.

We saw that briefing and debriefing sessions, as recommended by the NPSA (National

Patient Safety Agency) were not integral to the theatre checklist. We were told they were not routinely performed at the beginning of each day. Staff told us "they have never been done." We saw that staff passed any relevant information on informally, often needing to repeat this communication a number of times. This meant that staff missed vital information and spent time repeating the same information. We saw one example where staff were told by a surgeon that a patient had been cancelled from the list because of ill health. Following this, the anaesthetist came in separately and repeated the information to the same staff. Another member of the team was absent during both conversations and asked where the patient had gone. This resulted in staff being unsure of where the next patient was. A nurse said "I'm not sure where they are, I'll run around and check". This meant that the theatre preparation was delayed.

We saw another occasion where a surgeon and anaesthetist discussed a plan of action for a patient with complex healthcare needs who was coming to theatre as an emergency. This discussion was held away from the rest of the team who were standing in theatre. We saw that the information and equipment requests were repeated three times to separate staff. In addition, there were distractions during the sign in procedure.

Other evidence

The Trust had produced a comprehensive theatre safety action plan in response to the two never events. This was with the aim of increasing awareness and understanding of such events, and reducing the risk of further occurrences. The plan covered a range of areas where action was to be taken, for example in relation to cultural issues, accountability and policies and procedures.

These issues were being addressed in a number of ways, including training, meetings and the introduction of new processes. The Trust had also incorporated recommendations from a peer review into the action plan. The peer review was a very positive initiative which enabled the Trust to learn from the experience of another trust.

The plan had commenced on 4 October 2011; all the required actions were due to be completed by 5 December 2011, other than the undertaking of 'quantitative and qualitative' audits in relation to the WHO checklists, which had a completion date of 12 December 2011.

The Trust had told us that completion of the WHO checklist had been relevant to both never events. A significant part of the action plan concerned the need for theatre processes to be conducted to a consistent standard, with appropriate use of the checklist. The Trust was also looking at the content of the checklist to ensure that it was fit for purpose. Standardised checklists were being used and the Trust was using the amended checklist that the WHO has produced specifically for maternity cases. Unlike the main version, the maternity checklist did not include sections to show who had taken responsibility for the completion of the checks.

Our observations of processes and discussions with staff showed that the actions and expectations identified in relation to good communication and team working were not being consistently adhered to. Since visiting the hospital on 8 December 2011 we have been informed of another never event which has arisen within a maternity delivery room.

Our judgement

People have not been adequately protected from the risk of receiving unsafe treatment during surgical procedures. The Trust has identified measures to address this and is establishing new ways of working, however these have not yet been effectively implemented. Regulation 9 (1) (b) is not being met.

Overall, we found that improvements were needed for this essential standard.

Outcome 05: Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:

* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are moderate concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

When we last visited the hospital in July 2011 we found there was a risk of patients not receiving the support that they needed with maintaining hydration. We looked at this again during our visit on 8 December 2011 and went to two wards to see what improvements had been made.

People who were at risk of because of their poor hydration were being identified. Staff on both wards were aware of patients who needed support with hydration. Systems had been set up to monitor people's fluid balance, so that they received the necessary support. This was important so that any concerns about a person's fluid intake or output could be quickly recognised and responded to.

People could not be confident that their fluid balance would be monitored effectively. We spoke with staff about the concerns we had found in relation to individual patients. Staff acknowledged that more needed to be done and described the process that should have been followed.

Other evidence

Prior to our visit, we had been informed of an incident at the hospital in which a patient's fluid balance had not been adequately monitored, leading to them becoming dehydrated. The Trust had identified that fluid balance charts had not been recorded accurately. We were told that staff had been aware of the importance of monitoring in giving an early sign of deterioration in a patient's health.

During our visit we looked at the records for three patients who staff had identified as

being at risk of dehydration. In each case, their fluid balance charts had not being fully completed.

The fluid charts did not indicate what the expected fluid intake should be. Intake and output were not totalled on a daily basis and therefore totals were not brought forward to the following day. This meant that people's day to day hydration could not be monitored accurately.

The fluid output recorded for one patient on the day of our visit caused concern. The ward sister told us that that they thought the recording was incorrect and this would be investigated.

In the case of another patient, a nurse told us the fluid intake that was recommended for this person. Their record showed that they had not had fluid intake for over 12 hours. The recommended fluid intake had not been achieved, although there was no information recorded to show that this had been recognised and was being followed up.

We also saw one patient's food chart for the day of our visit. Staff had told us that this person was at risk of poor nutrition. The patient's name and ward had not been recorded on the chart. A section on the chart to indicate portion size had not been completed. There was no record of their lunch meal. We were later told that the patient had refused lunch, but this had not been recorded. We saw that observation sheets for this person for the last few days were also incomplete.

Our judgement

People who have needs in relation to fluid intake and hydration are being identified, so that staff know who requires support in this area.

There is a system in place for helping people to restore or maintain their fluid balance. However, there continue to be shortcomings in this area and not all patients are receiving the support that they require. In particular, patients' fluid balance is not monitored well enough to ensure that their needs are met and they are not at risk.

Regulation 14 (1) is not being met - people are not being adequately protected from the risk of dehydration.

Overall, we found that improvements were needed for this essential standard.

Action we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	<p>Why we have concerns:</p> <p>People who occupy the extra bed spaces feel that they are not being treated equally and some patients' expectations in relation to privacy and dignity are not being met. Additional facilities have been provided, although the extra bed spaces continue to be a source of dissatisfaction and complaint for some people.</p> <p>The extra bed spaces present difficulties for staff and there is a lack of good information and guidance about their intended use. This is important as there are risks associated with their use and they do not provide the higher standard of services and amenities that are usually available to patients.</p>	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	<p>How the regulation is not being met: People have not been adequately protected from the risk of receiving unsafe treatment during surgical procedures. The Trust has identified measures to address this and is establishing new ways of working, however these have not yet been effectively implemented. Regulation 9 (1) (b) is not being met.</p>	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	<p>How the regulation is not being met: People who have needs in relation to fluid intake and hydration are being identified, so that staff know who requires support in this area.</p> <p>There is a system in place for helping people to restore or maintain their fluid balance. However, there continue to be shortcomings in this area and not all patients are receiving the support that they require. In particular, patients' fluid balance is not monitored well enough to ensure that their needs are met and they are not at risk.</p> <p>Regulation 14 (1) is not being met - people are not being adequately protected from the risk of dehydration.</p>	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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