

County Durham and Darlington NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Acute services

Well-led

Facts and data about this service

Acute hospital sites at the trust

A list of the acute hospitals at County Durham and Darlington NHS Foundation Trust is below.

Name of acute hospital site	Address
Darlington Memorial Hospital	Hollyhurst Road, Darlington, DL3 6HX
University Hospital of North Durham	North Road, Durham, DH1 5TW
Bishop Auckland Hospital	Cockton Hill Road, Bishop Auckland, DL14 6AD

The trust runs services at University Hospital North Durham, Darlington Memorial Hospital, and a range of community services.

It provides the following acute core services:

- Urgent and emergency care

- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Children and young people
- End of life care
- Outpatients and diagnostics.

The trust also provides the following community health services;

- Community Health inpatient services
- Community health services for adults
- Community health services for children, young people and families (school nursing and health visiting are provided by Harrogate and District NHS Foundation Trust).
- End of life care
- Community dental services
- Community urgent care services

The trust has a network of six community hospitals. Community services are delivered from a wide range of clinics and operating bases across the area.

We inspected only the two main hospital sites during this inspection.

County Durham and Darlington NHS Foundation Trust (CDDFT) is a member of a collaboration of Cumbria and North East NHS bodies working towards Integrated Care System (ICS) status, and, at sub-regional level, a key member of the Integrated Care Partnerships (ICP) for the Centre (Sunderland, South Tyneside, North Durham) and the South (rest of Durham, Darlington, Tees Valley, Hambleton and Richmondshire) of the trust's geography.

(Source: Routine Provider Information Request (RPIR) – Sites tab / Acute context tab)

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The board was made up of five executive directors and five non-executive directors (NEDs) as well as the chairman. The chairman had been in post for over 4 years being reappointed in March 2018 and was previously a governor of the trust. Four of the five NEDs were in post during our last inspection with one being reappointed in October 2017. Two NEDs were reappointed in June 2019, one with experience in organisational development (OD), workforce management and change management.

The executive team was made up of the chief executive officer (CEO), director of finance, executive medical director, director of operations, and executive director of nursing. The CEO had

been in post for seven years and was previously the director of finance and chief operating officer. All five executive directors were in post at our last inspection. The director of workforce and OD also attended board as a non-voting member.

The director of finance had been in post for two years, having previously held the role of deputy. There was an experienced deputy director of finance and the calibre of the finance team was good. There was a well-functioning business partner model in place, providing the care group teams with dedicated financial expertise.

The chair of the audit committee had been in post for one year, after joining the board as a NED in 2017 (having also previously served the trust as a governor). He had experience at board level in both the charity and public sectors, with a background in audit and policy.

The trust had a wholly owned subsidiary. The company began to provide estates, facilities management and procurement services to the trust in 2017. There were two management contracts with the trust, one for services on the Darlington Memorial hospital site which is owned by the trust and one for the services relating to sites not owned by the trust. We spoke with the senior leadership team of the subsidiary; the team were patient driven and focused upon developing and engaging their workforce. There were clear governance arrangements with the trust and an expanding business plan. We saw how the subsidiary and trust communicated and engaged with one another to benefit the delivery of patient care.

The board had continued to review executive leadership capacity and capability as found at our last inspection. This was undertaken via several methods, including self-certification of the effectiveness of board and the committees reporting to board. We saw evidence that all board members had an annual appraisal and that this was in date for all members. The NEDs had a formal training programme which was developed following our last inspection. Training was logged, and the log reviewed at board level.

Governors were well engaged and had received some training and development although this could be developed more. We were told the board engaged well with governors but some of the governors felt sometimes agenda items were not fully explored. The trust had surveyed the governors with overall positive feedback on the role but there were mixed feelings about time given to agenda items for discussion.

On our last inspection we found that there had been no formal attention to talent management or succession planning at senior level. On this inspection we found that this had been strengthened and there was a focused talent management strategy in place supported by an annual appraisal system and more robust approach to succession planning. The trust had a leadership programme in place delivered by internal and external speakers including the use of psychometrics and using recognised healthcare leadership models. The trust had identified talent pools for key positions and supported staff through access to national development programmes including a 'Shadow Board' development programme.

The Chief Pharmacist (CP) reported via his care group to the Director of Operations and had regular face to face meetings with the medical director. Workforce succession planning in

pharmacy had been reviewed and the trust had a deputy chief pharmacist and a medicine safety officer.

The trust had recognised the need to increase Black, Asian and Minority Ethnic (BAME) representation at board level and had adapted their recruitment approach to seek more applications from individuals in groups with protected characteristics, attracting more credible applications from BAME candidates than previously. However, no appointments had yet been made.

Since our last inspection, the Board had agreed a formal programme of training and development seminars for 2018/19, which was based around four seminars delivered by NHS Improvement as part of the national 'Moving to Good' programme. The development programme for 2019/20 included the last of these seminars, mandatory training, a briefing on learning from complaints nationally and a workshop on the implications of the NHS People Plan. Further sessions were planned to build on learning from the 'Moving to Good' programme.

The trust's employment checks for executive and non-executive board members were inconsistent in line with the Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. Providers are required to ensure that directors are fit and proper to carry out their role. This includes checks on their character, health, qualifications, skills and experience.

We reviewed five personal files of board members and found that consistently Disclosure and Barring Service (DBS) checks were not repeated and in two cases not on new appointment. Also, the disqualified company directors register and disqualified charity trustees register were not completed in four out of five records. One file had the fit and proper person result (FPPR) and confidentiality form missing.

There was a comprehensive programme of executive and NED walkarounds within the trust. We saw evidence that the outcomes of walkarounds were reviewed at board level. This was reiterated by staff who told us senior leaders were visible. We were told care group leaders were appointed by the executive team and through the governance structure of weekly meetings the executive was able to engage and have overview of the functions of the groups. However, not all senior leaders had a good in-depth knowledge of risks to the organisation and at times deputies were relied upon to give detail which did not hold board members to account.

Board Members

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 40% were female.

Of the non-executive board members none were BME and 17% were female.

Staff group	BME %	Female %
Executive directors	0.0%	40%
Non-executive directors	0.0%	17%
All board members	0.0%	27%

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a clear statement of mission and vision with four underpinning ‘touch stones’ and eight key plans. We found on our last inspection that the development of the vision had been influenced by staff focus groups and this time we found that this had been developed further in 2018 with more engagement activities with staff.

The four ‘touchstones’ were:

- Striving for the best clinical outcomes.
- Delivering the best patient experience.
- Being a best employer.
- Achieving best efficiency in generating and using resources.

Five of the key plans focussed upon the ongoing delivery of services:

- Clinical services.
- Quality of care.
- Staffing.
- Informatics.
- Continuous improvement.

Three key plans were in place to enable transformation:

- Estates.
- Communication and engagement.
- Finance.

On our last inspection we found that frontline staff were not always aware of the vision and values of the trust. The trust had worked hard to rectify this by simplifying and reissuing strategy communications. On our last inspection not all executives described the vision and strategy in the same way, at this inspection the senior team gave a unified view of plans for the trust. They had cascaded briefings through senior managers and heads of department meetings through the organisation. Executive Directors held ‘listening events’ with each key service, which provided a forum for staff to share their views on vision, mission, values and strategy. As a result of staff feedback, including a survey of over 600 staff, the trust simplified their mission statement to focus on what matters most to them: “safe, compassionate, joined up care”. However we heard mixed views from staff on how well embedded the vision and strategy were and how it translated to frontline staff. some care group leadership teams were more focused upon immediate operational issues than long term strategy.

The trust had refreshed its annual planning process, by reviewing strategic priorities with the full Board and Council of Governors, to set planning parameters for the development of each care groups and corporate directorates. We saw evidence that governors were engaged in forward planning and the trust had given them guidance and capacity, so this was robustly achieved. We also saw evidence of care group involvement in the forward planning cycles.

On our last inspection we were told that there was a lack of engagement from the trust with external stakeholders. On this inspection we saw evidence that the trust had worked alongside partners to plan strategy together. They had ensured alignment of strategy with plans in the local economy, through proactive involvement in the development of the Cumbria and North East integrated care system, in integrated care partnerships and through the agreement of a joint health and wellbeing plan for County Durham.

The trust board assurance framework referenced a four-year region wide plan, which would support the trust in returning to financial sustainability, but some board members were unaware of their role in creating or delivering this.

The trust's pharmacy and Medicines Optimisation strategy was developed by staff and leadership team. It was then briefed to all staff groups. The pharmacy team had workforce plans in place for developing extended roles and recruitment and there was a business case being developed to bring outpatient dispensing in house.

Culture

Staff felt respected and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development.

As we found at our last inspection, the culture of the trust was patient focused. Frontline staff were motivated by wanting to provide the best care for patients and they spoke positively about the care they delivered. Most staff we spoke with spoke positively about the trust. Staff told us they were proud to work for the organisation.

The workforce experience was an increased focus for the trust as part of their 'moving to good programme'. The national programme develops culture and leadership capability with the premise that culture drives good patient outcomes at all levels of the NHS. The trust had recruited a workforce experience team, to lead the roll out of a wide-ranging programme of engagement interventions, working in partnership with NHS Improvement and the North East Leadership Academy.

We spoke with the guardian of safe working; a role which was introduced on a national basis to protect patients and doctors by making sure doctors were not working unsafe hours. There were no major concerns raised other than minor rota changes which had been implemented. There was fair engagement with the role from the medical workforce. The trust had developed the support offer to medical staff, including a new induction programme, and rolling out of a training programme developed and delivered with support from the general medical council (GMC). There was an improvement in trainee satisfaction from the most recent GMC survey.

As we saw at our last inspection, culture had been a challenge particularly in theatres and maternity. Staff told us that culture was improving, we heard examples where unacceptable behaviour had been addressed and working environments and plans had been improved based upon staff feedback. In theatres interventions had been put in place to address culture and safety such as Local Safety Standards for Invasive Procedures (LocSSIPs). Communication had improved between management and clinicians and this had led to less concerns being raised.

In the midwifery service, a new supervision approach was implemented, which had, according to the trust, been shown to increase midwives' resilience and wellbeing and improve quality of care. Work had been done on the quality of appraisals and staff told us that the appraisals systems had improved and could be used for revalidation.

The trust had carried out a survey of nursing staff on experience to enhance information they had from the staff survey and improve retention. They had also carried out a collective leadership survey across the trust on self- perceived leadership capability and offered training in the trust around staff engagement.

We were told about the teams in need service (TINS) which received multidisciplinary referrals from within care groups and provided human resources, occupational health and psychology support for teams with specific needs. This was an additional valuable resource outside of usual line management arrangements.

The trust used the communications team and social media to celebrate success. Bi-annual leadership conferences and annual conferences to recognise nursing and midwifery staff were held. These conferences coincided with International Nurses' Day and International Day of the Midwife and celebrated the achievements of staff. The trust had also showcased excellent work from staff and teams at the bi-annual leadership conferences and on their 'Tell Us the Good Stuff' walls at both main hospital sites.

During the process of this inspection we heard concerns from staff that there were issues with culture in maternity services particularly at the Darlington Memorial Hospital site. We followed this line of enquiry and spoke to staff on the wards as well as the senior leaders in maternity. We were told that the leadership team were well-sighted on the ongoing issues at Darlington and that recent incidents had heightened the feelings of vulnerability within the team. The senior team told us how difficult some of the incidents had been for the whole team to deal with and described the need to balance investigation and learning alongside caring for colleagues who had been part of distressing incidents. The senior team had increased their presence and support to the team in light of the incidents. However, some staff had not perceived the support in the same way the leadership team had and told us they felt unsupported and reprimanded by managers.

We also heard concerns from other areas of the trust around workload demands, lack of support for staff to take breaks and staffing shortages and that in some cases managers were unsympathetic to concerns and did not take action to improve staff experience. We were also told

of incidences where staff felt vulnerable due to lack of training and incidences where staff did not feel they would be supported raising issues to senior staff. Not all senior leaders had a good insight into issues for staff and an understanding of bullying and harassment.

The staff survey still highlighted issues with bullying and harassment, quality of appraisals, morale, and experience of violence. However, the trust showed us evidence of a comprehensive engagement plan to address the staff survey issues.

Some staff we spoke with told us that violence and aggression was still an issue and procedures in place were inadequate to prevent this particularly from patients who may not have the capacity to understand their actions.

The Staff Friends and Family Test (FFT) themes in the last year were:

- Staffing shortages, unrealistic working demands, budget cuts on staffing and equipment impacting upon the quality of patient care in some areas.
- Lack of support for staff with health issues/disabilities, this was reflected in the statistics as 30% of disabled staff responded as being unlikely or extremely unlikely to recommend the organisation as a place to work compared to 25% of staff overall.
- Lack of flexibility and work life balance despite having policies and procedures.

The trust had a freedom to speak up guardian in post. On our last inspection, we identified that there were issues with capacity for this role. In response to the demand on the FTSUG, their hours had increased from 20 to 30 per week. The trust had also recruited two champions to support the role, while this was an improvement more could be done to increase the profile and visibility of the role of the FTSUG. Knowledge of the role and visibility was variable across the trust. The FTSUG had a good understanding of their role and tried hard to promote it within the trust. They produced a biannual report for board and the themes of issues raised by staff were bullying and harassment and violence against staff which mirrored the staff survey and staff FFT.

The finance function engaged with operational management at all levels within the organisation through a business partner model with dedicated staff assigned to each of the care groups. Finance team members were reported as integral members of the care group management team. There was variability in the level of reliance placed by the operational leadership teams on their finance business partners, and some did not understand the financial position of their own care group in detail.

We saw limited evidence the trust communicates its financial plan and position throughout the organisation. Staff were not aware of the challenging financial position of the trust at ground level and the need to use resources wisely. However, operational teams were well-sighted on the trust's decision-making process through their attendance at Executive Clinical Leadership (ECL) meetings.

Staff Diversity

The trust provided us with the following data on ethnic diversity:

Ethnicity	Staff Details
White	90.59%
Asian/ Asian British: Indian	2.70%
Asian/ Asian British: Pakistani	0.57%
Asian/ Asian British Bangladeshi	0.07%
Asian/ Asian British Chinese	0.40%
Asian/ Asian British: Other Asian	1.07%
Black/ African/ Caribbean/ Black British: African/ Black British: Caribbean	0.60%
Any other Black African/ Caribbean	0.15%
Arab (do not collect data in CDDFT)	0.00%
Any Other	3.85%

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.



There were no themes where the trust's scores were significantly higher (better) or lower (worse) when compared to the 2017 staff survey.

(Source: NHS Staff Survey 2018)

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

WRES Indicators from ESR (HR data) ⁽¹⁾	BME Staff	White Staff	Are there statistically significant difference between...	
			BME and White staff?	Last year and this year? (BME staff)
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+	1.2%	2.8%	●	-1.7% ●
1b. Proportion of non-clinical staff in senior roles, band 8+	0.0%	7.4%	○	0.0% ○
2. Proportions of shortlisted staff being appointed to positions	7.2%	8.8%	●	-55.3% ↓
3. Proportion of staff entering formal disciplinary processes	0.5%	0.7%	●	0.3% ●
4. Proportion of staff accessing non-mandatory training and CPD	96.7%	99.1%	Not assessed	
Trust staffing numbers ⁽²⁾	2018		2017	
9. [BME Voting Board Members] and Board compared to overall staff demographic	[0]	●	[0]	●

⁽¹⁾ SOURCES: NHS England

Key

- Statistically significant or negative finding
- Not statistically significant
- Positive finding
- Statistical analysis not undertaken as less than 30 BME staff responded
- ↑ Statistically significant improvement
- No statistically significant change
- ↓ Statistically significant deterioration

As of March 2018, the ESR staffing indicators shown above (indicators 1a, 1b, 2, 3 and 4) show that there were no statistically significant differences between BME and White staff. Of note, Indicator 1b did not have enough responses to be statistically tested and Indicator 4 was not assessed. In comparison to the previous year (2017), Indicator 1b had not changed (0.0%) and Indicator 2 had a statistically significant deterioration (55.3%). This deterioration describes a 55 percentage point drop (from 62.5% to 7.2%) and is possibly associated with data quality problems.

Indicators 5 to 8, from the NHS Staff Survey 2018, were not published for this trust due to a combination of low numbers of BME staff, only carrying out a basic sample and having a low response rate to the staff survey.

There were no BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

The trust was above the national average score for equality and diversity on the staff survey. The trust had carried out a series of surveys as part of equality, diversity and inclusion work which identified issues for staff with long term health conditions or disabilities and the support they receive in the workplace. A second survey focused upon age highlighted that a number of younger members of staff (under 30) felt that there was a lack of career progression due to being seen as less experienced than older staff.

The trust had consulted with staff with protected characteristics and launched three staff networks covering staff from ethnic minorities, LGBT staff and staff considering themselves to have a disability.

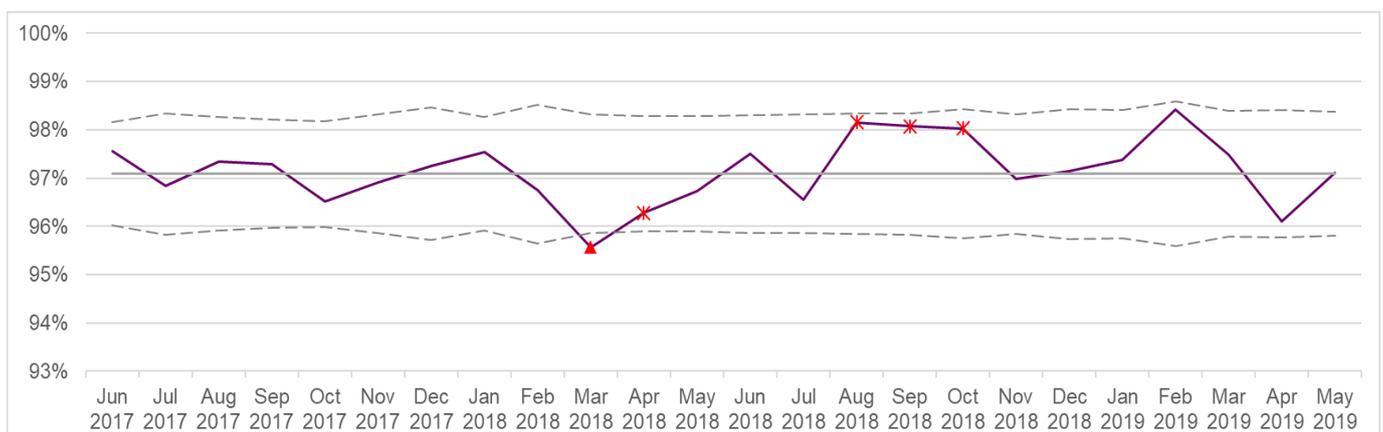
The trust had participated in the national 'Building Leadership for Inclusion' programme, to inform their approach to supporting staff with protected characteristics. One output from this was a #100 Faces campaign through which the trust had celebrated the diversity in the workforce. There was a need to roll this out further to include more staff in the trust.

Further feedback in local surveys highlighted that staff felt under pressure because vacancies were not filled, staff had to work with out of date equipment and unrealistic workloads were putting increasing pressure on staff mirroring the findings of the staff FFT. The trust planned to address these issues as part of the EDS2, WRES & WDES reports and action plans for 2019/20.

Friends and Family test

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 95.6% and 98.4% from June 2017 to May 2019.

There was one data point outside of the control limits (March 2018), one unusually low data point (April 2018) and three unusually high data points (August to October 2018). These unusual data points may be a sign of something out of the ordinary happening and merit further investigation to understand what happened in this time period and what can be learnt from this.

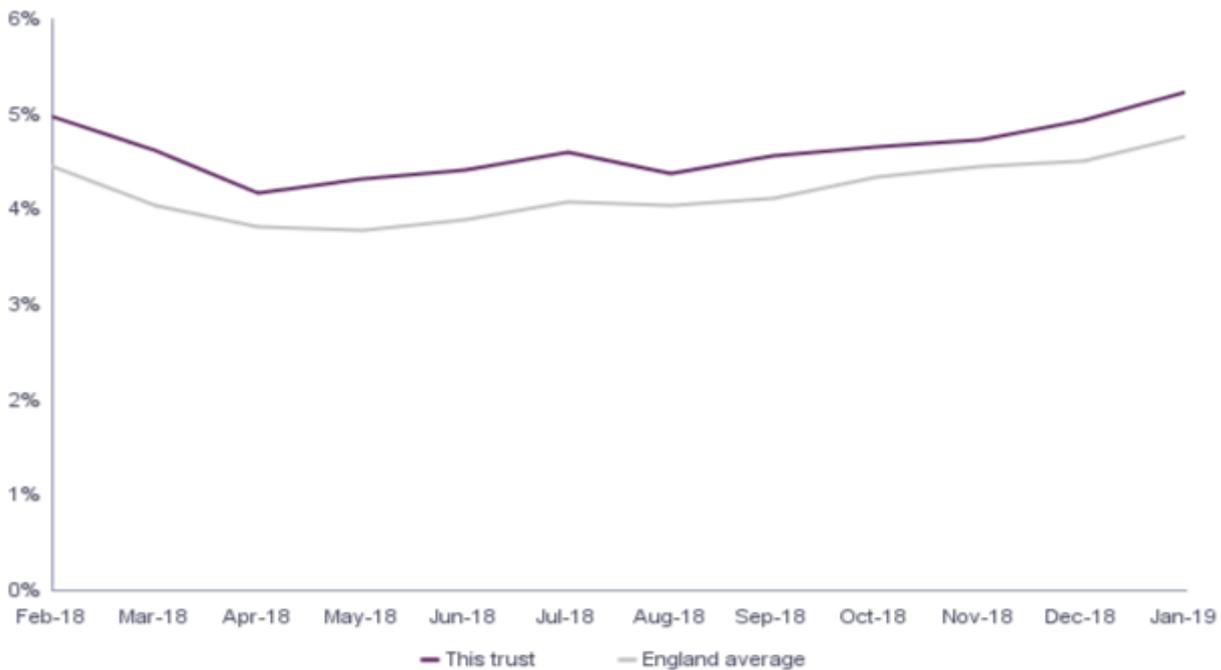


- Trust score
- Trust average
- Upper control limit
- Lower control limit
- ▲ Astronomical data point
- ✘ Sudden change
- ◆ Shift

(Source: Friends and Family Test)

Sickness absence rates

The trust's sickness absence levels from February 2018 to January 2019 were higher than the England average and followed a similar trend.



(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey, the trust performed the same as expected for all 18 indicators.

(Source: General Medical Council National Training Scheme Survey 2018)

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Board Assurance Framework

The trust provided their Board Assurance Framework, which has identified 16 principal business objectives, which underpin fulfilment of their core purpose of providing safe, compassionate, effective and joined up care to our patients.

Domain	Objective	Mapping to strategy
Quality	Minimise avoidable patient death	Quality Matters – Improving Learning from Deaths / Reducing Mortality
	Minimise avoidable patient harm	Quality Matters – Safety Objectives
	Right Care, Right Place, First Time	Clinical Services Matter – Sustaining and Improving Services, Transforming Community Services and Quality Matters – Improving Urgent and Emergency Care and Improving Cancer Care
	Best Outcomes	Clinical Services Matter - Sustaining and Improving Services
	Great Patient Experience	Quality Matters – Patient Experience Objectives
	Safe, secure, fit for purpose patient environment	Clinical Services Matter – Developing our Infrastructure and Facilities
Strategy	Strategy	All elements of our strategy – this objective concerns the design and overall delivery of it
Workforce	Right staffing capacity	Staff Matter – recruiting and attracting; building a workforce for the future
	Right skills	Staff Matter - Develop Talent; Support and embed a high-performance culture; Building a workforce for the future)
	Great staff engagement	Staff Matter - organisational culture; Workforce Health and Wellbeing (Staff Matter)
Resources and relationships	Financial sustainability	Medium-term financial strategy
	Stakeholder relationships	Communications and Engagement Strategy -
	Community and patient engagement	Communications and Engagement Strategy -
	IS Strategy	IS Strategy – all objectives
Regulatory compliance	Provider Licence	Core operational regulatory objective not directly linked to strategy
	Fundamental Care Standards	Core operational regulatory objective not directly linked to strategy

(Source: Trust Board Assurance Framework – July 2019)

At our last inspection we noted that the trust had implemented a new governance handbook to clarify the purpose and function of governance arrangements within the trust. This was to reduce repetition of committee work and to improve the oversight function of committees rather than performance management. The governance hand book also outlined expectations and behaviours at committee and board level.

There were five executive committees which reported to board level, four for assurance and one for assurance and approval. A variety of working groups then fed into these committees. There

were also four statutory committees for audit, nominations, remuneration and funds.

On a day to day basis, escalation from ward to board was through the care groups and executive committees, who reported to the appropriate assurance group or directly to the board. The trust had five care groups which were each managed by a triumvirate. Specialties held bi-monthly governance meetings and provided assurance / escalated risks to care groups who, in turn, escalated to and assured the executive directors. The assurance and compliance team attended care group governance meeting to be assured that all issues are covered, escalated and cascaded. The governance handbook specified structures and standards for clinical governance, including terms of reference for these meetings.

The Board's Integrated Quality Assurance Committee (IQAC) met every month to seek assurance on quality, workforce and access targets. The Committee received monthly assurance reports on audits of all wards and teams against quality standards and reports from monitoring functions. These were triangulated with patient stories and discussions with ward or team leaders, who attended by invitation. Directors maintained regular interaction with wards and teams; for example, through weekly 'back to practice' sessions, senior nurses, ward sisters and clinical leads meetings, informal breakfast meetings and the board's walkarounds programme. The Chairman and NEDs undertook proactive walkarounds to speak with staff and patients and use the information to sense check assurance from formal reporting. IQAC reported formally to the Board each month on the assurance it had obtained and any matters arising, supplementing Executive Directors' own detailed reports.

Two Executive Committees, covering patient safety & experience and clinical effectiveness, met monthly and were chaired by the nursing and medical Directors respectively, underpinned by working groups also chaired by these directors. Nursing line management and clinical leadership structures also facilitated escalation and assurance, and downwards direction communication. On our last inspection we found that safer staffing reports were not submitted IQAC so the committee was not made aware of issues for triangulation. We found on this inspection that the report was tabled at the patient safety and experience committee which then in turn fed into IQAC.

We attended the patient safety and experience committee, clinical effectiveness committee and the executive and clinical leadership committee prior to our inspection. We saw challenge and robust scrutiny within the committees. We also attended the IQAC and interviewed the chair. We saw that the NEDs provided good oversight and challenge and robust investigation of metrics through patient stories. We reviewed the minutes and papers for IQAC and saw that there was good oversight and scrutiny of quality issues. There was also evidence of how learning had been shared within the trust.

The executive clinical leadership (ECL) committee met weekly with all executive directors, directors and care group senior leaders, this same group then met monthly as the strategic change board (SCB) to review strategy and recommend approvals to the board. We reviewed the agendas and papers for the executive and clinical leadership committee (ECL), there was broad attendance from board to care groups and the agenda was wide and varied. However, the range of topics were well covered and aided by a front sheet on each paper which described briefly what the paper was, why it was tabled at ECL and what was being asked of the committee. Attendance at the meetings we reviewed was good and as care groups were involved, messages were directly

communicated within the trust on a weekly basis. We also saw that learning from incidents, serious incidents (SIs) and never events (NEs) were discussed on a weekly basis.

The SCB approved business cases prior to board review and monitored the implementation of any related major projects or work-streams. SCB also had oversight of the transformation of community services and any work on new clinical pathways as part of ICPs. Reports on progress against the quality of care and staffing strategies were scrutinised each quarter, with SCB able to mandate remedial actions for any areas off-track. Further reporting took place to IQAC, so that the NEDs could scrutinise and challenge progress.

We reviewed the minutes and papers of the finance committee and saw that there was involvement of executive directors, NEDs as well as care groups and the leadership team of the wholly owned subsidiary. Consistent feedback on the trust's procurement subsidiary company was that it was well-run and provided positive benefit to the care groups, in the form of shared procurement savings.

All the committees which reported to board provided an annual report. Each committee of the board had at least two NEDs in attendance. The finance committee had CEO, director of finance and the director of operations in attendance. IQAC had the medical director, director of operations and the director of nursing in attendance. Care groups also attended to test and corroborate assurances provided by directors.

The board assurance framework (BAF) was reviewed at risk management committee quarterly and alongside the review of key risks.

We saw changes as a result of the 'moving to good programme' in learning from reviewing incidents and the monitoring of data. Performance reports at board had been developed and annual effectiveness reviews of committees were undertaken. Scheduled work plans were reviewed annually alongside terms of reference by the relevant committee and the board. Board minutes were drafted within two weeks, signed off by the chair and presented to the next board meeting. Then any changes were made, and final board minutes were saved and sent to governors.

The Trust had a safeguarding group that was accountable to the executive patient safety and experience committee and reports to IQAC for the purposes of assurance. The group met on a monthly basis. The membership included safeguarding practitioners, designated professionals and care groups. The group reviewed an annual safeguarding action plan that had been developed from the safeguarding strategy. Minutes from three meetings were reviewed as part of the inspection, regular attendance from the business units was not always consistent.

The associate director of nursing for safeguarding produced a quarterly report to the quality governance committee and an annual report for board. The quarterly report identified safeguarding referral activity by care group, trust wide training compliance, and supervision activity. However, referral data and activity was not collected by team within each care group to monitor themes and trends. Whilst the report reflected basic safeguarding activity it did not adequately identify safeguarding concerns as a result of care received by patients within the trust. Therefore, the Trust Board would not have had assurance for enquiries where trust staff have been identified as the source of risk. However, we were informed that there was an 'allegations against health care professional standard operating procedure' and the trust provided evidence that this adequately covered issues raised.

The Medicine Safety Committee was a well-established multidisciplinary group and provided clear terms of reference for its members. A senior pharmacy technician was a member of the governance care group committee.

The trust was making some use of benchmarking tools such as “Model Hospital” and “Getting it Right First Time” to develop its cost improvement programme. Senior leaders acknowledged the programme management office (PMO) needed to strengthen its analytical skill set in this regard, as this work was undertaken by the care group teams. There was limited evidence the PMO provided much on-the-ground support to care group teams with cost improvement plan (CIP) delivery and appeared to provide more of a central coordination role. This was due to a wide remit on improvement rather than focus upon specific cost improvement schemes.

The trust used a risk-based approach in setting the annual internal audit programme and the audit committee had overseen progress implementing internal audit recommendations.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. Teams identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust provided simple guidance to frontline teams in the development of the risk register and operational risk. The first step was to raise the risk with the ward manager, if it could not be ‘fixed’ at this level then a mitigation plan and monitoring would be put in place and escalated to matron level. Target dates for closure and closure at a level where the team felt the risk was sufficiently mitigated was managed at this level. These risks would be considered at care group level and those that could not be mitigated would be reported from care groups to the risk management committee once a quarter and then reviewed at board. If the risk was a quality risk and not so urgent to go directly to the director of nursing, it would be reviewed at the executive patient safety committee or executive clinical effectiveness committee. The risk management team oversaw this process and gave assurance that appropriate action plans were in place. The team worked to key performance indicators and reports were submitted to the risk management committee on risks above tolerance, long standing amber risks and red risks.

There were clear processes in place to ensure who was accountable for and who took responsibility for each risk. If the risk was shared across care groups the assurance and compliance team ensured that the multiple owners were on track. However, on our core service inspection we saw that some risks such as the environment at Durham emergency department (ED) was not on the risk register.

In terms of the board’s overview of risk, the BAF identified sixteen principal business directives. These identified a principle inherent risk and controls and actions in place for mitigation. Each identified action had an executive director lead. The board assurance framework (BAF) was reviewed by the board on a quarterly basis, with consideration given to whether objectives were in line with planned risk trajectories. The BAF included patient engagement, which was a positive addition made by the board.

The board reviewed the Trust's risk appetite and tolerance annually. The board spent time discussing the risk groups and the level of appetite and tolerance for each. The board agreed that an additional group be added to recognise the workforce related risks in April 2019.

The judgment of risk within the BAF was however, not always robust. We saw risks such as those related to staffing which were scored on tolerance despite ongoing staffing issues across the trust. Senior leaders could not give adequate explanation to us how the scores they arrived at, were robust and there was a risk that scores were too low and were not therefore reviewed at appropriate levels within the trust.

On our last inspection there had been several never events in theatres which the trust was addressing but processes to prevent and learn from issues were not embedded. On this inspection we saw an improvement in processes of monitoring issues and performance, and the sharing of learning within the organisation.

There was clear guidance on the escalation and reporting of SIs and NEs. NEs trustwide had reduced from eleven in 2017/18 to four in 2018/19 with only two in surgery. All open incidents were reported to meetings of the patient safety forum held twice each month, with those incidents that were over 84 days old highlighted for escalation to IQAC. The care group patient safety reports clearly stated all outstanding incidents in the main body of the reports and included a spreadsheet which detailed individual outstanding incidents. We saw evidence that the trust had reviewed the incident investigation process to reduce numbers overdue and ensure actions were implemented.

We reviewed six SI reports and found that the reports were adequately detailed in content and addressed issues in a timely manner. The trust provided training for duty of candour responsibilities compliance rates for this training was on target at 93.82%. Between March 2018 and March 2019, the trust had applied duty of candour 166 times. Between March 2018 and March 2019, the trust had reported 108 SIs.

The trust carried out mortality reviews as per the trust policy and had a standard operating procedure (SOP) for mortality process. We saw evidence that learning from deaths was brought to board level with exceptions highlighted and trends considered. We clarified that if issues with capacity and best interests were raised in the review these were passed to the team who audited capacity and best interest assessments.

The senior team told us they had good oversight of issues and that there was an openness to discuss risks and problems with performance. Staff told us that issues were escalated and resolved quickly by the senior team for example last minute staffing issues. They also told us that they heard about where things had gone wrong in other areas of the trust and the learning from this. Although some staff told us that senior managers did not always take into account acuity of patients in planning staffing and frontline staff felt too much under pressure to refuse plans when the hospital flow was under pressure.

The trust had implemented a tool to support monthly audits of wards and teams, covering a comprehensive range of nursing-sensitive indicators. This allowed ward sisters to focus on areas

for improvement and provide assurance to nursing management and IQAC on adherence to nursing standards.

The trust had made improvements in the management of sepsis and reduction of falls. They had introduced LocSSIPs and achieved the priority standards for seven-day services. They had made improvements in all key areas and metrics for end of life care and care of patients with dementia. They had also identified further work to review and strengthen safety culture, policies and procedures in the light of the never events experienced in 2016/17. In addition, they identified the need to continue to improve rates of incident reporting, improve learning from incidents and sustain compliance with the statutory duty of candour.

On our last inspection, the trust had identified that performance reporting could be too lengthy. The trust had strengthened their performance reports, to ensure a 'balanced scorecard' approach covering all four key strategic 'touchstones'. There was detailed scrutiny of care group performance by corporate monitoring teams in monthly meetings and escalation into bi-monthly executive performance review meetings.

On our last inspection the adult safeguarding and children's safeguarding team were separate with only one safeguarding adults lead. On this inspection we found that the trust had a safeguarding lead and a team of professionals who provided support and advice on all aspects of safeguarding. The associate director of nursing for safeguarding was working towards a fully integrated safeguarding service which was in line with national trend. The safeguarding team were responsible for adult safeguarding, child safeguarding, domestic abuse/ PREVENT, mental capacity assessments and mental health assessments. This was an appropriate portfolio however the head of service needed to ensure that all of this activity was be reported upon separately.

Training compliance had improved from our last inspection from 70% to safeguarding children training level 2 at 86.6% and safeguarding Children training level 3 80.45%. However, this was still below the target for level 3 of 85%. The training plan was appropriate and adequate monitoring arrangements were in place. The associate director of nursing for safeguarding told us that there was a plan in place to address the compliance deficit. The trust had also implemented a bespoke safeguarding training for senior managers.

The head of safeguarding described a safeguarding reporting system which ensured that completion of referral forms were forwarded to the local authority and also overseen by the trust safeguarding team. This provided an opportunity to monitor activity and audit quality. Appropriate policies were in place that linked to the local safeguarding boards. The head of safeguarding described an annual safeguarding audit schedule that was intelligence led as well as priority led. They also described a safeguarding communication plan that included a website quarterly newsletter and the safeguarding brand of "Protect" that was the universal term for safeguarding across the trust.

The Trust had a Medicine Safety Officer who reviewed medicine incidents reported through the electronic system. These were reviewed monthly by medicine safety committee. There was a system in place to monitor and disseminate medicines alerts and recalls actioning new alerts and holding outcomes for future reference. Risk registers were regularly reviewed by the senior medicines managers and a clear process was in place for risk escalation. Performance and quality

in pharmacy was measured through internal and external audit and an action plan was in place to deliver improvements.

Finances Overview

Financial metrics	Historical data		Projections	
	Previous Financial Year (2016/17)	Previous Financial Year (2017/18)	Last Financial Year (2018/19)	This Financial Year (2019/20)
Income	£481.5m	£475.0m	£480.4m	£493.5m
Surplus (deficit)	(£2.0m)	(£0.8m)	(£13.3m)	£9.5m
Full Costs	£483.5m	£475.8m	£493.7m	£483.9m
Budget (or budget deficit)	£7.6m	£3.7m	£8.1m	£9.5m

The deficit reported in 2018/19 was higher than the previous year. In this financial year, the trust is projecting a surplus of £9.5m.

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The trust had a planned turnover of £493m in 2019/20. The control total was a deficit of £1.2m, excluding £10.7m of Provider Sustainability Funding. Meeting this deficit required a cost improvement programme (CIP) of £32m (6.8%), which the trust was unlikely to achieve. The trust was therefore relying on local clinical commissioning groups (CCGs) providing £8m of funding to bridge the gap, as well as joint delivery of £4m of system CIP schemes. Should these system schemes fail to deliver, the trust was anticipating further non-recurrent funding would be made available by the CCGs. This is based on a risk-sharing arrangement and the CCGs' acknowledgement that system pressures have exceeded planned activity.

The trust's efficiency programme was not risk adjusted to provide the board with a realistic picture of the position. This exacerbated the fact that, although there was an awareness of the CIP gap for 2019/20, there were no clear plans to bridge this internally.

The trust previously had a good track record of financial delivery; however, it was not clear that the reporting of the underlying deficit position was something that regularly took place within the trust. Although the trust's leadership team was well-balanced for its current performance, they were not used to acting as a team within an environment of financial stress. However, we recognise that the Board is able to draw on experience of working in an environment of operating and financial stress from within its number.

The trust's reliance on CCG non-recurrent funding was masking its underlying financial position. In addition, the board's lack of awareness of the underlying deficit means it may be unable to identify and then manage the drivers of the deficit, and therefore to improve the position.

However, the trust had a timely budget-setting process, and transparent sign-off process through the ECL, had resulted in a positive attitude to ownership of budget delivery within the care groups.

Care group management teams were supported by a well-regarded finance business partner model.

The care group management teams were well-sighted on the risks within their own care groups. However, although the board is sighted on the trust's financial position at a high level, and aware of the level of risk within it, there was no evidence there is an understanding of the underlying financial position.

The trust's quality impact assessment (QIA) process was not completely clear. Although it was explained to us that all cost improvement schemes are approved through ECL, it was not clear what the guidance is for schemes to bypass this process.

The operational leads we spoke to were well sighted on the risks within their own care groups, and of the governance arrangements in place to escalate these, for example through their care group board and then up through ECL.

Trust corporate risk register

The trust provided a document detailing their 16 highest profile risks. Each of these has a current risk score of 16 or higher.

Date risk opened	ID	Description	Risk score (current)	Risk level (target)
October 2017	2048	EPR: Current health informatics systems may become unavailable, increasingly unreliable and not fit for purpose due to the inability to prioritise timely replacement. Leading to non-delivery of benefits (e.g. clinical quality, safety and efficiency) and non-compliance with the national requirements set out in Personalised Health and Care 2020 (e.g. requirement to become paperless).	25	20
December 2018	2179	Risk of IMS reaching an £11m overspend at the end of year 2018-19 (forecast) from unachieved CIP (£6.9m) and unbudgeted but Executive authorised overspends in ED and Gastro and two major CIP schemes delayed by external process (Ward 6 and Stroke).	20	16
October 2017	2047	EPR: Insufficient capital available in the HI Capital Programme to deliver any or all of the benefits identified in the EPR OBC for all options including Do Minimum. Leading to the non-delivery of the HI strategic objectives, inability to meet the national requirements set out in Personalised Health and Care 2020 (e.g. requirement to become paperless), and potential significant impediment to the organisation.	20	12

Date risk opened	ID	Description	Risk score (current)	Risk level (target)
August 2017	2030	Insufficient capital available in the 10 year HI Capital Programme to deliver the HI Strategy Delivery Programme including Do Minimum. Leading to the non-delivery of the HI strategic objectives and failure of the organisation.	20	12
May 2017	2010	The Rheumatology service has ever increasing demand and decreasing capacity. There is a shortage of both doctors and specialist nurses which has become critical. NICE guidance and quality standards cannot be met.	20	3
February 2017	1985	Due to Trust capacity issues on both acute sites, the care group frequently need to review surgical patients for planned surgery and cancel accordingly, which may result in inability to achieve 18 week pathway.	16	4
November 2018	2169	Insufficient capacity within the Dermatology Department to meet demand. The Service have support from IS and the Locums are required to action their own radiology and pathology results. This may provide delays in patients being notified of results. Risk of a significant result being missed.	16	6
February 2017	1983	Unable to carry out any endoscopic procedures due to the inability to decontaminate equipment between cases due to decontamination units reaching the end of their functioning life span. The equipment on all sites have been reported as breaking down more frequently, this could significantly impact on two week referral pathways. Risk is further compounded due to change in decontamination regulations which our current footprint does not support.	16	4
July 2018	2126	There is a risk that patients referred breast services may wait longer than the NHS constitution two week (2ww) referral target. This is due to increased high volume 2ww referrals. This then also has an impact on 31 and 62 day targets access position risk.	16	6
April 2015	1728	Consultant paediatric medical staffing capacity reduced due to gaps on rota. Difficulty filling the gaps from staff doing additional hours and from agency cover. Existing staff becoming exhausted for additional cover when agency not available.	16	6

Date risk opened	ID	Description	Risk score (current)	Risk level (target)
February 2019	2194	Following reconfiguration of the Children's Continuing Care Team there have been high levels of sickness absence (up to 85%). This team carries out initial and review assessments for children with complex needs being cared for in the community. The levels of sickness absence within the team has led to delays in assessments being carried out for children and young people.	16	4
August 2018	2139	Failure of Air Handling Unit (AHU) in Sterile Services Department at DMH. The AHU controls the temperature, humidity and air pressures required to meet the pharmaceutical standard for the integrity of the room where the disinfected instruments are packed and prepared for sterilisation. When the AHU has failed temperatures reached 34°C, positive pressure was lost and humidity rose this coupled with the PPE the staff are required to wear made the working conditions, at times, unbearable. The AHU is old and replacement parts are specialist and more difficult to source.	16	4
April 2019	2208	Risk that the Surgery Care Group will not meet the CIP target for 2019/20. Financial penalties levied.	16	8
April 2018	2098	The trust's current PC replacement programme is an annual rolling programme which replaces end of life devices. Currently the trust keep PCs active within the trust for six years and laptops for four years - which is longer than the standard three year (at warranty expiration) replacement. Decommissioning devices at this age also holds a cost neutral removal and destruction process. The current business case for the replacement requirements for 18/19 stands at £375k. Due to the revision in the way in which the trust receives funding this financial year, ICT have been requested to review the requirements for this year and explore options of reducing the overall cost for this financial year (2018/19). The replacement programme has been re-profiled and reduced by a total of £150k; however, this has not reduced the requirement for the items to be	16	3

Date risk opened	ID	Description	Risk score (current)	Risk level (target)
		replaces and has moved the reduction in cost into the cost pressures for next year. There is a risk that the PC estate cannot support clinical services which rely on IT equipment to perform their duties.		
May 2018	2110	Lack of available clinical assessment rooms in ED, UHND, resulting in the inability to identify and assess patients, especially those who are critically ill, in a timely fashion. This is compounded by 'exit block', whereby patients are waiting in ED for admission for long periods of time. This also impacts on ED performance with time to initial assessment being greater than 15 minutes, time for ED clinician to be greater than one hour, and decreased performance against the four hour ED standard.	16	6
December 2018	2180	The new Emergency Care Centre may not be funded (funding not approved from NHSi). Future ED services may not be fit for purpose.	16	12

(Source: Trust Corporate Risk Register – April 2019)

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

On our last inspection we found that information to inform performance was not always accurate and timely. On this inspection, we saw that reports to board made better use of charts which showed variation over time and statistical analysis of variation. The operational teams we spoke to reported that they were provided with good quality data, and that this formed a solid basis on which they set their annual business plan.

There were numerous data quality reports run by the trust daily and weekly designed to target potential record errors. These reports were distributed to those that are likely to have made the errors so they could be investigated and corrected if appropriate prior to the data being used for any national or internal reporting or return. The volumes of data quality issues and the specific issues themselves were discussed monthly at the trust data quality group. Issues were escalated from this group to the information quality assurance group which was a held as part of the senior information asset owners information risk management group.

The clinical coding team also completed data quality error forms when they came across an inconsistency with a PAS record and reported to the input source for correction. Themes from these reports were shared at the data quality group. Random sampling of records took place each month to ensure that time stamps on the systems were consistent with the record.

External audits of quality accounts provided significant assurance to the trust in both referral to treatment and A&E national returns. Audits of demand and capacity and cancelled operations reported no significant data quality risks.

The trust had implemented a system of reporting from the subcommittees to the board whereby each non-executive chair prepared a 'preface' document to cover all the business of each subcommittee for each board meeting. This allowed the board full transparency of issues going through its sub-committees, whilst also requiring these committees to continue to flag key issues.

The trust used an electronic track and trigger and patient flow system, the system was used to record nursing interventions, assessments and observations and monitor patient flow. It allowed the trust to identify deteriorating patients and real time monitoring of patient care. The trust was able to report upon performance in relation to nursing assessments including compliance for malnutrition universal screening score (MUST), Waterlow scores (a score for determining the risk of pressure ulcer), fluid balance charts, falls, moving and handling and bedrails risk assessments. The report allowed ward managers and matrons to identify, and share with their teams, where further improvements could be made. The report also included information on overdue observations with the system determining the frequency of observations based on national early warning (NEWS) score. The report also enabled ward managers to benchmark themselves against other wards and had been seen to increase motivation to improve documentation and recording. However on our inspection of core services in some cases fluid balance charts were incomplete for patients with intravenous (IV) fluids.

The data was also used by corporate teams such as the falls team and back care service to identify wards that may need increased support and training. The special project team, acute intervention team and cardiac arrest prevention team also reviewed performance of observations overdue to target training and support for areas where concern was identified. We were told about instances where this had resulted in a reduction of overdue observations.

The electronic recording for this system was done on hand held devices. There was a management process in place to ensure the security of devices in line with information governance requirements including reporting and escalation of lost devices. The Trust also advised us that a formal infection control assessment of the devices was completed at the time of selection.

Other electronic systems implemented included an electronic clinical document management system where all records are digitised at the end of a direct care period and made appropriately available to clinicians. The functionality of the current in-hospital system was also extended to include electronic prescribing and medications administration, this was currently being expanded to include obstetric and paediatric patients.

The trust had introduced an electronic prescribing and medicines administration system and a phased implementation was in place. This was used to manage medicine reconciliation

performance and to highlight priority patients, missed doses and antibiotic prescribing information and well as other medicine searches and audit. Internal dispensing errors were now digitalised and easier to report and analyse.

We were also told about a future health informatics strategy to replace much of the current infrastructure and the trust had approved a business case in principle. This would provide easily accessible, fully integrated patient information for decision-making thereby improving the quality of care. However this strategy required a £32million over 10 years in investment.

The trust had developed and was starting to deploy a range of performance measures for community services which extended beyond contractual and nationally-mandated indicators. The trust had rolled out patient level information and costing system (PLICS), which helped clinicians to understand and examine variation as a tool for improvement.

Staff told us about ergonomic issues working in community and connectivity problems generally. However, they were positive about the electronic track and trigger system and the impact this was having on improving care. We were told examples of clinical engagement in the development of clinical systems and the director of nursing led on the health informatics agenda.

To give high profile to IT development, management and safety the CEO had the role of senior information risk owner (SIRO). We were told of examples where resilience had been tested but business continuity plans had protected the trust from IT breaches.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

On our last inspection we found that the trust had limited engagement with patients in developing services and there was no patient experience strategy. Since this inspection the board had approved a community engagement and patient experience strategy. We saw on this inspection evidence to show patients and families had been involved in the development of end of life care. The trust incorporated patient feedback into service changes and, at the request of the NEDs, included this in the QIA process and patient engagement in the BAF.

The trust had increased its use of patient stories, using thematic analysis of clusters of similar patient experiences, in board sub-committees. Discussion of themes arising had led to improvements for patients and the NEDs told us they requested patient stories to triangulate them with other sources of information presented at committees. The trust also used information and learning from complaints for wider learning and developments across the trust.

On our last inspection we did not see that the trust actively engaged with patients with protected equality characteristics such as race or sexuality in order to shape planning and delivery of services. On this inspection we were told that the trust had worked with learning disability groups to devise a variety of assessment tools and care pathways to support patients and families in hospital. They had used Healthwatch to support hard to reach groups such as deaf and blind communities. They had surveyed and worked with looked after children to inform their care and assessment.

The trust had a lead Dementia Nurse who participated in both Durham and Darlington dementia friendly community project groups and had invited people living with dementia to visit services to look at improvements. The trust were in the process of developing a transgender framework to support staff and patients. The patient experience strategy was therefore in the early stages and required more time to embed and develop to spread initiatives across more clinical services.

The director of nursing had led a joint initiative, with the local mental health trust and two neighbouring trusts to implement the recommendations of the 'Treat As One' report, resulting in a joint application for Psychiatric Liaison Accreditation Network (PLAN) accreditation, which was expected to be submitted during August 2019. At our last inspection, we found very poor awareness of processes around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). On this inspection during our core service inspection we found low compliance rates with training for MCA and DoLS in some areas, however, leadership teams were aware of this and had a plan to address it. Trust wide, the MCA and DoLS training compliance rate was on track to meet the trajectory of training over a three year period and was in target but was only 34.29%. This trajectory and target had been agreed at the safeguarding group.

We saw evidence that events were delivered by the trust to improve engagement with community stakeholders, this was part of the engagement strategy linked to the corporate strategy and there was focus upon developing knowledge and relationships with the trust's governors. As part of the strategy the trust had run 'behind the scenes tours' for Governors, members, stakeholders and the public at each of the main hospital sites.

The trust had also redesigned their planning processes, to secure the views of Governors (representing their members) in a joint seminar with the board, which were used to define planning parameters for care groups and corporate directorates.

Executive Directors had held listening events with staff to seek views on strategy including the continuing relevance of mission statements. The trust had taken action to change the statements based upon this feedback. Strategic priorities had also been discussed and agreed with staff. The staffing strategy 'Staff Matter' was consulted on and agreed with staff side groups representing all staff groups.

The NEDs and executive directors had a planned walk around programme and actions were tracked and followed up on through the governance processes. We did however still hear concerns from staff that their views on managing demand and high workloads weren't always listened to and appropriate action taken.

On our last inspection we were told by external stakeholders that the trust could do more to engage with them and be more proactive. This was reiterated by external audit of the trust and the

trust had worked to improve their routes of engagement with commissioners and partners across the region. We heard from a range of leaders in the trust about the challenges and the willingness to work in partnership. Staff were well informed and realistic about these developments.

Stakeholders told us that the trust engagement was improving and that concerns were taken on at board level. Issues that were raised to us by stakeholders were also cited by senior leaders in the trust as areas of concerns and in most cases plans were in place to address them. The trust had self-evaluated their relationships with partners and there was also a focus on developing clinical links with stakeholders and working with the wider system.

The trust worked closely with partner organisations within the sustainability and transformation partnership (STP) and more especially within its ICS. There is cognisance of the complexities and challenges to be managed in aligning and meeting the objectives of cross-system working in several different geographies. There was also some uncertainty around the next steps for the systems and partners which made it difficult for the trust to describe the impact upon patient pathways in the future.

The director of finance reported a positive and constructive working relationship with the clinical commissioning group counterpart, and there were now improved relationships in place which were helping with local contracting. There was a system programme board and PMO in place, which was planning development of system-wide schemes required to meet the trust's financial control total.

There was a joint programme board in place between the local CCGs and the trust, which was joint-chaired by the trust's director of finance. The trust and CCG programme management offices are also working together to enable delivery of system improvement programmes.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

On our last inspection we could not see that appraisals were linked to strategic objectives or included individual learning objectives. Since our last inspection the trust had implemented a new appraisal system that made appraisals more directed and included clear objectives in line with trust strategy.

On our last inspection, role specific training compliance was at 55% which was below the target set by the trust. On this inspection the trust gave us broken down figures for role specific training. Out of 44 training modules across the trust, 31 met the target set by the trust (targets were variable dependent upon the type of training and its relevance to role and its trajectory for completion). Nine out of 44 were classified as amber rating and below target although we were not told how the RAG rating was applied. Three modules were rated red and below target. For each module the trust provided us with trajectories for compliance rates and those that were below

target the trust gave an explanation for delays in delivery of training and plans to address compliance.

Staff were able to tell us about learning from NEs and we saw evidence of various methods of sharing learning in evidence provided to us by the trust.

The trust had implemented the recommendations of 'learning from deaths' guidance and had a mortality review process which reviewed whether deaths were avoidable and also drew out other potential improvements in care across a wide range of criteria. The trust had increased reporting of near miss incidents, aiding the identification of themes for learning.

On our last inspection we found that root cause analysis training had only been completed by 10% of the consultant workforce which may impact upon the quality of SI investigations. The trust provided us with evidence that they were addressing this over a three-year period to achieve a training rate of 75%. We saw that this trajectory was on track for its first year of implementation at above 25%, this trajectory had been reviewed and agreed at safety committee but still gave a risk to the quality of SI investigations over this training period for SIs which required the input of consultant staff.

As seen at our last inspection the trust had implemented a talent management programme and had identified pools of talented individuals within the trust for development. There was positive feedback regarding the trust's own leadership development programme. Clinical and non-clinical managers were encouraged to take part, helping to further develop the cohort of strong middle management grades.

Since our last inspection the board development programme had been further embedded with the use of the 'moving to good' programme and the NEDs had a planned programme with logs to record attendance and receipt of training.

The trust had refreshed its research and development function and had 87 live studies covering 12 medical and surgical specialties. To increase their ability to deliver research projects at scale, and undertake commercial studies, the trust had joined with other local partners to form the Durham and Tees Valley Research Alliance. The trust had also worked and developed links with local universities. The trust was also looking at ways to use research funding to best effect and to increase research activity and interest.

The trust had implemented its own continuous improvement methodology ('IMPS') and planned to have trained 400 staff in the 'novice' level by the end of November 2019. The IMPs programme (one-day IMP novice; three-day IMP practitioner training, which involved delivery of improvement projects) was based on the plan, do, study and act (PDSA) methodology. The trust reported strong engagement with this initiative, with NEDs and executive directors all acting as ambassadors. The trust aimed for all medics, within three years to be trained to novice level.

We saw evidence of improvement projects across the trust, the approach however, was still at an early stage of implementation and needed embedding throughout the organisation. Some board members although trained as ambassadors were not clear of how this role would deliver projects and the vision for the programme. However, we did see plans that executive directors would sponsor projects to raise the profile and impact of the work.

Staff told us about initiatives and developments which had been implemented and supported within the trust. In particular staff praised developments in end of life care. The trust had introduced an innovation forum and increased resources in the innovation team to provide support to staff with ideas and help to take them forwards. To maximise resources to support innovation and better access a range of funding, the trust was working with partner trusts.

The trust had recently commenced Schwartz rounds (a multidisciplinary meeting to review difficult cases and situations) which staff told us had been really valuable for reflection and team working. The trust had adopted the national 'perfect week' initiative (a national initiative based upon change management theory to improve safety and patient flow), they had extended this to the 'perfect month' and were planning for a 'perfect quarter'. Although this was ambitious, it may have been over-optimistic.

Finance training was provided for budget holders by the care group business partners. An example was provided of finance business partners providing their clinical colleagues with budgets translated into whole time equivalents (WTEs) to better aid their understanding of variances against plan. The broader finance team made time for training and professional development through internal time outs and dedicated training time.

Complaints process overview

We saw evidence that learning from complaints was shared within the trust and feedback and experience of complainants was a focus for this learning. Learning was presented clearly with the findings of the complaint and the actions taken from it.

We reviewed five sets of complaints records and found them to be well presented, outlining the issues and concerns raised by the complainant and outcomes were recorded. Response letters were clear with action plans and a clear lead for the completion of action plans. An apology was offered to each person individually. We also noted good practice in dealing with a complainant where the clinician involved had left the trust. We also reviewed the complaints policy which was detailed, up to date and included all relevant documentation.

We heard that themes for complaints were staffing and staff attitude, but the numbers of these complaints were diminishing. Overall the trust took an average of 33 days to respond to complainants with 98 to 100 per cent acknowledged in three working days. The trust's target to respond to complaints was 40 days and this was achieved in 85% of cases.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	3	99%
What is your target for completing a complaint	40	85%
If you have a slightly longer target for complex complaints please indicate what that is here	N/A	N/A
Number of complaints resolved without formal process in the last 12 months?	1,026 (April 2018 to March 2019)	

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

Trust level

From April 2018 to March 2019, the trust received a total of 573 complaints. The highest number of complaints were for medical care (including older people's care), with 20.8% of total complaints, followed by outpatients (20.4% of complaints) and urgent and emergency care services (16.2%).

A breakdown of the number of complaints by core service at trust level is shown below:

Core Service	Number of complaints	Percentage of total
Medical care (including older people's care)	119	20.8%
Outpatients	117	20.4%
Urgent and emergency services	93	16.2%
Surgery	77	13.4%
Community Health Services - Adults Community	33	5.8%
Maternity	31	5.4%
Services for children and young people	26	4.5%
Diagnostics	25	4.4%
Community Health Services - Urgent Care	12	2.1%
Gynaecology	11	1.9%
Provider wide	11	1.9%
Community Health Services - Community Inpatients	5	0.9%
Other	4	0.7%
End of life care	3	0.5%
Community Health Services - Children, young people and families	3	0.5%
Critical care	2	0.4%
Community Health Services - Sexual health	1	0.2%
Total	573	100%

A breakdown of the top five complaint types is shown below:

Complaint type	Number of complaints	Percentage of total
Patient care including nutrition / hydration	194	33.9%
Access to treatment or drugs	123	21.5%
Patient care	87	15.2%
Values and behaviours (staff)	80	14.0%
Appointments	28	4.9%

Darlington Memorial Hospital

From April 2018 to March 2019, Darlington Memorial Hospital received a total of 209 complaints. The highest number of complaints were for medical care (including older people's care), with 23.9% of total complaints, followed by surgery (18.7% of complaints), urgent and emergency care services (17.7%) and outpatients (17.7%).

A breakdown of the number of complaints by core service at Darlington Memorial Hospital is shown below:

Core Service	Number of complaints	Percentage of total
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Medical care (including older people's care)	50	23.9%
Surgery	39	18.7%
Urgent and emergency services	37	17.7%
Outpatients	37	17.7%
Services for children and young people	16	7.7%
Diagnostics	11	5.2%
Maternity	10	4.8%
Gynaecology	5	2.3%
Provider wide	3	1.4%
Community Health Services - Adults community	2	0.9%
End of life care	1	0.4%
Total	209	100%

A breakdown of the top five complaint types at Darlington Memorial Hospital is shown below:

Complaint type	Number of complaints	Percentage of total
Patient care including nutrition / hydration	76	36.4%
Access to treatment or drugs	42	20.1%
Patient care	35	16.8%
Values and behaviours (staff)	28	13.4%
Facilities	11	5.3%

University Hospital of North Durham

From April 2018 to March 2019, University Hospital of North Durham received a total of 264 complaints. The highest number of complaints were for medical care (including older people's care) with 24.2% of total complaints, followed by outpatients (22.4% of complaints) and urgent and emergency care services (20.8%).

A breakdown of the number of complaints by core service at University Hospital of North Durham is shown below:

Core Service	Number of complaints	Percentage of total
Medical care (including older people's care)	64	24.2%
Outpatients	59	22.4%
Urgent and emergency services	55	20.8%
Surgery	36	13.6%
Maternity	17	6.4%
Services for children and young people	10	3.8%
Diagnostics	8	3.0%
Provider wide	6	2.3%
Gynaecology	5	1.9%
Critical care	2	0.8%
Other	1	0.4%
End of life care	1	0.4%
Total	264	100%

A breakdown of the top five complaint types at University Hospital of North Durham is shown below:

Complaint type	Number of complaints	Percentage of total
Patient care including nutrition / hydration	92	34.9%
Access to treatment or drugs	65	24.6%
Patient care	36	13.6%

Values and behaviours (staff)	33	12.5%
Appointments	11	4.2%

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments

From April 2018 to March 2019, the trust received a total of 19,386 compliments. The highest number of compliments were for medical care (including older people's care) with 59.4% of total compliments, followed by provider wide / other (9.0% of compliments) and community health service (CHS) – Adults community (6.7%).

A breakdown of compliments by core service can be seen in the table below:

Core Service	Number of compliments	Percentage of total
Medical care (including older people's care)	11,509	59.4%
Provider wide / Other	1,743	9.0%
CHS - Adults community	1,291	6.7%
Outpatients	1,019	5.3%
Surgery	969	5.0%
CHS - Community inpatients	924	4.8%
Maternity	690	3.6%
Diagnostics	439	2.3%
Urgent and emergency services	203	1.1%
Gynaecology	199	1.0%
CHS - End of Life Care	129	0.7%
CHS - Children, young people and families	118	0.6%
Critical care	90	0.5%
CHS - Community dental	23	0.1%
Services for children and young people	15	0.1%
CHS - Sexual health	14	0.1%
End of life care	11	0.1%
Total	19,386	100%

A breakdown of compliments by site/location can be seen in the table below:

Site/location	Number of compliments	Percentage of total
University Hospital North Durham	11,881	61.3%
Community	3,467	17.9%
Darlington Memorial Hospital	1,589	8.2%
Trust wide	1,122	5.8%
Bishop Auckland Hospital	706	3.6%
Dr Piper House	325	1.7%
Chester le Street Hospital	125	0.7%
Shotley Bridge Hospital	106	0.6%
Peterlee Community Hospital	58	0.3%
Sedgefield Hospital	7	<0.1%
Total	19,386	100%

The main themes that run through the compliments relate to the staff going above and beyond what a patient expects them to do, supporting the patient and family during difficult times for them and taking the time to listen and explain things to patients.

All compliments that the trust receive from a patient or the family are all shared with the staff named and their managers, along with the CEO if requested to or if it is from a staff member. The

trust ask that managers share the compliment with the staff on the ward or in the department.

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	Service accredited
Joint Advisory Group on Endoscopy (JAG)	Provisional accreditation was given in November 2017 subject to estate works to be undertaken at DMH and BAH. Work completed in February 2019 and currently awaiting confirmation from JAG if they will issue full accreditation on photos or video evidence of estate works.
Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189	Haematology (register no.8770) November 2016 achieved, expires October 2021. Biochemistry (8666) June 2017 achieved, expires May 2021. Immunology (8811) October 2016 achieved. Microbiology (9341) May 2017 achieved. Cell Pathology (9717) achieved July 2018. All services re-assessed annually.
MacMillan Quality Environment Award (MQEM)	County Durham and Darlington Foundation Trust, Peterlee (Macmillan Information and Support Centre) - April 2018. University Hospital of North Durham (Macmillan Information & Support Centre) - Award held consistently since 2012.
Family Health	UNICEF UK Baby Friendly Accreditation.
Family Health	Quality Review Programme ANNB (ante-natal and new-born).
Family Health	Quality Assurance Programme Colposcopy.
Family Health	RCPCH National Neonatal Audit Programme.
Family Health	Investing in Children Award.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)

University Hospital of North Durham

Surgery

Facts and data about this service

The service operates at three main sites, with elective and emergency surgery being undertaken at two main sites, Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND), and elective (general surgery, orthopaedics, chronic pain, ophthalmology, dental,

endoscopy, ear nose and throat/ head and neck, and dermatology) is undertaken at Bishop Auckland Hospital (BAH). In addition, day surgery, plastic surgery, general surgery and orthopaedics are undertaken at Shotley Bridge Hospital (SBH).

Surgery and ophthalmology services have close working relationships with other NHS Trusts within the North East.

From July 2018 the provision of the urology was transferred from CDDFT to South Tees Hospitals NHS FT, this service can be accessed at the DMH site.

A breakdown of location, services provided, and number of beds is below.

Location/Site	Ward/Unit	Services provided	Number of beds
Darlington Memorial Hospital	Oral Surgery	Undertakes oral surgery	0
Darlington Memorial Hospital	Theatres	Theatres for all surgical wards at DMH	0
Darlington Memorial Hospital	Ward 11	Undertakes day surgery procedures	22
Darlington Memorial Hospital	Ward 23	Ophthalmology ward	-
Darlington Memorial Hospital	Ward 32	General surgery and colorectal ward.	25
Darlington Memorial Hospital	Ward 33	Elective and trauma ward	31
Darlington Memorial Hospital	Ward 31	Surgical ward (Community)	24
Darlington Memorial Hospital	Day Surgery	Team providing day surgery only procedures.	12
University Hospital of North Durham	Day Surgery	Team providing day surgery only procedures.	25
University Hospital of North Durham	Surgical Admissions Unit	Surgical admissions ward	10
University Hospital of North Durham	Theatres	Theatres for all surgical wards at UHND	30
University Hospital of North Durham	Ward 12	Orthopaedics/Plastics	33
University Hospital of North Durham	Ward 13	Vascular surgery, general surgery	10
University Hospital of North Durham	Ward 15	Ortho/plastics Elective	20
University Hospital of North Durham	Ward 16	General surgery and colorectal	23
Bishop Auckland Hospital	Day Surgery	Small team providing day surgery only procedures	23

Bishop Auckland Hospital	Theatres	Planned day case and inpatient theatre cases	20
Bishop Auckland Hospital	Ward 18	Elective orthopaedic ward specialising in primary arthroplasty	22

(Source: Routine Provider Information Request (RPIR) – Sites tab / Context acute tab)

The trust had 33,338 surgical admissions from February 2018 to January 2019. Emergency admissions accounted for 12,460 (37.4%), 16,672 (50.0%) were day case, and the remaining 4,206 (12.6%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

University Hospital of North Durham surgery department

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in surgery at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Information Governance	104	108	96.3%	95%	Yes
Deteriorating Patient and Resuscitation	103	115	89.6%	85%	Yes
Equality & Diversity	100	117	85.5%	85%	Yes
Immediate Life Support (ILS)	15	21	71.4%	50%	Yes
Paediatric Immediate Life Support (PILS)	14	20	70.0%	50%	Yes
Immediate Life Support Re-Certification (ILS) - 1 Year	11	21	52.4%	50%	Yes
Paediatric Immediate Life Support Re-Certification (PILS Re-Cert) - 1 Year	10	20	50.0%	50%	Yes
Conflict Resolution	98	116	84.5%	85%	No

Infection Prevention and Control - Level 2 - 1 Year	60	116	51.7%	85%	No
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In surgery, the targets were met for seven of the nine mandatory training modules for which qualified nursing staff at University Hospital of North Durham were eligible.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Medical staff had met the trust's completion rate target for five of the mandatory training courses.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in surgery at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Acute Illness Management - No Specific Renewal	1	1	100%	50%	Yes
Advanced Trauma Life Support (ATLS) - 4 Years	1	1	100%	85%	Yes
Equality & Diversity	78	85	91.8%	85%	Yes
Immediate Life Support (ILS)	11	12	91.7%	50%	Yes
Immediate Life Support Re-Certification (ILS) - 1 Year	11	12	91.7%	50%	Yes
Information Governance	59	65	90.8%	95%	No
Deteriorating Patient and Resuscitation	62	79	78.5%	85%	No
Conflict Resolution	66	81	81.5%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	41	83	49.4%	85%	No
Advanced Life Support (ALS) - 4 Years	11	33	33.3%	50%	No
European Paediatric Advanced Life Support (EPALS)	8	29	27.6%	50%	No

In surgery, the targets were met for five of the 11 mandatory training modules for which medical staff at University Hospital of North Durham were eligible.

We received updated figures from the trust post inspection up to June 2019

Training module name	As at June 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Deteriorating Patient & Resuscitation - 2 Years	123	131	94%	85%	Yes
Hand Hygiene - 2 Years	117	133	88%	95%	No
Immediate Life Support (ILS) - 3	18	19	95%	85%	No

Years					
Dementia awareness - No Specified Renewal	103	133	77%	85%	No
Dementia identification, assessment and diagnosis - Tier 2 - No Specified Renewal	47	65	72%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	117	133	88%	85%	No

We asked the trust to share updated figures with us showing safeguarding training compliance for the full year from April 2018 to March 2019. We received updated figures; however, these figures were not split by site, so we were unable to review safeguarding training compliance at University Hospital of North Durham specifically.

The mandatory training was comprehensive and met the needs of patients and staff. It covered a wide range of topics such as deteriorating patient and resuscitation, life support, infection prevention and control, acute illness management.

Medical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff told us they completed training on Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS). We examined 10 medical records and saw that for the one patient that had DoLS, the appropriate documentation had been correctly completed and stored in their record.

Some staff we spoke with said that classroom-based training for sepsis was undertaken two yearly and covered in the deteriorating patient and resuscitation training platform. Post inspection the trust confirmed sepsis was taught on all essential training programmes. They told us all staff who attended two yearly deteriorating patient and resuscitation received this training. The acute intervention team also delivered ward-based education on sepsis to meet individual clinical area needs.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was a RAG reporting system in place which alerted the ward manager when a member of staff's training was due for renewal. As a result, the ward manager sent a reminder email to staff to complete the mandatory training that was due for renewal. The care group were aware of low compliance for infection control training and intended to take a pragmatic approach moving forward to increase compliance; however, we lacked assurance how the service would improve upon this.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

The trust set targets ranging from 33% to 85% for completion of safeguarding training.

University Hospital of North Durham surgery department

Nursing staff had not kept up to date with safeguarding training specific for their role; for example, only 59.5% of nursing staff had completed safeguarding children level 2 compared with the trust's completion rate of 85%.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in surgery at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	86	116	74.1%	33%	Yes
Safeguarding Children Level 2	69	116	59.5%	85%	No

The targets were met for one of the two safeguarding training modules for which qualified nursing staff in surgery at University Hospital of North Durham were eligible. Safeguarding children level two training module did not meet the trust target of 85%, with a 59.5% completion rate.

Medical staff had not kept up to date with safeguarding training specific for their role; for example, only 54.4% of medical staff had completed safeguarding children level 2 compared with the trust's completion rate of 85%.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in surgery at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	51	83	61.4%	33%	Yes
Safeguarding Children Level 2	43	79	54.4%	85%	No

The targets were met for one of the two safeguarding training modules for which medical staff in surgery at University Hospital of North Durham were eligible. Safeguarding children level two training module did not meet the trust target of 85%, with a 54.4% completion rate.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Although safeguard training was below the trust' internal targets at the time of inspection, the trust told us they had implemented a three-year plan to roll out training to all staff. This was in line with intercollege guidance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. There was a safeguarding strategy in place which was aiming to increase the profile of the safeguarding agenda and making safeguarding everyone's responsibility.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Some staff had completed safeguarding adults and children training which included protecting vulnerable children and adults such as those living with dementia and patients with a learning disability. All patients that were admitted to the wards underwent risk assessments for a variety of risks such as falls, moving and handling, pressure damage, malnutrition, VTE, smoking and alcohol consumption.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding adult lead in place and named nurses for safeguarding children. There were dementia and learning and disability link nurses in place. Patients with learning disabilities brought in their own passports. If such patients had carers, they would remain on the ward with the patient.

Staff followed safe procedures for children visiting the ward. They informed accompanying adults to supervise their children at all times and not to leave them unsupervised on the wards.

The surgery care group has raised 11 safeguarding concerns in the last 6 months. This demonstrated a good understanding and recognition of potential safeguarding concerns including domestic violence and abuse.

The issues raised were surrounding discharge and communication, as well as the appropriate actions being taken, these were also routinely fed into the trust discharge work stream next step home.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. We saw that the corridors were clear from clutter and spillages. Any equipment in the corridor was neatly aligned against the walls to prevent trip hazards.

Staff used records to identify how well the service prevented infections. Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff wearing standard NHS uniforms and staff were bare below the elbows. Aprons, gloves and antibacterial gels dispensers were available throughout the ward. There was signage near the ward entrances encouraging visitors to use the antibacterial hand gels.

We reviewed the University Hospital North Durham's cleaning audits scores from April to June 2019 which evidenced a site average of 93%.

Staff cleaned equipment after patient contact. However, we did not see 'I am clean' stickers on equipment stating when it was last cleaned.

There were side rooms available on each ward to care for patients who required isolation. Staff told us they identified patients requiring isolation with a sign on their door and we observed this in practice.

Staff worked effectively to prevent, identify and treat surgical site infections. For the period October – December 2018 under 'repair of neck of femur' there were 187 patients and four infections. This gave a rate of infection of 2.1% which was slightly higher than the national average of 1.2%. The infection control team worked with the lead microbiologist for orthopaedic surgery and the orthopaedic clinical lead to reduce the number of infections.

We asked the surgery care group for updated information surrounding the following:

There had been no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia reported for the last 2 years within the Surgery care group

There had been two cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) reported during 2019/20.

- The first case was deemed hospital onset and attributed to pneumonia
- The second case was community onset in a patient who had a pacemaker inserted at another Trust

There had been four hospital onset clostridium difficile infections reported during 2019/20 within the surgery care group. We reviewed three of the root cause analysis reports made available to us following inspection. The root cause analysis evidenced a clear time line of events, actions taken, lessons learned and a robust dissemination through governance. The fourth root cause analysis was ongoing.

When infections occurred, the trust had a system of investigation, including a peer review or post infection review, following which an action plan was produced.

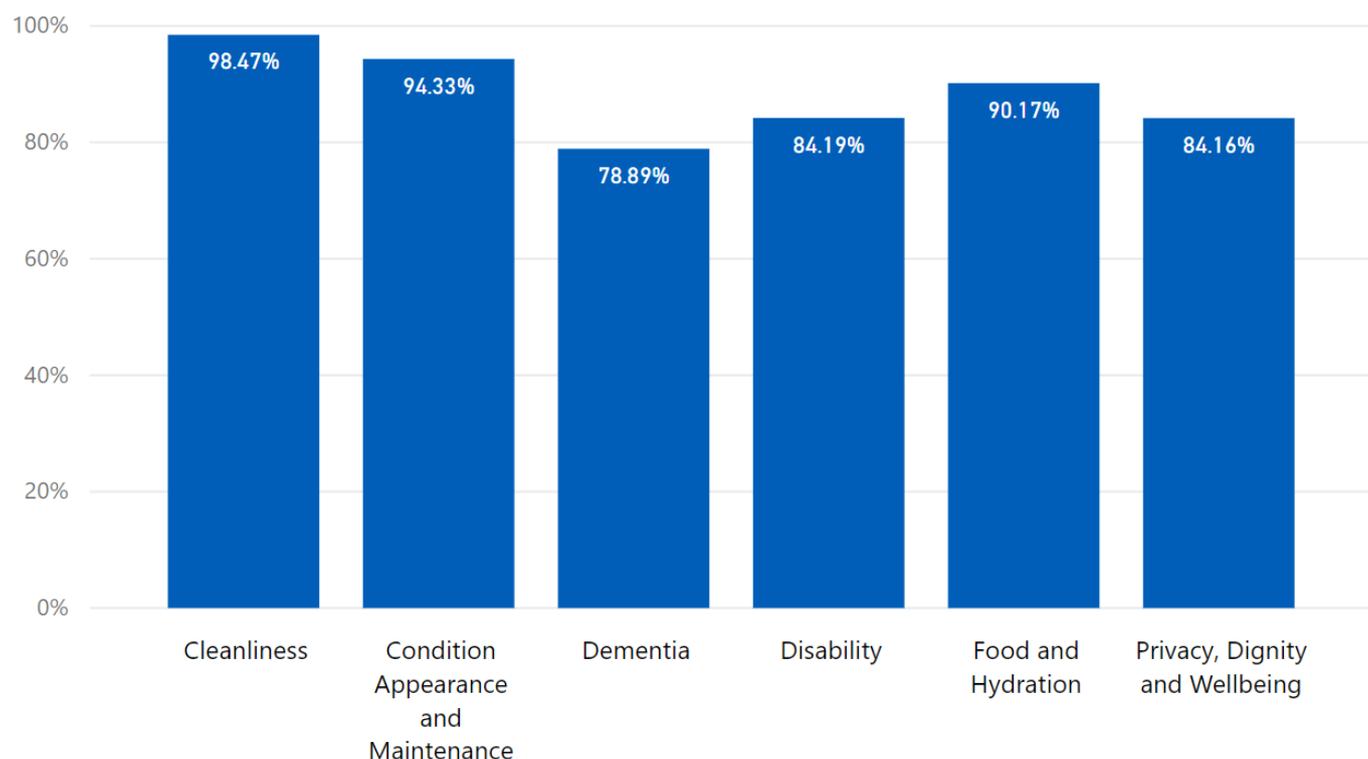
The care group had achieved 100% compliance in all clinical areas in the most recent commode audit (June 2019). We were assured by the senior management team that the trust was ranked second in the North East for cleanliness audit data analysis and action.

Post inspection we received information to support the roll out of tiger striped bags for the safe disposal of offensive clinical waste across sites:

We were told that this was a key part of the trust's response to the collapse of healthcare environmental services, primarily because it enabled the trust to be more resilient by using companies outside of the clinical waste industry and also because it had the potential to reduce the greatly escalating costs. Currently, the orange bags (clinical waste) were still being transported up to 250 miles for disposal whereas the offensive waste (tiger bags) were going to an energy incinerator in Stockton. Since March this had eliminated around 25 clinical waste truck journeys, which had saved around £50,000 and prevented around 20 tonnes of waste and carbon dioxide emissions.

The wards had a link nurse for infection control. Side rooms were available on all wards. We saw notices displayed on doors where patients with infections were being cared for and doors were closed in line with policy for managing infectious patients.

PLACE National Averages



The results highlighted how the trust was performing individually and nationally to drive improvement across hospital sites, enhance services and better the patient experience.

The PLACE assessment results for cleanliness scored 98.97% which was marginally higher than the national average of 98.47%. For condition, appearance and maintenance the trust scored 97.95% which was higher than the national average of 94.3%.

Most patients said food was good, menus were varied. The quality and quantity of food was monitored through patient led assessments of the care environment (PLACE) which showed an overall satisfaction with food provided. The PLACE scores for ward food was 94.90% which was higher than the national average of 90.17%.

The Patient Led Audit of the Care Environment (PLACE) score for privacy, dignity and wellbeing was 88.86%, which was higher than the national average of 84.16%.

The PLACE audit score for dementia scored 80.5% which was higher than the national average 78.9%. The trust had developed action plans from these assessments monitored by matrons. The PLACE score for disability was 90.16% which was higher than the national average of 84.19%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Call bells were available throughout the hospital including emergency call bells in bathrooms. We observed staff attending to patients' needs in a timely manner.

The design of the environment followed national guidance. The wards were clean and free from clutter. Any equipment in the corridor was neatly lined against the walls to prevent trips and falls. We examined the dirty utility room and found it to be clean and tidy and fully compliant with

national standards. The sharps bins were fully compliant with national standards. However, on the day surgery unit the dirty utility rooms were unlocked with COSHH chemicals on display including tubs of Haz-tabs which should have been locked in the COSHH cupboard. The unlocked dirty utility room and COSHH chemicals being on display were escalated to the senior nurse and advised to move the chemicals to a locked cupboard. On ward 12, the main entrance was not locked, however the ward put in appropriate interventions where patients were at risk of leaving the ward without informing staff.

Staff carried out daily safety checks of specialist equipment. We saw that equipment on wards and in theatres was appropriately checked and cleaned regularly and the equipment we saw had service stickers displayed and these were within date. However, there was no evidence that the anaesthetic machines were being examined daily to ensure they were working effectively, whereas log books were signed daily as policy at the other trust site after each examination. The log book should be completed on a daily basis and recorded in the manufacturer's log as per the Association of Anaesthetists of Great Britain and Ireland (AAGBI 2012) recommendations. All the equipment came from Central Equipment Lab Library (CELL) and following use were cleaned by staff. However, none had 'I am clean' sticker; thus, were not reassured that equipment was being cleaned after each use

In the eight theatres out of 10 that we visited, the medicine cupboards in all of the anaesthetist's rooms were found to be open. There was a risk that drugs could be tampered with or removed during quiet periods when there weren't many staff around.

Single use sterile instruments were stored appropriately and were within their expiry dates. Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis.

Emergency resuscitation equipment on each ward had daily and weekly checks completed in line with policy. We checked the resuscitation policy which had a named author, version control and review date in place. We saw that daily checks were recorded as being completed. We checked consumable items, such as medicines, gloves, oxygen masks and suction equipment and did not find any items that were out of date on the trollies.

The service had suitable facilities to meet the needs of patients' families. There were day rooms in the wards for family members to use when visiting their relatives. These were clean and tidy with chairs neatly lined against the walls to prevent trips and falls.

The service had enough suitable equipment to help them to safely care for patients. The wards and theatres we visited contained sufficient number of equipment in order for staff to care for patients in a safe manner.

Staff disposed of clinical waste safely. There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. We saw that there were different colour coded bins located throughout the wards and theatres for the disposal of different waste. We observed staff wearing gloves, aprons and uniforms above the elbows when handling waste and disposing of this in the appropriate coloured bins.

Sharps bins were properly assembled, stored off the floor, not over full and signed and dated. Staff carried out daily safety checks of specialist equipment.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified. The NEWS2 scores were accessed through hand held electronic devices that were password protected with various levels of access for different staff. These devices could also be used to access other risk assessments that had been conducted upon admission of patients in to the hospital.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. We examined eight nursing records and found these to contain comprehensive risk assessments and risk management plans were developed which ensured staff delivered safe care and treatment. Patients were assessed by staff at first contact and on an ongoing basis to identify potential risks to their health and wellbeing. Appropriate actions were taken following assessments to reduce the possibility of patients suffering any avoidable harm. The records that we examined contained patient identifiers on every page, all entries were written in black ink, were legible and were signed and dated. Good practice included individual care plans being present in all records, evidence of patients being involved in their care and records being written in full.

Staff knew about and dealt with any specific risk issues. The nursing records we examined contained fully completed risk assessments for falls, moving and handling, pressure damage, malnutrition, bed rails, venous thrombo-embolism (VTE), smoking and alcohol dependency. Sepsis screening was conducted through the electronic hand-held devices and if a trigger was reached, then doctors and the outreach team were alerted.

The electronic patient record automatically and continuously cross-referenced patients' vital signs, laboratory results and clinical notes, identifying potential sepsis, acute kidney injury and other conditions as soon as results were available, with the aim of eliminating delays and errors that could be associated with manual checking of results. It initiated automated workflows for time-critical actions such as beginning antibiotic treatment for patients with suspected sepsis and sent alerts to the relevant clinician.

The trust had a sepsis policy and treatment pathway in place to provide best practice guidance to all staff involved in the care of patients presenting with sepsis. The pathway incorporated the sepsis six treatment bundle. The policy covered initial management of patients with sepsis and was based on recommended research-based evidence. Emphasis was placed on actions within the first hour and reflected National Institute for Health and Care Excellence (NICE) guidance (July 2016). We saw wards displayed posters about the risk of sepsis.

Measures were put in place for patients deemed to be at risk of pressure damage. These included the provision of pressure relieving equipment, regular position change and nutritional assessments. The service had a tissue viability lead nurse with link nurses on each ward.

On admission all patients had an initial skin integrity body map assessment as part of the adult nursing care pathway. A Waterlow risk assessment tool was used to record mobility, sensory perception, moisture, nutrition, friction and shear risks for all patients. The service had a pressure categorisation tool available to staff to identify high, medium and low risks. Staff could refer patients to the tissue viability nurse if they had concerns. We observed intentional rounding being completed by individual staff and observations recorded in individual patient care pathways.

To enable effective observations, the trust was implementing a dedicated cohort team consisting of health care assistants. Training was ongoing for the health care assistants in distraction techniques and engagement with patients who required one to one support. The scheme facilitated protected and uninterrupted time for staff to carry out observations surrounding patients at risk of falls. The nominated staff member was given protected time and responsibility of patients deemed at risk of falls. We observed that staff were able to carry out this duty without being asked to attend to other matters. Patients deemed to be at risk of falls were cared for in high risk bays.

The trust had taken action to address the historic problems in embedding the World Health Organisation (WHO) checklists. The '5 steps to Safer Surgery, WHO surgical safety checklist should be completed for patients prior to and following surgical intervention. The trust monitored completion of the WHO checklists monthly and took action where checklists were not fully completed.

The care group had historically collected quantitative data in respect of completion of WHO checklists. The care group had revised the WHO checklist as a difference between the checklist and the audit tool had been identified. Alongside the quantitative information, following never events and as part of theatre matters work, the care group had developed and implemented an observational audit tool.

There had been a trust wide programme to support learning from never events. There had been joint working with NHS Improvement and the Clinical Commissioning group (CCG). The safety culture had been reinforced; training and raising awareness had taken place. The trust had commenced a mandated training video surrounding the World Health Organisation the '5 steps to Safer Surgery for all staff members.

There was a plan to further embed and audit the use of Local Safety Standards for Invasive Procedures (LocSSIPs) and further reinforce the WHO checklist to reduce risks of harm to patients and to help prevent recurrence of the never events.

We reviewed recent audits of the WHO checklist post inspection.

Compliance rates evidenced score rates of:

- March 2019 – 99%
- April 2019 – 96%
- May 2019 – 96%

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Ward staff told us that the psychiatric liaison team provided support to clinical staff supporting patients with mental health. Ward staff were able to access the team through a telephone referral and all staff we spoke with told us that the team responded quickly to their requests. In addition, ward staff were able to utilise the crisis team based with the hospital. Ward staff told us that high risk patients such as those experiencing suicidal behaviours were often known to the crisis team before they arrived at the ward and therefore clinical support was swift.

In addition, the trust engaged with the local mental health trust, which provided specific consultant advice to ward staff. For example, patients whom required a mental health section. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. . Ward staff told us that if they required additional staff to safely support these patients, a request was made through their specific matrons.

Staff shared key information to keep patients safe when handing over their care to others. Information stored electronically and on paper was up to date and thus could be shared with other wards when transferring patients.

Shift changes and handovers included all necessary key information to keep patients safe. Safety huddles were held in the mornings at 9:30 am with the Multi-Disciplinary Team (MDT) and then at 1 pm with the nurses and healthcare assistants.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

University Hospital of North Durham

The service had enough nursing staff of all grades to keep patients safe. Ward managers told us that they had recruited sufficient number of nursing staff at different grades to ensure that patients received safe care. We saw planned and actual numbers of staff displayed on the corridors of each ward that we visited.

Operating theatres were fully established against the 'Association for Perioperative Practice (AfPP) staffing recommendations. During inspection we saw this guidance was met on early, night and on late shifts.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Ward managers regularly reviewed nurse staffing. They used the Safer Nursing Care acuity tool (SNCT), along with professional judgement, to plan and flexibly adjust staffing levels accordingly. Staffing numbers were collected twice daily and staff were reallocated to ensure safe staffing. Patient numbers were reviewed regularly, and bed numbers were adjusted as demands required.

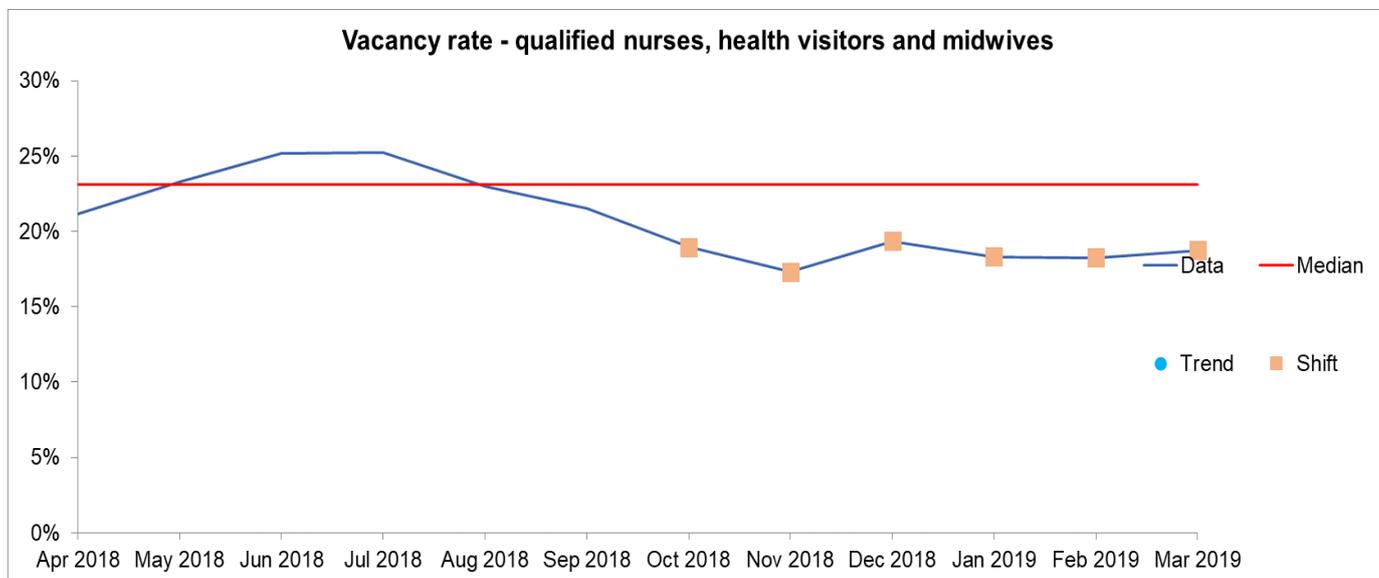
Managers planned and organised services so they met the needs of the local population. The service ensured that there were sufficient staff on duty during each shift. We saw this on display boards which showed the planned and actual number of different grades of staff on each shift.

We saw the planned and actual number of nurses and healthcare assistants displayed on corridors in each ward; for example, on the surgical admissions unit there were four nurses and four healthcare assistants planned for the morning shift and this number of staff were on duty. On ward 16, there were two nurses and one healthcare assistant planned for the afternoon shift and this number of staff were on duty in the afternoon. However, there wasn't wasn't a dedicated paediatric trained nurse in the recovery area which is best practice where children are being nursed.

Nurse staffing rates within this core service at University Hospital of North Durham were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank/agency use.

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site

Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from October 2018 to March 2019. The vacancy rate for nursing staff remained steady at 20% from October 2018 to March 2019. On all wards that we visited staff vacancies had reduced due to successful recruitment campaigns. Ward managers told us that regular staff appraisals, ongoing continual professional development and clear lines of communication were key to retaining staff and maintaining a positive staff culture.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

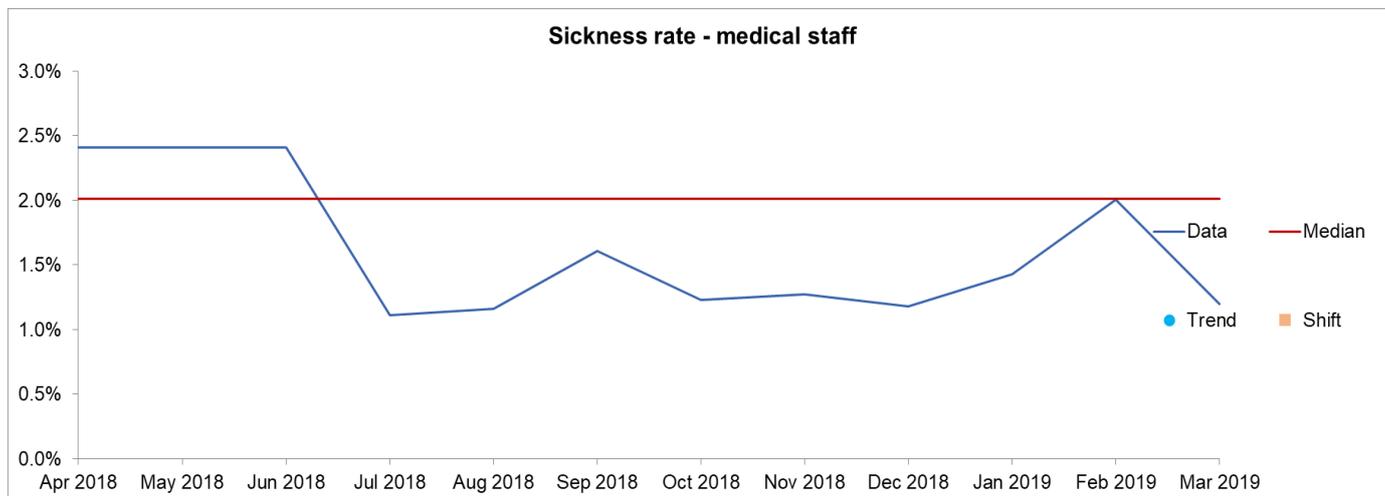
The service had enough medical staff to keep patients safe. The proportion of consultant staff, middle career staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust were all higher than the England average.

University Hospital of North Durham

Medical staffing rates within this core service at University Hospital of North Durham were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and bank staff use.

The following information and charts highlight specific staffing areas where there is noteworthy evidence that there may be change.

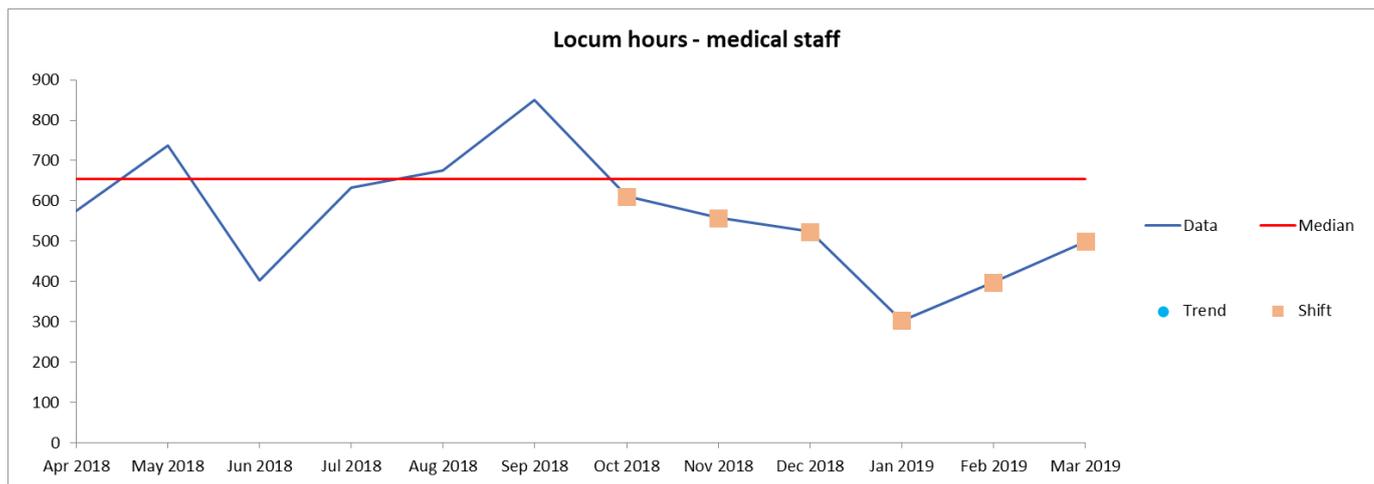
Sickness rates



Monthly sickness rates over the last 12 months for medical staff are not stable and may be subject to ongoing change.

(Source: Routine Provide Information Request (RPIR) – Sickness tab)

Bank and locum staff usage



Monthly agency hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

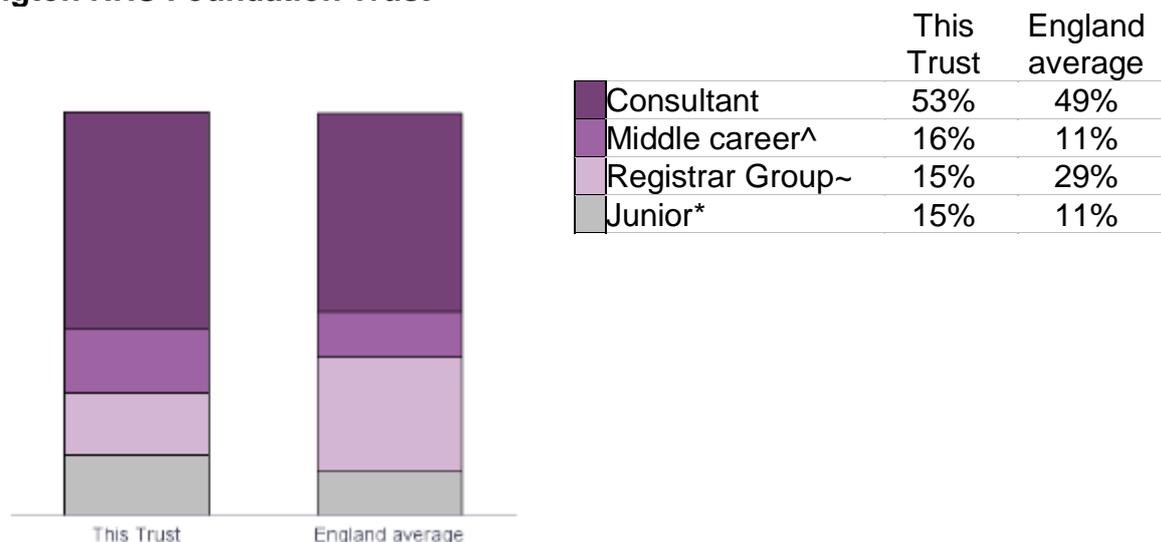
(Source: Routine Provide Information Request (RPIR) – Medical locum tab)

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In January 2019, the proportion of consultant staff, middle career staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust were all higher than the England average. The proportion of registrar staff group reported to be working at the trust was lower than the England average by almost half.

Staffing skill mix for the whole time equivalent staff working at County Durham and Darlington NHS Foundation Trust



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

The service always had a consultant on call during evenings and weekends. Staff told us they could contact the consultant via telephone for advice for patients with complex health needs.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. We examined 10 medical records and found them to be comprehensively written. These were stored electronically and accessed through a hand held device. Staff had different levels of access depending on their role. Nursing records were kept manually and we examined eight records and found these to be legible, written in black ink with each entry dated and signed. The trust were in the process of moving more assessments and care plans on to the digital platform.

The medical and nursing records we examined across all wards we visited and checked contained comprehensive information, were updated regularly and included sepsis checks, nutrition and hydration records, appropriate frequency of observations, pressure care, falls assessments and do not attempt cardiopulmonary resuscitation (DNACPR) forms where appropriate.

Staff had recorded outcomes following reviews and discussions with the multidisciplinary team, patients and their families. We saw good evidence of individualised care plans, appropriate risk assessments and discharge planning for patients. Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff in other areas of the hospital could access patients' notes through the hand-held electronic device. Paper nursing records were transferred with the patient so there was no delay in accessing their records by the new ward.

Medical records were stored securely. The electronic records were stored securely on an electronic hand-held device that was password protected. Staff had different levels of access according to their roles. However, the management of obtaining patient consent for storage of contemporaneous records at the patient's bedside was not robust. The trust had instigated a process for obtaining patient consent; however, on inspection of four patient consent forms, only one consent form had been signed for by the patient.

The clinical record keeping and healthcare records management policy, appendix 12.1 page 13 - consent for accessing contemporaneous records clearly stated the need for a patient signature. This was a deterioration since the last inspection, where the trust had received a should do action requiring that the trust should ensure patient records are complete. We were advised by the senior team that this was not recorded on the surgical risk register as an identified risk.

Data provided by the trust showed that 96.3% of nursing staff and 90.8% of medical staff had completed information governance training; the trust target was 95%.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. We examined 10 medical records and saw that consultants reviewed patient's medicines regularly and provided advice which was clearly documented in the medical records.

Staff stored and managed all medicines and prescribing documents in line with the Trust's policy. The trust had a medicine policy in place written by their chief pharmacist in 2005 and which had been reviewed and ratified in June 2019. This policy clearly stipulated that the safe and secure handling of medicines was the responsibility of every healthcare professional and that all healthcare professionals were accountable for their actions.

Staff followed current national practice to check patients had the correct medicines.

We checked medicines and equipment for emergency use and found they were readily available; staff carried out regular checks to ensure these were fit for use in line with the trust policy. We found that fluids and medications were within their use-by-date on all wards that we inspected.

Medicines management was regularly audited across the trust and included antibiotic management, missed critical medicines doses, controlled drugs and the storage of medicines. We reviewed these audit results and noted that actions resulting from the audits were fed back by lead clinical pharmacists and matrons through individual dashboards.

The Trust had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The trust had a medicine policy in place which stipulated that staff had to complete a safeguard incident report in the event of missing medicine. The patient and carer had to be informed in line with the trust's 'Being Open' policy and in accordance with the duty of candour. The manager receiving the safeguard incident report had to ensure further investigation or action in line with the trust's policies.

The trust policy was to follow the British Thoracic Societies (BTS) guidance for the administration of oxygen. We observed during the inspection that oxygen was not prescribed or recorded in line with BTS guidance on all wards that we inspected. This increased the risk of harm to patients as clear records of administration and use were not maintained. We escalated this to the trust at the time of inspection.

Post inspection we raised concerns surrounding the prescribing of oxygen with the trust. The trust had an ongoing programme of improvement work taking place with respect to oxygen therapy, being overseen by the clinical effectiveness committee. The committee instigated the improvement programme following evidence of variable compliance from audits undertaken by the acute intervention team. A key improvement action was the implementation of a system prompt, on the electronic prescription management and administration system (EPMA), which required the clinician to state whether the patient was to have oxygen therapy when the prescribing record is set up. If the patient was to be placed on oxygen therapy the system would force the clinician to enter the prescription details before allowing further entries to take place. This work had been approved and was scheduled for go-live by 22 July 2019. As an interim measure, the acute intervention team checked all patients on oxygen therapy on the digital platform for a corresponding prescription on EPMA, each night and where a patient did not have a prescription an electronic task would be raised to the medical staff on duty to ensure that the prescription was entered.

This practice, in effect, ensured that there was full compliance for the patients admitted during that day; however, until the EPMA functionality is in place, there may be a delay in the prescription being raised. The trust gave assurance that they will continue to monitor compliance, via the acute intervention team after the new functionality goes live, to ensure that the associated practice becomes embedded.

We saw evidence on all wards we visited that nurses checked controlled drugs (CDs) in line with policy. There were separate CD registers for patients own medicines, registers were completed correctly. Ward managers were responsible for ensuring that CD checks were completed on a daily basis. The surgery care group had worked with pharmacy colleagues to ensure that CD cupboards had been risk assessed. Pharmacy teams completed six monthly audits of CD cupboards and surgery ward managers supported this work.

We saw trust policies that were regularly reviewed, covered most aspects of medicines management and were accessible through the hospital intranet to all staff.

Staff told us that patients wanting to self-administer medicines had a risk assessment performed and recorded before this was initiated, however, we did not see any examples of patients self-medicating. We found that all patients we reviewed had been prescribed appropriate prophylaxis for venous thromboembolism (blood clots) where this was indicated.

The introduction of an electronic medications management system (eMeds) had ensured that the trusts approach to medicines management had been further improved. The electronic patient medication administration (EPMA) system supported the improved quality, safety and effectiveness of medication management within the hospital. This included providing support for doctors, nurses and pharmacists to digitally prescribe, order, check, reconcile, dispense and record the administration of medicines.

Both hard and electronic copies of the medicine dashboards were sent directly to ward managers, matrons and clinical pharmacy teams. Ward managers were expected to share the results with the ward teams. Staff assured us on inspection that the medicines dashboard data was discussed at hand over meetings.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff we spoke with told us that they reported incidents on the electronic reporting system accessed through the intranet and they could request feedback on any learning. There was an open culture around incident reporting. All staff had the ability to report incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff described receiving emails about quality and safety updates and learning from incidents. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff reported all incidents that they should report. Staff we spoke with gave examples of the last incident that they had reported; for example, pressure ulcers. They told us that they would report all incidents.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to March 2019, the trust reported one never event for surgery. This was in May 2018, for a surgical invasive procedure meeting serious incident criteria where an old ureteric stent was reinserted instead of a new one. The duty of candour was adhered to, the patient was informed of the incident and agreed to a second anaesthetic procedure to replace the old stent and replace with a new one.

The service instigated an immediate root cause analysis investigation into the incident. The findings were disseminated through governance streams and all relevant staff informed in order to reduce risk and prevent further incidents. Learning was evident following this never event, staff could explain the incident and the actions taken to prevent recurrence. Improvements in practice were effectively embedded with continuous development to support continued awareness and learning. This was an improvement since the last inspection.

The surgery care group had been instrumental in the development of procedural Local Safety Standards for Invasive procedures (LocSSIPs) and safety protocols. The service had developed an educational video, observational audits in respect of completion of safety checks within theatre and posters highlighting the learning from never events. We saw evidence of this during inspection.

The Trust had a comprehensive LocSSIP development programme; this had been running for the last two years and was now supported by a programme of audit that was currently being rolled out. The trust was seen as an exemplar in this field and had been recognised and shared this work regionally, nationally and internationally.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff and across the trust. A never event occurred involving the reinsertion of an old stent that had been removed. The trust applied the duty of candour verbally and in writing with the patient and their next of kin. A root cause analysis was conducted with the findings and recommendations being compiled in to a report. This report also contained an action plan with staff responsible for the different actions with their respective deadline dates.

Breakdown of serious incidents reported to STEIS

Trust level

Staff reported serious incidents clearly and in line with trust policy. Staff we spoke with told us that they all had the ability to report incidents on the electronic reporting system accessed through the intranet. They could request feedback on the incidents that they reported to managers.

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from April 2018 to March 2019.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	5	50.0%
Surgical/invasive procedure incident meeting SI criteria	1	10.0%
Treatment delay meeting SI criteria	1	10.0%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	10.0%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	10.0%
Medication incident meeting SI criteria	1	10.0%
Total	10	100.0%

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour protocol. They were open, transparent, and gave patients and families a full explanation if and when things went wrong. Staff applied the duty of candour both verbally and in writing. They explained to patients what had gone wrong and how they expected to correct their mistake; for example, during an elective procedure on a patient in November 2018, the patient slid and fell on to the floor. The surgical team transferred the patient back on to the stretcher and completed the operation. The patient was then transferred to the CT scanner to take scans of the neck and head as a precaution. These showed that no injuries had been sustained.

When the patient regained consciousness from the anaesthesia, the surgeon verbally apologised to the patient and their family and explained what had happened in theatre. Additionally, the surgeon explained that a root cause analysis would be conducted and a written account would be sent to the patient and learning points highlighted. The anaesthetist also reviewed the patient, gave an explanation about the fall and also gave a verbal apology.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff reported incidents through the trust's electronic system accessed through the intranet. They could check a box requesting feedback from the investigation in to the incident.

Staff met to discuss the feedback and look at improvements to patient care. The feedback received from the root cause analysis involving the patient were discussed at the governance meeting. The trust also advised staff of the benefits of taking patients off the blue slide sheet to prevent them from slipping.

There was evidence that changes had been made as a result of feedback. The incident involving the patient sliding and falling on to the floor resulted in a root cause analysis report being compiled with recommendations for staff. We saw that this report was thorough with robust recommendations which had been discussed at the governance meeting.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw in the root cause analysis report that managers investigated the incident of the patient sliding and falling from the operating table thoroughly. They also involved the patient and their family members by apologising verbally and in writing. The managers explained to the patient how the incident would be investigated and that the final report would be shared with the patient and their family members.

Managers debriefed and supported staff after any serious incident.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see. We saw safety thermometer data clearly displayed on boards in the wards that we visited.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

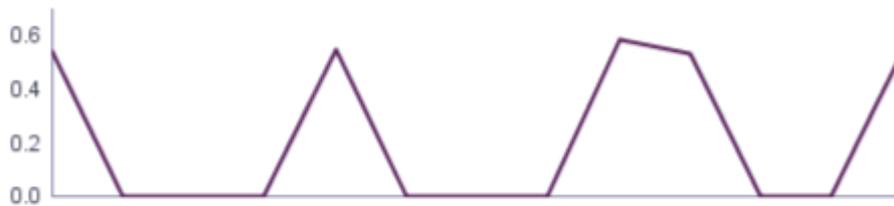
Staff used the safety thermometer data to further improve services. Staff analysed the number of falls on each ward and if they saw an increase in numbers, they increased the number of staff on duty to counteract the risk of more patients falling, in order to protect vulnerable patients from harm as a result of falls.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, four falls with harm and two new catheter urinary tract infections from March 2018 to March 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at County Durham and Darlington NHS Foundation Trust

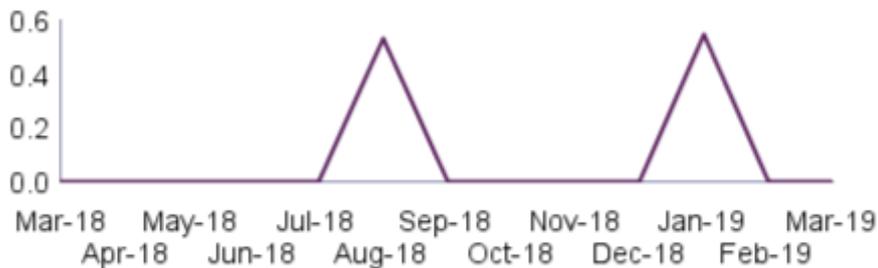
Total Pressure ulcers (5)



Total Falls (4)



Total CUTIs (2)



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. We observed staff in theatres and wards adhering to National Institute for Health and Care Excellence (NICE) guidance on infection control and preventing surgical site infections. The hospital had processes to monitor deteriorating patients that were in line with NICE for Health and Care Excellence guidance on managing acutely ill patients in hospital. We saw sepsis screening in line with the Sepsis Six pathway (a set of six tasks to be completed within an hour of identifying probable sepsis).

Staff protected the rights of patients' subject to the Mental Health Act and followed the Code of Practice. Staff had completed training in Mental Capacity Act and Deprivation of Liberty Safeguarding (DoLS). We examined 10 nursing records and for one patient staff had completed a DoLS in accordance with the Mental Capacity Act.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Safety huddles were held in the mornings at 9:30 am with the Multi-Disciplinary Team (MDT) and then at 1 pm with the nurses and healthcare assistants.

The trust had a robust structure to support the identification, dissemination, implementation and monitoring of recommendations and quality standards from the National Institute of Clinical Excellence (NICE). New guidance was disseminated monthly to each area of the trust, including medicine, to review and assess for relevance and level of implementation through their governance arrangements. Quarterly report on status with meeting NICE Guidance was presented to clinical effectiveness committee and integrated quality assurance committee.

Staff had access to trust policies via the intranet. Patient records showed staff used standardised care pathways to plan care for patients. We looked at some of the trust's clinical protocols and patient pathways used for patients on surgical wards. We found these followed nationally recognised best practice and current evidence base. For example, staff used a sepsis screening tool and placed patients who met the criteria on the sepsis pathway. This pathway included the 'Sepsis Six,' designed by the 'UK Sepsis Trust,' which consists of diagnostic and therapeutic steps to be taken within one hour of diagnosis to improve patient outcomes, including up to a 50% reduction in mortality.

The trust participated in the 'Getting It Right First Time' (GIRFT) project, commissioned by the Department of Health. This is a national programme designed to improve the quality of care within the National Health Service by reduction of unwanted variations and or divergence from the best evidence. Senior leaders within surgery told us about GIRFT quality improvement projects in orthopaedics and general surgery.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink. Especially those with specialist nutrition and hydration needs. The trust used a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that staff followed MUST scoring for nutrition and hydration appropriately. Nutrition and hydration needs were identified and managed as part of the electronic care plan system.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We examined eight nursing records and saw that where applicable staff had fully completed fluid balance charts including the recording of positive and negative fluid balances. We observed patients being offered hot and cold drinks throughout the day. These were placed on tables within easy reach of patients.

Specialist support from staff such as dieticians was available for patients who needed it. The care group had access to dietitians and patients who scored low on the MUST score were referred to dietitians for advice.

Patients waiting to have surgery were not left nil by mouth for long periods. We reviewed care plan documentation and saw that risk assessments were fully completed and fluid and food charts were completed appropriately.

We observed protected meal times were in place and saw patients supported to eat and drink. Systems were in place to identify patients who needed additional support with eating and drinking. Patients who required assistance were given a water jug with a red lid and a red placemat at meal

times to highlight assistance was required. Drinks were readily available and were in easy reach of patients.

Individual multicultural patient needs were catered for including, vegetarian, vegan and halal choices. Patients assured us that food was warm, fresh and of good quality. We observed food being distributed to individual patients, the food looked appetising and fresh. However, the complaints received by the care group from April 2018 to March 2019 showed that 20 were about nutrition and hydration. This was the single highest category from the total number of complaints received during the year.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Pain assessments were completed during the admission process within the trust. Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff told us they used a pain score system (zero to 10, with 10 being the worse pain imaginable). For dementia and learning and disability patients the care group used the Abbey pain scale.

If required, ongoing assessment was continued on paper subsequently during the admission period. The surgery care group were evaluating whether the admission pain assessment document could be utilised for ongoing monitoring meaning pain assessments for the duration of patient stay are captured within the digital platform. We were told if this was agreed through the governance process then the group would expect to be in a position to roll this out within the next three months.

The trust adhered to the Royal College of Anaesthetists (RCOA), faculty of pain medicine: Core Standards for Pain Management Services in the UK – October 2015. We reviewed the trusts adherence against the standards and were assured that the trust had a robust pain management process in place.

Patients received pain relief soon after requesting it. Staff told us that they initially gave patients medicine such as paracetamol and mild opioids. If this did not have the desired effect, the patient was referred to the pain management team. There was a pain link nurse available on the wards. A specialist pain team was available for patients.

The surgery care group conducted a patient experience survey. This evidenced that 94% of respondents rated their overall experience of the acute pain service as being good to excellent

On ward 12, there was a resident pharmacist whose primary role was to manage pain of patients with fractured hips and to advise the doctors on the suitability and effectiveness of medicines for different patients. The pharmacist worked 8 am until 5 pm. After this time and at the weekends staff rang an on-call number for advice. The pharmacist gave advice over the telephone but could also come in to the hospital if necessary during out of hours.

Ward staff told us that patients experiencing pain and subsequently prescribed PRN analgesia should have pain levels reviewed and assessed each time medication was due to be dispensed, or at least four-hourly. Ward staff stated that a care plan for pain management would be activated on the electronic patient records if patients required regular analgesia and subsequently assessment of pain would be logged within the electronic system.

However, we saw that paper pain assessment documents were still used across some of the wards. We reviewed four patients receiving PRN analgesia and saw that three did have a paper pain assessment and one did not. The one patient whom did not have a paper pain assessment record had been assessed using the nerve centre pain care plan seven days ago but had not been reviewed since. However, we saw PRN analgesia had been dispensed. Therefore, we were not assured that all patients experiencing pain were consistently monitored in accordance with the trust policy.

Ward staff told us that paper records were discouraged and staff were proactively supported to use the electronic patient recording system for recording and assessing pain but staff were still getting used to the new systems.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further. The trust participated in a variety of audits; for example, bowel cancer. This audit showed that the risk-adjusted 90-day post-operative mortality rate was within the expected range when compared to other trusts. However, the risk-adjusted 2-year post-operative mortality rate was worse than expected when compared to other trusts. The trust had action plans in place to address issues identified in audits; for example, audit of fractured neck of femur resulted in pain scores being assessed within 15 minutes of patients arriving at the hospital.

The trust continued to use a wide range of mechanisms to monitor and measure patient and clinical outcomes and performance. There was a robust local clinical audit programme in place with active participation in the national programme of audits. Implementation of NICE guidance and other professional guidelines was monitored and reviewed and incorporated into trust policies and clinical guidelines wherever appropriate.

Following the instigation of the digital platform for National Early Warning Score (NEWS2) in adult inpatient areas, the trust no longer completed the traditional monthly observation chart audit. In surgery, the observations overdue performance scored 19.5% in June 2019. The ward performance report for May 2019 stated that performance was excellent at 19.5%. The performance was reviewed through governance meetings and escalated through clinical team meetings for shared learning. The compliance data was also shared in a number of ways with care groups and clinical teams via the ward performance report shared with senior nurses.

The surgery care group undertook audit of sepsis. All staff were familiar with the sepsis screening tool within the digital platform. The current audit that was completed was in line with the Commissioning for Quality and Innovation (CQUIN) for sepsis management which was a random trust sample of patients with confirmed sepsis. Most recent data was for quarter four where 100% sepsis screens were completed and compliance for antibiotics within 1 hour was 94%. Surgery care group patients were included in this audit.

The surgery care group worked collaboratively with the infection control team to support the ongoing monitoring of surgical site infection.

In line with surveillance of surgical site infection (SSI) in orthopaedic surgery which became mandatory for all English NHS trusts; the trust complied with a minimum requirement of one, three-month period of surveillance being performed in at least one of the following orthopaedic procedures:

- Total hip replacement

- Total knee replacement
- Repair of neck of femur
- Internal fixation of long bones

From January to March 2019 the total number of repair of neck of femur procedures across both sites at Darlington Memorial Hospital and the University Hospital of North Durham was 158. The trust reported two inpatient/readmission infections and 0% post discharge infection. The trust reported a total of two infections in that timeframe which equated to 1.26% infection rate.

The care group instigated audit surrounding the insertion and management of nasogastric tubes. The audit demonstrated that there were some deficits in documentation at the time of the audit and a re-audit was planned for August 2018. However, the trust had introduced a Local Safety Standards for Invasive Procedures (LocSSIP) for nasogastric tube (NG) insertion and had also recently changed the NG tubes used within the trust. The re-audit had been re-scheduled later in 2019.

We discussed nasogastric tube insertion with nursing staff during inspection. They were aware of the trust nasogastric check list and process surrounding the insertion and management of nasogastric tubes. Registered nurses informed us that they were required to meet the competency framework for the insertion and management of nasogastric tubes.

Following our inspection, the trust provided venous thromboembolism (VTE) risk assessment audit data at trust level. The information department reviewed all cases and identified if the individual patient had been receiving care within the organisation within 90 days prior to the event so a full root cause analysis (RCA) was instigated. The care group leads for VTE received the names and identification details, so a review took place.

The care group reported in quarter 4, January to March 2019 the trust had reported and investigated 17 venous thromboembolisms.

The Trust had a VTE group who ensured policy and drug regimens remained current. The safety committee received a copy of this report.

The associate director of nursing reviewed the monthly data of new VTE and those who had been within the surgery care group prior to the VTE being identified. This information was collated through the patient safety team and reported to the commissioners on a quarterly basis.

The Pharmacy team conducted bi-monthly audits on surgical wards. The trust provided data which indicated that monthly antimicrobial care bundle audits were undertaken. The results of these audits showed that surgical wards were predominantly compliant with most aspects of the audit. There were some areas of non-compliance in daily reviews of intravenous antimicrobial prescribing, patients switching to oral antibiotics once they were deemed to be clinically appropriate to do so and a review date or duration being documented. The lowest documented compliance score was 20% for review date recorded on surgical admissions unit.

We reviewed the surgery care groups audit compliance for medicines reconciliation, critical missed doses and controlled drugs audits post inspection. Pharmacy delivered surgical medicines reconciliation in line with priorities agreed with the surgical clinical directors. In orthopaedics, this involved focusing on the patients most at risk of post-operative complications (e.g. hip and knee replacement, patients with a fractured neck of femur). The audit undertaken in January 2019 evidenced low compliance rates on the four wards audited (see table below)

Medicines reconciliation, University Hospital North Durham (January 2019)

Site	Ward	Speciality	MR completed	MR completed <24hrs	Comment
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UHND	SAU	Surgical Admissions	56%	11%	Aim to see all patients
	12	Trauma Orthopaedics	41%	32%	All patients seen with priority to #NOF
	15	Plastic / Ortho Electives	67%	57%	All patients seen with priority given to hip/knee replacement
	16	General Surgery	81%	57%	Aim to see all patients

As part of the pharmacy operational plan for 2019/2020 a number of work streams were underway in relation to medicines reconciliation. These included:

- 1) Review of medicines reconciliation processes to streamline based on lean principles. Lean is a set of operating philosophies and methods that help create a maximum value for patients by reducing waste and waits.
- 2) Front-loading of pharmacy technicians to admissions areas (implemented May 2019)
- 3) Identification of patients for review on high risk medicines (via ePMA) in areas without a regular pharmacy service.

The data for missed doses was not available at surgery care group level. A recent audit of the ePMA data and incident data identified that 14 of 18 omitted dose incidents in April 2019 related to critical medicines.

In response to this the Pharmacy team implemented the following actions

- 1) The Pharmacy team developed a critical medications site on the intranet site. This allowed staff to search for the medication that was unavailable and identified the action to be taken.
- 2) Added specific warnings to critical medicines in the additional information on ePMA system
- 3) Delivered a presentation to all clinical staff in a number of forums including care group governance meetings, senior nurse forum and sisters away day.
- 4) Publicised it through “the week ahead” and “medicines bulletins”.

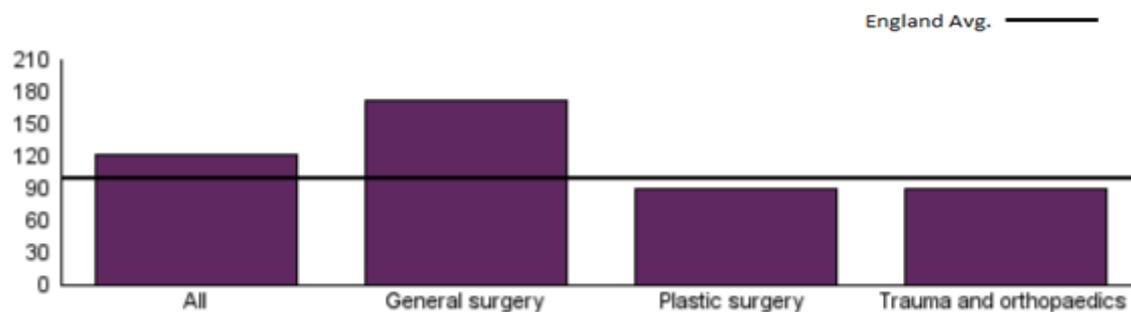
Relative risk of readmission

University Hospital North Durham

From January 2018 to December 2018, all patients at University Hospital North Durham had a higher than expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at University Hospital North Durham had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Plastic surgery patients and trauma and orthopaedics patients at University Hospital North Durham both had a lower than expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - University Hospital North Durham



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

All patients at University Hospital North Durham had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients and trauma and orthopaedics patients at University Hospital North Durham both had a similar to expected risk of readmission for non-elective admissions when compared to the England average.
- Plastic surgery patients at University Hospital North Durham had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - University Hospital North Durham



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

(Source: Hospital Episode Statistics (HES) - Readmissions (January 2018 – December 2018))

National Hip Fracture Database

University Hospital of North Durham

The table below summarises University Hospital of North Durham's performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, 'similar' means that the trust's performance fell within the middle 50% of results nationally.

Metrics (Audit indicators)	Hospital performance	Comparison to other Trusts	Meets national standard?
Case ascertainment (Proportion of eligible cases included in the audit)	100.8%	Similar	✓

Crude proportion of patients having surgery on the day or day after admission <i>(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</i>	74.1%	Similar	x
Crude peri-operative medical assessment rate <i>(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</i>	97.6%	Top 25%	x
Crude proportion of patients documented as not developing a pressure ulcer <i>(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient's admission); this measures an organisation's ability to report 'documented as no pressure ulcer' for a patient</i>	98.9%	Top 25%	x
Crude overall hospital length of stay <i>(A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</i>	21.7 days	Similar	No current standard
Risk-adjusted 30-day mortality rate <i>(Adjusted scores take into account the differences in the case-mix of patients treated)</i>	7.2%	Within expected range	No current standard

(Source: National Hip Fracture Database 2018)

Post inspection the surgery care group provided an update with regard the above data: The 2017/18 report demonstrated a number of areas for good practice including:

- Prompt surgery
- National Institute of Clinical Excellence (NICE) compliance
- Return to original residence
- No evidence of delirium when assessed post operatively, which the service had sustained.

There were two main areas of non-compliance identified:

- Ortho geriatric review at Darlington Memorial Hospital
- Prompt mobilisation at University Hospital of North Durham.

The Trust had recruited an additional consultant ortho-geriatrician at Darlington Memorial Hospital. This had provided a more consistent approach, with performance dashboard shared three times a year at governance meetings and the hip fracture steering group. Currently physiotherapy staff attend ward huddles and rounds, prioritising patients for first day post-operative mobilisation.

Bowel Cancer Audit

The table below summarises County Durham and Darlington NHS Foundation Trust's performance in the 2018 National Bowel Cancer Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Meets national standard?
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	114.4%	Good	Good is over 80%
Risk-adjusted post-operative length of stay >5 days after major resection <i>(A prolonged length of stay can pose risks to patients)</i>	71.3%	Worse than national aggregate	No current standard
Risk-adjusted 90-day post-operative mortality rate <i>(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)</i>	1.7%	Within expected range	No current standard
Risk-adjusted 2-year post-operative mortality rate <i>(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)</i>	27.9%	Worse than expected	No current standard
Risk-adjusted 30-day unplanned readmission rate <i>(A potential risk for early/inappropriate discharge is the need for unplanned readmission)</i>	9.7%	Within expected range	No current standard
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection <i>(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases, it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)</i>	53.8%	Within expected range	No current standard

(Source: National Bowel Cancer Audit 2018)

Post inspection the surgery care group provided an update with regard the above data: The 2018 annual report contained data from the 2017/18 reporting period covering patients in England and Wales with a date of diagnosis from 01 April 2016 to 31 March 2017. In December 2017 the trust implemented the Somerset Cancer Registry (SCR) which was a more robust national data collection system. Following this the team cancer services team carried out a review of data collection strategies and implemented a number of changes as to how the trust collected and nationally reported key data items.

The following actions had been implemented:

- Performance status is discussed at all treatment planning multi-disciplinary team meetings (MDT's) and recorded on the corresponding MDT module within the Somerset Cancer Register

- Cancer outcomes and services data set (COSD), data reports are validated prior to the monthly data submission deadlines and where, as far as possible, missing data items are located within the patient's digital record and the summary care record updated.
- National bowel cancer audit (NBCA) data compliance reports (available via the Health and

Social Care Information Centre HSCIC portal) are utilised to identify any missing data missing items and gaps filled where possible.

The results from the national bowel screening audit were discussed by the colorectal clinical lead at the general surgery clinical governance meeting on 29th January 2019 and it was highlighted that County Durham and Darlington Foundation Trust was an outlier for recording performance status.

National Vascular Registry

The table below summarises County Durham and Darlington NHS Foundation Trust's performance in the 2018 National Vascular Registry.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Meets national standard?
Abdominal Aortic Aneurysm Surgery <i>(Surgical procedure performed on an enlarged major blood vessel in the abdomen)</i>			
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	108.0%	Not applicable	✓
Risk-adjusted post-operative in-hospital mortality rate <i>(Proportion of patients who die in hospital after having had an operation)</i>	3.0%	Within the expected range	No current standard
Carotid endarterectomy <i>(Surgical procedure performed to reduce the risk of stroke; by correcting a narrowing in the main artery in the neck that supplies blood to the brain)</i>			
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	100.0%	Not applicable	✓
Crude median time from symptom to surgery <i>(Average amount of time patients wait to have surgery after the onset of their symptoms)</i>	17 days	Not applicable	✗
Risk adjusted 30 day mortality and stroke rate <i>(Proportion of patients who die or have a stroke within 30 days of their operation)</i>	4.6%	Within the expected range	No current standard

(Source: National Vascular Registry 2018)

National Oesophago-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises County Durham and Darlington NHS Foundation Trust's

performance in the 2018 National Oesophago-gastric Cancer Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Meets national standard?
Trust-level metrics <i>(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</i>			
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	>90%	Better	No current standard
Age and sex adjusted proportion of patients diagnosed after an emergency admission <i>(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)</i>	15.7%	Similar	No current standard
Risk adjusted 90-day post-operative mortality rate <i>(Proportion of patients who die within 90 days of their operation)</i>	Not eligible	N/A	No current standard
Cancer Alliance level metrics <i>(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.)</i>			
Crude proportion of patients treated with curative intent in the Cancer Alliance <i>(Proportion of patients receiving treatment intended to cure their cancer)</i>	38.3%	Similar	No current standard

(Source: National Oesophago-Gastric Cancer Audit 2018)

National Emergency Laparotomy Audit

University Hospital of North Durham

The table below summarises University Hospital of North Durham's performance in the 2018 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).

Metrics (Audit measures)	Hospital performance	Audit's Rating	Meets national standard?
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	94.5%	Green	✓
Crude proportion of cases with pre-operative	57.7%	Amber	✗

documentation of risk of death <i>(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</i>			
Crude proportion of cases with access to theatres within clinically appropriate time frames <i>(Proportion of patients who were operated on within recommended times)</i>	89.9%	Green	✓
Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre <i>(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)</i>	97.6%	Green	✓
Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively <i>(Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)</i>	75.5%	Amber	✗
Risk-adjusted 30-day mortality rate <i>(Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)</i>	6.0%	Within expected range	No current standard

(Source: National Emergency Laparotomy Audit 2018)

Post inspection the surgery care group provided an update with regard to the above data. The trust told us they exceeded the national target for surgical and anaesthetic consultant presence in theatre and the mortality figures were 6% at the University Hospital of North Durham and 6.5% at Darlington Memorial Hospital against a national mortality of 9.5%. County Durham and Darlington Foundation Trust have been approached to share best practice, that is ortho geriatrician input at University Hospital of North Durham.

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises County Durham and Darlington NHS Foundation Trust's performance in the 2018 National Ophthalmology Database Audit.

Metrics <i>(Audit measures)</i>	Trust performance	Comparison to other Trusts	Meets national standard?
Trust-level metrics <i>(Measures of hospital performance in the treatment of cataracts)</i>			
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	100.0%	N/A	No current standard
Risk-adjusted posterior capsule rupture rate <i>(Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from</i>	1.5%	Within expected range	No current standard

<i>surgery and is widely accepted by surgeons as a marker of surgical skill.</i>			
Risk adjusted visual acuity loss <i>(The most important outcome following cataract surgery is the clarity of vision)</i>	0.8%	Within expected range	No current standard

(Source: National Ophthalmology Database Audit 2018)

National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

University Hospital of North Durham

The table below summarises University Hospital of North Durham's performance in the 2018 National Joint Registry.

	Metrics (Audit measures)	Hospital performance	Comparison to other hospitals	Meets national standard?
Trust-level	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) <i>(Patient details help 'track and trace' prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)</i>	88.9%	Similar	x
Hospital level: Hips	Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture) <i>(Proportion of patients who need their hip replacement 're-doing')</i>	1.00	Within expected range	✓
	Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) <i>(Proportion of patients who die within 90 days of their operation)</i>	1.25	Within expected range	✓
Hospital level: Knees	Risk-adjusted 5 year revision ratio (for knees excluding tumours) <i>(Proportion of patients who need their knee replacement 're-doing')</i>	1.20	Within expected range	✓
	Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) <i>(Proportion of patients who die within 90 days of their operation)</i>	1.00	Within expected range	✓

(Source: National Joint Registry 2018)

Post inspection the surgery care group provided an update with regard the above data. University Hospital of North Durham's performance for knee replacement was similar to other trusts in comparison. Consent documentation was identified as an area for improvement. The

Trust had implemented a new system in early 2018, the report only correlated data until March 2018 so it was expected that an improvement would be seen in the next report.

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

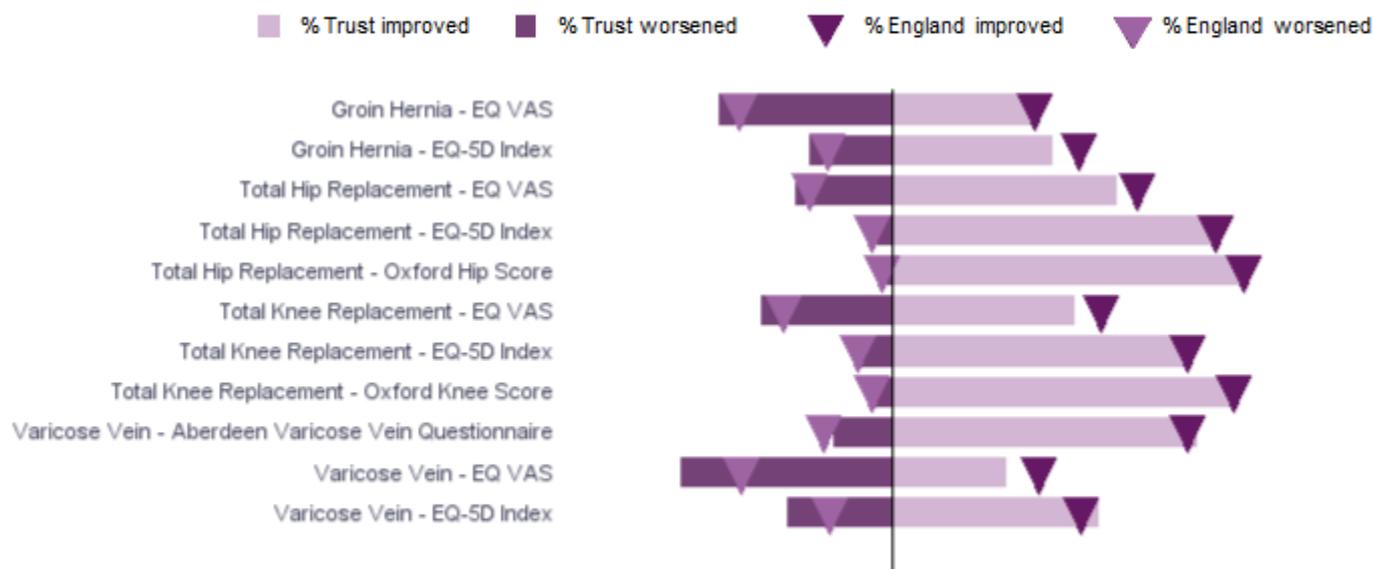
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific Issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.



In 2016/17 performance on groin hernias was slightly worse than as the England average

For varicose veins, performance was worse than the England average.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was slightly worse than the England average.

(Source: NHS Digital)

The surgery care groups journey through PROMS had led to essentially a move from 75% uptake of from one to 100% uptake of questionnaire one. There had been year on year improvement in PROMS data in knee replacement with a whole two-point increase on the Oxford score over five years (above the national average).

The surgery care group had identified that hip replacement PROMS were skewed because patients were not correctly recording their co-morbidities and so the data currently says the trust were operating on patients who were fitter than average when in fact the reverse was the case. The care group had introduced policies to correct this.

The surgery care group had also identified patients who were not getting their operation within three months of their questionnaire one. The care group expected to see an improvement through questionnaire two uptake.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The care group ensured that staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support. We spoke with ward managers who told us that staff completed a wide range of mandatory training such as Mental Capacity Act, Deprivation of Liberty Safeguarding (DoLS), adult and children safeguarding. These training courses were a mixture of classroom-based and online courses. The renewal of these courses varied; for example, some courses had to be repeated yearly whereas other were renewed over a longer period of time.

Managers gave all new staff a full induction tailored to their role before they started work. The trust had an induction policy in place dated April 2005 which had been reviewed on 30 May 2017 with the next review date 30 May 2020. This policy stipulated that all new staff had to complete the corporate induction upon commencement of their employment. The corporate induction programme consisted of strategic direction of the organisation, health and safety, fire awareness, information governance, patient safety and governance, safeguarding, equality and diversity, moving and handling theory, infection control and hand hygiene, referral to treat 18-week target. The induction programme for each individual also included the minimum role specific essential training the new starter needed to attend.

Managers were responsible for ensuring that all their staff received a robust local induction and this induction was carried out by the employing manager. The local induction programme as a minimum covered the following topics: orientation to the department, local fire procedures, health and safety, hours of work and shift patterns, sickness reporting procedures, key policies relevant to the area of work, key roles and responsibilities.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers had an open-door policy where staff could come and talk to them about any issues they had rather than waiting for their formal supervision meetings. Staff were encouraged to develop professionally in their careers.

University Hospital of North Durham surgery department

Staff group	April 2018 to March 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add Prof Scientific and Technic	27	27	100%	95%	Yes
Allied Health Professionals	7	7	100%	95%	Yes
Healthcare Scientists	19	19	100%	95%	Yes
Administrative and Clerical	60	61	98.4%	95%	Yes
Additional Clinical Services	70	72	97.2%	95%	Yes
Nursing and Midwifery Registered	99	103	96.1%	95%	Yes
Medical and Dental	59	65	90.8%	95%	No
Estates and Ancillary	2	3	66.7%	95%	No
Total	343	357	96.1%	95%	Yes

From April 2018 to March 2019, 96.1% of required staff in surgery at University Hospital of North Durham received an appraisal compared to the trust target of 95%. Nursing and midwifery registered staff met the trust target with 96.1%, whilst medical and dental staff did not meet the target with 90.8%.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Post inspection we received additional data to support appraisal compliance for the surgery care group. The surgery care group had ensured a robust focus on appraisals and role specific training. Individual ward management had supported staff to ensure they had protected free time to undertake training and appraisal. We were told by the surgery care group that they were keen to invest in staff as part of the journey on cultural improvement.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. They also told us they found appraisals beneficial as they used them to reflect on their achievements over the past year and to set goals for the next financial year. The trust had a support in practice policy that described the support available for clinical staff in the organisation. All nurses and midwives received trust support with their personal and professional development leading to revalidation.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. For the financial year ending March 2019, medical and dental and estates and ancillary staff groups did not meet the trust's appraisal completion target.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Ward managers told us that it was difficult asking staff to come in to work for team meetings on their days off. Instead, key messages discussed during team meetings were printed off and placed in the communications file for staff to read that didn't manage to attend the team meeting. Staff had to sign and date a declaration that they had read these key messages.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Ward managers reminded their staff when their mandatory training was due for renewal and sent them a reminder email. Staff were also given time to complete mandatory training that was due for renewal.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff could identify training other than mandatory that they felt would benefit their career development and seek approval from their manager to fund this training.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff of different kinds worked together as a team to benefit patients. They used these meetings to discuss any issues relating to patients and beds. Additionally, these meetings were used to relay information coming from senior management. Doctors, nurses and other healthcare professionals such as physiotherapists worked well together which benefitted patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. The hospital had a dementia link nurse in place. Staff referred patients to this nurse for assessment where they suspected patients to be living with dementia.

Specialist nurses were available to review patients in specialties, such as acute pain, acute intervention team (deteriorating patients), pharmacy and adult mental health liaison. Specialists were also available to support staff groups with training and to participate in multidisciplinary meetings to discuss patient care and treatment.

Allied health professionals confirmed there was good multidisciplinary working and offered training to nursing staff where appropriate. Dieticians completed reviews of patients referred for their input.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on their care pathway. We saw consultants on the ward conducting ward rounds with other healthcare professionals. We examined nursing records and saw that consultants had written legibly in black ink in their assessment of patients and the recommended course of treatment.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The trauma orthopaedic ward employed two geriatricians five days a week and they were on call at the weekends. The trust monitored its current working scheme against National Health Services (NHS) seven days a week clinical standard.

The trust submitted its board assessment of seven-day standards in June 2019. The Trust declared compliance with all four standards. The report demonstrated an improvement in the percentage of emergency admissions receiving a consultant review within 14 hours from 80% in the previous audit to 92% in June 2019. The trust was 100% compliant with patients receiving a daily or twice daily review as appropriate. Both standards relating to seven-day access to appropriate diagnostics were met.

Patients had seven day a week access to consultant led acute surgical care, diagnostic services, pharmacy and emergency therapies and interventions such as those for emergency surgery. The trust provided this through on-call services, rotas and working with other providers across clinical networks.

There was regular availability of physiotherapy, occupational therapy and speech and language therapy from Monday to Friday. Therapists (occupational and physiotherapists) supported the service with seven day working, whereas speech and language therapy operated a six-day service.

The psychiatric liaison team were available to provide support for patients in mental health crisis 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff told us they offered health promotion advice to patients relating to smoking, weight loss and healthy lifestyles as well as specific advice about the patient's condition.

Staff could refer patients to support services if they thought patients needed additional help or support.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Patient leaflets were available and displayed at the service including preventing falls and alcohol awareness. The wards participated in the 'End PJ Paralysis' campaign which was a national campaign to promote patients to get out of bed and dressed as the increased function and activity had been shown to improve recovery rates and feeling of well-being. All patients were asked about smoking and alcohol consumption as part of their pre-assessment.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. We examined eight nursing records and saw that patients were assessed for falls, moving and handling, pressure damage. Malnutrition, bed rails, VTE, smoking and alcohol consumption. Where appropriate, patients were referred to relevant healthcare professionals such as physiotherapist and dieticians.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personal measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The care group had policy and procedures for consent which were aligned to Mental Capacity Act 2005 (MCA) which the staff had access to. Staff told capacity assessments started at the pre-admission assessment stage to ensure patients met their admission criteria. Staff understood the consent to care and best interest process. Staff could identify other situations when capacity assessments would be necessary.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The trust had a consent to examination or treatment policy in place which was last reviewed in October 2016 with the next review due in October 2019. This policy clearly described

that valid consent to treatment was absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff used the trust's policy as a guidance to make decisions in the patient's best interests.

Staff made sure patients consented to treatment based on all the information available. Patients told us that the consent process was explained to them when they first saw the consultant. The consultant explained the benefits and risks of their surgical procedure and they had the right to change their mind.

Staff clearly recorded consent in the patients' records. We examined eight care records and these showed that consent for treatment was clearly recorded with the signature of the healthcare professional seeking consent clearly written in the records.

Mental Capacity Act and Deprivation of Liberty training completion

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. They had achieved the trust's target completion rate of 33%.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards; however, they had not met the trust's target completion rate of 33%. Instead only 12% of eligible medical staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training.

University Hospital of North Durham surgery department

The trust set a target of 33% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training modules from April 2018 to March 2019 for qualified nursing staff in surgery at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	9	21	43%	33%	Yes

In surgery the target was met for the MCA/DOLS training module for which qualified nursing staff at University Hospital of North Durham were eligible.

A breakdown of compliance for MCA/DOLS training modules from April 2018 to March 2019 for medical staff in surgery at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	9	74	12%	33%	No

In surgery the target was not met for the MCA/DOLS training module for which medical staff at University Hospital of North Durham were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff told us they would contact the dementia link nurse for advice where they suspected a patient was living with dementia. There was also a learning and disability link nurse in place who assessed patients with learning disabilities.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff completed training in the Mental Capacity Act and thus knew how to complete DoLS. Managers monitored the use of DoLS to ensure that they were being used in the correct way and in the least restrictive manner.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they could access relevant policies on the intranet and would contact the dementia link nurse for advice if they suspected a patient lacked capacity.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We examined eight nursing records and found one of these to contain a completed DoLS documentation. We saw that this had been completed in line with the trust's policy.

Staff implemented DoLS safeguards in line with approved documentation.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff treating patients with care and respect. Patients said their privacy and dignity was respected and maintained; for example, staff used the bed curtains when conducting medical examinations. Patients told us that staff spoke to them in a way which they could understand; for example, avoiding the use of medical terms.

Patients said staff treated them well and with kindness. We observed staff speaking to patients in a professional and friendly manner. When patients had any questions, staff gave their full attention to the patients concerned.

Staff followed policy to keep patient care and treatment confidential. We observed staff drawing curtains before commencing medical examinations of patients or commencing treatment.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We saw staff from all roles speaking to patients in a caring and courteous manner, displaying a genuine desire to help. We saw confused patients being cared for with kindness and compassion, providing distraction whilst keeping them safe. We saw staff treating patients with kindness, respect and preserving their dignity, sometimes in difficult circumstances.

The Patient Led Audit of the Care Environment (PLACE) score for privacy, dignity and wellbeing was 88.86%, which was higher than the national average of 84.16%.

Friends and Family test performance

The Friends and Family Test response rate for surgery at County Durham and Darlington NHS Foundation Trust was 35%, which was better than the England average of 25% from April 2018 to March 2019.

A breakdown of response rate by site can be viewed below.

Location/Site	Response rate	Total responses
Darlington Memorial Hospital	22%	2,730
University Hospital of North Durham	49%	5,378
Bishop Auckland Hospital	37%	1,227
Shotley Bridge Hospital	108%	315

A breakdown of response rate by ward can be viewed below.

Ward name	Total Resp ^{1,2}	Resp. Rate	Percentage recommended ³												Annual perf ¹
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	
DC Day Surgery - UHND	3,583	60%	99%	98%	100%	97%	99%	98%	99%	100%	100%	100%	99%	98%	99%
DC Day Surgery - DMH	853	17%	98%	98%	100%	100%	96%	100%	99%	99%	99%	100%	100%	98%	99%
Ward 18 - BAH	724	79%	98%	100%	100%	100%	100%	100%	98%	96%	100%	100%	100%	100%	99%
Ward 33 - DMH	637	50%	100%	100%	98%	100%	95%	99%	95%	98%	98%	100%	100%	98%	98%
Ward 16 - UHND	632	63%	96%	97%	100%	100%	93%	98%	100%	98%	100%	93%	95%	97%	97%
DC Ward 20 - BAH	500	25%	N/A	N/A	98%	100%	100%	98%	100%	100%	100%	100%	100%	100%	99%
Ward 32 - DMH	482	38%	89%	95%	85%	92%	92%	88%	98%	90%	98%	93%	100%	96%	93%
SSU - DMH	397	20%	98%	100%	100%	100%	100%	100%	100%	95%	97%	100%	100%	100%	99%
SAU - UHND	379	62%	100%	100%	97%	100%	95%	100%	100%	100%	94%	100%	97%	100%	98%
Ward 15 - UHND	374	30%	100%	100%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%
DC Day Surgery - SBH	315	118%	100%	98%	100%	100%	N/A	97%	N/A	100%	100%	100%	100%	100%	83%
Ward 31 - DMH	297	14%	86%	83%	95%	92%	98%	94%	100%	97%	93%	94%	96%	100%	95%
Ward 12 - UHND	240	21%	100%	95%	96%	100%	92%	91%	N/A	90%	N/A	100%	N/A	100%	95%
NEVU (Ophthalmology) - UHND	170	31%	100%	91%	95%	93%	93%	100%	100%	100%	100%	100%	100%	100%	89%

Highest score to lowest score

Key 100% 50% 0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Across the care group, ward 31 at Darlington Memorial Hospital had the lowest response rate with 14%, whilst day surgery at Shotley Bridge Hospital had the highest response rate with 100%.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff answering questions from patients in a clean and professional manner and offered advice where requested.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff spoke about patients with mental health needs/learning disabilities/dementia in a compassionate and kind manner.

Spiritual and pastoral support was available to patients, relatives, carers and staff. Chaplains were available 24 hours a day to provide services for different faiths in the chapel or at the patient's bedside. The chaplaincy held a list of local faith group contacts which could be called upon if there was a specific need that could not be met from within the team.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We saw that patients were well supported emotionally, and staff were caring and empathetic. There was a room available on wards visited for the use of patients and families and for staff to hold discussions with patients if they were distressed.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients told us that staff explained to them the risks and benefits of their surgery. They also told us that staff explained to them the side effects of any medication that they were prescribed to help reduce any anxiety .

Staff spoke of the importance of maintaining a person's privacy and dignity whilst managing their safety. They used rooms closest to the nursing station to enable closer monitoring of patients who required this.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us that staff spoke to them in a clear manner avoiding the use of jargon. Staff also involved patients in the planning of their care. Patients told us they knew what was happening with their surgery and what their treatment plans were and how long they were expected to stay in hospital.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff talking to patients, families and carers in a professional and friendly manner. Patients were supported to have family and friends to support them and staff said they were always welcome.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw a leaflet 'how to raise compliments, concerns, comments, complaints' on the corridor in the wards.

Staff supported patients to make informed decisions about their care. We heard patients being given clear instructions in a caring manner. We spoke with patients who had a good understanding and involvement in their plan of care. Patients told us they and their families had been involved in care decisions and we saw that conversations with patients and families, including questions and decision-making, were recorded in patient notes. Patients said they felt staff listened to their preferences or concerns and acted appropriately to support them.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. For the 12 months ending March 2019, the percentage of people who would recommend the hospital for treatment was at least 93% and for some wards during some months it was 100%.

The feedback from the Friends and Family Test was positive for all wards. No ward scored lower than 93% for recommending the ward to other people for treatment.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people. .

Surgical services were available to meet the needs of the local population and the service worked in partnership with local clinical commissioning groups (CCG) and other providers across clinical networks to deliver them.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff ensured that separate bays were allocated for patients of different sex. Staff we spoke with explained that they never allowed mix sex accommodation.

Facilities and premises were appropriate for the services being delivered. The premises had step-free access at the main entrance and there was a reception desk to assist patients and families that needed assistance in locating their wards.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Ward staff told us that the hospital employed both a named learning disability nurse and named dementia nurse which covered both hospital sites. Ward staff told us that ward visits were made each day and these nurses could be contacted easily for support and advice. We saw the 'passport' system was used for patients with learning disabilities. This provided clinical staff with clear consistent information regarding the patient, each time they visited the hospital. In addition, dementia link nurses were identified to support staff deliver appropriate care and support across the wards.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had dementia and learning and disability link nurses. On ward 12 there were two bays for patients who have increased needs including dementia. The trust had a dementia strategy in place which described how staff would be trained in dementia awareness and the identification of dementia champions in each department and service.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had dementia and learning and disability link nurses. Where staff suspected patients were living with dementia they were referred to the link nurse for an assessment. There was also a dementia team in the hospital. Patients with learning disabilities usually brought their own carer with them but they could also use the support of the learning and disability link nurse.

Wards were designed to meet the needs of patients living with dementia. . On ward 12 there were two bays for patients who have increased needs including dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients with carers were allowed to bring their carer on to the wards to stay with the patient and offer the required support.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community. Staff told us that information leaflets could be ordered in other languages if requested by patients.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that interpreters could be booked through the hospital switchboard and they either attended the hospital or could provide interpretation through the telephone.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us the service provided meals that catered for patients' religious needs such as halal and Kosher meals.

Staff had access to communication aids to help patients become partners in their care and treatment. Ward staff told us that additional support was available through on site speech and language teams, translation services and occupational therapy.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

A standard operating policy was in place for surgical emergency admissions via the clinical decisions unit, surgical assessment units (SAU) or direct admissions to ward areas. This supported staff in the flow of patients through the service. Patients attended the clinical decisions unit. Following assessment people were either discharged or admitted to inpatient wards. The clinical decisions unit was nurse led.

GPs referred patients to the trauma clinic for assessment if their case was urgent. The emergency department could refer to the trauma clinic for ongoing management.

Staff said there was occasion when surgery cancellations including on the day cancellations had occurred. Reasons for these cancellations were due to, patient sickness, or bed capacity problems within the surgical unit.

Average length of stay

University Hospital North Durham - elective patients

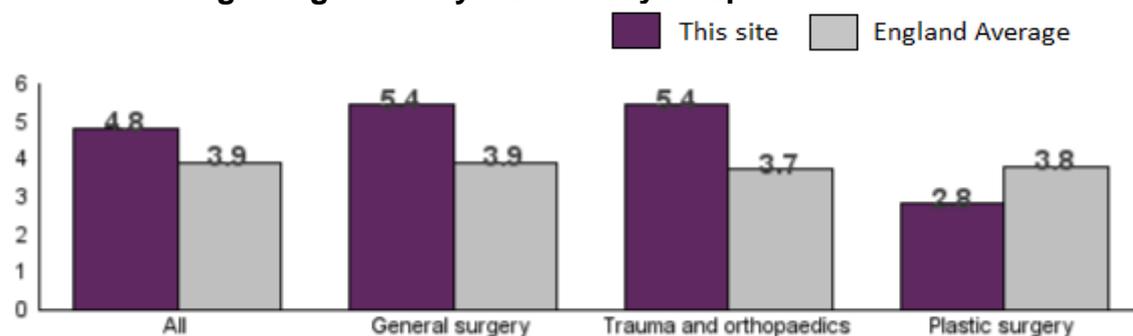
From February 2018 to January 2019, the average length of stay for patients having elective all surgery at University Hospital North Durham was 4.8 days. The average for England was 3.9 days.

The average length of stay for patients having elective general surgery at University Hospital North Durham was 5.4 days. The average for England was 3.9 days.

The average length of stay for patients having elective trauma and orthopaedics surgery at University Hospital North Durham was 5.4 days. The average for England was 3.7 days.

The average length of stay for patients having elective plastic surgery at University Hospital North Durham was 2.8 days. The average for England was 3.8 days.

Elective average length of stay - University Hospital North Durham



Note: Top three specialties for specific site based on count of activity.

University Hospital North Durham - non-elective patients

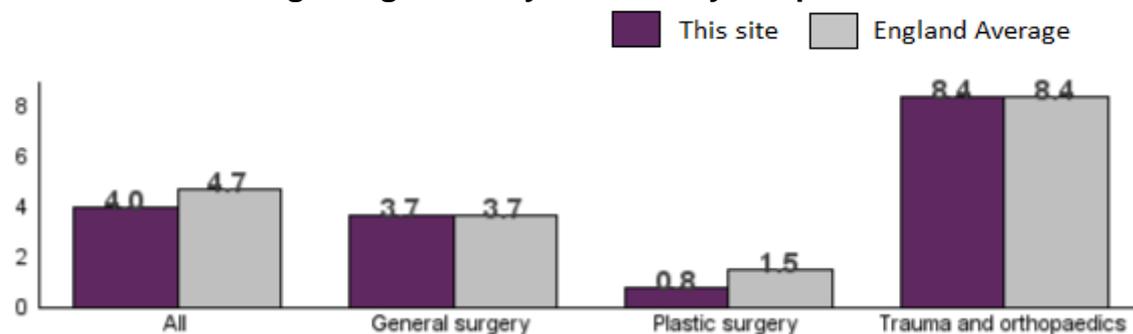
From February 2018 to January 2019, the average length of stay for patients having non-elective all surgery at University Hospital North Durham was 4.0 days. The average for England was 4.7 days.

The average length of stay for patients having non-elective general surgery at University Hospital North Durham was 3.7 days. The average for England was 3.7 days.

The average length of stay for patients having non-elective plastic surgery at University Hospital North Durham was 0.8 days. The average for England was 1.5 days.

The average length of stay for patients having non-elective trauma and orthopaedics surgery at University Hospital North Durham was 8.4 days. The average for England was 8.4 days.

Non-elective average length of stay - University Hospital North Durham



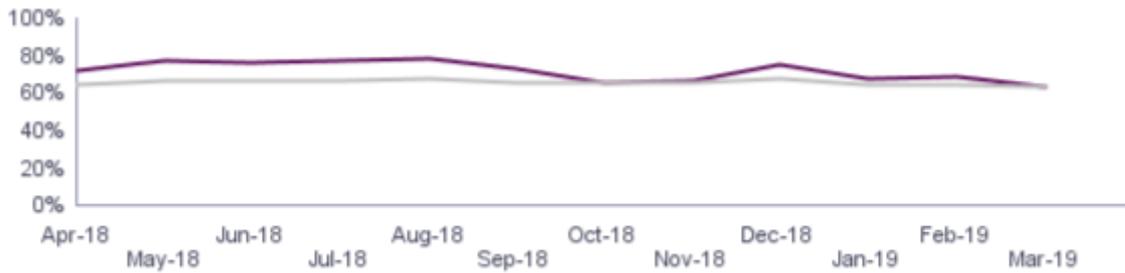
Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From April 2018 to March 2019, the trust's referral to treatment time (RTT) for admitted pathways for surgery overall was better than the England average, with the exception in October 2018, November 2018 and March 2019 where performance was similar to the England average. In the latest month, March 2019, RTT for admitted pathways for surgery was 63.7%, compared to the England average of 63.3%.

— This Trust — England Avg.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Seven specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Cardiothoracic surgery	100.0%	78.4%
Urology	91.2%	75.7%
Plastic surgery	84.9%	79.4%
Ear, nose and throat (ENT)	82.1%	60.2%
Oral surgery	79.7%	56.4%
General surgery	77.0%	71.8%
Trauma and orthopaedics	63.7%	58.5%

One specialty was below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Ophthalmology	62.5%	64.3%

(Source: NHS England)

Cancelled operations

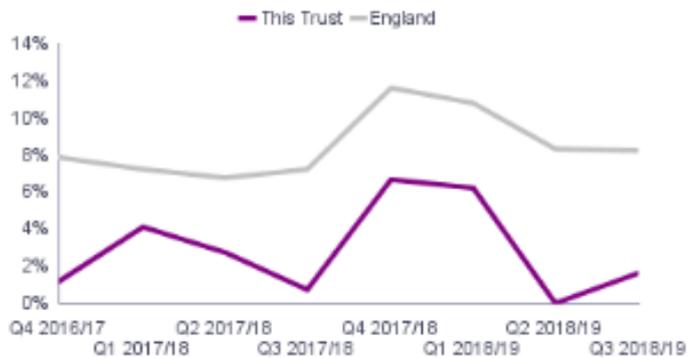
Managers worked to keep the number of cancelled operations to a minimum.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

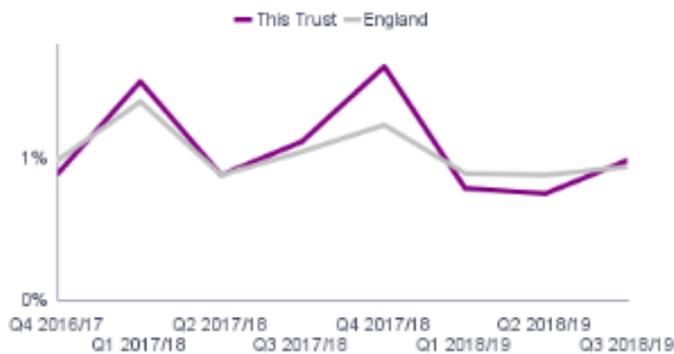
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations at the trust was lower than the England average and showed a similar trend. In the latest period, October 2018 to December 2018, this trust cancelled 121 surgeries. Of the 121 cancellations 2% weren't treated within 28 days. The period from January to March 2018 saw the highest number of cancellations (195). Of these cancellations, 7% of patients weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - County Durham and Darlington NHS Foundation Trust



Cancelled Operations as a percentage of elective admissions - County Durham and Darlington NHS Foundation Trust



Over the two years, the percentage of cancelled operations at the trust showed a similar performance and trend to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Managers monitored that patient moves between wards/services were kept to a minimum. Patients were only moved if there was pressure for bed space on the surgical wards. Staff did not move patients between wards at night. Staff told us they tried to move patients by 8 pm and by 10 pm the latest. If a patient was moved after 10 pm then it was reported as an incident. Patients living with dementia and at risk of falls were not moved.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff commenced discharge planning as soon as patients arrived on the ward and discussed a discharge strategy with family and relatives. This plan was reviewed and updated daily.

Patient moving wards at night

From April 2018 to March 2019, there were 3,555 patient moving wards at night within surgery. Across all surgery wards, January 2019 saw the highest number patient ward moves at night (408).

Location/Site	Number of patient	Proportion of
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	moving wards at night	total (%)
Darlington Memorial Hospital	2,821	79.3%
University Hospital of North Durham	728	20.5%
Bishop Auckland Hospital	6	0.2%
Total	3,555	100%

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. In the corridor on the wards there were patient information racks. These contained a leaflet titled 'how to raise compliments, concerns, comments and complaints'. The trust had a complaints and concerns policy which had been approved in April 2018 and was due for a review in February 2020.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. We saw from the complaints analysis tool that managers logged all complaints with the date that complaints were received and the date they were closed. This log also recorded the number of days that complaints remained open as well as the final outcome of the complaint. Managers also logged the themes of complaints in order to identify any trends so that appropriate action could be implemented to improve care for patients.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw that staff wrote to the complainant acknowledging their complaint and explaining the steps involved in investigating their complaint and when they could expect to receive a reply.

University Hospital of North Durham surgery department

From April 2018 to March 2019, the trust received 36 complaints in relation to surgery at University Hospital of North Durham. The trust took an average of 32.0 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed in 40 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Patient Care including nutrition / hydration	20	55.6%
Access to treatment or drugs	5	13.9%

Patient Care	5	13.9%
Communications	2	5.6%
Facilities	2	5.6%
Appointments	1	2.8%
Values & behaviours (staff)	1	2.8%
Total	36	100%

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2018 to March 2019, there were 969 compliments received for surgery at the trust (5.0% of all received trust wide).

A breakdown of compliments by site is shown below:

Site	Number of compliments	Percentage of total
University Hospital of North Durham	506	52.2%
Bishop Auckland Hospital	278	28.7%
Darlington Memorial Hospital	185	19.1%
Total	969	100%

The main themes that run through the compliments relate to the staff going above and beyond what a patient expects them to do, supporting the patient and family during difficult times for them and taking the time to listen and explain things to patients.

All compliments that the trust receive from a patient or the family are all shared with the staff named and their managers, along with the CEO if requested to or if it is from a staff member. The trust ask that managers share the compliment with the staff on the ward or in the department.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care

The trust surgical nursing hierarchy included an associate director of nursing, matrons and band 7 ward managers supported by band 6 nursing sisters. The ward manager reported to a matron, who reported to the associate director of nursing. Staff said they felt supported by their individual matrons.

We saw that senior leaders within the surgery care group were aware of the challenges to quality, risk and safe care. Responses to never events had been proactive with dissemination and learning to reduce risk and prevent recurrence.

Frontline staff were aware of leadership development or succession planning. The leadership structure comprised of a care group triumvirate team, a medical director, associate director of

nursing and associate director of operations. Staff said that senior managers were supportive. Senior staff told us the surgical care group triumvirate structure worked well within the service.

We saw good local leadership on surgical wards. Front line staff told us their immediate line managers were visible and approachable.

Clinical staff told us engagement from senior management with theatres had improved since the last inspection. They said senior managers were visible and attended theatres or were involved in departmental meetings. Staff felt that managers had listened to concerns and had involved staff in decision making surrounding planning of the service, risks and continued professional development.

A comprehensive improvement programme covering all aspects of theatre operations (safety, staffing, training and education, scheduling, operational efficiency, staff and patient experience), with local leadership and support from executive directors and the full board which had helped to achieve improved results and team morale. Staff we spoke with spoke positively of the improvement in culture and leadership within the theatre setting since the last inspection.

We observed staff were respectful their peers. Staff told us they worked well together and we found they worked cohesively as a team offering support to one another. Staff told us morale was good and there was an 'open door policy' operated by ward managers which meant staff could raise any concerns and they were listened to. All staff were clear about their roles and responsibilities and worked well together.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn in to action, which it developed with staff

The service had held strategy meetings at the beginning of the year as they needed to develop a strategy and communicate this to staff. The trust had set out their mission and values and from this overarching strategy the surgical division had developed their local strategy. Staff had been involved in the development of this strategy. The strategy for general surgery was from 2019 – 2021 and contained four strategic objectives:

1. To deliver excellent emergency and core general surgery and to provide a safe, effective and responsive service for patients within the region
2. To improve the emergency surgical pathway to enhance patient and staff experience and reduce delays front of house
3. To embrace innovation to attract and retain medical / nursing staff and enhance patient experience as well as attract patients from outside of the area
4. To enhance educational experience and offer progression opportunities for all staff within the Division

Quality Matters' was the clinical quality and safety improvement strategy for the trust. The purpose of the strategy was to support the delivery of the organisation's vision, which is 'Right First Time, Every Time'. The trusts strategy was 'our patients matter'.

Staff were not always able to articulate this or say how they would contribute to the strategy, although they told us their aim was to do their best for patients.

As part of the ongoing strategy the service was looking to undergo a bed reconfiguration to give the clinical decisions unit more space as currently it was small and to develop and train middle grade staff in dermatology as consultant dermatologists were scarce.

The 2019/20 financial year presented a lot of change and challenge to the care group. However, the surgery care group was striving to be as prepared as possible to ensure objectives were met and key changes delivered in a high quality and minimally disruptive way. At the same time, the service was working with colleagues in the other care groups and the corporate departments to ensure the best experience was delivered for patients and staff.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values

A significant journey of staff culture, support and improvement had been undertaken within the surgery care group over the last 15 months to help improve the work environment and make surgery an area of choice for staff. At the last inspection, cultural issues in theatres were identified as a result of feedback from staff and poor staff survey results. We saw the staff survey indicated a mixed response from staff. Some felt supported by senior staff and would recommend their area as a place to work, whereas others did not. Staff were not able to tell us how the staff survey was being used to make improvements to culture at work.

Staff survey results highlighted a number of improvement areas, the care group had worked to improve the working life of staff, with the last staff survey being undertaken in 2018 at the start of this journey the group expected significant improvements to be made in the recent survey.

The NHS staff survey 2017 asked staff about equality and diversity. The trust told us there were relatively low numbers of black and minority ethnic employees which reflected the local population demographic. Although the numbers of respondents were not high (53 in surgery and 18 in theatres), of those that did respond, the results demonstrated that some staff with protected characteristics felt they had been treated equitably. This was an improvement since the last inspection.

The care group had focused on a number of key areas highlighted in the staff matters action plan to help ensure staff were proud and happy to work at County Durham and Darlington Foundation Trust (CDDFT) in Surgery.

Staff told us that an annual staff survey was conducted and the results of the survey were published on the intranet. The trust had a 'Moving to Good' – culture and leadership programme in place. The aim of this programme was to create collective leadership where staff at all levels were empowered as individuals and in teams to act to improve care within and across trusts. This would help to create cultures that delivered high quality, continuously improving, compassionate care.

We reviewed the staff matter - people strategy action plan 2017-2020 which listed a strategic theme, objectives, action, owner and timeframe. The plan was rag rated and listed a number of key strategic themes including: staff recruitment (nursing and medical), staff retention and turnover, reduce agency staffing, leadership development, staff development, appraisal, core essential training and staff engagement.

The theatres, anaesthetic and critical care team, with support from the surgery care group triumvirate had developed and implemented the theatre matters action plan. This consolidated all the findings of the theatre culture review that was undertaken in 2016. The key findings and

associated work streams had been pulled into one project and action plan that was closely monitored. The management teams had worked closely with key stakeholders and support staff working within the theatre environment to proactively manage the change process to ensure sustainability.

We reviewed the theatre matters update on year two progress (January 2019). The update included; work stream never events review, skills matrix, leadership, embedding behaviour, staffing review and recruitment, retention, team development and communication. The update was robust and evidenced clear progress made to date within each key area.

We saw staff were open and transparent. They told us they were encouraged to be open and honest when things did not go well.

Governance

The service systematically improved service quality and safeguarded high standards of care

The trust had a governance handbook in place which described the governance structures, responsibilities, standards, behaviours and reporting requirements. This handbook described the different types of governance; for example, corporate, clinical and information. On a day to day basis, management of operations took place within care groups and corporate care groups. Associate directors and clinical directors were expected to take action to achieve care group objectives and to manage risk and escalating risks where necessary to executive directors. Two committees existed to provide executive-level oversight of clinical quality and to allow issues to be escalated.

Performance in meeting objectives was monitored through the Integrated Performance Framework, consisting of integrated reporting and a two-tier review process in which key issues were escalated to a bi-monthly performance review meeting with executive directors. Risks and issues which needed to be escalated for executive-level decisions and or action were escalated to the Executive and Clinical Leadership Committee or depending on the extent to which issues did not require support or consensus from the Clinical Leadership they could be taken to the meetings of the Executive Directors Group.

The board had established assurance committees to enable non-executive directors to seek assurance from the directors on the achievement of core operational and strategic objectives, including the development and implementation of strategy, management of key risks and meeting of compliance obligations. These consisted of the Integrated Quality and Assurance Committee (IQAC) and the Finance Committee.

All surgical specialties had dedicated multi-disciplinary clinical governance meetings as a minimum on a bi-monthly basis. Information from the care group governance team was provided to the specialties for wider discussion through this forum and provided in a format that replicated the care group governance and quality meetings. Any matters for escalation and minutes from the meetings were returned and tabled within the care group governance meeting agenda.

The governance committee meetings discussed aspects affecting the service, for example, serious incidents, complaints and incidents. Pharmacy feedback took place at care group quality governance meetings.

We reviewed meeting minutes from the plastic surgery care group (May 2019) which evidenced review of previous minutes, review of action log and on-going actions and concerns.

The minutes of the hospitals clinical standards and therapeutics committee confirmed ongoing review and discussion across the trusts multi-disciplinary teams in relation to clinical standards, guidelines and protocols and where necessary any changes agreed before approval.

The integrated quality assurance committee was responsible for providing assurance to the board of directors that the trust was managing the quality of patient care, the effectiveness of clinical interventions, patient experience and patient safety.

The deteriorating patient and resuscitation trust level report, reported monthly, to all care group leads, executive director of nursing and executive medical director and resuscitation and deteriorating patient committee members.

The deteriorating patient and resuscitation care group reports were shared with the care group governance meetings. All cardiac arrest calls were followed up by the cardiac arrest prevention (CAP) team. Details of all medical emergency calls (patient with a NEWS \leq 9, clinical concern and uncontrolled end of life symptoms) were held in a central database.

Staff told us ward managers attended clinical governance meetings. Staff demonstrated a basic understanding of clinical governance and said that outcomes of incidents and audits were communicated to them.

The 'Quality Matters' feedback was discussed at matron's meetings, team and ward meetings where actions and discussions take place with staff.

Staff informed us that safety incidents and concerns as well as ward performance against various audits were discussed at staff meetings.

Ward and department sisters used multiple methods to ensure timely and effective cascade of information to individual teams. Regular updates were disseminated through the clinical governance lessons learned information and to avoid delay in sharing of information, teams used their team brief / huddle as a formal way of communicating key messages.

The multidisciplinary care group clinical governance meeting encompassed patient safety and subsequent management, there was no additional patient safety forum. The governance meeting was structured in line with the trust governance handbook and there was a clear, explicit way to be able to ensure that lessons learned were shared alongside an escalation process.

Management of risk, issues and performance

The service had good systems to identify risks, plans to eliminate or reduce them and cope with both the expected and unexpected

The used the Board Assurance Framework (BAF) to capture and monitor action plans for board or executive-level risks. In addition, each directorate or care group had its own operational risk register. The trust did not maintain a separate 'corporate risk register'. All risks were managed by care groups and directorates on the electronic risk management system. The system could be used to report at different levels. When reporting to the risk management committee, risks were reported where the current score was outside the trust's risk tolerance level set by the trust board.

We examined the risk register for surgery and saw that risks were clearly described and numbered with the impact of each risk recorded. The register also described the mitigating actions that would be implemented if the risk materialised. Each risk had an owner, the date the risk was added to the register, the review date of each risk and the risk target date. There were actions described that would be implemented to counteract the risk with the action owner and a target date. We saw

that each risk was evaluated and given a score based on its likelihood of occurring and severity of its impact.

One risk identified on the risk register was the increased risk surrounding patient safety incidents within the theatre environment. The risk had been added to the risk register in December 2016 with a risk review date and a risk target date of December 2019. The risk included a recent never event that had highlighted not all new staff had, had sight of the training video regarding the World Health Organisation (WHO), Stop Before You Block (SBYB), Prosthetic Pause. The action was to ensure all staff had sight of this. This was currently a priority to ensure that all staff were aware of correct procedures and had a target date of 31 July 2019. We were assured by the senior management team in theatre that this was given high priority and that staff were given protected time to complete this.

The care group risk register was able to be viewed by the whole senior management team. Risks were identified through specialty (directorates / governance) and care group meeting forums. The care group robustly reviewed the red risks and risks outside of tolerance formally on a monthly basis in the multi-disciplinary care group governance and quality meeting. A full risk register review is undertaken quarterly through this forum. Any staff member through their service specialty meetings had the opportunity to highlight and escalate risks and concerns.

We reviewed two sets of meeting minutes of the surgery care group, integrated governance report (April and May 2019) which confirmed that trust risks were presented to the trust integrated quality assurance committee.

The surgery care group had rolled out and embedded the use of Local Safety Standards for Invasive Procedures (LocSSIPs) and further reinforced the World Health Organisation (WHO) checklist to reduce risks of harm to patients and to help prevent recurrence of never events. The Trust formed a LocSSIPs implementation and governance group (LIGG). This group brought together members of the corporate governance body with care group representatives in order to develop LocSSIPs. The LocSSIPs were fully implemented in theatres. Safety issues were highlighted to staff groups through the monthly team brief and newsletters. Monthly reports were submitted by pharmacy to the safety group.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards

All designated staff had access to patients' nursing, therapy and medical records which included assessments, test results, current medicines, consent forms and clinic notes. The nursing and therapy records were paper based and held at the end of patient's beds. This was a security risk as visitors could read this confidential information. The medical records had been transferred to an electronic system that was accessed through a hand-held mobile device. This device was password protected with different levels of access given to staff based on their role within the service. The trust were in the process of moving more assessments and care plans on to the digital platform.

The service used systems and processes to manage the storage of patient records. However, the management of obtaining patient consent for storage of contemporaneous records at the patients' bedside was not robust. The trust had instigated a process for obtaining patient consent; however, on inspection of four patient consent forms inspected only one consent form had been signed for by the patient. The clinical record keeping and healthcare records management policy, appendix

12.1 page 13 - consent for accessing contemporaneous records clearly stated the need for a patient signature. This was a deterioration since the last inspection, where the trust had received a should do action requiring that the trust should ensure patient records are complete. We were advised by the senior team that this was not recorded on the surgical risk register as an identified risk.

Engagement

The service engaged well with patients and staff to plan and manage appropriate services

People using the service were encouraged to provide feedback on the quality of care and service they received. We saw the friends and family test for University Hospital North Durham had a response rate of 49% which was better than the England average of 25% from April 2018 to March 2019. The test showed that for the majority of the wards at University Hospital North Durham, 100% people would recommend it to others for treatment, this recommendation did not fall below 91% from April 2018 to March 2019.

Staff told us that an annual staff survey was conducted and the results of the survey were published on the intranet. The trust had an 'Excellence Reporting' scheme where staff could nominate colleagues that had gone beyond the call of duty. Nominated staff received certificates. On an annual basis, the trust had recognition awards where staff that went beyond the call of duty received certificates from senior management as an evening award ceremony.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong and promoting training.

The hospital encouraged staff to find innovative solutions to problems they encountered at work. To assist staff to bring their ideas to fruition, the trust had an innovation team. If this team felt they could not assist, they would forward the idea or concern to people that could assist. In June 2018, the trust had launched the innovation forum which acts as a recognised and central hub to capture bright ideas from innovative staff members and raise the profile of innovation throughout the trust.

The forum took place monthly, with staff invited to present their ideas to a small panel, which included senior representatives from an array of specialities and backgrounds including, research and innovation, business development, service transformation, procurement, risk management, medicine, nursing, allied health professionals and communication.

Some examples of learning, continuous improvement and innovation within surgery care group were as follows:

Waste Management

The trust was in the process of rolling out the use of offensive waste (tiger striped bags) at the Darlington Memorial hospital site with a view to trust wide moving forward. Waste management was a key part of the trust's response to the collapse of healthcare environmental services, primarily because it enabled the trust to be more resilient by using companies outside of the clinical waste industry and also because it had the potential to reduce the greatly escalating costs. Currently, the orange bags (clinical waste) were still being transported up to 250 miles for disposal whereas the offensive waste (tiger bags) were going to an energy incinerator in Stockton. This

implementation had resulted in elimination of around 20 tonnes of waste and carbon dioxide emissions.

Trauma and orthopaedics

1. The care group had recruited an ortho-geriatrician to help ensure top tier outcomes and length of stay.
2. The multidisciplinary team and physiotherapy leads now included in hip fracture strategy group to ensure an encompassing review for patients.
3. The care group had improved coding to ensure more accurate data for the National Joint Register (NJR) / hip and Patient reported Outcome measures (PROMS).
4. The surgery care group had instigated a virtual fracture clinic
5. Musculoskeletal (MSK) triage service introduced to review every orthopaedic referral ensuring best use of resources.

General Surgery

1. National Emergency laparotomy Audit (NELA). Outcomes were better than the national average for CDDFT for mortality and length of stay. Percentage of patients with geriatrician input at UHND commended as best in region/ country, funding agreed to introduce geriatrician support at DMH to replicate good practice at UHND
2. Funding and recruitment approved for an ortho-geriatrician to improve as above
3. Durham Functional Bowel Service – multidisciplinary, award winning and nationally renowned service – strong clinical research links with other NHS and commercial providers
4. HALO technology for treatment of haemorrhoids funded and introduced to improve patient experience and length of stay.
5. Twice daily consultant emergency ward rounds across surgical wards on both acute sites.
6. Clinical decision units on both acute sites – nurse practitioner led surgical assessment for ambulatory patients (supported by on call surgical team). Metrics and outcomes discharging 80% same day.
7. Plans in place for implementation of faecal immunochemical test (FIT) from June 2019 in line with NHS England recommendations.
8. Introduction of coblation for tonsillectomy. Improved patient experience and reduced length of stay (increased day case rates).
9. Introduction of clinician led ultrasound for head and neck cancer clinic to reduce delays at front end of pathway
10. Successful bid for three whole time equivalent cancer care co-ordinators via Macmillan funding for three years to support cancer patients across the organisation.
11. Durham Functional Bowel Service – multidisciplinary, award winning and nationally renowned service – strong clinical research links with other NHS and commercial providers.
12. Increased number of consultants, investment in an additional three consultants to help with demand and develop a centre of excellence.

Theatres and anaesthetics

1. Organ donation team – trust ranks as outstanding for referrals and 100% compliant for assessing potential donors
2. Getting It Right First Time (GIRFT). Highlighted as one of the best performers with regards to diabetic patients.
3. Post anaesthesia care unit (PACU). Enhanced care implemented, and all training and support given to help ensure patient safety and experience.
4. Digital platform programme specific to PACU to allow the flow of observations from recovery to PACU area.
5. World Health Organisation (WHO) video rolled out to assist with staff development to train and inform staff on the correct process of the safety check lists within the WHO pathway. The surgery care group was moving towards having this as part of role specific training.

Dermatology and plastics

1. Tele-dermatology triage service was implemented allowing rapid review of suspected cancer and a quick implementation of appointments through innovative telemedicine.
2. Implementation of dermatoscopes in primary care across all areas has allowed community colleagues to refer high quality photos of suspected abnormalities meaning improved speed and accuracy.
3. Agreed five clinical pathways where patients currently seen in secondary care but could be managed in community implementing referral pro-forma to ensure patients were seen in the right place (Acne, psoriasis, eczema, paediatric eczema, rosacea). This joint work with community and primary care had ensured patients are actively managed in a timely way in the correct setting.

We saw that when things went wrong, the trust carried out root cause analysis and compiled a report so that lessons could be learnt and implemented to prevent reoccurrence; for example, during an elective procedure on a patient in November 2018, the patient slid and fell on to the floor. The surgical team transferred the patient back on to the stretcher and completed the operation. The patient was then transferred to the CT scanner to take scans of the neck and head as a precaution. These showed that no injuries had been sustained. When the patient regained consciousness from the anaesthesia, the surgeon verbally apologised to the patient and their family and explained what had happened in theatre. Additionally, the surgeon explained that a root cause analysis would be conducted and a written account would be sent to the patient and learning points highlighted. The anaesthetist also reviewed the patient, gave an explanation about the fall and also gave a verbal apology.

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

At County Durham and Darlington NHS Foundation Trust (CDDFT), there are Emergency Departments at Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND).

CDDFT manages five Urgent Treatment Centres (UTC):

- Darlington Memorial Hospital operate a 24/7 GP-led UTC, with GP provision at all times.
- Bishop Auckland and Peterlee UTC operate as a practitioner-led minor injuries unit 08:00-20:00 Monday to Friday and GP-led UTC at all other times.
- Shotley Bridge operates as a practitioner-led UTC service Monday to Friday 08:00-18:00 treating both minor injury and illness and revert to GP-led UTC at all other times.
- North Durham UTC operate 18:00-08:00 Monday to Friday as a GP-led UTC and 24/7 weekends and Bank Holidays.

(Source: Routine Provider Information Request (RPIR) – AC1 Context acute)

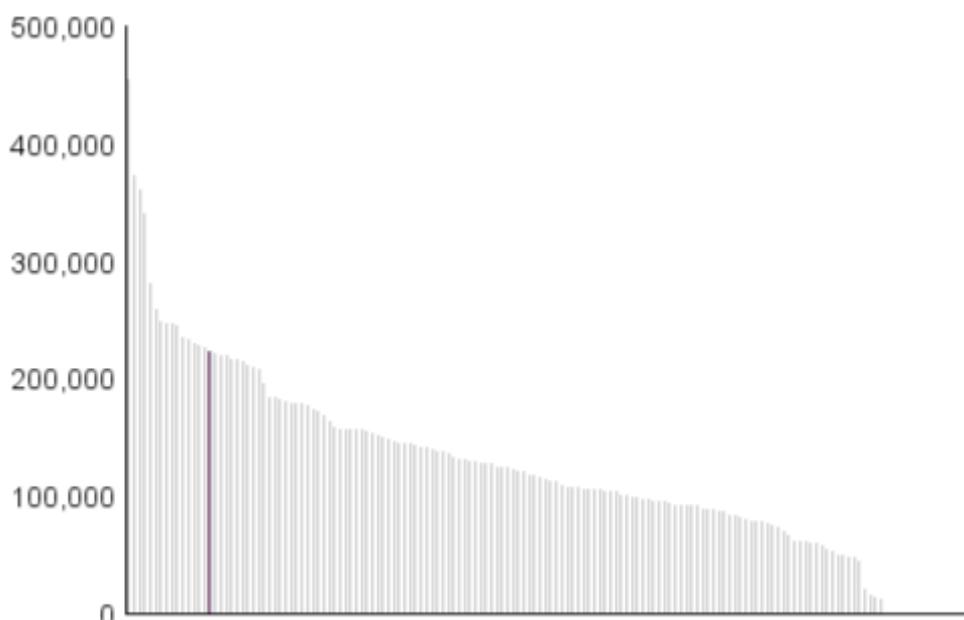
The UHND provides urgent and emergency care services 24-hours, seven days a week to the local population. There is no separate paediatric accident and emergency department at the hospital. Between July 2018 and June 2019 there had been 12,364 paediatric attendances, of these, 2,636 were admitted to the main hospital.

The hospital is a trauma unit and part of the trauma network. However, more serious injuries may be transferred to the regional major trauma centre in Middlesbrough.

The department had five main treatment areas; resus, a six-bedded monitoring bay, cubicles, a 'see and treat' area for minor injuries and illnesses and a short stay area to enable an extended period of monitoring or for patients with complex discharge needs. There was no separate paediatric department at the time of inspection, although there were plans for this to be in place a few weeks after the inspection date.

Activity and patient throughput

Total number of urgent and emergency care attendances at County Durham and Darlington NHS Foundation Trust compared to all acute trusts in England, February 2018 to January 2019

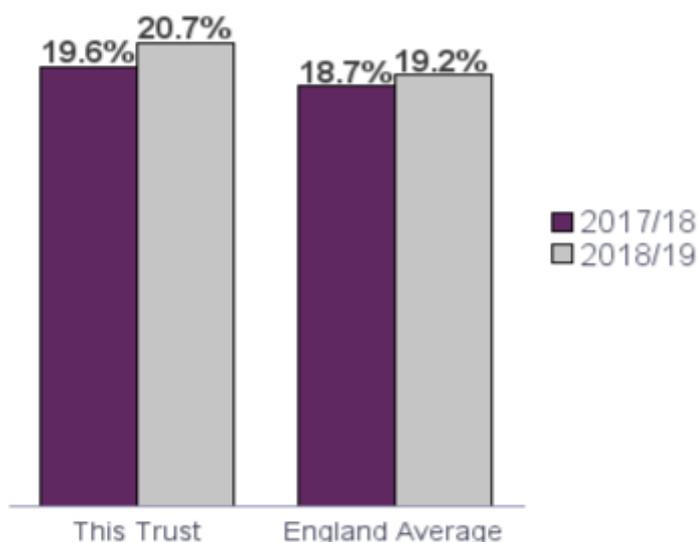


From February 2018 to January 2019 there were 222,185 attendances at the trust's urgent and

emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

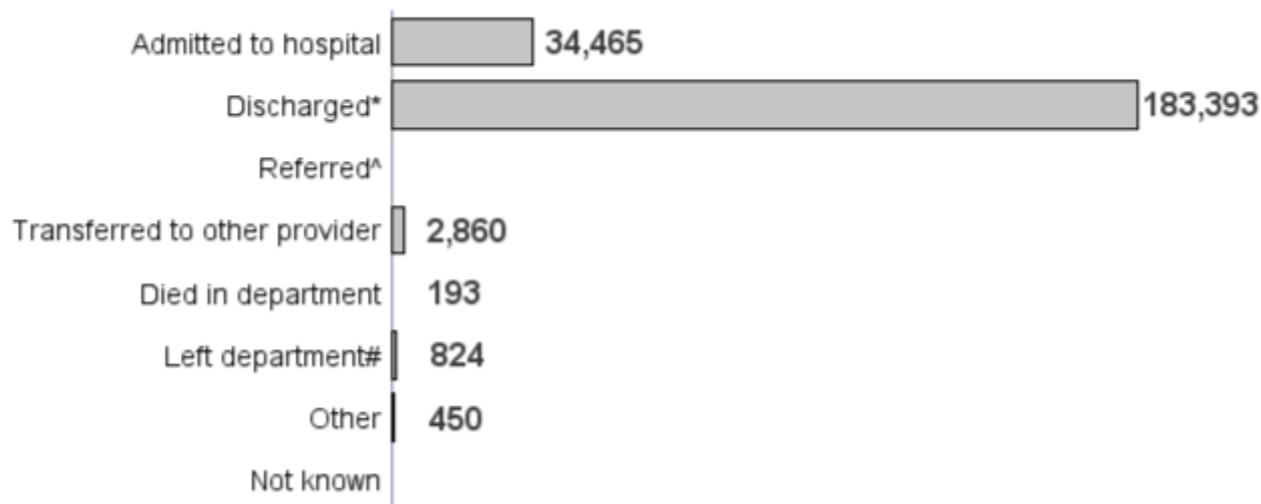
Urgent and emergency care attendances resulting in an admission



The percentage of urgent and emergency care attendances at this trust that resulted in an admission increased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from February 2018 to January 2019



* Discharged includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and had plans in place to meet end of years trajectory targets.

Mandatory training comprised of face to face and online learning. The service had systems in place to ensure all staff received mandatory training. We observed that mandatory training compliance was displayed in the department. The information was red, amber and green (RAG) rated to indicate which staff were up to date with training.

Mandatory training completion rates

The trust set targets ranging from 50 to 95% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Deteriorating Patient and Resuscitation	1	1	100%	85%	Yes
Information Governance	101	106	95.3%	95%	Yes
Conflict Resolution	93	109	85.3%	85%	Yes
Equality & Diversity	95	112	84.8%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	54	112	48.2%	85%	No
Immediate Life Support (ILS)	0	1	0.0%	50%	No
Immediate Life Support Re-Certification (ILS) - 1 Year	0	1	0.0%	50%	No
Paediatric Immediate Life Support (PILS)	0	1	0.0%	50%	No
Paediatric Immediate Life Support Re-Certification (PILS Re-Cert) - 1 Year	0	1	0.0%	50%	No

In urgent and emergency care the targets were met for three of the nine mandatory training modules for which qualified nursing staff were eligible. Four of the courses had 0.0% completion rate due to only one eligible nursing staff not completing the courses. Care should be taken when interpreting low staffing numbers.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at

trust level for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Acute Illness Management - No Specific Renewal	2	2	100%	50%	Yes
Immediate Life Support (ILS)	2	2	100%	50%	Yes
Immediate Life Support Re-Certification (ILS) - 1 Year	2	2	100%	50%	Yes
European Paediatric Advanced Life Support (EPALS)	14	15	93.3%	50%	Yes
Equality & Diversity	40	45	88.9%	85%	Yes
Advanced Life Support (ALS) - 4 Years	27	31	87.1%	50%	Yes
Advanced Trauma Life Support (ATLS) - 4 Years	13	17	76.5%	85%	No
Deteriorating Patient and Resuscitation	16	22	72.7%	85%	No
Information Governance	21	32	65.6%	95%	No
Conflict Resolution	21	35	60.0%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	22	45	48.9%	85%	No
Paediatric Immediate Life Support (PILS)	0	5	0.0%	50%	No
Paediatric Immediate Life Support Re-Certification (PILS Re-Cert) - 1 Year	0	5	0.0%	50%	No

In urgent and emergency care the targets were met for six of the 13 mandatory training modules for which medical staff were eligible. Two of the courses had 0.0% completion rate due to only five eligible medical staff not completing the courses. Care should be taken when interpreting low staffing numbers.

University Hospital of North Durham urgent and emergency care department

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the urgent and emergency care department at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Conflict Resolution	54	60	90.0%	85%	Yes
Information Governance	54	59	91.5%	95%	No
Equality & Diversity	51	62	82.3%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	32	62	51.6%	85%	No

At University Hospital of North Durham urgent and emergency care department the targets were met for one of the four mandatory training modules for which qualified nursing staff were eligible.

Infection prevention and control level two had the lowest completion rate with 51.6%, compared to the trust target of 85%.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in the urgent and emergency care department at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Acute Illness Management - No Specific Renewal	1	1	100%	50%	Yes
Advanced Life Support (ALS) - 4 Years	16	16	100%	50%	Yes
Advanced Trauma Life Support (ATLS) - 4 Years	7	7	100%	85%	Yes
European Paediatric Advanced Life Support (EPALS)	9	9	100%	50%	Yes
Immediate Life Support (ILS)	1	1	100%	50%	Yes
Immediate Life Support Re-Certification (ILS) - 1 Year	1	1	100%	50%	Yes
Equality & Diversity	21	23	91.3%	85%	Yes
Deteriorating Patient and Resuscitation	13	16	81.3%	85%	No
Conflict Resolution	8	14	57.1%	85%	No
Information Governance	9	16	56.3%	95%	No
Infection Prevention and Control - Level 2 - 1 Year	10	23	43.5%	85%	No

At University Hospital of North Durham urgent and emergency care department the targets were met for seven of the 11 mandatory training modules for which medical staff were eligible. Infection prevention and control level two had the lowest completion rate with 43.5%, compared to the trust target of 85%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following the inspection, we were provided with updated training information as it was identified that some of the original information was incorrect. The updated information showed improved compliance levels and indicated all areas of training were on trajectory to meet the trusts year end targets.

Nursing staff at University Hospital of North Durham

Subject	Staff trained	Staff eligible	Compliance %	Yearend target
Moving and Handling	54	68	79%	95%
Infection prevention and control	46	68	68%	85%
Fire Safety	59	68	87%	95%
Information governance	53	68	78%	95%
Conflict resolution	56	66	85%	95%

Medical staff at University Hospital of North Durham

Subject	Staff trained	Staff eligible	Compliance %	Yearend target
Moving and Handling	15	20	75%	95%
Infection prevention and control	13	20	65%	85%
Fire Safety	15	20	75%	95%
Information governance	18	20	90%	95%
Conflict resolution	9	14	64%	95%
Deteriorating Patient & Resuscitation	8	12	67%	85%

Within the last 12 months we were told the department had received bespoke training on sepsis. Training data was not provided on this but the staff we spoke talked about the training and spoke about it in a positive way.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. There were robust safeguarding processes in place for children and adults. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Trust protocols and guidance on safeguarding were easily accessible and included policies specific to children. There was a safeguarding team who could be contacted if further advice was needed. There was also a safeguarding links team who delivered key messages and acted as a resource for the staff in the department.

Senior staff told us due to new staff starting, the department had been working closely with the safeguarding department over the previous 12 months. This had helped improved understanding and knowledge for staff. Safeguarding supervision was also in place for staff.

Safeguarding alerts were flagged on patient records; these would be picked up by reception staff and alerted staff involved in their care. Staff we spoke with could describe what may be seen as a safeguarding concern, including domestic violence and how they would escalate this.

Safeguarding training included information about child sex exploitation (CSE), female genital mutilation (FGM) and domestic violence. Senior nurses were confident about staffs understanding of safeguarding.

Any children that had been referred for safeguarding or early intervention had their outcome recorded in their electronic record. Work had been done to implement a robust safeguarding process for the management of the child. On each attendance an assessment form was completed which asked who lived in the house, significant others involved, whether the child was on a plan and whether they had a social worker. This was completed with parental consent and acted as a prompt if the information had not been obtained on previous attendances.

The department had developed the role for an Independent Domestic Violence Advocate (IDVA). An IDVA was present in the department twice a week. They were a useful resource in identifying domestic abuse and assisting patients through the referral process.

Key messages were also shared on a noticeboard. The most recent one shared information on a serious case review and areas for improvement identified from reviewing records. For example, ensuring NHS numbers were included and to indicate if family members were made aware of any referrals. The key messages also included information on upcoming supervision dates. The staff we spoke with were aware of the information outlined in the document.

We observed, and staff told us about robust safeguarding processes in place for when children came to the department. The triage system included a screening tool staff used to establish parental responsibility, who had attended with the child and whether the child had a social worker.

The electronic record system also included mandatory fields within the patient records relating to the assessment and care of the child. From the paediatric records we reviewed we saw that this had been completed. We also saw good multidisciplinary working and information sharing with external staff such as health visitors and GP's.

Safeguarding huddles took place twice a week and the safeguarding team visited the department each day. Children's safeguarding had recently been included as part of the junior doctors' Induction. Staff were also invited to serious case reviews and to attend debriefs following a child death.

HEADSS was being implemented in the department; this is a framework for adolescent assessment and used a methodology to structure the assessment process. An adult assessment sheet which was given to patients on their initial attendance to identify vulnerable adults was also being imbedded.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training, with the exception of safeguarding adults level one where the target is 33%.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	90	111	81.1%	33%	Yes
Safeguarding Children Level 3 Roles and Responsibilities	87	109	79.8%	85%	No

In urgent and emergency care the targets were met for one of the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 3 Specialist	1	1	100%	85%	Yes

Safeguarding Adults Level 1	16	40	40.0%	33%	Yes
Safeguarding Children Level 3 Roles and Responsibilities	11	19	57.9%	85%	No
Safeguarding Children Level 2	0	14	0.0%	85%	No

In urgent and emergency care the targets were met for two of the four safeguarding training modules for which medical staff were eligible.

University Hospital of North Durham urgent and emergency care department

Staff working in an emergency department are expected to hold level three safeguarding for children. A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the urgent and emergency care department at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	49	62	79.0%	33%	Yes
Safeguarding Children Level 3 Roles and Responsibilities	49	60	81.7%	85%	No

At University Hospital of North Durham urgent and emergency care department the targets were met for one of the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in the urgent and emergency care department at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 3 Specialist	1	1	100%	85%	Yes
Safeguarding Children Level 3 Roles and Responsibilities	6	8	75.0%	85%	No
Safeguarding Adults Level 1	6	19	31.6%	33%	No
Safeguarding Children Level 2	0	9	0.0%	85%	No

At University Hospital of North Durham urgent and emergency care department the targets were met for one of the four safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Further updated information provided by the trust following the inspection showed the following regarding training compliance.

Nursing staff at University Hospital of North Durham

Training module name	Staff trained	Eligible staff	Completion rate	Trust target
Safeguarding adults awareness	65	68	96%	95%

Safeguarding Adults Level 1	58	68	85%	66%
Safeguarding Children Level 1	67	68	99%	95%
Safeguarding Children Level 3 Roles and Responsibilities	48	66	73%	85%

Medical staff at University Hospital of North Durham

Training module name	Staff trained	Eligible staff	Completion rate	Trust target
Safeguarding adults awareness	18	20	80%	95%
Safeguarding Adults Level 1	10	17	59%	66%
Safeguarding Children Level 1	20	20	100%	95%
Safeguarding Children Level 2	9	9	100%	85%
Safeguarding Children Level 3 Roles and Responsibilities	6	8	75%	85%

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Infection prevention and control training for this site showed that compliance was 52% for nursing staff and 44% for medical staff. This was significantly below the trust target of 85%. We were provided with more recent data following the inspection, this showed that compliance had increased to 68% for nursing staff and 65% for medical staff. The trust confirmed they were on trajectory to achieve their target of 85% by year end.

Cleanliness and hand hygiene audits took place monthly. The results were displayed in the department. Information showed most recent hand hygiene compliance was 100% and there was 95% compliance with weekly infection prevention and control audits. Information on hand hygiene and cleanliness was collated in the emergency departments governance report. We were provided with the report from June 2019. Information showed there was 100% compliance in hand hygiene audits in quarter four of 2018/2019 and 100% in commode cleaning audits.

This supported what we found and observed during the inspection. The department was visibly clean, tidy and free from clutter. Cleaning services were provided by domestic staff.

Hand wash facilities, alcohol gel and personal protective equipment (PPE) were available in each area. We found appropriate waste segregation and disposal systems in place and a biohazard spill kit.

We observed staff interactions with patients were compliant with key trust infection control trust guidelines, for example hand hygiene and the use of PPE. All the staff we observed were compliant with arms bare below the elbow.

These areas of compliance were audited via the trusts 'perfect ward' system. This went live in May 2019 replacing a previous system. This reported on four components, one of which was observations within the department. This covered a number of areas related to cleanliness as well as staff compliance with uniform policy. Data from April 2019 to June 2019 showed high levels of compliance.

There were cubicles which could be used if a patient required isolation. Patients requiring isolation were isolated appropriately and staff could describe the appropriate precautions which

would be put in place.

There was a system in place for cleaning children's toys kept in the paediatric waiting room. Cleaning was undertaken each day and we saw evidence of daily checklists for this being completed. The toys we saw were made from washable and wipe clean materials and were visibly clean.

Environment and equipment

There was also unrestricted access to all areas within the department. We requested a risk assessment, but this was not provided. We were particularly concerned about staff safety in the reception area as it was very accessible to the public. Staff voiced concerns over lone working and security, particularly at night.

Improvements had been made to ensure the room for patients with Mental health needs met the required standards. There were also plans to improve the environment for children attending the department.

The department pre-dated national guidance for compliance with Health Building Notice 15-01 for Accident and Emergency Departments. There was closed circuit television in place and restricted access to treatment room and room where drugs were stored but unrestricted access to all other areas. We were particularly concerned about the reception area which was open and had a low desk at one side. There was unrestricted access to the area behind the reception desk. Reception staff highlighted safety concerns in relation to this, especially at night when they could be sat at the desk alone.

We requested any risk assessments related to this. The reception area, lone working and violence were identified as hazards in a local safety document provided by the trust following the inspection. This document stated, "where hazards are identified a risk assessment must be completed and be available for staff to refer to". We were not provided with this risk assessment and the reception staff we spoke with did not refer to this document.

The reception area did not provide privacy and confidentiality for patients. The receptionist and streaming nurse were sat next to each other and we observed throughout the inspection, patients gathered at the reception desk. This meant conversations could be overheard. There was nothing to indicate patients should wait to be called to the desk to be seen. We were told a private room was available if patients wanted privacy, however from our observations we were not assured this was regularly used.

The waiting area for patients was located in the main entrance, there was a children's waiting area separated by a partition wall. The children's waiting areas had direct access to two dedicated paediatric rooms.

The waiting areas were visible to staff. We did observe that there was not always segregation of children and adults. During each inspection day we observed children in the adult waiting area and vice versa. We were told of plans that had been put in place to provide a separate paediatric front of house department within the hospital. Identified estate had been vacated and prepared for the new model. This was due to be in place a few weeks after the inspection and would provide a much-improved paediatric environment.

The see and treat area did not have clear signage and did not have a receptionist. There was a sign informing people if they had been sent from the accident and emergency department to take a seat. The inspection staff were approached by two patients asking when they would be seen or if

anyone knew they were waiting. However, another patient's reported they were happy to sit and wait to be seen.

There were separate entrances for 'walk in' and ambulance patients. There was a handover area for up to three patients arriving by ambulance. The resuscitation area had two bays one of which could be used for children. We found that all consulting and treatment cubicles were of an appropriate size and contained the necessary equipment for both adults and children.

There were five short stay beds. These were used for patients requiring an extended period of observation, for example, following a head injury, or for patients with complex discharge needs. There was a six bedded bay which was used for sicker patients to enable closer monitoring. There was also a 'see and treat' area for minor injuries and illnesses.

There was easy access to x-ray and scanning facilities from the department

The previous inspection identified the room used for patients with mental health needs did not conform to the Psychiatric Liaison Accreditation Network (PLAN) standards. We found that this had been addressed and the room used met the required standards. A standard operating procedure had been developed to guide staff in where to manage patients within the department to facilitate close observation. A ligature policy was developed in 2018 and a comprehensive ligature assessment had been carried out with the Health and Safety team.

We checked the major incident equipment storeroom and found all equipment present and in date. Staff told us they had enough equipment in the department to meet the needs of patients.

We checked several pieces of equipment, including blood pressure machines, blood gas machines and infusion pumps and found evidence of up to date electrical safety testing.

Staff we spoke with said that they had adequate stocks of disposable equipment. We checked disposable equipment within all areas of the department and saw they were in date.

There were resuscitation trollies centrally located in each of the areas in the department. There was also a difficult intubation trolley and transfer bags. Each of these were checked and we found the contents to be correct and in date. We observed that the system for daily checks of resuscitation equipment was a signature in a diary. Whilst we did not find any gaps in daily checks, for audit and assurance this did not seem to be the most robust system.

Assessing and responding to patient risk

Triage and streaming processes supported early identification of any risks and staff quickly acted upon patients at risk of deterioration.

However; the service did not always have staff with paediatric competencies available to see children who were streamed away from the emergency department. There was also no system in place for the prioritisation of children in the department if triage times exceeded 15 minutes.

Deteriorating Patient and Resuscitation Training

The trust deemed that if staff had current Immediate Life Support (ILS) or Advanced Life Support (ALS) compliance, they had the relevant training to be safe in practice, but they must complete the deteriorating patient course by the end of December 2020. Compliance with this would be monitored through the Resuscitation Committee.

Six staff had been identified that did not have either competency. Two had been booked on ILS or ALS training for the following week and the remaining four were planned to complete appropriate training within two weeks of the data being sent.

Site	Compliant	Non-compliant	Grand Total
DMH	25	19	44
UHND	44	21	65
Grand Total	69	40	109

The table below demonstrates the breakdown of staff non-compliant with DPR training that have a current ILS/ALS qualification.

Site	Non-compliant	ILS/ALS competency	No current competency	Total with relevant competency	Total	% Compliance	Target
DMH	19	18	1	42	43	97%	85%
UHND	21	16	5	60	65	92%	85%
Grand Total	40	34	6	102	108	94%	

Emergency Department Survey 2017

The trust scored about the same as other trusts for the Emergency Department Survey questions relevant to safety.

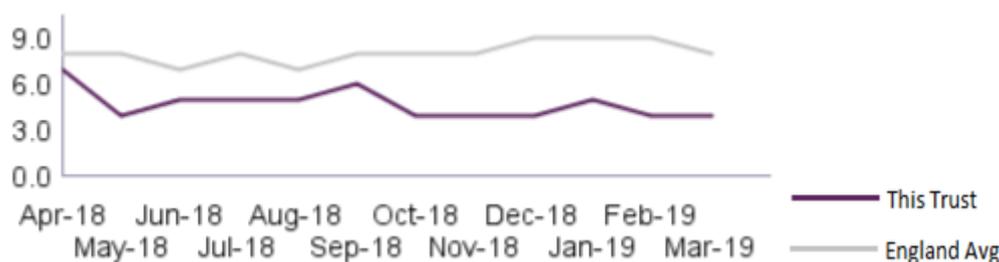
Question	Score	RAG
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.5	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.7	About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.3	About the same as other trusts

(Source: Emergency Department Survey, published June 2018)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was better than the overall England median in each month over the 12 month period from April 2018 to March 2019. In the last month, the median time to initial assessment was four minutes compared to the England average of eight minutes.

Ambulance – Time to initial assessment from April 2018 to March 2019 at County Durham and Darlington NHS Foundation Trust



(Source: NHS Digital – Urgent and emergency care quality indicators)

Clinical streaming is identified as best practice in emergency departments. This process involves a quick assessment to allow patients to be directed to the most appropriate area or service in the department to meet their needs. Streaming should be undertaken by a trained clinician as soon as possible following arrival. We observed and spoke with the clinician undertaking streaming. This person was either a senior nurse or nurse practitioner. A recognised tool was used to support this process.

Patients who self-presented were streamed by a clinician based at the main reception desk. There was also a rapid access and treat (RAT) consultant in the ambulance bay between 1pm and 11pm. RAT involves the early assessment of 'majors' by a senior doctor. This enabled the early initiation of investigations and/or treatment.

The service was aware that the Royal Collage of Paediatrics and Child Health (RCPCH) standards relating to the streaming of children away from the emergency department were not being fully met. This was due to staff with paediatric competencies not always being available. We were provided with the department's gap analysis against the RCPCH standards which stated a process was being developed to address this gap and was due to be in place by August 2019. This was also identified as a risk on the department risk register.

The gap analysis also identified that the department did not have a prioritisation system in place for children to have a full assessment if the triage time exceeded 15minutes. Work was ongoing with this.

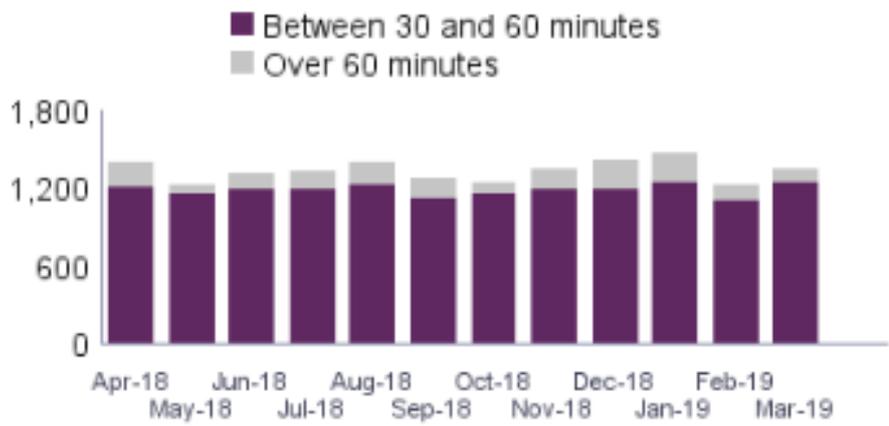
Following streaming, triage should be delivered within 15 minutes of the arrival in the department. We observed triage and there was a clear process for this. During this inspection we tracked the time of arrival to time of initial assessment for eight patients arriving into the department, each of these were assessed within 15 minutes. In addition to this we looked at triage times on 12 sets of adults records and six sets of children's notes (from patients who arrived by ambulance and those who self-presented to the department). We found time to initial assessment ranged from four to 55 minutes, with patients waiting on average 18 minutes.

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

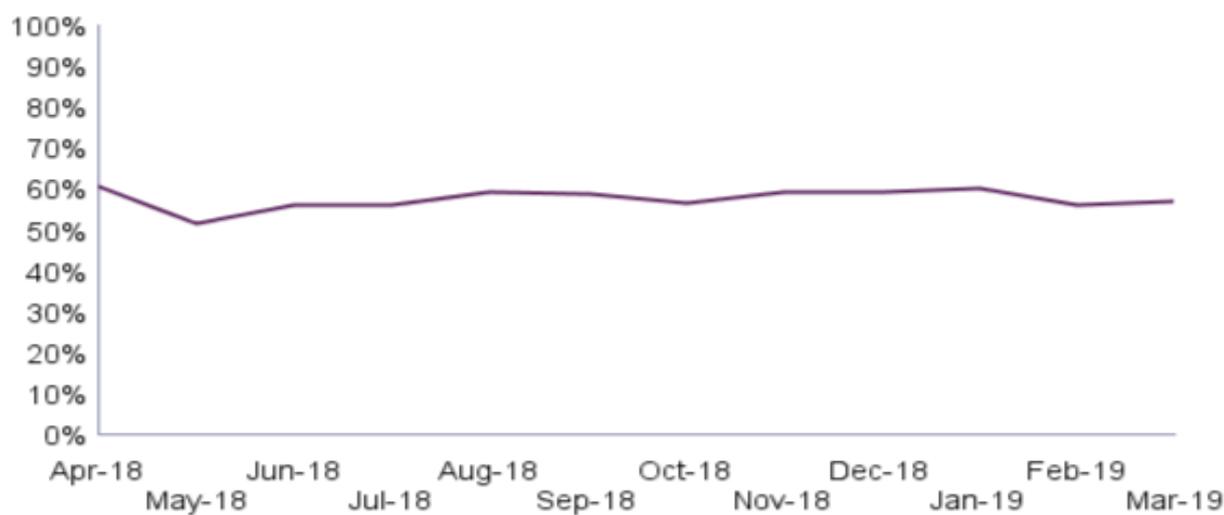
University Hospital of North Durham urgent and emergency care

From March 2019 to March 2019 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at University Hospital of North Durham urgent and emergency care. In the latest month, March 2019, 56.9% of ambulance journeys had turnaround times over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes - University Hospital of North Durham urgent and emergency care



Ambulance: Percentage of journeys with turnaround times over 30 minutes – University Hospital of North Durham urgent and emergency care



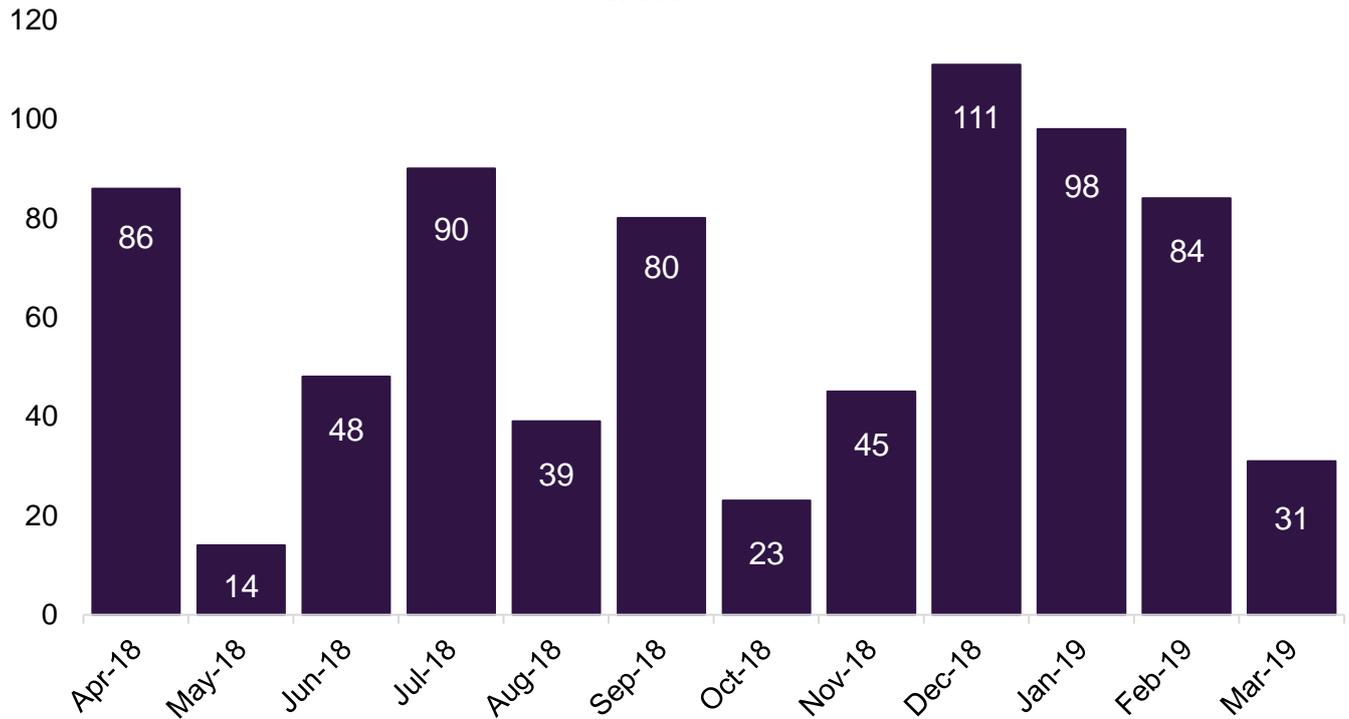
(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From April 2018 to March 2019, the trust reported 749 “black breaches”, with a fluctuating trend over the period. December 2018 saw the highest number of black breaches (111).

Black Breaches - County Durham and Darlington NHS Foundation Trust



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Staff in the department and ambulance staff spoke in a positive way about the ambulance handover area. This provided a designated area for patients brought in by ambulance to go. There was a process in place if the area became full or if several ambulances arrived together. We saw the bay being used effectively during our inspection.

As part of the triage process the national early warning score system (NEWS) was used. This is a tool for identifying deteriorating patients. A paediatric version was used for children. We reviewed 12 sets of adult records and six paediatric records and found that NEWS was recorded. Where required appropriate action was taken if the score was raised.

The trust had a monthly audit programme called the 'perfect ward'. As part of this information was collected each month on a number of different areas for the department. One area was checking that neurological observations had been recorded for those patients presenting with a head injury. Data from April 2019 to June 2019 showed that compliance was consistently 100%.

Pre-alert calls were made to the department if a patient arriving by ambulance was particularly unwell. We observed this on four occasions during the inspection. A team was on standby in the resuscitation bay in readiness to attend to the patient. We observed prompt decision making with no delays. For example, a patient suspected to be having a stroke was brought into resus, within five minutes they had had a CT scan and were going to the acute stroke ward for treatment.

Suspected sepsis would be flagged via a pre-alert. Pathways were in place which identified a specific bundle of care to be provided including the timely administration of antibiotics. The sepsis screening tool was automated within the electronic patient record. All patients were screened at the first time their observations were recorded using a regional screening tool. If this screening indicated the suspicion of sepsis, there was then a prompt to commence the sepsis six bundle.

The trust monitored sepsis screening rates and the timeliness of the first dose of antibiotics, which should be within an hour. Information provided by the trust for quarters one to four in 2018/2019 was consistently 100%. There has been a sustained and significant improvement in antibiotics being given within an hour. For the same time period this had increased from 55% to 93%.

The department had developed the 'Silver Survey', this was a framework for managing the elderly patients. The focus was to provide a structured assessment of the patient. In doing so the likelihood of the patient developing a delirium is reduced as a result of a structured assessment and prompt treatment. The department was cognisant of the importance of managing delirium, given its correlation with an increase in mortality and morbidity and increased length of stay for patients.

The department had developed local Safety Standards for Invasive Procedures (LocSSIPs) using the national Safety Standards for Invasive Procedures. Procedural checklists could be easily accessed online.

The department had recognised that delays in leaving the department could compromise patient safety. In response the department used the principles of the Bristol Safety Checklist to provide a framework for patients that were in the department for more than four hours. Risk assessments were carried out which included a pressure area assessment, a nutritional assessment and falls assessment. To facilitate the implementation of this framework the department had embedded the use of intentional rounding. This ensured that patients were seen, assessed for comfort, and that skin inspection and positional changes took place as required. The regularity of checks was determined by the nurse caring for the patient. We found these checklists to be in place for each patient we reviewed, and they had been fully completed.

Staff had access to specific risk assessment and care plans to support patients with mental health associated risks. This was done as part of triage to assess the level of risk. The triage document allowed staff to risk assess the patient for harm both to themselves and others and it provided staff with a framework to determine the level of observation that was required whilst the patient was in the department.

The triage tool provided a more comprehensive assessment which allowed detailed information to be provided to Liaison Psychiatry, even before they attended the department. There was twenty-four-hour access to Liaison Psychiatry, who were co-located in the department. They could also provide support if any patients required 15-minute observations for longer than an hour.

To improve the safety of the patients, other patients in the department and staff there was a structured proforma to identify if patients are carrying weapons as part of the triage document.

We spoke with the mental health team who said the department has embraced 'treat as one' agenda. This was published in 2017 and focuses on bridging the gap between mental and physical healthcare in general hospitals. The team were also currently piloting a streamlined process to reduce adverse incidents among patients with mental health associated risks who were waiting in the department. The tool focused on keeping the person safe, rather than staff making decisions about being safe to discharge. The decision over whether it was safe or in the best interest for the patient to be discharged was made by the mental health team.

The electronic patient record also had a flag to identify any patients who were on chemotherapy treatment. This enabled staff to provide them with an alternative to the waiting room at the earliest possible time. Oncology nurses were also available during office hours Monday to Friday who would also come and provide specialist support.

Nurse staffing

The service had enough adult nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels.

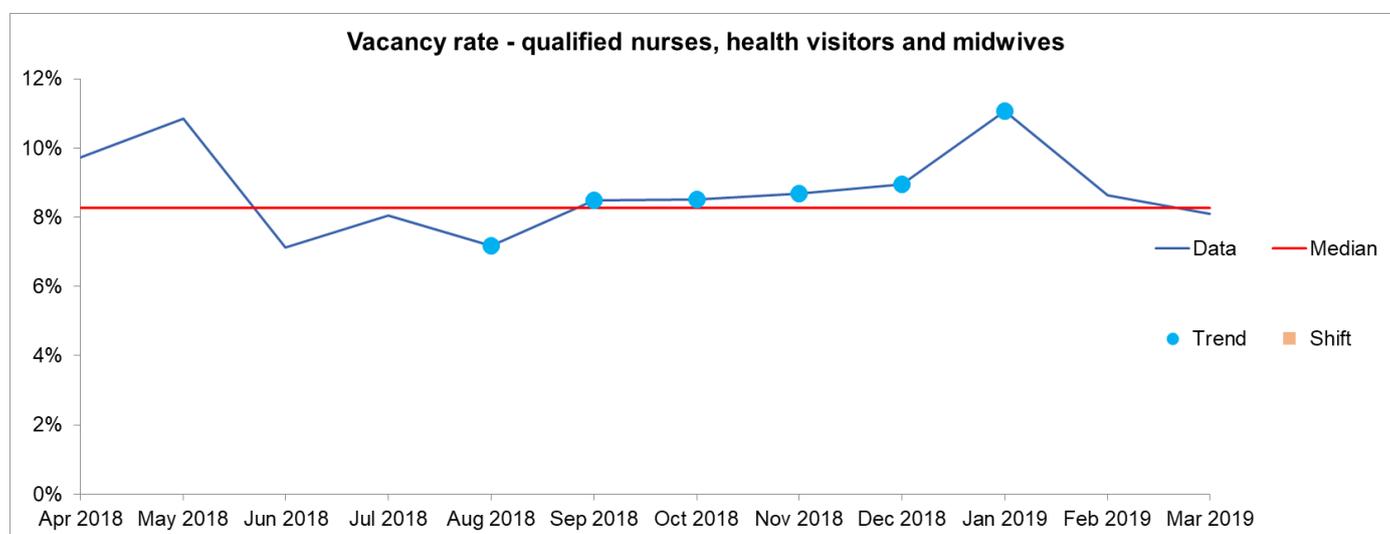
However; Two registered sick children's nurses were not available on each shift as per RCPCH guidelines.

The department ran the Baseline Emergency Staffing Tool (BEST) in 2018. This is a national tool developed to calculate staffing numbers and skill mix needed, taking into account workload and rostered staffing levels. This was repeated in March 2019 but during a particularly busy period so there were plans to run the tool again to ensure accuracy of the data.

The department had also used the National Quality Board guidance on safe staffing. The department took part in the sensitivity testing of the proposed safe staffing model for ED, this was a collaborative piece of work with NHS Improvement. The challenge that had been identified by UHND was the lack of parity across the different roles presently working in EDs.

Looking ahead the department planned to undertake extended searches to find a tool that could assess their staffing model to include additional roles.

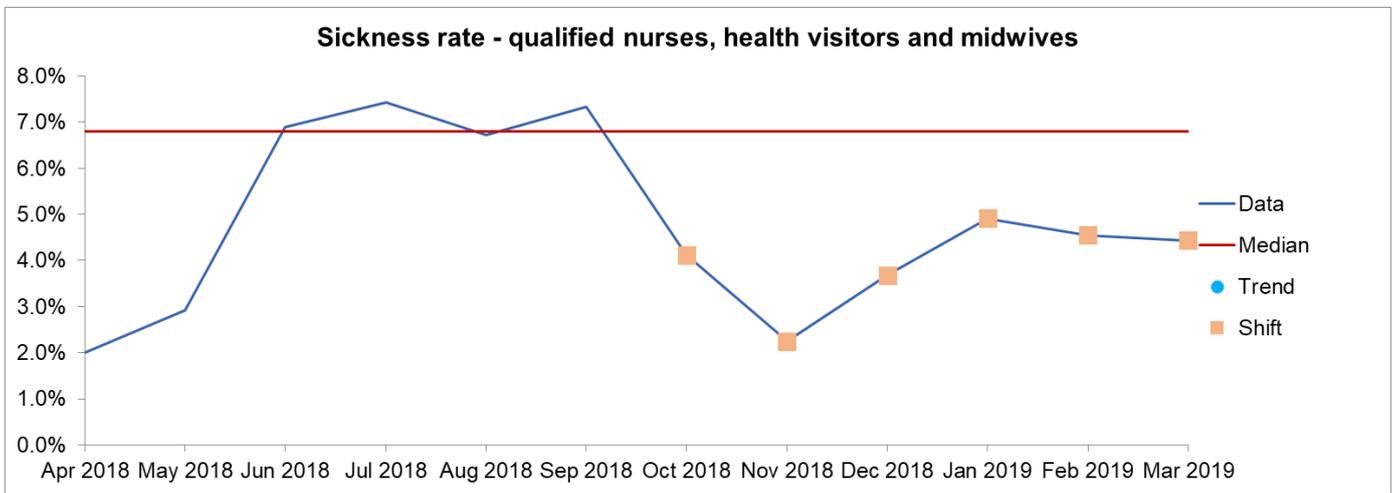
Trust level Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from August 2018 to January 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

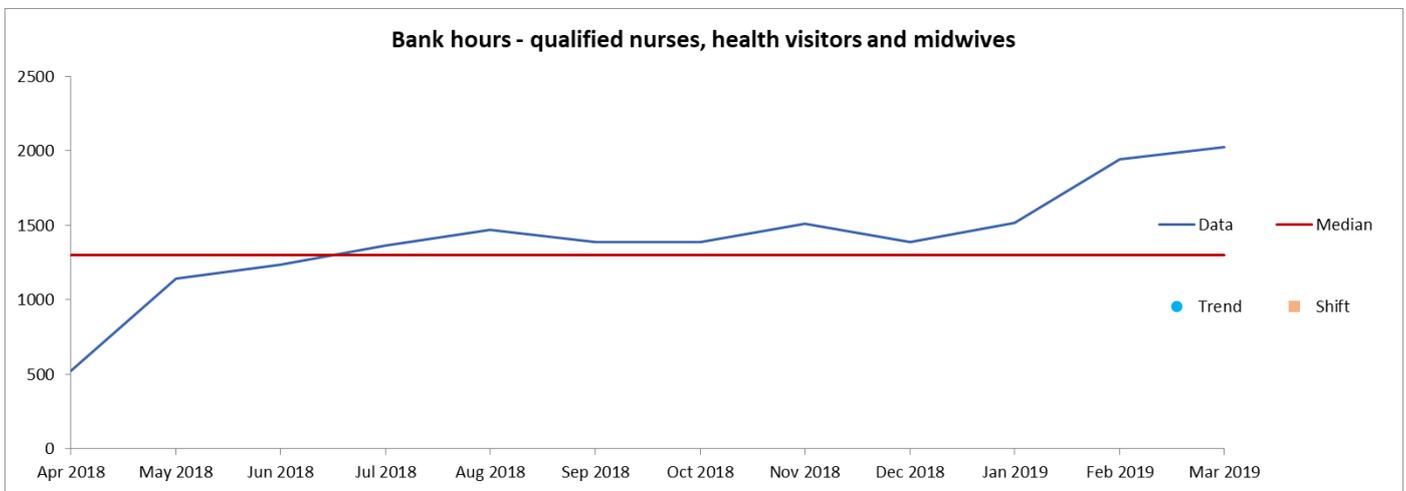
Sickness rates



Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage



Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Nursing Bank Agency tab)

University Hospital of North Durham

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at University Hospital of North Durham compared to the trust's targets, where applicable:

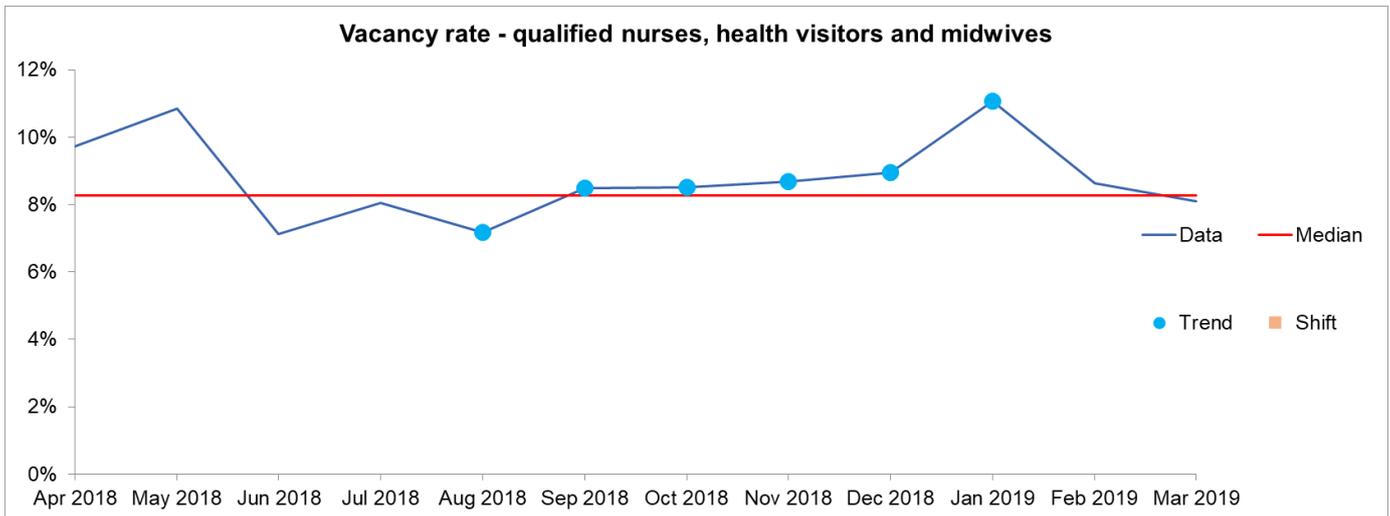
Urgent and emergency care annual staffing metrics							
April 2018 – March 2019							
Staff Group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours	Annual agency hours	Annual unfilled hours
Target	N/A	5%	None	4.0%			

All staff	222.7	7.9%	16.4%	3.5%			
Qualified Nurses	N/A	8.8%	10.3%	4.2%	20,538	212	3,651

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within this core service at University Hospital of North Durham were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank/agency staff use.

Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives show an upward trend from August 2018 to January 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

We reviewed nurse staffing on site with senior nursing staff and looked at the electronic rostering system. Staff had up to information related to vacancy rates and were fully aware of establishments and requirements within the department. Band six nursing posts were recruited to and equated to just below 16 whole time equivalent (WTE) posts.

The department had three WTE vacancies for registered nurses at band five, however, one of these posts had been recruited too. There were 3.85 WTE vacancies for health care support workers.

Current establishments for registered sick children's nurses (RSCN's) did not support RCPCH recommendations of having two staff on duty each shift. The department had struggled to recruit and retain RSCN's. The current establishment was 2.5 WTE, with one of these staff members due to start maternity leave.

This was identified as a risk on the departments risk register. It was also identified on the gap analysis provided against the RCPCH standards. There was ongoing recruitment and it was hoped the new dedicated paediatric area would help with this. There were mitigating actions in place. These included; joint pathways and close working between accident and emergency and the paediatric department particularly during times of increased activity; assistance from the paediatric ward when staff were available and using the skills of appropriately trained adult nurses to provide support.

Staffing was additionally reviewed three days in advance to ensure there are no staffing gaps. The allocation of staff was done on a daily basis and written on a whiteboard. This also identified the co-ordinator for the shift and the nurse for paediatrics.

Nurse staffing was predominantly over two shifts, long days and nights. Additional shifts had also been put in place to allow flexibility and responsiveness within the department. This had been done with consultation with staff and looking at activity within the department. Staggered shift start times had also been implemented to further support this.

Nurse staffing numbers and allocations are shown below.

	Role	Number on duty	Area of responsibility
Long day and night shift	Supernumerary co-ordinator	1	Oversight of department
Long day and night shift	Registered nurse (bands five and six)	9	Allocated to; streaming, triage, resus, monitoring bay, short stay, cubicles
Long day and night shift	Health care support worker	5	Main department 2 would be allocated to the monitoring bay
7.30am to 8pm	Band six nurse	1	See and treat
10.30am to 11pm	Band six nurse	1	See and treat
10am to 8pm	Emergency nurse practitioner	1	See and treat

In addition to the staffing above there was a nurse allocated to the ambulance handover bay and a nurse who worked from 2pm to 10pm to provide support to wherever was required in the department.

Any gaps in staffing would be covered by bank staff, there was very little use of agency staff. This was seen from reviewing staffing rotas. Assurance checks were in place for any bank staff.

If shifts remained unfilled, managers or matrons would provide support. We observed several periods of increased activity during the inspection. The matron and associate director of nursing were in the department providing support.

We reviewed four weeks of nursing rotas to compare the planned and actual registered nurse figures. Whilst there were some gaps in the rota, (23 shifts over the four-week period) there were mitigating actions in place. For example, there were supernumerary staff in place, staff were moved within the department to support areas of increased activity, such as see and treat and the urgent care centre.

Nursing and medical handovers took place twice a day. We observed each of these which detailed discussions about numbers of patients and any potential flow issues as well as information about individual patients.

Medical staffing

There were challenges in meeting the Royal College of Emergency Medicine (RCEM) workforce recommendations due to consultant vacancies. Sixteen hours of consultant presence was not achieved.

The service did not have a dedicated paediatric emergency medicine (PEM) consultant as per RCPCH standards, however mitigating actions were in place.

The department had determined what number of medical staff was required on each shift to maintain safety of patients. This involved shift patterns reflecting times of peak activity to provide

additional support. The department had challenges in meeting the medical staffing recommendations outlined by Royal College of Emergency Medicine (RCEM) workforce recommendations. The department had a consultant establishment of eight WTE. At the time of the inspection, there were 6.6 WTE in post. A paper had also gone to the board to recommend an increase in the level of consultant cover.

There were two consultants present during the day from Monday to Friday covering the department from 9am to 5pm and a RAT consultant from 1pm to 10pm. There was another consultant available Monday to Friday running the review clinic. This provided 14 hours of consultant cover each day. This was below the RCEM guidance of 16 hours.

On a weekend there was consultant presence during the day, outside of these hours an on-call consultant was always available. All of the staff we spoke with confirmed a consultant was always available when required.

We received information from the trust regarding the middle grade rota to provide assurance that that the Royal College of Emergency Medicine (RCEM) guidelines were being met. Whilst the guidance gives an expectation that an ST4 grade will be present to lead a department when no consultant is on site, it also recognises there is a national shortage. The department included ST3 grade doctors in the rota, however, there was a robust process to assess skills and competence. This was reviewed monthly during senior staff meetings, information from the trust stated no risks had been identified.

From reviewing two weeks of rotas we saw there was always a minimum of ST3 level cover overnight. Whilst this had been highlighted at the previous inspection. RCEM guidance had been revised since then, as discussed above. The trust had also put more robust monitoring processes in place.

The medical rota was also supported daily by two junior doctors working a range of shifts; 8am-6pm, 12pm to 10pm, 2pm to 12am and 10pm to 8am. Advanced care practitioners also supported the medical rota twenty-four-hours a day. There were 9.72 WTE of these employed.

The RCPCH standards identifies departments should have a dedicated paediatric emergency medicine (PEM) consultant. There was not one in place despite ongoing recruitment, however mitigating actions were in place. These included; working closely with the hospitals paediatric department to develop joint pathways of care and following departmental escalation processes. It was also hoped that the plans for a new paediatric 'front of house' department would help with recruitment.

We reviewed four weeks of medical staffing rotas, whilst some gaps were identified there were all covered by locum staff.

Trust level

The table below shows a summary of the medical staffing metrics in urgent and emergency care at trust level compared to the trust's targets, where applicable:

Urgent and emergency care annual staffing metrics

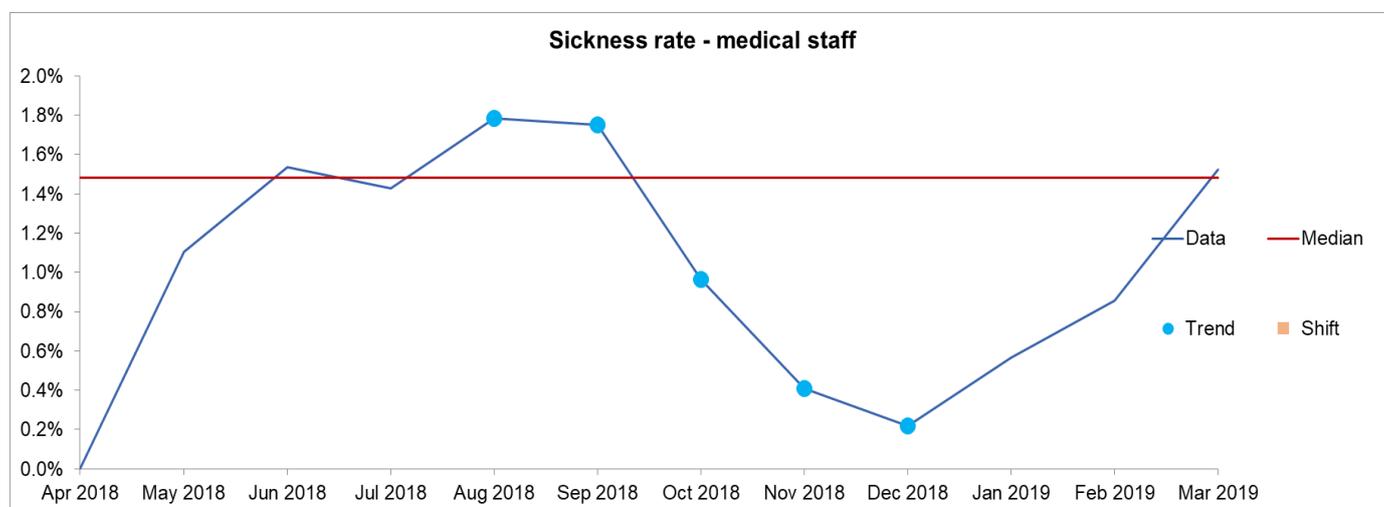
April 2018 – March 2019

Staff Group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours	Annual agency hours	Annual unfilled hours
Target	N/A	5%	None	4.0%			
All staff	244.8	7.7%	17.5%	3.1%			
Medical staff	43.6	8.3%	43.8%	1.0%	36,636	3,026	33,686

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical Locum tabs)

Medical staffing rates within this core service at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover.

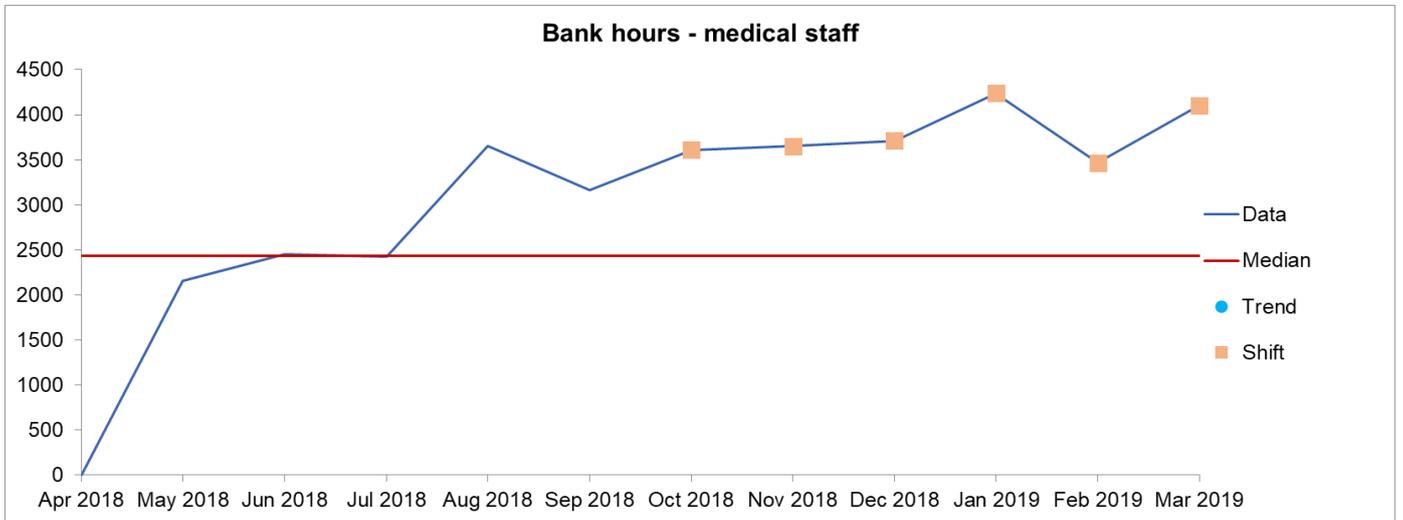
Sickness rates



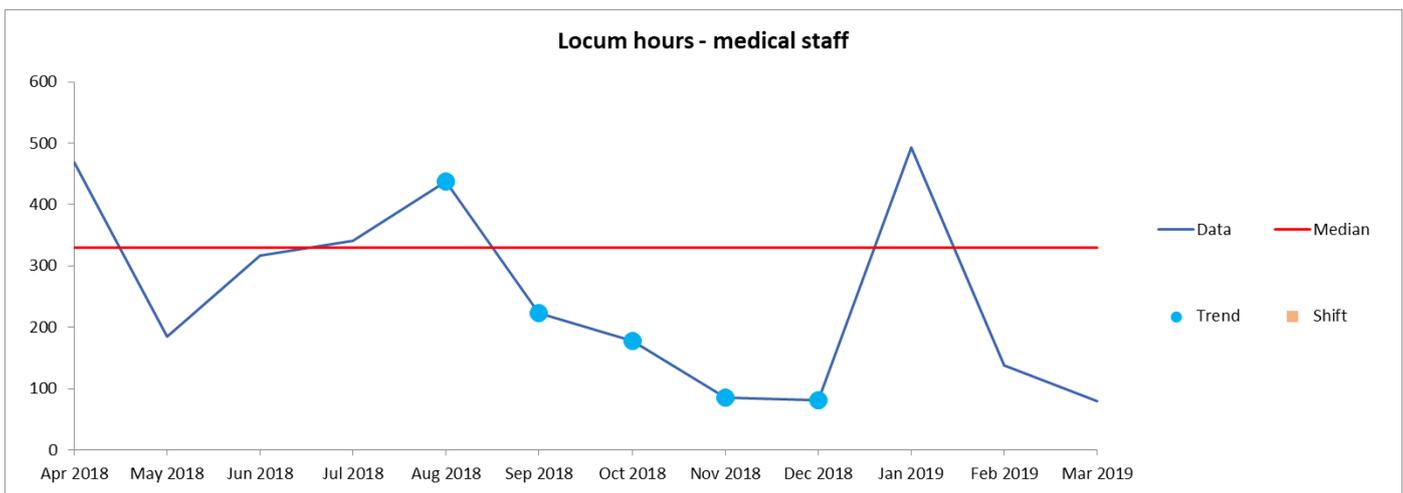
Monthly sickness rates over the last 12 months for medical staff shows a downward trend from August 2018 to December 2018.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage



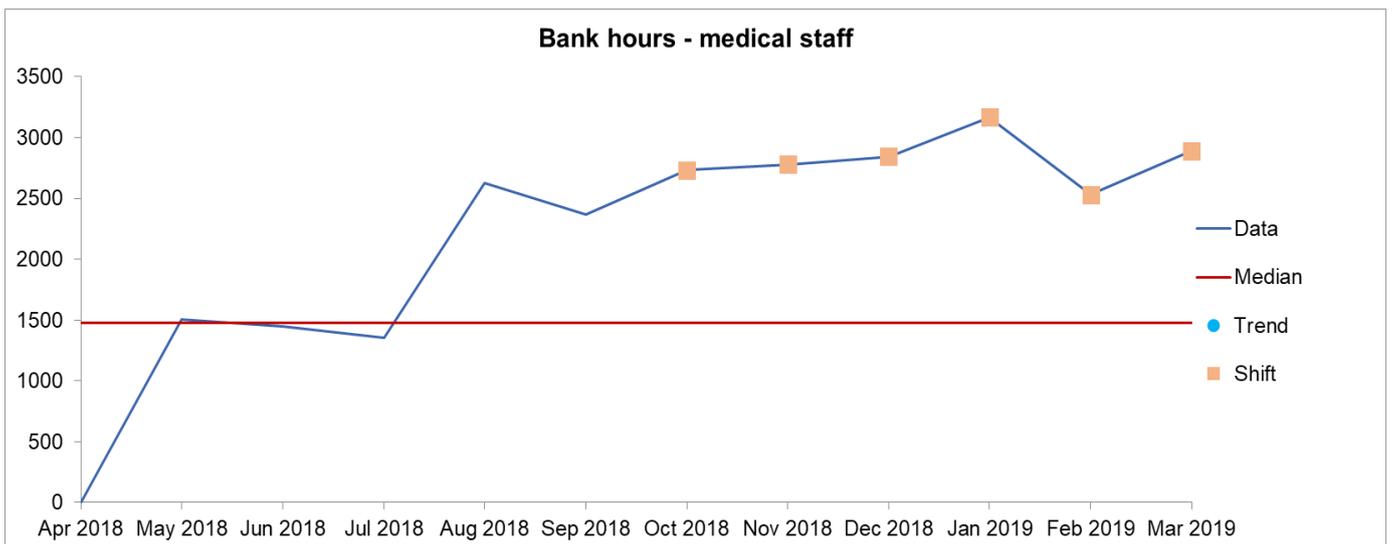
Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.



Monthly agency hours over the last 12 months for medical staff shows a downward trend from August 2018 to December 2018.

(Source: Routine Provider Information Request (RPIR) – Medical Locum tab)

Bank and locum staff usage



Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical Locum tabs)

University Hospital of North Durham

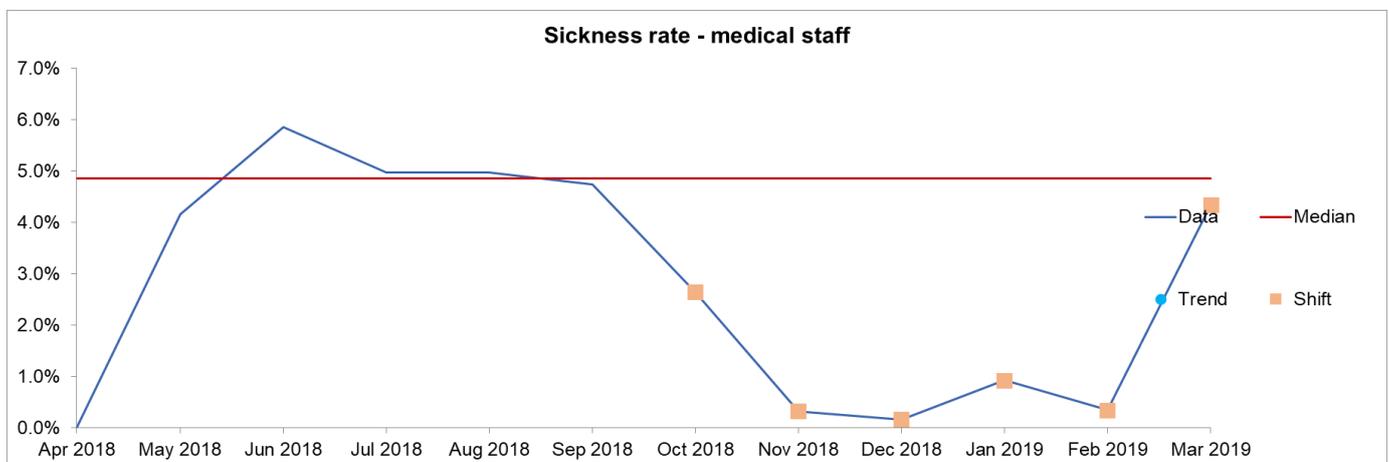
The table below shows a summary of the medical staffing metrics in urgent and emergency care at University Hospital of North Durham compared to the trust's targets, where applicable:

Urgent and emergency care annual staffing metrics							
April 2018 – March 2019							
Staff Group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours	Annual agency hours	Annual unfilled hours
Target	N/A	5%	None	4.0%			
All staff	222.7	7.9%	16.4%	3.5%			
Medical staff	N/A	8.3%	39.0%	2.8%	10,395	1,856	19,766

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical Locum tabs)

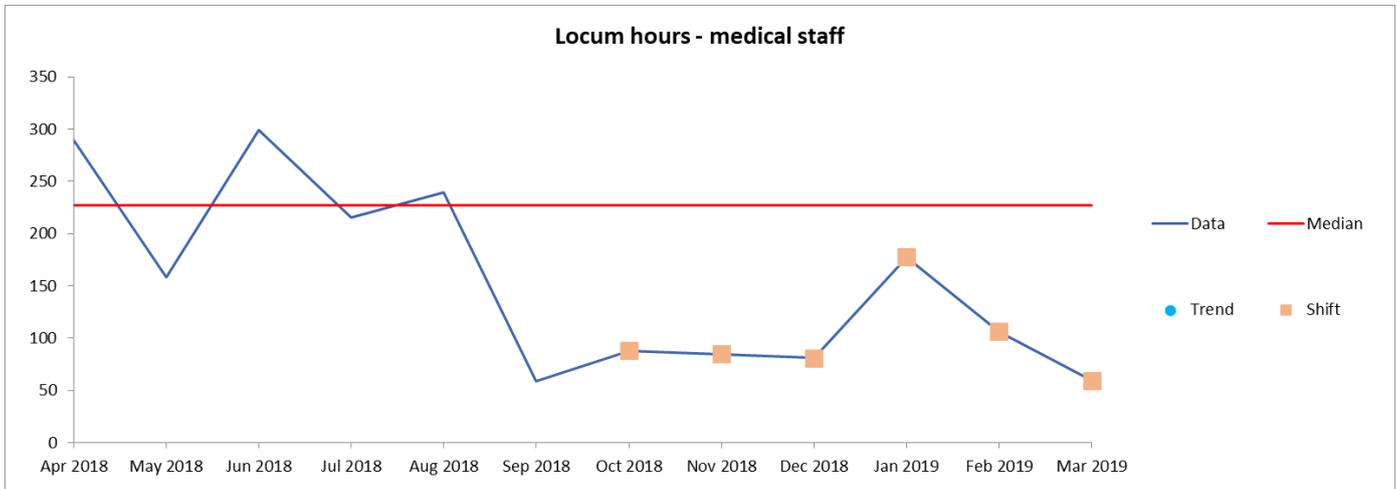
Medical staffing rates within this core service at University Hospital of North Durham were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover and locum staff use.

Sickness rates



Monthly sickness rates over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

Bank and locum staff usage



Monthly agency hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical Locum tabs)

Staffing skill mix

In January 2019, the proportion of consultant staff reported to be working at the trust were slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 48 whole time equivalent staff working in urgent and emergency care at County Durham and Darlington NHS Foundation Trust.



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Paper and electronic records were used in the department. Paper records were stored securely on individual clipboards and in areas where staff were always present. Written records were scanned into the electronic record system.

We observed safety checklists identifying information that needed entering onto the electronic system within the first hour of the patient arriving. This included details of triage and assessment, observations, patient identification bands being applied, infection control screening and others.

Ambulance staff also used both electronic and paper records which were reviewed during the handover of patients.

We also observed in each of the different areas computer screens were locked when not in use to maintain patient confidentiality and adhere to the trusts information governance policies.

Information governance training was mandatory. Trust level compliance for nursing staff in urgent and emergency care was 78%, for medical staff it was 90%. Both were on trajectory to meet the trusts year-end target of 95%.

With support from staff, we reviewed 18 sets of patient records in detail looking at care plans and risk assessments. Records also showed evidence of patients mental health as well as physical needs being assessed, where appropriate. If patients were reviewed by other specialties for example the mental health team, there was clear documentation of care plans and discussions between the relevant staff.

The electronic and paper elements of records were accurate and in line with trust and professional standards. The electronic systems were set up to ensure discharge summaries were sent to GP's within 24 hours of patients leaving the department.

Audits of patient records took place monthly and were reported as part of the trusts 'perfect ward' data. This included questions on the accuracy and completeness of records, including risk assessment. Data from April 2019 to June 2019, showed high levels of compliance; between 95% and 100%.

At the previous inspection it had been identified that patients' blood sugar levels were not always recorded as required. In the notes we reviewed we found only one incidence of this which was discussed with staff on duty. The trust also provided audit information related to this. Each month 32 records of patients with diabetes or conditions which would require a blood sugar level to be recorded were reviewed. From January 2019 to June 2019 compliance was between 94% and 100%. If any omissions were identified they would be discussed with the staff involved.

The electronic system had flags in place for example, if there were known safeguarding concerns or if the patient was a frequent attender.

Medicines

The concerns identified at the last inspection in relation to medicines had been addressed. We found systems and processes in place to safely prescribe, administer, record and store medicines.

At the previous inspection several issues had been identified in relation to medicines management. During this inspection we found that these had been addressed with no concerns identified.

Controlled drugs were stored correctly with access restricted to authorised staff. We reviewed stock balance checks and found they had been undertaken in line with trust policy. Random checks of individual controlled drugs showed complete and accurate records.

Stock medicines and patients own medications were stored securely. Intravenous fluids containing potassium were also stored securely and separated from other fluids.

Pre-packed medications were available for patients to take home, such as analgesia and antibiotics. There was a two person check system in process for staff to dispense these.

Information related to the correct administration of oral medications and the completeness of prescription charts was audited through the trust 'perfect ward' process. Data from April 2019 to June 2019 showed consistent scores of 100% in each area. This was reflective of the prescription charts we reviewed.

We looked at medicines prescribing in the 18 sets of records we reviewed. We found they were completed in line with trust and national guidance. On each prescription the allergy status had been completed. Where appropriate, antibiotics and oxygen had been prescribed in line with national guidance.

We looked at Patient Group Directions (PGDs). PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). The department had access to a wide range of PGDs, these were in date and correctly signed to authorise staff to use them.

There were guidelines in place to support patients withdrawing from drugs or alcohol, if required pharmacy staff would provide advice and support. Pharmacy services were available seven days a week, with an on-call service available out of hours and on a Sunday. Pharmacy staff would visit the department daily and check stock levels.

We saw a medicines bulletin displayed which provided staff with information on safe and secure handling of medicines and controlled drug stock checks. Twice daily safety huddles were also used to remind staff about medication administration for patients who had been in the department for more than four hours as they may be due to take their regular medications.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Processes were in place to share learning from incidents.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to March 2019, the trust did not report any never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Data from April 2018 to March 2019 showed there had been no serious incidents at this site.

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and could give examples of the types of things they would report, this included 'near misses'.

Lessons were learned following the investigation of incidents and learning was shared with staff via staff meetings, safety huddles and emails. Several staff also told us they had been provided with direct verbal feedback.

During the inspection we observed posters displaying 'what have we learned from incidents?'. This included information on escalating any patient's with a neurological deterioration and a reminder to undertake patient observations before they leave the department.

Trust wide information on learning from incidents was seen in the key messages briefing note in the staff communication file.

From reviewing clinical governance minutes and reports we saw evidence of incidents being monitored and discussed. This was further evident from staff meeting minutes. There was also evidence of safety alerts being monitored and actioned.

The electronic incident reporting system included a prompt on the duty of candour. This is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from March 2018 to March 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Patient safety information was displayed in the department.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Departmental policies were based on NICE (National Institute for Health and Clinical Excellence) and Royal College of Emergency Medicine (RCEM) guidelines. Staff were aware of policies and procedures and knew where to find them.

NICE guidance was a standing agenda item on the departments governance meeting minutes. Any new guidance would be reviewed and discussed with amendments made as appropriate. The

minutes also identified any areas of non-compliance; however, this often due to it not being applicable to the emergency department.

Any policies coming up for renewal were also listed with the responsible person identified.

An associate specialist who had worked in the department had developed an emergency department icon which could be quickly accessed from the computer desktop. This provided a quick link so several different resources for staff. It included recent alerts such as, informing staff that the vascular referral flow chart and paracetamol overdose guidance had been updated. There was a link to commonly used resources such as the chest pain and CT head algorithms; there were also links to all the cardiac arrest algorithms. The system was very easy to navigate and locate information. It also included emergency department specific documents and documents by speciality. For example, under trauma and orthopaedics there were guidelines related to c-spine injuries and major trauma.

There were a range of pathways in use which linked in with the electronic record system. These were based on the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) clinical standards for emergency departments. Care pathways had been established for conditions such as acute kidney injury (AKI) and pulmonary embolisms (PE). Within these there were links to other relevant guidance such as the antibiotic formulary and Toxobase. These pathways aimed to promote early treatment and improve patient outcomes.

The department participated in national RCEM audits to monitor standards of care and improve practice. Action plans were put in place based on audit result recommendations. Staff in the department participated in audit activity.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

We observed, and patients told us they were provided with fluids and food if they could have them. All the patients we spoke with were aware if they could have anything orally or not. Checklists to evidence food and fluids had been provided to patients were fully completed in each of the records we reviewed. We observed patients being provided with meals in the monitoring bay and the short stay beds. Assistance was offered to patients if required. We observed staff regularly asking patient's and relatives if they required a drink.

The department was also looking at funding options for jelly drops and intelligent hydration systems to encourage and support fluid intake for patients who were at risk of dehydration or were reluctant to drink.

Food could be requested if it wasn't readily available in the department, this included any specific dietary requirements.

In the waiting room there were vending machines which contained cold and hot drinks and a variety of snacks.

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We saw evidence of this being completed. The completion of nutritional assessments, oral hygiene needs and related care plans was monitored through the 'perfect ward' metrics.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

From the notes we reviewed we found evidence of pain scores being completed and appropriate action taken in response to any indicating a patient was experiencing pain. This was completed as patients were triaged we observed the triage of eight patients. Pain scores were recorded for each of these.

The patients and relatives we spoke with reported pain control being effective and that it was provided in a timely way.

The department had action plans in place to achieve RCEM standards in relation to pain relief. This included implementing a Paediatrics Analgesia Pathway. It had been identified by the department that improvements were needed regarding the reassessment of pain following the administration of analgesia. Further detail is in the patient outcomes section of the report.

A visual pain score tool was available for patients who may not be able to verbalise their level of pain. There was a paediatric pain assessment tool with pictures and descriptors to help identify the level of pain. A pain passport was also used for children, this prompted parents and carers to ask staff to reassess pain scores after 45 mins.

Emergency Department Survey 2017

In the CQC Emergency Department Survey, the trust scored 7.4 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey published June 2018)

Patient outcomes

Staff monitored the effectiveness of care and treatment through clinical audit. Information from re-audit showed improvement, this suggested action plans were effective in improving care and treatment in the department.

The RCEM has a range of evidence based clinical standards to which all emergency departments should aspire to achieve to ensure optimal clinical outcomes. The emergency department had participated in a number of audits to benchmark their performance against the standards.

There was variable performance in relation to the majority of the standards described below.

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, University Hospital of North Durham emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for two standards:

- Standard 1a (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 37.0%; UK: 19%.

- Standard 3 (fundamental): High dose nebulised β 2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 47.0%; UK: 25%.

The department was in the lower UK quartile for three standards:

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β 2 agonist bronchodilator therapy. This department: 32.0%; UK: 77%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
 - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
 - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
 - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
- Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 0.0%; UK: 19%.
- Standard 5b (fundamental): within 4 hours (moderate). This department: 0.0%; UK: 28%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
 - Adults 16 years and over: 40-50mg prednisolone for 5 days
 - Children 6-15 years: 30-40mg prednisolone for 3 days
 - Children 2-5 years: 20mg prednisolone for 3 days
 This department: 64.7%; UK: 52%.

The department's results for the remaining two standards were both within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, University Hospital of North Durham emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for one standard:

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 0.0%; UK: 8%.

The department's results for the remaining three standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, University Hospital of North Durham emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for two standards:

- Standard 3: O₂ was initiated to maintain SaO₂>94% (unless there is a documented reason not to) within one hour of arrival. This department: 70.5%; UK: 30.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 55.0%; UK: 18.4%.

The department's results for the remaining six standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

Following the inspection, we were provided with the departments audit plan. A number of audits were planned, these included;

- Assessing Cognitive Impairment in Older People (care in emergency departments)
- Mental Health (care in emergency departments)
- Care of Children in Emergency Departments
- Re-audit Renal Colic
- National Audit of Seizure Management in Hospitals

Information on further audits undertaken and related action plans were also provided. We saw evidence that these were reviewed and discussed at the departments governance meetings.

Other audits included:

- Re-audit of Fractured neck of femur 2018/2019. This identified improvement in five of the nine standards from the previous audit in 2017/2018. Notably pain scores being recorded within 15 minutes of arrival. This had improved to 74%, it had previously been 29%.
- Re-audit of Procedural sedation in adults 2019. This highlighted a significant improvement in eight of the 11 standards. These related to documentation, monitoring, pain and comfort.

Assurance was gained from the improvements seen in the re-audits. This suggested action plans were effective and improving care and treatment in the department.

Trauma Audit and Research Network (TARN)

University Hospital of North Durham

The table below summarises University Hospital of North Durham's performance in the 2016 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

Metrics (Audit measures)	Hospital performance	Audit Rating	Meets national standard?
Case Ascertainment <i>(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</i>	67.3% - 78.6%	N/A	x
Crude median time from arrival to CT scan of the head for patients with traumatic brain injury <i>(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is</i>	43 minutes	Takes longer than the TARN aggregate	x

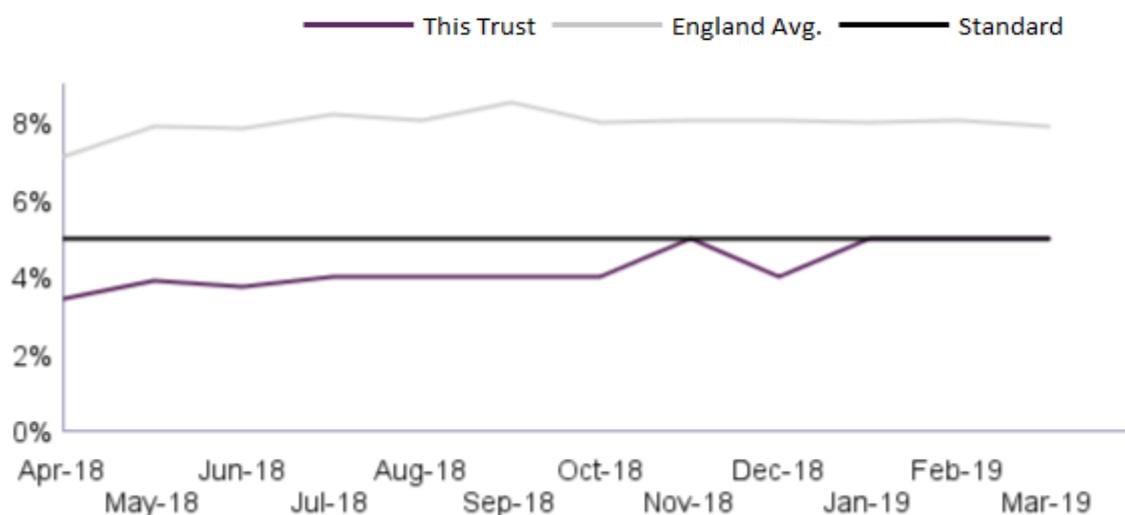
<i>critical to allowing appropriate treatment which minimises further brain injury.)</i>			
Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury <i>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</i>	Not eligible	N/A	N/A
Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care <i>(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</i>	Not eligible	N/A	N/A
Risk-adjusted in-hospital survival rate following injury <i>(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)</i>	1.4 additional survivors	Similar to expected	✓

(Source: TARN)

Unplanned re-attendance rate within seven days

From April 2018 to March 2019, the trust's unplanned re-attendance rate to urgent and emergency care within seven days was better than or the same as the national standard of 5% and better than the England average. In the latest month, March 2019, trust performance was 5.0% compared to an England average of 7.9%.

Unplanned re-attendance rate within seven days - County Durham and Darlington NHS Foundation Trust



(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Appraisal rates

From April 2018 to March 2019, 91.8% of staff within the urgent and emergency care department at the trust received an appraisal compared to a trust target of 95%. Nursing and midwifery registered staff met the trust target with 95.1%, whilst medical and dental staff did not meet the target with 72.7%.

Trust level

Staff group	April 2018 to March 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional clinical services	35	36	97.2%	95%	Yes
Administrative and Clerical	24	25	96.0%	95%	Yes
Nursing and Midwifery Registered	97	102	95.1%	95%	Yes
Medical and Dental	24	33	72.7%	95%	No
Total	180	196	91.8%	95%	No

University Hospital of North Durham urgent and emergency care department

Staff group	April 2018 to March 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional Clinical Services	22	22	100%	95%	Yes
Administrative and Clerical	14	15	93.3%	95%	No
Nursing and Midwifery Registered	53	57	93.0%	95%	No
Medical and Dental	10	17	58.8%	95%	No
Total	99	111	89.2%	95%	No

At University Hospital of North Durham, 89.2% of staff within the urgent and emergency care department at the trust received an appraisal compared to a trust target of 95%. Nursing and midwifery registered staff was slightly below the trust target with 93.0% and medical and dental staff did not meet the target with 58.8%.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Further up to date information provided after the inspection showed that compliance for medical appraisals had increased to 94% this was just below the trust target of 95%.

The trust clarified that frontline nursing staff require either an Immediate Life Support (ILS) or Advanced Life Support (ALS) qualification and similarly a Paediatric Immediate Life Support (PILS) or European Paediatric Advanced Life Support (EPALS) qualification. Data regarding this is below.

Urgent and Emergency Care

Nursing and Midwifery staff

	Compliant	Non-Compliant	Grand Total	% compliance	Target by end of March 2020	On/off trajectory
UHND						
439 LOCAL ALS/ILS Training - 4 Years	42	23	65	65%	85%	
439 LOCAL EPALS/PILS Training - 4 Years	46	19	65	71%	85%	
439 LOCAL ALS/ILS Training - 4 Years 	77	31	108	71%	85%	
439 LOCAL EPALS/PILS Training - 4 Years 	85	23	108	78%	85%	

There was always a doctor and a nurse or advanced nurse practitioner on site who had skills in advanced life support for adults and children. This person was identified each shift on the staff board.

We spoke with the trainer for non-invasive ventilation in the department. A standard operating policy was in place and a patient pathway. Competency was assessed by a designated senior nurse using a competency framework. Seven consultant and 23 nurses had been trained.

Any newly qualified staff or staff new to the department would have a four-week supernumerary period. A full day of training away from the department was also provided as part of level one and level two study days to orientate staff into the department and teach skills to function within the department. The Royal College of Nursing competencies were also used for staff training.

For the last six months the department had been teaching the Trauma Immediate Life Support Training Course (TILS). This provided staff with general training and prepared them for attending a more advanced trauma course.

The department had recognised that compliance with decontamination training was lower than the Trust standard. This was reviewed, and senior nursing staff were prioritised to complete the training. Information provided showed compliance was around 95%. Decontamination training has since commenced monthly and had taken a simulation approach. We observed this training taking place during the inspection.

Teaching sessions for medical staff took place on a Tuesday however staff reported pressures in the department had meant they were not always run. It was hoped they would be re-established.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

We observed good multidisciplinary team working; this was supported by the staff we spoke with.

Staff reported good working relationships with other departments in the hospital for example, paediatrics. The referral process for speciality doctors worked well and there was access to clinical nurse specialists.

There were clear internal referral pathways to mental health services, Psychiatric Liaison team were co-located in the department. Staff were clear on the referral pathways and how the team were accessed.

We spoke with ambulance staff who told us they had good working relationships with staff in the department, and they all worked together to support and assist each other.

The department worked closely with the Crest team. This multidisciplinary team comprised of seven staff, including; a consultant, physiotherapist, advanced nurse practitioner and an assistant practitioner. The team reviewed any patients who were frail and/or over the age of 75. They looked at any issues related to delirium, functional decline or reduced mobility and provided specialist advice.

Seven-day services

Key services were available seven days a week to support timely patient care.

The department operated 24 hours a day, seven days a week. Consultants provided 24 hour on call medical cover. There was 24 hour access to a paediatric consultant.

The ambulance handover bay was operational seven days a week from 12:30 to 23:00. A review of ambulance attendances was conducted to determine the most appropriate operating period of the ambulance bays.

There was 24-hour access to there was access to services such as X-ray and computerised tomography (CT) scanning with facilities within the department. Pharmacy and pathology services were also available, this was via an on-call system out of regular working hours.

There was 24-hour access to mental health liaison services for adults.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff completed assessments on admission to the unit about patients' individual needs and provided support as appropriate.

There were guidelines in place to support patients withdrawing from drugs or alcohol and the pharmacist would provide advice and support in such situations.

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions. The department provided patients with information leaflets about their condition and aftercare such as from falls or head injuries.

We saw there was information available for patients about smoking cessation services and access to drug and alcohol services. The department had an alcohol nurse specialist. Initially this role focused on auditing, but the role had extended, and the nurse also saw patients in the department.

The "Positive Lives" resource was utilised by the department. This offered coaching and training workshops to improve creativity, confidence, and communication skills for individuals, groups and teams. It also delivered story-based projects to evidence work and engage with clients, and empower service users through creative writing and a Recovery Stories programme.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Mental Capacity Act and Deprivation of Liberty training completion

Trust level

The trust set a target of 33% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	14	42	33.3%	33%	Yes

In urgent and emergency care the target was met for the MCA/DOLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	3	21	14.3%	33%	No

In urgent and emergency care the target was not met for the MCA/DOLS training module for which medical staff were eligible.

University Hospital of North Durham urgent and emergency care department

The trust set a target of 33% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at University Hospital of North Durham for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	6	23	26.1%	33%	No

In urgent and emergency care the target was not met for the MCA/DOLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at University Hospital of North Durham for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	2	9	22.2%	33%	No

In urgent and emergency care the target was not met for the MCA/DOLS training module for

which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following the inspection, we were provided with updated training information which is in the table below. This shows a slight improvement. The information stated that training compliance was reviewed monthly to ensure performance was maintained. The information also stated 19 staff were booked to attend this course. This would increase compliance to 67%, which would meet the year end trajectory.

MCA/DOLS training for medical staff

Staff trained	Eligible staff	Completion rate	Year-end target
3	8	38%	66%

MCA/DOLS training for nursing staff

Staff trained	Eligible staff	Completion rate	Year-end target
10	24	42%	66%

We spoke with staff about MCA and DoLs and capacity assessments. Staff demonstrated an understanding of these and could identify where this information would be recorded in patient records. We found evidence of best interest decisions being discussed and documented and an assessment of capacity in the notes we reviewed.

Staff we spoke with said they access to mental health referral pathways and they would use these with any patients they had concerns about. Further policies had been written to facilitate the care of patients including a Capacity Policy and 'Patient who absconds from the Emergency Department' Policy.

During the inspection, we reviewed a patient record with a do not attempt cardiopulmonary resuscitation (DNACPR) order in place. This had been fully completed with decision making with the patient and family discussed and documented.

Where possible, doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and asking permission prior to performing tests or examinations.

The Crest team often were involved with patients who had a level of cognitive impairment. They were able to undertake capacity assessments and again would link in with mental health colleagues as appropriate.

Consent forms were available and completed for some specific procedures within the department, for example, if patients required sedation.

Paediatric staff we spoke with were aware of the Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

During our inspection, we spoke with 12 patients and their relatives, they provided us with consistent positive feedback about the staff within the department. They stated staff were kind, caring and friendly. Comments were made such as 'the staff have been great', 'the nurses are absolutely fabulous' and 'the staff were lovely, they really couldn't have done any more'.

We observed all members of staff providing care for patients' in a kind and compassionate way. Staff communicated with patients in a caring manner even when it was clear they were under pressure due to the busyness of the department.

We observed several examples of staff taking time to listen to patients, for example, a staff member accompanying an elderly couple who were leaving the department and chatting to them. We also observed staff persevering with a patient with limited capacity asking them to straighten their arm. Their tone was patient despite having to repeat the instruction numerous times.

The privacy and dignity of patients was maintained when care and treatment was being delivered by pulling curtains round or ensuring doors were closed.

Patients we spoke with said that staff attended to them quickly if they required assistance. We observed throughout the different areas patients were provided with buzzers which were within reach.

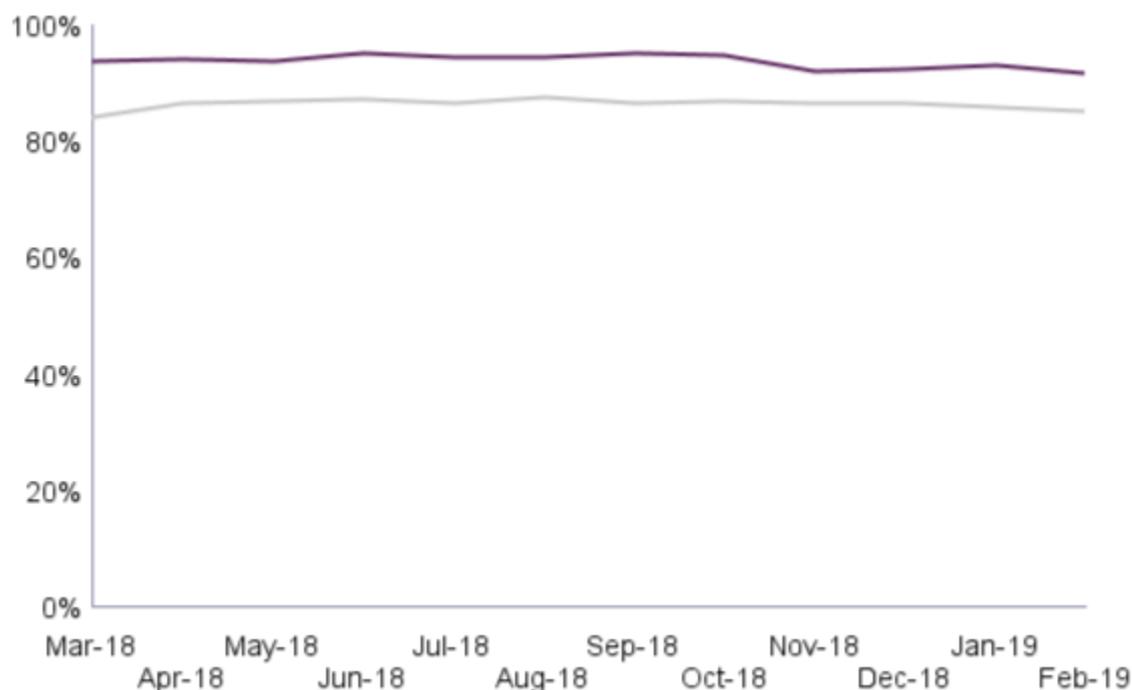
Patient experience including friends and family tests (FFT) data was a standing agenda item on departmental governance meetings. The departmental governance report also detailed where excellence certificates had been given. There had been two issued to the department in May 2019. These were for staff going 'the extra mile' for the care given to a patient, and 'attention to details' to ensure a patient received their regular medication which was due at handover time.

Friends and Family test performance

The trust's urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from March 2018 to February 2019. In the latest month, February 2019, performance was 91.6%, compared to the England average of 85.3%,

Urgent and emergency care department Friends and Family Test performance - County Durham and Darlington NHS Foundation Trust

— This Trust — England Avg.



(Source: Friends and Family Test – NHS England)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff told us about how they would provide support to patients who were distressed or anxious and they saw this as a key part of their role. The department had rooms available that could be used by people such as family and friends of patients in the resuscitation room.

A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients. End of life care training was also provided for staff.

The department has also been involved in the 'Treat as One' initiative which focuses on bringing together both mental and physical needs of patients. Staff had been provided with training for this. Two of objectives were to have richer relationships with patients in emotional crisis and for staff to feel more confident about their skills in working with very distressed or confused patients. Staff spoke in a positive way about this training and felt it had been of benefit.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

During our inspection, we witnessed positive interactions with patients and staff. Staff took time to reassure patients and explain to them why they were waiting or what the next stage of their treatment or care was. This supported patients to make decisions about their treatment. People's emotional and social needs were considered by staff.

We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment. We observed that relatives were provided with care alongside the patients. Staff recognised if relatives needed support. We also observed relatives were offered drinks.

Patients we spoke with said that medical staff took time to explain their care and the risks and benefits of treatment. Patients we spoke with said they felt able to ask questions if they were unclear about any information they were provided with and that they were aware of who to approach if they had any issues regarding their care.

We observed a staff member attending to a patient living with dementia. The staff asked his wife if he would prefer a male nurse and if there was anything else they could do to reduce his distress.

Staff made sure information they gave was in a language that the patient and their family could understand without complicated medical terminology. Patients and relatives told us they understood their care and treatment plans. One patient explained how she was hard of hearing but that everyone spoke slowly and clearly and checked that she had understood what had been said.

Emergency Department Survey 2017

The trust scored better than other trusts for one of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored worse than other trusts for one question and about the same as other trusts for the remaining 22 questions.

The question that scored better than other trusts was “Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?” and the question that scored worse than other trusts was “Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?”.

Question	Trust 2017	2017 RAG
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	9.3	About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	6.2	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.3	About the same as other trusts

(Source: Emergency Department Survey, published 2017)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people.

The department had an urgent treatment centre co-located in the emergency department which meant that patients could be streamed to the relevant service. This met the Royal College of Emergency Medicine (RCEM) recommendations to achieve safe sustainable care in emergency departments in terms of configuration of services.

The department had been working closely with mental health colleagues. The mental health liaison team had moved and was co-located in the department which had helped support joint working. The department had been involved in a pilot of mental health triage, to try and identify any other underlying issues which may not be identified via traditional triage systems. Training was provided for staff and feedback was that having a different perspective on patients who presented in the department was helpful. Information and learning from the pilot were to be used to inform service provision and develop pathways of care.

In early 2018 the department also carried out a mapping exercise to influence the mental health pathway across the police, acute trust, mental health trust and local authority.

The trust involved patients and families when investigating some complaints to help reflect the views of local people who have used the service. The senior nurse gave an example of poor care relating to a patient with diabetes. They worked closely with the relatives involved to support shaping the service going forwards across the trust.

In 2018 the department underwent some estate changes which included an ambulance handover bay. The ambulance handover bay facilitated the early assessment of patients arriving by ambulance.

Other estate changes supported a more open approach to patient management. This involved the staff base in the centre of the department being 'opened up' to encourage patients and relatives to speak with staff. An additional area was also provided for quiet and confidential conversations within the department.

Staff had recognised that were improvements that could be made in the management of children and the environment was part of this. The team were aware the facilities in the department did not meet the needs of children. A new model of working had been developed and approved by the trust with a new area identified to provide dedicated paediatric care and treatment.

Improvements had been made to ensure that the mental health room and toilet were to PLAN standards. This improved patient safety for those patients who required mental health services.

The general waiting areas had adequate seating and there were chairs available for relatives visiting in the monitoring bay and short stay areas.

There was a private relatives room which had tea and coffee making facilities and a telephone. It was a pleasant environment.

The department also had a separate room for the triage and assessment of patients brought to the department from prison. This gave them some privacy and helped with security in the department.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The trust IT system had a flagging system that could alert staff to specific needs of patients who had attended before. For example, patients with an existing dementia diagnosis and patients with a known learning disability which alerted staff to their needs. A teddy bear icon was also in place to alert staff to children being in the department.

The trust had access to interpreting services for people whose first language was not English, or those who used sign language. Staff we spoke with were aware of how to access these when required.

In January 2019 Psychiatry Liaison worked closely with the department and carried out a pilot of a mental health nurse being present in triage. The aim was to understand those patients who present to the department and assist in identifying those patients with undiagnosed or unrecognised mental health concerns.

We spoke with staff about patients living with complex needs, dementia, or a learning disability. All staff told us they would treat patients as individuals, would try to involve family and carers in discussions about care needs to find out more about the patient. Two staff in the department were doing further improvement work on making the department more dementia friendly and were fundraising for this.

Staff in the department had developed a box with a number of resources to assist in the management of patients of dementia. This included dolls and twizel muffs and resources to hide cannulas. An orientation board and local historical pictures were also in place by the short stay area.

A treatment room had also been identified where patients could see a member of staff at all times. This room was prioritised for patients living with dementia to ensure their safety.

The department has adopted the Rockwood score which assesses the patient for their degree of frailty. This information is used to support decision-making. The Rockwood score has become a mandatory field within the ED electronic system and can be seen at a glance on the system. The CREST team can then review this system on a daily basis to actively triage patients and assess whether a facilitated discharge can take place. The CREST team work front of house and they have admission rights for the frailty unit which is based on the Acute Medical Unit. Additionally, where a patient is thought to benefit from frailty services then the patient would be referred to the frailty unit pending review the following day. Operational hours for the CREST service are 08:00-18:00.

The children's waiting area had toys, books, child sized tables and chairs. There was a designated toilet/baby change/feeding room and direct access from this area to two paediatric friendly rooms.

Emergency Department Survey 2017

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

Question – Responsive	Score	RAG
Q20. Were you given enough privacy when being examined or treated?	9.3	About the same as other trusts

(Source: Emergency Department Survey published June 2018)

Access and flow

Whilst improvement had been made in terms of access and flow, challenges still remained which impacted on wait times in the department for patients.

The previous inspection highlighted the need for patients to be seen and transferred or discharged within four hours. From May 2018 to April 2019, the trust failed to meet the standard related to this, however, this was in line with the England average.

From May 2018 to April 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average. January 2019 saw the highest number of patients (1,177).

Whilst no patients waited more than 12 hours from the decision to admit until being admitted between May 2018 to April 2019; there were large number of patients waiting between four and 12 hours.

There had been a focus on access and flow in the department following the last inspection. A "front door" approach was taken in the department. This involved senior nurse and medically led assessments to support timely diagnostics, decision-making and prompt treatment. GP's were integrated in to the department and provided an ambulatory stream for patients.

From the small cohort of patients included in the pilot of a mental health nurse being present at triage, it was identified that for one or two patients admission could have been avoided. The information showed that staff were not aware of all of the support networks available to these patients, so the default position was to admit them. The findings also hoped to embed screening for delirium to try to identify patients at risk at the earliest stage.

During our inspection, ambulance staff told us the emergency department staff were responsive to pre-alert patients arriving by ambulance. They told us there were pathways in place for specific pre-alerted conditions which meant patients could commence treatment more quickly.

Staff told us there was a clear pathway for paediatric patients and a paediatric consultant was available. Paediatric patients could be fast tracked to the paediatric department provided triage and observations were completed and it was appropriate to do so.

The department aimed to have speciality referral done within 30 minutes of patients being seen by a consultant.

Hourly board rounds took place and we observed these during the inspection. These enhanced patient flow and helped escalate any barriers to the safe movement of patients either in to the hospital or out from the department.

Exit block was identified by staff as the biggest challenge in terms of access and flow. It was identified on the risk register. There were a number of actions in place to try and mitigate this, they were clearly outlined in the trusts full capacity protocol. We saw elements of this being put in to place at times of peak activity and capacity during the inspection. The protocol clearly defined what would trigger its application and the actions that could be put in to place.

Examples included; patients going directly to base wards following discussion between consultants. We saw this in place for paediatric patients attending the department during the inspection; speciality in-reach in to the department; and opening of escalation areas in the hospital.

We observed conversations between staff where any potential discharge issues were identified. The Crest team played a key role in such situations and focused on admission avoidance. There was proactive and early identification during handovers and board rounds of any patients suitable for their service.

The Crest team could refer to community hospitals and intermediate care as well as arrange home care packages to support timely discharge home for patients.

The department was extremely busy, we were told 39,000 patients had been seen since the 1 January 2019. During the inspection we observed surges in activity. We saw proactive management of breaches, between the department and site management teams.

The charts below show in line with other trusts, the department was challenged in admitting, transferring or discharging patients within four hours. On one of the days we visited the department had 57 four-hour breaches. However, on average the department performed better than the England average and they had not had any 12-hour breaches.

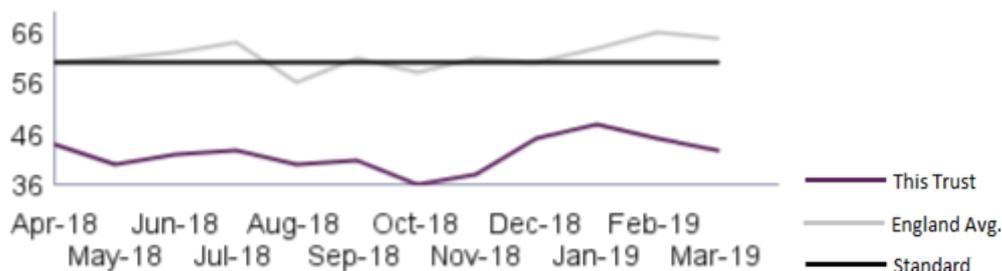
We observed actions such as the ambulance bay being kept open overnight to help with access and flow during busy periods. It was hoped that the 24-hour opening of this would occur as it had a positive impact on access and flow in the department.

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. From April 2018 to March 2019, the trust met the standard for all months over the 12 month period and was better than the England average.

From April 2018 to March 2019, performance against this standard was better than the England average and followed a similar trend. In the latest month, March 2019, the median time to treatment was 43 minutes compared to the England average of 65 minutes.

Median time from arrival to treatment from April 2018 to March 2019 at County Durham and Darlington NHS Foundation Trust



(Source: NHS Digital – Urgent and emergency care quality indicators)

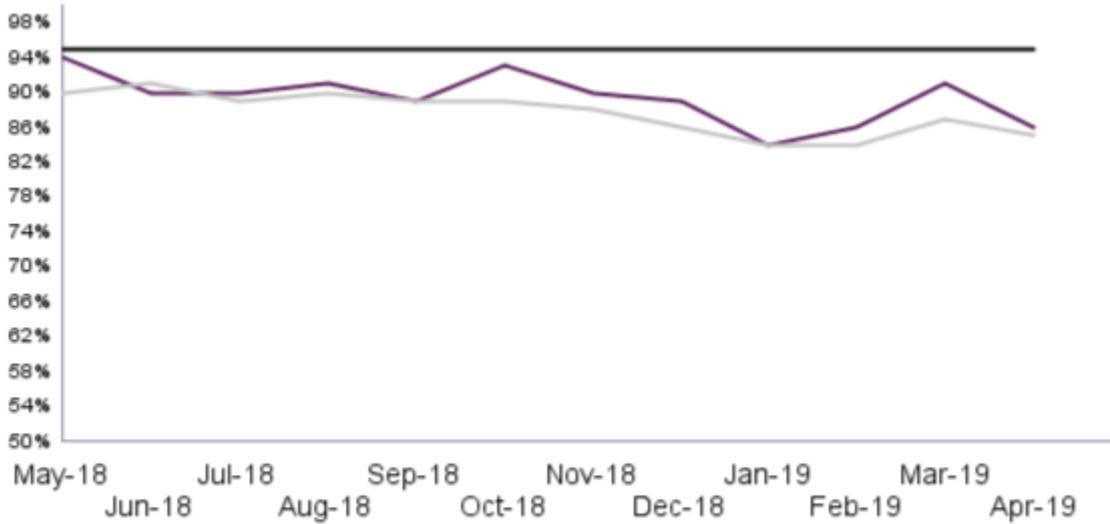
Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From May 2018 to April 2019, the trust failed to meet the standard and performed similar or better than the England average.

Four hour target performance - County Durham and Darlington NHS Foundation Trust

— This Trust — England Avg. — Standard

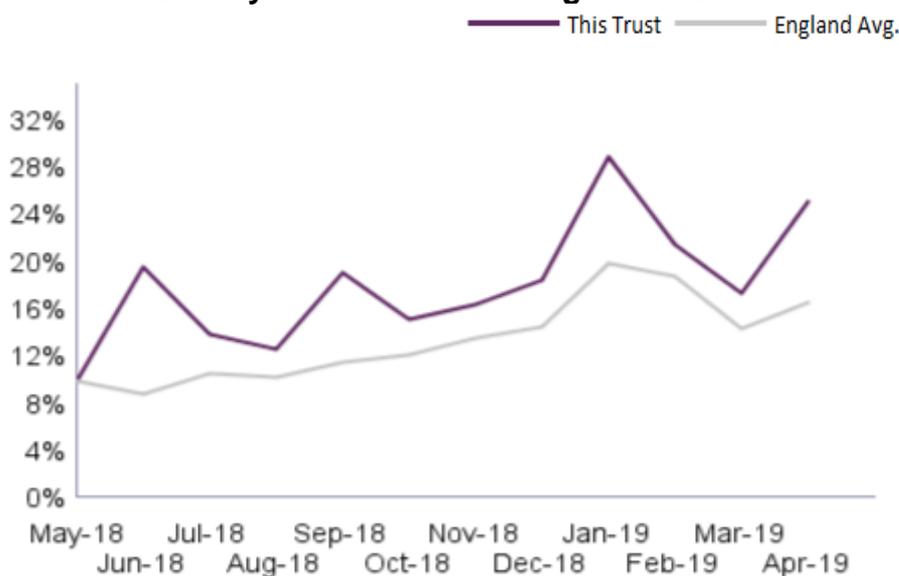


(Source: NHS England – Urgent and emergency care waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From May 2018 to April 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average, with the exception of May 2018 where this was similar.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - County Durham and Darlington NHS Foundation Trust



The table below shows the number of patients waiting more than four hours to admission:

Month	Number of patients waiting more than four hours to admission
May 2018	354
June 2018	685
July 2018	523
August 18	438
September 2018	664
October 2018	546
November 2018	619
December 2018	724
January 2019	1,177

February 2019	763
March 2019	678
April 2019	940

January 2019 saw the highest number of patients (1,177) waiting more than four hours to admission and May 2018 saw the lowest (354).

(Source: NHS England - Urgent and emergency care SitReps).

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from May 2018 to April 2019, no patients waited more than 12 hours from the decision to admit until being admitted.

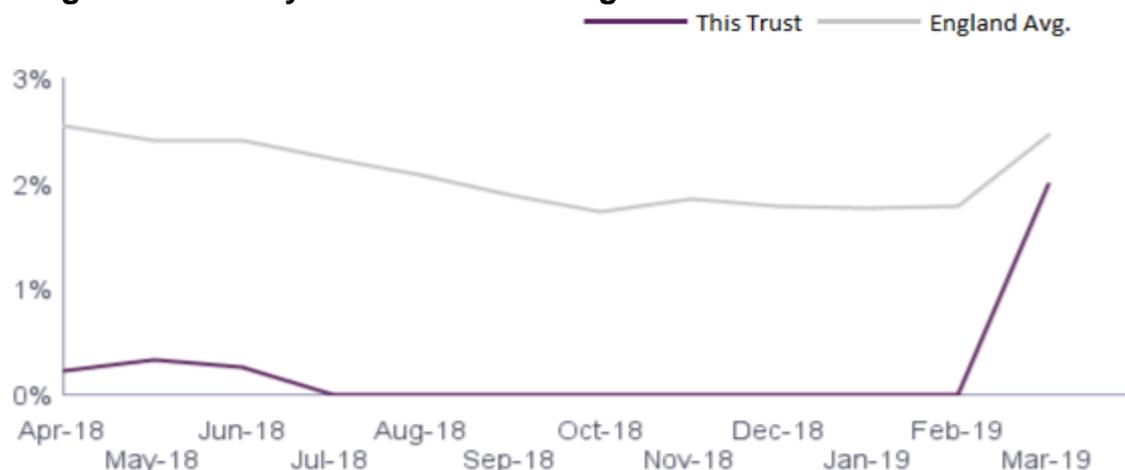
(Source: NHS England – Urgent and emergency care waiting times)

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

From April 2018 to March 2019, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was better than the England average.

From July 2018 to February 2019, the percentage of patients leaving the trust’s urgent and emergency care services before being seen was 0.0% and increased in the latest month, March 2019, to 2.0%, compared to the England average which was 2.5%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - County Durham and Darlington NHS Foundation Trust



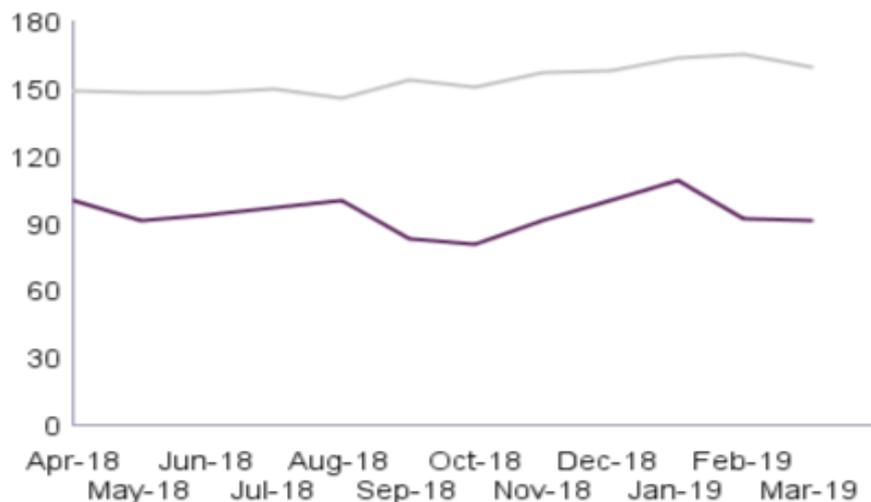
(Source: NHS Digital – Urgent and emergency care quality indicators)

Median total time in urgent and emergency care per patient (all patients)

From May 2018 to April 2019 the trust’s monthly median total time in urgent and emergency care for all patients was lower than the England average. In the latest month, March 2019, the trust’s monthly median total time in urgent and emergency care for all patients was 91 minutes compared to the England average of 160 minutes.

Median total time in urgent and emergency care per patient - County Durham and Darlington NHS Foundation Trust





(Source: NHS Digital - Urgent and emergency care quality indicators)

Medical and nursing staff completed a handover twice a day and had hourly board rounds. The electronic board in the staff base was used during these discussions. This gave information on the length of time patients had been in the department and their current status. We observed staff discussing patients' reason for attendance, reviewing their treatment plans and any barriers to them being admitted or discharged.

The trust used technology to link with the local ambulance trust. There was a system in place to show the presenting complaint of an incoming patient and their estimated time of arrival.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Summary of complaints

Trust level

From April 2018 to March 2019, the trust received 93 complaints in relation to urgent and emergency care at the trust (16.2% of total complaints received by the trust). The trust took an average of 33.2 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed within 40 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Patient Care including Nutrition / Hydration	40	43.0%
Access to treatment or drugs	29	31.2%
Values & behaviours (staff)	13	14.0%
Patient Care	6	6.5%
Facilities	3	3.2%
Communications	1	1.1%
Appointments	1	1.1%
Total	93	100%

University Hospital of North Durham urgent and emergency care department

From April 2018 to March 2019, there were 55 complaints about urgent and emergency care at University Hospital of North Durham. The trust took an average of 35.1 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be 40 working days.

A breakdown of complaints by type is below:

Type of complaint	Number of complaints	Percentage of total
Patient Care including Nutrition / Hydration	25	45.5%
Access to treatment or drugs	20	36.4%
Values & behaviours (staff)	5	9.1%
Patient Care	3	5.5%
Communications	1	1.8%
Appointments	1	1.8%
Total	55	100%

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2018 to March 2019, there were 203 compliments about urgent and emergency care at the trust. A breakdown of compliments by site is below.

Site	Number of compliments	Percentage of total
University Hospital of North Durham	127	62.6%
Darlington Memorial Hospital	51	25.1%
Bishop Auckland Hospital (UCC)	10	4.9%
Peterlee Community Hospital	8	3.9%
Shotley Bridge Hospital (UCC)	7	3.5%
Total	203	100%

The main themes that run through the compliments relate to the staff going above and beyond what a patient expects them to do, supporting the patient and family during difficult times for them and taking the time to listen and explain things to patients.

All compliments that the trust receive from a patient or the family are all shared with the staff named and their managers, along with the CEO if requested to or if it is from a staff member. The trust ask that managers share the compliment with the staff on the ward or in the department.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We saw information displayed for patients and families about how to contact the Patient Advice and Liaison Service (PALS) and on how to make a complaint.

All staff we spoke with said they would try and resolve any concerns at the time they arose. Often this may be dealt with by the nurse in charge. However, staff were aware of the policy for managing concerns.

We saw from reviewing governance meetings and performance reports, complaints and compliments were a standing agenda item under patient experience. The number of complaints was monitored as well as response times and identifying any themes.

Information in the June 2019 governance report (data from April to May) showed only a small number of complaints. There were 12 in total with no real themes although actions and learning was identified in relation to communication.

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

The service had a clear management structure. Some changes had been made since the last inspection, elderly medical care had joined the care group, and this had allowed for closer working with this speciality.

There were seven senior nurses in the department who each took responsibility for different areas, for example, staffing and audits. They were supported by band six staff. The leaders we spoke with were experienced and knowledgeable.

Staff were allocated areas of responsibility for each shift. We observed the shift co-ordinator in the different areas of the department checking on staff and patients to enable them to have clear oversight of activity in the department.

The leadership team and senior staff were highly visible and approachable. Matrons visited their units daily and were involved in daily safety huddles and patient flow meetings. Senior nurses were extremely positive about the service and very proud of all the staff and the quality of the care they provided for their patients and families.

We observed the department when it was busy, and we were assured that there was appropriate oversight and management of activity by senior staff. Appropriate escalation procedures were also seen.

There was strong nursing and medical leadership in the department. From our observation and from speaking with staff, it was clear that staff had confidence in the leadership at all levels. The service ensured that there were experienced staff on every shift including night and weekends. Staff consistently reported feeling very supported by their teams and managers.

The leadership team understood the current challenges and pressures impacting on service delivery and patient care. There was evidence of actions taken and processes put in place to mitigate these.

Areas for improvement identified at the previous inspection has been addressed and built up on.

There was a focus on developing and training for staff at all levels to ensure effective leadership and improvement. This was evident from discussions with staff during the inspection.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The department was aligned to the trust strategy of 'our patients matter'. The management team had a clear vision for the service and was working with other departments within the hospital as well as local providers and commissioners to ensure services met the needs of the local populations.

The strategic plan contained appropriate planning and assessment of risk, finance, estates and communications. The management team were working to ensure that the service was sustainable for the future. Much of this was dependent on the plans for a new emergency care centre at this site.

The vision of the trust focused on, getting care 'right first time, every time'. This was to be achieved through eight key plans which included, staff, clinical services and health informatics. Information on the strategy was seen displayed throughout the department.

More local and immediate to the department, was the development of a common vision and new model of working with an estate that was suitable to operate in. This was focused around the paediatric provision. The new model had been presented to the executives and accepted as a scheme of work.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us they felt proud of their work and the care they provided to patients and their relatives. They said they felt able to raise concerns and were aware of the importance of being honest and open. They were able to explain the duty of candour and the need to apologise to patients and relatives in line with trust policy if there had been a mistake.

Managers recognised the challenges for staff working in the department, due to activity and the numbers of patients attending. Staff well-being was a key focus for the service. Staff played a key part in the strategy and vision for the service and there was a strong focus on valuing staff and their well-being when we spoke with senior staff and the leadership team.

We found the culture of the department open and inclusive. Staff of all levels felt they were valued and respected by their colleagues and managers. We asked staff about the morale of the department and they all said that morale was good despite the challenges in the department.

There was a desire from all staff to provide good care and treatment to patients. Staff were highly engaged, and we found effective systems in place for sharing information. We observed staff working well together and there were positive working relationships with the multidisciplinary teams.

Governance

Although it was noted that governance meetings had only occurred twice in 2019. There were effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The emergency department was part of the integrated medical specialities care group. The department has a governance lead who is a consultant with support from the matron. Bi-monthly

governance meetings took place between August and November 2018. However, it was noted meetings had been more sporadic in 2019 with meetings only occurring in March and July.

Monthly meetings often included a learning event, examples included, the safety checklist and discharge pathways. Governance reports were also produced which included retrospective information from the two previous months. They covered a wide range of areas from root cause analysis progress to compliments received.

From our observations and discussions with staff there were systems and processes in place to share information and learning with staff. Information was displayed on notice boards and during handovers and huddles we saw information being shared about incidents, risks or learning. This was also evidenced in team meeting minutes.

Staff at all levels were aware of their individual roles and responsibilities.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There was a divisional risk register in place. Each risk was live on an electronic system and allocated to a named lead. Each had evidence of recent review, actions and progress against actions and a target risk score.

Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact giving a red, amber, green (RAG) rating.

From our discussions with the leadership team and senior staff they were clear about key risks to the service. They talked about staffing, the environment and the paediatric service. The risk register was reflective of these risks and provided information on current mitigation. Examples included, staff supporting the department from other areas and additional paediatric staffing for staff.

The trust had a major incident policy on the trust intranet. Staff understood their roles and responsibilities regarding major incidents. The department had a major incident plan with clear guidance and action cards for individual roles in the event of specific incidents. There was a designated store for major incident equipment that contained specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials.

The governance report enabled the service to monitor and manage the performance of the department against local and national indicators. These were closely observed by the management team.

Performance was also measured by the outcomes of RCEM audits. The department contributed to a number of these. We found that performance had improved following re-audit.

We saw evidence of a range of local audit activity, this was clearly collated and shared with staff via the 'perfect ward' metrics. These metrics made areas of improvement and decline easy to identify. Local audit was also comprehensively detailed in the governance report. Performance which was shared with all staff.

Information management

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff accessed information relating to policies and guidance electronically. The system was easy to navigate.

Staff received training on information governance. Electronic patient records were in use. Some records were still paper, we found these were stored securely. We found computer screens were locked when not in use.

The department used IT systems to collect and share information such as test and x-ray results, admission and discharge times and ambulance handover times as well as patient records.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The staff we spoke with felt engagement and involved in the department and the trust. Examples of staff engagement included a staff consultation in October 2018. This considered the effect of implementing surge shifts. Positive elements were identified such as managing staff and patient safety later in the day when it was recognised that attendances increased. Following consultation surge shifts were implemented.

As there had been a number of changes to staff experience, a culture survey was conducted with staff during June and July 2019. The emerging themes were being reviewed at the time of inspection.

Monthly excellence certificates were given to staff and shared via the governance report to give recognition to staff for 'going the extra mile' or managing a difficult or challenging situation.

In 2018 a volunteer for the department won a televised 'Unsung Hero' award. The department was extremely proud, and the award demonstrated the important contribution of volunteers.

The department participated in the friends and family test and CQC surveys. In 2018 the service held a mental health patient forum to enable patients to provide feedback on their experience of acute care.

The service has sought feedback from patients and relatives that have experienced care and used these to make changes. Examples include, meeting with patients that have a learning disability and a patient with sickle cell and them visiting the department and speaking with staff. As a result of patient engagement and getting their person perspective and feedback from their experiences, changes were made.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The department was committed to improving the facilities and environment for children and their families attending the department.

We saw information about the use of Schwartz rounds, which are an opportunity for health staff to reflect on the emotional aspects of work. The next topic advertised was 'a patient I will never forget'.

A significant amount of work had been by the service since the last CQC inspection. In particular regarding patient access and flow, closer working with mental health and medicines management. Progress continued to be made with further work planned.

The department was looking at different ways of working and different roles such as pharmacy technicians.

Due to the success of ED review clinic it had been extended to five days weekly.

The Crest team audited length of stay for patients they were involved with and used this information to identify any issues to further develop their service.

End of life care

Facts and data about this service

The trust provides end of life care at two sites, Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND).

End of life (EOL) care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

EOL is provided across the organisation by many clinicians in a wide range of services and was delivered 365 days a year. Ward staff were supported by the acute specialist palliative care team and acute intervention team across both hospital sites. Both teams also provided support to patients with a life limiting/progressive illness, not limited to those with cancer. Ward staff were able to refer to both teams using the electronic patient database or by telephone.

The 'Guidance for Care of Dying Patient' guidance is used to provide support to all County Durham and Darlington NHS Foundation Trust (CDDFT) staff who provide care for dying patients and the families.

In DMH and UHND there are specialist palliative care teams who work 09:00-17:00 Monday to Friday to provide advice and support to ward teams, patients and families. The focus is on complex symptom management, end of life discharge and effective end of life care.

The acute intervention team is an innovative service providing assessment and input to critically ill patients in acute hospitals with the recognition that many of these patients will have palliative care needs. They work closely with the palliative care team and receive ongoing education and support in palliative and end of life care.

A Macmillan educator for palliative and end of life care has supported the development of an education strategy and delivers mandatory end of life education training. For registered nurses (RNs) there is a full training day 'Providing care and support to the dying person in the last days and hours'.

The community specialist palliative care service operates seven days a week, 09:00-17:00 and receives about 2,000 referrals per year. The team is located in three bases across the county.

The trust has commissioned 24/7 specialist palliative care advice from the consultant led palliative care service at Marie Curie Hospice Newcastle.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The trust had 2,032 deaths from February 2018 to January 2019.

(Source: Hospital Episode Statistics)

This report focuses on the inspection of end of life and palliative care services (medical, nursing, mortuary, chaplaincy and bereavement). Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

We observed daily practice and viewed eight sets of patient records and 'do not attempt cardiopulmonary resuscitation' (DNACPR) records and four prescription charts. During the inspection we visited surgical, medical and care of the elderly wards, and also visited the mortuary and the hospital chapel. We spoke to patients who were receiving end of life care and patients' relatives.

We spoke with 35 members of staff, which included medical and nursing staff, the specialist palliative care team, the leadership team for end of life care, chaplaincy, mortuary and bereavement staff.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills but did not ensure all staff had completed it.

At our previous inspection in 2015, end of life care training was not part of the trust's mandatory training programme.

All staff received an introduction to palliative and end of life care at trust induction sessions, which included information about the specialist palliative end of life care team, how they could be contacted, the priorities of end of life patient care, and care of the dying principles.

Manual handling training was completed as part of mandatory training for porters and staff working in the mortuary.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training, with the exception of information governance module where the target is 95%.

University Hospital of North Durham

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the end of life care department at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Conflict Resolution	5	5	100%	85%	Yes
Equality & Diversity	7	7	100%	85%	Yes
Information Governance	7	7	100%	95%	Yes
Deteriorating Patient and Resuscitation	5	7	71.4%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	4	7	57.1%	85%	No

At University Hospital of North Durham, the targets were met for three of the five mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Conflict Resolution	1	1	100%	85%	Yes
Deteriorating Patient and Resuscitation	1	1	100%	85%	Yes
Equality & Diversity	1	1	100%	85%	Yes
Infection Prevention and Control - Level 2 - 1 Year	1	1	100%	85%	Yes
Information Governance	1	1	100%	95%	Yes

At University Hospital of North Durham, the targets were met with 100% completion for all of the five mandatory training modules for which the one member of medical staff was eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Managers monitored mandatory training and alerted staff when they needed to update their training.

Mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning, disabilities, autism and dementia.

The Macmillan palliative care educator and members of the specialist palliative care service had developed a comprehensive training programme enabling staff to be trained in a three-year cycle. On line learning had been developed including capacity assessment and best interest decision making modules from the national e-learning programme ('End of Life Care for All'). Latest figures available showed 48.2% of nurses across the trust had received specific end of life and palliative care training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Specialist palliative care nurses were able to explain their responsibilities in relation to safeguarding patients. They were able to share examples of when they had needed to submit safeguarding concerns for patients in their care.

We discussed safeguarding with ward staff caring for patients approaching the end of their life, and they were able to outline their responsibilities and gave examples of recent practice. Contact details for hospital and local authority safeguarding teams were displayed on wards visited.

Safeguarding training completion rates

The trust set a target of 33% for completion of the safeguarding adults level one and 85% for completion of safeguarding children level two training modules.

University Hospital of North Durham

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	5	5	100%	33%	Yes
Safeguarding Children Level 2	1	5	20.0%	85%	No

At University Hospital of North Durham, targets were met for one of the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in the end of life care department at University Hospital of North Durham is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	1	1	100%	33%	Yes
Safeguarding Children Level 2	0	1	0.0%	85%	No

At University Hospital of North Durham, targets were met for one of the two safeguarding training modules for the one eligible medical staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding Adults level 1 is a three-year requirement for all staff; training was planned over a three-year period to ensure all staff who are allocated the competency accessed training over the three-year period.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to describe the safeguarding process and could name the adult safeguarding lead who they would contact if they had any concerns.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

All areas where palliative and end of life care were provided appeared clean, tidy and well maintained. This included wards, bereavement offices and the mortuary.

Staff in all areas followed infection control principles including the use of personal protective equipment (PPE). We observed staff using PPE such as gloves and aprons, adhering to the 'bare

below the elbow' guidance and washing their hands between reviewing different patients to help prevent the spread of infection.

Mortuary areas were well maintained, although at the time of inspection the mortuary was undergoing refurbishment to eliminate infection control risks and develop a more conducive environment for bereaved family members and friends. We returned to the mortuary later in the inspection and saw that refurbishment was progressing well through decoration, improved furnishings and the replacement of floor coverings.

The mortuary was very clean and odour free with downdraught ventilation in examination areas. Good housekeeping standards were observed throughout the mortuary. The 'Mortuary disinfection policy' (undated) gave directions for immediate direct disinfection of any leakage, spillage or contamination by any material (blood or body fluid), likely to cause infection. A 'Mortuary disinfection policy (undated) was in place for the hospital and the latest health and safety walkaround checklist (July 2019) showed the mortuary was compliant in all areas including chemicals, fire, waste, PPE and general housekeeping.

Staff were informed by wards when patients with an infection were transferred to the mortuary and these patients were identified on trust systems. We were told deceased patients with an infection were appropriately covered and completed a label to indicate the infection risk. Staff ensured deceased patients who had been confirmed to be an infection control risk were kept in a designated area. The trust had purchased a lead lined coffin, in the specific event of death due to toxic chemical poisoning.

There was a handover process for patients brought to the mortuary by porters. We saw this was completed and porters were able to explain their role.

Mortuary fridges were cleaned, and temperatures monitored daily through an electronic temperature monitoring system that alerted the estates team if temperatures were out of range.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Staff told us they could access equipment for patients at the end of life or those needing palliative care. Although the hospital did not have designated beds for palliative and end of life care, ward managers told us demand for side rooms was prioritised for end of life care.

We saw call bells were within reach for patients and we were told staff responded quickly if they needed anything.

The hospital had suitable facilities to meet the needs of patients' families, for example, private rooms where sensitive or private discussions could take place. Wards were clean, uncluttered and in good decorative order.

The trust used one type of syringe drivers to deliver pain relieving and other medication to palliative and end of life care patients. Staff told us they were able to access syringe drivers held by the central equipment library when necessary. Discharged patients were able to take a syringe driver when required and this was recovered by the hospital.

The trust developed guidelines in accordance with the NPSA Rapid Response Report; Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010, which advised that ambulatory syringe drivers should change over to devices with specific safety features. We saw all syringe drivers in use adhered to this.

Staff told us that syringe driver safety checks were completed for all patients with a driver in use. Syringe driver documentation reviewed showed that these checks were not completed in accordance with the 'Policy for the administration of subcutaneous medication' (2017) which stated safety checks must be completed every four hours. In all records we reviewed, all syringe drivers were checked between five and six hourly intervals.

Although, we were not assured through discussion with staff and managers that this training was followed up or monitored at ward level we were informed that the trust had identified robust action to ensure compliance with the policy. This included data to show 482 qualified nurses had received training in the specific syringe devices used throughout the trust.

We were told ward, department and line managers of staff who used medical devices were responsible for '...reviewing current competencies, identifying any training needs and ensuring that staff receive instruction and guidance on the use of equipment as part of the local induction process and followed by annual reviews thereafter'.

The mortuary had capacity for 25 patients designed for standard width and for bariatric patients, lifts were available to access the refrigerators. Mortuary staff told us that they had not experienced any capacity issues but could access the mortuary at Darlington Memorial Hospital if needed. The main autopsy suite was modern and spacious.

A viewing room for adults, children and babies was available and the trust confirmed the deceased was presented respectfully on a covered trolley when a viewing took place. Although this was not formally audited, the mortuary had been visited by executive and non-executive directors on senior staff walk-arounds and observations had confirmed appropriate practice was followed.

At the time of inspection, we were shown refurbishment plans and a second visit to the mortuary confirmed these were being enacted to ensure the viewing area was sensitively decorated and furnished. Following inspection, we were given further documentary evidence (video: 'Improving the mortuary and bereavement suite at UHND') that showed areas within the mortuary accessible to relatives, friends and carers had been transformed in to a sensitive and caring environment.

Staff disposed of clinical waste safely. We observed that waste was segregated appropriately between clinical and non-clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Risk assessments for each patient were completed on admission and updated when necessary. Staff shared key information to keep patients safe when handing over their care to others.

Ward staff provided care to patients requiring palliative and end of life care. Ward staff referred patients to the acute specialist palliative care team or the acute intervention team for patients who experienced complex symptoms or additional support was required to meet patient needs. Risk assessment tools were in place covering nutrition and hydration, falls and pressure care.

Referrals to the specialist palliative care team were made directly to the team or identified through the trust's electronic systems. The team had given training and education on wards that meant

staff were clear when to make a referral. Visits to the individual patient and wards were arranged and advice given.

An end of life pathway would be initiated following discussion with the patient, their family, and the multi-disciplinary team involved in their care. an individualised care plan in line with guidance for patients who are ill enough to die would be initiated.

Ward staff told us that both teams had a visible presence on the wards and support and guidance was readily available for all ward staff.

Shift changes and handovers included all necessary key information to keep patients safe. Huddles were conducted twice daily and key patient information such as care interventions, risk management and goal setting for each patient was discussed.

Access to mental health liaison and specialist mental health support was available at all times and staff completed, or arranged, psychosocial assessments for patients thought to be at risk of self-harm or suicide.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Trust level

End of life care annual staffing metrics

April 2018 – March 2019

Staff Group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours	Annual agency hours	Annual unfilled hours
Target	N/A	5%	None	4.0%			
All staff	21.0	0.1%	9.7%	5.7%			
Qualified Nurses	5.5	-5.9%	16.9%	3.1%	N/A	N/A	N/A

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within this core service at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank/agency staff use.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Trust level

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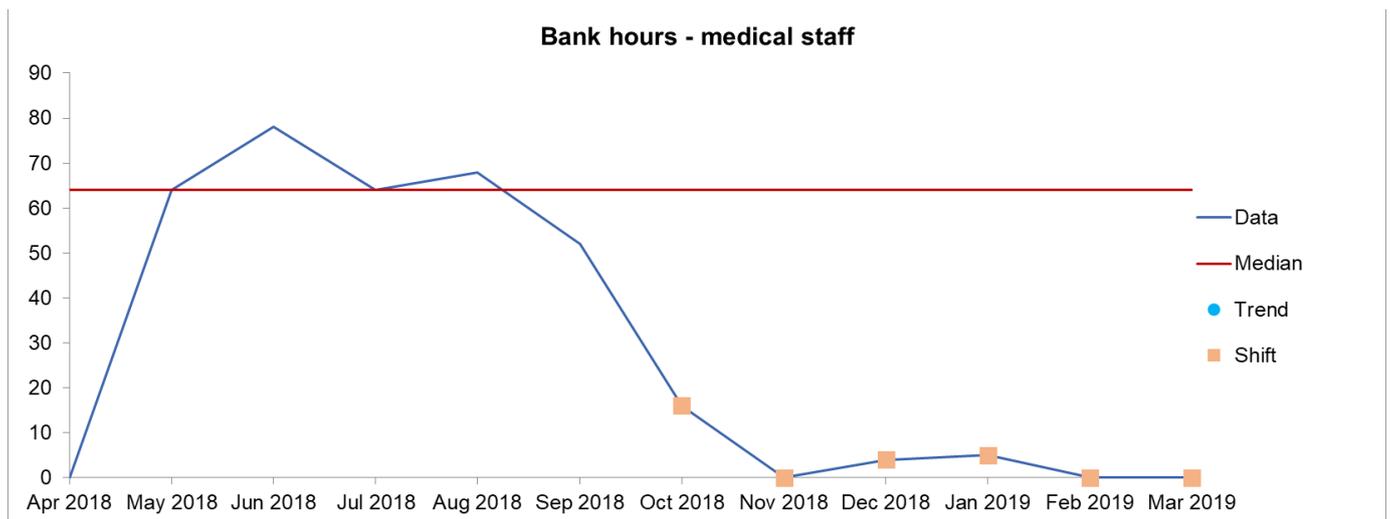
End of life care annual staffing metrics							
April 2018 – March 2019							

Staff Group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours	Annual agency hours	Annual unfilled hours
Target	N/A	5%	None	4.0%			
All staff	21.0	0.1%	9.7%	5.7%			
Medical staff	0.1	100.0%	0.0%	5.5%	351	0	22

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Medical staffing rates within this core service at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank/agency staff use.

Bank and locum staff usage



Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical Bank Locum tabs)

University Hospital of North Durham

End of life care annual staffing metrics

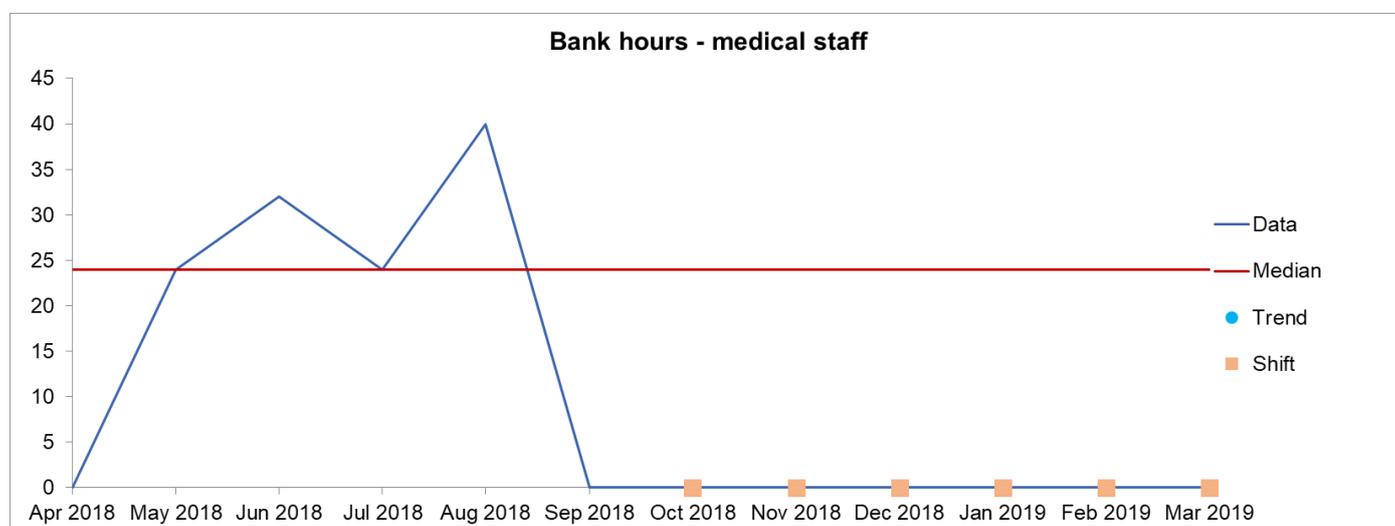
April 2018 – March 2019

Staff Group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours	Annual agency hours	Annual unfilled hours
Target	N/A	5%	None	4.0%			
All staff	9.5	2.4%	7.0%	8.3%			
Medical staff	N/A	N/A	N/A	N/A	120	0	0

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical Bank Locum tabs)

Nurse staffing rates within this core service at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and locum staff use.

Bank and locum staff usage



Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical Bank Locum tabs)

Records

Staff kept detailed records of patients' care and treatment. Records were clear and easily available to all staff providing care. However, assessments were not always kept up to date.

Care plans developed by the trust included the 'Five Priorities for Care of the Dying Person' identified in 'One Chance to Get It Right' (Leadership Alliance for the Care of Dying People, 2014). These prioritised:

- the possibility that a person may die within the next few days or hours is recognised and communicated clearly decisions made and actions taken in accordance with the person's needs and wishes are regularly reviewed and decisions revised accordingly;
- sensitive communication takes place between staff and the dying person, and those identified as important to them;
- the dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants;
- the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible; and
- an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

In line with these priorities the trust was following principles of advance care planning and recorded patients and relatives wishes and preferences, preferred place of care, do not attempt cardio-pulmonary resuscitation (DNACPR) discussions in patients' notes.

The trust used both electronic and paper-based records. We saw developments with the electronic system facilitated options for individualised care planning. Ward staff were positive about the new care plan options and were becoming more confident at navigation between paper based and electronic records. Staff told us that over time they felt the system would become easier to use and proactively sought to activate all electronic care plans applicable for EoLC patients.

The trust 'Audit of Documentation of Care in the Last Hours and Days of Life for Expected Deaths in CDDFT' (February 2018) showed:

- in 96% of expected deaths there was documentation demonstrating clinical teams had recognised the patient was dying;
- 86% of the patients who were recognised to be dying had daily monitoring of signs and symptoms;
- 96% of relatives or those close to patients and 94% of patients with capacity were involved in developing individualised end of life care plans;
- 97% of patients had an individualised end of life care plan in the notes. End of life care plans were most likely to include reference to symptom control needs and preferred care setting. They were least likely to include reference to spiritual care needs; hydration preferences and care needs after death;
- there were high levels of achievement of preferred place of death (PPD); in 96% of community cases where PPD was known it was achieved and in 76% of acute hospital cases where this was known it was achieved;
- 88% of patients had documentation to show that they had been assessed for likely symptoms. Over 80% of patients in acute hospitals had all anticipatory as required medication prescribed with clear indications;
- discussion of risks and benefits of hydration needs to improve (52% of cases). Similarly, documentation of daily assessment of hydration status needs to improve (74% of cases).

Patient notes reviewed were stored securely and all authorised staff could access them. Patient records included medication history, pain management, microbiology information, documentation

of discussions with the patient about their physical and emotional wellbeing, ongoing place of care, and discharge planning. They were updated when needed and were available when the patient transferred to a new team.

Although we did see completed mental capacity assessments and best interest decisions recorded, these were not always contemporaneous with the completion of DNACPR forms for patients lacking capacity. For some patients they had been completed by the specialist palliative care team in the two or three days following DNACPR completion. There were inconsistencies in the records we reviewed. Although care plans were individualised, nursing staff did not always record outcomes of pain assessments, plans and monitoring. Specific pain documentation was available, but use was variable across wards visited. Also, the form designed to ensure ongoing monitoring of syringe drivers was not always completed every four hours in line with trust policy.

There was a case review of each patient who had a resuscitation call, to determine if it had been an appropriate treatment and to identify lessons learnt. This was initiated by the cardiac prevention team and palliative care consultant and provided learning to wards involved, disseminated through the 'Decision making towards the end of life' consultant training and end of life training for nurses and healthcare assistants.

The hospital had systems in place to identify and prioritise EoLC patients out of hours and between primary and secondary care settings. We observed effective correspondence between primary and secondary care through the use of common documentation.

The trust participated in the regional 'Electronic Palliative Care Co-ordination Systems (EPaCCS)' enabling the recording and sharing of people's care preferences and key details about their care at the end of life. This identified quality improvement to emergency health care plans (EHCPs) to enable better patient care and outcomes. The aim was to improve the number, quality and access to EHCPs, better support patients with complex medical needs and/or a life limiting condition, ensure patients have the care and treatment they need in the right place and reduce the risk of inappropriate clinical decisions being made.

EHCPs are the regional document for communicating key information including advance decisions. The clinical lead for palliative care was chairing a task and finish group to improve the creation and communication of EHCPs across the trust area. Key actions included systems for creating EHCPs electronically within the acute and community sites, a standing operating procedure for EHCPs and clarity on competencies and training for staff.

Medicines

The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines.

Although care plans were selected on the electronic recording system, nursing staff did not consistently record outcomes in nursing and medical notes in line with the trust 'Medicine Policy' (2019).

For example, the pain care plan required the administration and monitoring of medication to be recorded, this was not done in all patient records. Similarly, records of pain assessments and re-assessments were not consistently completed.

Syringe driver safety checks were completed for all patients with a driver in use although these checks were not completed in accordance with the 'Policy for the administration of subcutaneous

medication' (2017) which stated safety checks must be completed every four hours. In all records reviewed, syringe drivers were checked between intervals of five and six hours.

Prescribers on wards used pre-defined order sets for end of life prescribing of anticipatory medicines. These order sets contained a predetermined selection of medicines in line with trust policy. When these order sets were accessed by ward staff, the patient's status was updated to EOL. This triggered an alert to the chaplaincy team. The palliative care team proactively monitored the system for patients with this status.

Although we reviewed completed mental capacity assessments (tool 1) and recording best interest decisions (tool 2), these were not always contemporaneous with the completion of DNACPR forms for patients who may lack capacity. We saw these were often followed up by the specialist palliative care team after 2 or 3 days and completed well.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff delivering palliative and end of life care understood their responsibilities to raise concerns, to record safety incidents and near misses and knew how to report them appropriately. All staff were aware of the incident reporting procedure. Outcomes from incident investigations were used as a learning opportunity and we saw discussion around incidents at team meetings. We saw good evidence of incident sharing between ward staff and end of life teams and lessons learnt.

We reviewed the last four incidents recorded which were specific to end of life and palliative care and saw these related to medication incidents (two), delay in obtaining a service (one) and unsafe discharge (one). None of these incidents were recorded at UHND.

Staff told us that serious incidents were investigated with the involvement of relevant staff. We saw discussion of serious incidents within the minutes of end of life care governance minutes.

Staff we spoke with showed understanding about the duty of candour regulations, they understood their responsibility to be open and transparent. They gave us verbal examples of when they had used duty of candour and we saw duty of candour was included in the incident reporting policy.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to March 2019, the trust did not report any never events for end of life care.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning with their staff about never events that happened elsewhere.

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from April 2018 to March 2019.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety.

Safety thermometer data was displayed on wards for staff and patients to see.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Ward managers told us that electronic dashboards were maintained to collate key data for each ward. We saw dashboards recorded monthly end of life and palliative care referrals as well as incident numbers, rapid discharge, complaints and compliments, end of life training targets and coding accuracy.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Policies were available to access on the trust intranet and included care pathways and guidance which reflected national evidence based best practice and guidelines.

Nursing staff had received training which enabled them to treat patients with a mental health condition and liaised with the psychiatry team daily in such cases. Staff knew how to refer to the drug and alcohol service, should they need to do so. At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers. Staff protected patients subject to the Mental Health Act and followed the Code of Practice to protect their rights. The palliative care team worked closely with ward-based link nurses for end of life care.

The trust end of life care strategy was developed in line with 'The National Palliative and End of Life Partnership' and 'National Ambitions for Palliative and End of Life Care', which outlined eight ambitions of care. Two of the foundations for ambitions included education and training and personalised care planning. The trust responded to personalised care planning with the recent development of an electronic care plan, which supported nursing staff to select bespoke outcomes for patients reaching end of life. The care plan was developed in line with the 'Deciding Right' initiative and the five priorities of care within the 'One Chance to get it Right' publication.

Additionally, the trust used 'Guidance for care of patients ill enough to die' (2014) to guide clinical teams in the priorities for end of life care. This document was introduced following the discontinuation of the Liverpool Care pathway and is aligned to the National Institute for Health and Clinical Excellence (NICE) quality standards for care of the dying in the last days of life. This consists of four quality statements which relate to assessing signs and symptoms, individualised care, anticipatory prescribing and hydration. These quality standards were used to audit clinical practice and outcomes in care settings within the trust.

In addition, guidance relating to mental health and specifically capacity and consent during end of life care was provided by trust policies, developed in line with the Mental Health Act.

Staff conducted multi-disciplinary team huddles in which key clinical information was shared to enable individualised outcome planning for patients.

The end of life steering group participated in the ratification of clinical policies and the review and development of new guidance for palliative and end of life care.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff understood the importance of nutrition and hydration in palliative and end of life care and made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs.

We saw staff completed patients' fluid and nutrition charts and evidenced mouth care for those patients unable to tolerate fluids. The trust used a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Patient records showed that staff followed MUST scoring for nutrition and hydration appropriately. Patient's nutrition and hydration needs at the end of life were identified and managed as part of the electronic care plan system. Specialist support was available from dieticians and speech and language therapists for patients who needed it.

The results of the first round of the 'National Audit of Care at the End of Life' (2019) showed the trust scored lower (39%) when compared nationally (61%) for documented assessments of nutrition between recognition and time of death. Hydration was also lower at 55% compared to 75% nationally.

The trust had developed action plans to ensure quality outcomes are monitored but it did not show agreed timescales for action.

Pain relief

Staff did not assess and monitor patients regularly to see if they were in pain and gave pain relief in a timely way.

Pain assessments were inconsistently documented for palliative and end of life care patients across wards visited. We saw documentation specific to pain assessments were used on some wards and on others we saw no evidence of pain assessment.

We reviewed the electronic pain care plan and saw that guidance was to '*...administer medication and monitor*'. Records reviewed showed no evidence of monitoring specific to pain management and we were not assured monitoring of syringe drivers (every four hours) was taking place in line with trust policy ('Policy for the administration of subcutaneous medication', 2017).

We saw the trust used an alert system for anticipatory medicines. This ensured immediate recognition that these medicines were prescribed. Prescribers on wards used predetermined selection of medicines order sets for end of life prescribing of anticipatory medicines. However, ward staff told us that dispensing of these medicines was not prioritised for those patients for whom they were prescribed.

Automatic alerts were sent to the palliative care team and chaplaincy staff to inform them when the patient's status was updated to end of life. The palliative care team proactively monitored the system for patients with this status. The use of anticipatory medicines sets removed the need for completed prescription charts.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers used information from the audits to improve care and treatment.

National Care of the Dying Audit (2014)

The trust participated in the National Care of the Dying Audit (published 2014). This measured performance against organisational and clinical key performance indicators (KPIs). The trust

achieved KPI 5 - clinical protocols for the prescription of medications for the five key symptoms at the end of life.

However, the trust did not achieve any of the other six KPIs - care of the dying: continuing education, trust board representation and planning for the care of the dying, formal feedback processes regarding bereaved relatives and family, access to information relating to death and dying, access to specialist support for care in the last hours or days of life, clinical provision/protocols promoting patient privacy, dignity and respect up to and including after the death of the patient.

The trust performed below the England average and failed to meet any of the ten clinical key performance indicators.

In response the trust developed an action plan that addressed issues raised following the audit, including the recruitment to an end of life care educator post, the appointment of a non-executive director to take the lead on end of life care and the implementation of regional 'guidance for care of patients who are ill enough to die'. At the time of our inspection in 2015 the 'guidance for care of patients who are ill enough to die' had been implemented but other actions had not been completed.

End of Life Care Audit: Dying in Hospital (2016)

The trust did not participate in the End of Life Care Audit: Dying in Hospital 2016.

(Source: EoLCA – End of Life Care Audit – Dying in Hospital)

National Audit of Care at the End of Life (2019)

The trust took part in the National Audit for Care at the End of Life (NACEL), a three-year project commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

The audit focused on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. The audit changed from the End of Life Care Audit: Dying in Hospital.

Summary scores for the trust were calculated against recognising the possibility of imminent death 9.2 (national summary score 9.2), communication with the dying person 6.1 (6.9), communication with families and others 5.0 (6.6), involvement in decision making 8.2 (8.4), needs of families and others 5.0 (6.1), individual plan of care 6.3 (7.4), families and others experience of care 6.4 (7.1), governance 10.0 (9.5) and workforce/specialist palliative care 5.0 (7.6).

The results from the first round of the audit indicated that the trust performed better than the national summary score in two out of nine areas and worse in the other seven areas. The following actions had been identified:

- Guidelines developed to support clinical staff in assessment, discussion and documentation of hydration and nutrition requirements of individual dying patients.
- Palliative care service will ensure all wards are using 'Care of Dying Guidance' and will support ward doctors and nurses to improve conversations and documentation.

- Guidelines developed to support clinicians in what should be said and documented in relation to common side effects of medications used at end of life.
- Electronic care plans developed to support end of life care.
- Development of end of life ('comfort') observations on electronic system.
- The palliative care service will work with the new medical examiner to identify cases where the possibility of dying was not recognised early enough or where there was a lack of escalation planning which had a negative impact on care.
- The palliative care service will work with the new medical examiner to create a process for rapid feedback and support for staff

The 'Palliative Care Annual Report' (2019) acknowledged the audit results '...will be used as a focus for education and to guide system improvements. Several changes have already been made and others will follow over 2019'.

These included:

- increase in the involvement of end of life and palliative care from below 20% (2015) to above 40% (2018) for dying patients, the highest rate of care involvement in the region;
- fewer patients dying each year in the hospital. Public Health England uses 'death in usual place of residence' (DIUPR) as a high-level marker of effective palliative care provision (51.8%, England average 46.8%);
- worked jointly with the Public Health Department of the local council and local university to conduct a postal questionnaire (views of informal carers, evaluation of services (VOICES)) of bereaved relatives that is used nationally to understand more about people's experience of end of life care;
- developed a palliative care dashboard for key elements of data to be monitored monthly;
- developed combined incident and complaint analyses to provide insight into the issues that require improvement. This has been used in conjunction with the national audit data and the responses from VOICES to inform the action plan for palliative care.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

From April 2018 to March 2019, 100% of staff within end of life care department at the hospital received an appraisal compared to a trust target of 95%.

University Hospital of North Durham end of life care

Staff group	April 2018 to March 2019
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	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Add Prof Scientific and Technic	5	5	100%	95%	Yes
Additional Clinical Services	4	4	100%	95%	Yes
Healthcare Scientists	4	4	100%	95%	Yes
Administrative and Clerical	1	1	100%	95%	Yes
Allied Health Professionals	1	1	100%	95%	Yes
Total	15	15	100%	95%	Yes

From April 2018 to March 2019, 100% of staff within end of life care department at University Hospital of North Durham received an appraisal compared to a trust target of 95%.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The Macmillan palliative care educator and members of the specialist palliative care service had developed a comprehensive training programme enabling staff to be trained in a three-year cycle. On line learning had been developed including capacity assessment and best interest decision making modules from the national e-learning programme ('End of Life Care for All').

The end of life and palliative care education strategy identified competence levels for four distinct groups of staff - those working entirely focused on the care and support to the dying person, staff who frequently deal with the care and support for the dying person, staff working within other services who are infrequently involved with the care and support to the dying person, and staff working within ancillary and non-clinical support services who are infrequently involved with the care and support for the dying person.

The palliative care team had attended advanced symptom management (two-day conference, 2018 and 2019), advanced communication course, non-medical prescribing and clinical skills. The palliative care team participated in quarterly Macmillan countywide meetings. The strategy also identified competences for staff who frequently deal with the care and support for the dying person involving role specific training designed to be delivered to 85% of staff by 2021.

Training to the other identified groups of staff was delivered through core mandatory training. In addition, education was provided around principles and competences for the care and support for the dying person and those closest to them as part of 'Deteriorating Patient and Resuscitation' and 'Acute Illness Management'. The Acute Intervention Team had delivered 124 hours of teaching on wards to 819 staff since April 2019 on palliative care, including the rapid discharge flow chart, who to escalate to in and out of hours, symptom control and management, the contents of support files on wards and the 'Care of the Dying' and 'Care after Death policy' (2018).

Latest figures available showed 48.2% of nurses across the trust had received specific end of life and palliative care training. Link staff had completed specific end of life training enabling them to support staff on the wards. In addition, the trust had plans to include end of life training as part of mandatory training. There was a rolling education programme with 24 palliative care link nurses across UHND and community hospitals with four sessions each across the year. This forum was used to disseminate information and offer shadowing opportunities within the specialist palliative care team.

Specialist palliative care and acute intervention staff provided ward staff with complex symptom control advice and end of life care planning and nursing care. End of life and palliative care training sessions were held on wards visited. Ward staff were encouraged to attend these events

which included symptom management and presentations for professional colleagues such as hospice and ambulance providers.

The medical devices team had also delivered trust wide training for the competent use of syringe drivers. Although large numbers of staff had attended the training, staff competence was not monitored or re-validated.

The chaplaincy team were all appropriately experienced, including specialist knowledge in areas such as child and adult death and bereavement, issues around faith and ethical issues. They also provided training to staff and external organisations including ethics and bereavement and contributed to trust induction.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The electronic database system enabled ward staff to submit electronic referral to colleagues within the hospital. This included the palliative care team, acute intervention team, mental health and chaplains. Ward staff told us these professional colleagues were visible on the wards and we saw teams working together to proactively support effective care planning and treatment delivery.

Ward staff told us that all referrals and requests for patient's reviews were addressed, even if the patients had not been identified as approaching end of life. We saw teams supported each other to ensure the needs of each patient were met. Staff referred patients to allied health professionals such as occupational therapists and speech and language therapists to ensure that their individual needs were met.

We saw examples of effective multidisciplinary working on wards, discussions and treatment planning was a collaboration of different professionals working together to enhance patient care.

Ward 'huddles' were used at the start of each shift to discuss individual patient care planning. We saw discharge co-ordinators were integral to these meetings specifically at the end of life when patients preferred place of death was not the hospital. The hospital had clearly defined the role and responsibilities for the palliative care discharge facilitator including effective communication, documentation, liaison with other agencies, support ward discharge facilitators, facilitate link nurse training, and to be visible on wards on a daily basis.

Acute and community staff worked together to ensure patients' needs and wishes were met. For example, palliative medicines in community pharmacies were routinely reviewed to ensure smooth discharge planning from the hospital. The hospital had systems in place to identify and prioritise EoLC patients out of hours and between primary and secondary care settings. The community Macmillan nurse specialist service provided care seven days per week (9am to 5pm).

We saw palliative and end of life steering group meetings involved staff from other areas, such as safeguarding, pharmacy and local ambulance providers. Learning and consistent practice was shared, and policies reviewed.

Seven-day services

Key services were available seven days a week to support timely patient care.

The palliative care team was available five days a week and their role complemented by the acute intervention team in the evenings and at night. At weekends and out of hours a telephone service was available to provide consultant advice and support from a local hospice. Staff were aware of this service and we saw information leaflets on the wards we visited.

During weekdays, consultants, doctors and nurse specialists reviewed patients daily. At weekends, reviews were conducted by nurse specialists.

Following the last inspection in 2015, community specialist palliative care teams had been extended to provide seven-day support services.

Mortuary staff did not work evenings or weekends but were on call to attend if a body needed to be released during these periods. They told us they did not have any problems releasing a body in a timely manner if all paperwork was complete and were able to meet the needs of those faiths requiring prompt burial. Chaplaincy services provided 24-hour cover and aimed to respond within one hour, out of hours.

Radiology and pharmacy services were available out of hours, either directly or on an on-call basis, and allied health professionals such as physiotherapists were available at the weekend.

Ward staff told us that an additional ward huddle was held on a Friday to ensure patients requesting to die at home were clearly identified and appropriate discharge arrangements were made.

Health promotion

Staff gave patients practical support to help them live well until they died.

We saw relevant information promoting healthy lifestyles and support on every ward and staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The service promoted the national 'Dying Matters' week each year involving particular events at the hospital, encouraging both patients and staff to discuss death and dying, and also highlighting the work of other services such as local hospices.

We saw Macmillan support centres were based in both hospital sites and were staffed by volunteers offering leaflets and guidance for patients and their relatives in a range of subjects, including emotional, financial and therapy information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Mental Capacity Act and Deprivation of Liberty training completion

University Hospital of North Durham

The trust set a target of 33% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at University Hospital of North Durham for qualified nursing staff in end of life care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	1	3	33.3%	33%	Yes

In end of life care, the target was met for the MCA/DOLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at University Hospital of North Durham for medical staff in end of life care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	1	1	100%	33%	Yes

In end of life care, the target was met for the MCA/DOLS training module for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLs). DoLs can only be used if the person will be deprived of their liberty in a care home or hospital.

We looked at the trust's policies for consent and mental capacity act, including DoLs. We found that these were in date and contained appropriate references to legislation such as the mental capacity act, equality and diversity and the human rights act. Specialist end of life care staff told us that mental capacity act and deprivation of liberty safeguards training was part of a mandatory training programme which was managed centrally.

At the time of inspection mental capacity assessments and decision-making tools were not part of the electronic records system. Staff recorded assessments using the designated MCA 1 and MCA 2 forms, nationally recognised documentation.

In some cases, DNACPR forms had been completed on admission and a mental competency carried out within the following two or three days. We discussed with the leadership team who explained that this enabled a temporary lack of capacity to be taken in to consideration. The trust continued to provide DNACPR training as part of all medical teaching and had revised the competency framework for nurses to undertake DNACPR decisions and had increased the number of nurses competent to undertake these discussions.

The mortuary had developed a leaflet explaining the consent process for retention or disposal of organs and tissues following a post-mortem. This was developed in 2018 with input from histology, mortuary and bereavement teams and the coroner service and with support and advice from the director of infection prevention and control. This was used to provide simple and clear information for families relating to the consent process for retention of material following a post-mortem.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Ritual washing facilities were available for those families wishing to use them.

We observed interactions between staff, patients and relatives and saw patients were treated with dignity and respect. Staff were polite and professional and responded well to emotional and pain needs of individual patients quickly and in an appropriate way. Staff discussed patients with complex needs in a respectful, non-judgemental way and confidentiality was maintained at all times. Patients said they knew the plan for their care and where appropriate, had spoken with staff about their preferred place of death.

All patients said their care had been good. An example given by one patient (ward 42) was when she had been unable to attend her son's wedding. Staff had arranged for her wedding outfit to be brought to the ward. The patient dressed for the wedding and the ceremony was streamed live to the ward allowing the patient to fully participate.

Porters told us they had received moving and handling training on how to sensitively transport a deceased patient to the mortuary. They knew how to use protective equipment, and how to book the patient in on arrival. However, they told us that they had not received specific end of life care to support bereaved relatives and carers.

The trust had developed a cross-site porter standard operating procedure (SOP) with support from multiple teams including the mortuary, porter and ambulance services across the trust to ensure consistency in handling the deceased.

Bereavement services gave advice on obtaining a death certificate, funeral services, mortuary services and administration procedures. Patient's property was returned through the bereavement services team when necessary, to avoid relatives having a potentially upsetting visit to the ward.

Emotional support

Staff always provided emotional support to patients, families and carers to minimise their distress. They always understand patient's personal, cultural and religious needs.

Staff had received training to be prepared for a range of emotions according to a person's reaction, and ensure all interactions were conducted as sensitively as possible. This included breaking bad news.

Chaplaincy staff provided emotional, practical and spiritual support to both staff and patients. This included sitting with patients when a visit had been requested and offering their services to all patients identified as nearing the end of their life.

Families and patients described a caring and compassionate workforce. Feedback we received during inspection was very positive and families told us ward staff were 'amazing' and 'could not do enough'.

Nursing staff told us that side room availability was limited but where possible patients reaching end of life were prioritised. Where side rooms were not available patient's families said care was delivered in a sensitive and dignified manner. Comfort packs were provided for families visiting the wards and included free parking permits, overnight provision if families wished to stay at the hospital and refreshments.

We visited the mortuary viewing room which was being renovated, for example, laying a new floor. On our first visit the room was not presented in a sensitive way that considered the needs of families and carers visiting their deceased. We raised these concerns with staff at the time of inspection and measures were taken immediately to enhance rooms for families at the hospital.

We returned later in the inspection and saw renovation work had progressed, rooms were sensitively decorated and the room for the presentation of the deceased had been transformed into a welcoming and calming environment.

Results from the most recent bereaved relatives survey (January - July 2017) showed 66% of families felt that dignity and respect was always provided and 93% felt that family were supported after death in a sensitive manner. Further, 92% said they had received support regarding feelings about illness and death from other services, for example, bereavement services.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients said the ward and palliative care teams were very supportive and answered concerns thoroughly. Wards did not limit visitor access for patients nearing the end of life, open visiting times were in place.

We were told that the team and ward staff had been very caring and had involved patient's families at every opportunity. Staff supported patients to make advanced and informed decisions about their care.

Families gave feedback on the service and their treatment, and staff supported them to do this. Results from the most recent bereaved relative's survey showed 86% of respondents felt that they were involved in decisions about their care. Additionally, 90% of respondents felt that death occurred in the right place and 81% felt as involved as possible in the decisions regarding end of life care.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

End of life services were planned to meet the needs of the local population and ensure patients received co-ordinated care accessible and responsive to people's needs. There was good partnership working between the hospital and community teams, local hospices, primary care providers and the ambulance service.

The trust had developed integration of the community and acute palliative care teams to ensure a seamless flow between settings with trust systems identifying palliative patients newly admitted to the acute setting. Medical palliative care staff worked across hospital, hospice and community settings. 'Deciding Right' documentation was used within both the acute and community settings to support patients and their families to make decisions right for them. There was recognition that sharing information to appropriate services, for example ambulance services, was crucial for an effective service.

The mortuary management team was accountable for securing services for the deceased throughout the trust and across agency boundaries and had developed a multi-agency mortuary group. The primary responsibility of the group was to ensure effective end-to-end care for the deceased and their family were in place and monitored. The group included representatives of coroner's officers, funeral directors, the patient reference group, crematoria and the registry office.

The second trust annual palliative care symposium was held in May 2019 attended by 129 delegates. Emphasis was placed on the end of life care strategy, the ambitions to achieve the strategy (each person seen as an individual, fair access to care, maximum comfort and wellbeing, co-ordination, all staff prepared to care and each community prepared to help) and included input from chaplaincy services. Evaluation showed 96% of attendees recommended the event.

The trust was working with the local clinical commissioning group (CCG) to improve the creation and delivery of emergency health care plans as well as exploring the use of treatment escalation plans to support individualised care plans for patients nearing the end of life. The development of protocols to improve the sharing of advance care planning with the local ambulance service for patients at home and in care homes was progressing.

The trust was continuing to reduce the number and proportion of cardiac resuscitation attempts that could have been avoided with better assessment and care planning. This had been improved through the initial introduction of the new format for end of life care planning on the electronic record system. These were supported through the trust promoting guidance for the care of the dying patient with an education and communications programme.

The trust provided end of life care in all ward settings with medical, nursing and allied health professional teams supported by the specialist palliative care team (SPCT) and the acute intervention team to deliver the best possible end of life care.

The trust had appointed a lead medical examiner to create a more effective and robust mechanism for death certification in the hospital. The palliative care service will work with the examiner to develop ways for more immediate feedback from bereaved relatives and more directed service improvement.

There were no visiting restrictions on the wards for friends or family of those receiving end of life care, arrangements were made for relatives who wished to stay overnight.

The service had worked to improve delays in the completion of death certificates and mortuary staff investigated any delays and documented actions taken.

The trust was a member of the regional palliative care partnership and had improved the implementation of the 'care of the dying patient' document and training and dissemination of information for the 'Deciding Right' initiative.

The acute intervention team provided assessment and support to deteriorating patients in hospital. Trust figures showed 50% of patients seen by the team had palliative care needs and where needed, acute treatments were delivered to make people better. The acute intervention team were trained to recognise and manage end of life and palliative care needs and worked closely with ward staff to deliver these, especially during out of hours.

Public Health England uses 'death in usual place of residence' (DIUPR) as a high-level marker of effective end of life and palliative care provision (51.8%, England average 46.8%). The trust was improving on this measure, each year fewer patients were dying in the hospital and better than the England average.

Staff told us they found it easy to refer a patient to the palliative care team who visited new patients the same day. The team provided specialist advice, either on the ward or through telephone advice. The team's assessment of a patient covered physical issues such as pain relief, nausea and mobility, their reaction to the deterioration of their condition, where they might prefer to die and how they were coming to terms with their prognosis.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff moved dying patients to a single room as soon as possible to ensure patients' privacy and dignity and to enable relative's overnight accommodation if needed.

The chaplaincy team visited patients when notified by ward staff or the trust electronic record system. During visits, the team spoke to patients and their families about the support they offered, left them contact details and recorded their visit in the patient's notes. Chaplaincy staff supported people's spiritual needs regardless of faith, including the needs of staff. The chapel had facilities for many faiths including, amongst others, Christian, Islam (Wuḍū' and ablution) and identified the Qibla (the direction that should be faced when a Muslim prays during ṣalāh).

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Trust electronic record systems identified patients with needs related to patients with mental health problems, learning disabilities and dementia. Staff contacted a specialist learning disabilities nurse when needed.

The trust had developed a mental capacity act team to provide support to staff to understand their duty of care within the principles of the MCA. Full day training on the principle of the Mental Capacity Act and Deprivation of Liberty safeguards (DoLS) had been provided to build staff understanding.

The trust had developed a clinic-based service accessible to patients with lymphoedema who may or may not have end of life or palliative/diagnoses.

Ward staff told us there was a learning disabilities team who were available for support and guidance, and who would work alongside patients and relatives, for example to support with communication needs. Members of the learning disabilities team attended monthly multi-disciplinary team meetings.

Staff understood their responsibilities on meeting the information and communication needs of patients with a disability or sensory loss. Individual mobility and communication needs were assessed within an initial nursing assessment which all patients received and documented in an individual care plan. Staff, patients, relatives and carers received help from interpreters through telephone or direct contact.

Bereavement services staff provided booklets in a range of other languages and accessed telephone or face to face translation services if needed. Computer tablets were available to them to provide an internet linked BSL signing service and they had not experienced any problems with availability of this or any other translation services.

Families were provided with free parking passes and volunteers had created syringe driver bags to maintain privacy and dignity and memory bags to hold important jewellery to hand over to families when their relative dies.

Public Health England uses 'death in usual place of residence' (DIUPR) as a high-level marker of effective end of life and palliative care provision (51.8%, England average 46.8%). The trust was improving on this measure, each year fewer patients were dying in the hospital and better than the England average. The trust's unscheduled care service had improved access to palliative assessment and management for patients dying at home.

The trust had supported improvements in provision of end of life and palliative care medicines during out of hours period. This has resulted in the use of anticipatory medicines, updates to the palliative care medicine stock list, an electronic version of the palliative care alert system and the development of a palliative care pharmacy network.

Palliative care discharge coordinators had developed rapid palliative discharge guidance which enabled same day discharge. Staff were able to use this guidance for discharge even when the coordinators were not on duty. To support this the trust had developed prescribing sets for anticipatory medicines and combined these with the discharge process to ensure that more palliative patients were discharged with medicines for symptom control at home.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Patients for end of life and palliative care were identified through a multidisciplinary discussion involving those involved in a patient's care on the ward, either directly with the specialist palliative care team or through the trust's electronic record system.

Once a referral was received the team assessed the patient to determine the level of support required. Specialist palliative care nurses reviewed and triaged all referrals. Where necessary patients were also referred for a review by a palliative care consultant. Patient's notes were reviewed by the team and a specialist nurse reviewed the patient's pain relief and began arrangements for discharge. Ward staff said they had received good support from the palliative

care team when arranging discharge. Discussions about the patient's preferred place of death took place as soon as was practicable and documented in the patient's notes.

The trust 'Audit of Documentation of Care in the Last Hours and Days of Life for Expected Deaths in CDDFT' (February 2018) showed there were high levels of achievement (76%) of preferred place of death (PPD). This had increased to more than 90% for seven of the last twelve months before inspection. The specialist palliative care service had improved personalised care planning and supported preference for place of death for 95% of patients known to the service in 2018.

Three palliative care training fellows were now in post (two new consultants joined the palliative care service in 2018) providing increased capacity in end of life and palliative medicine and developing potential future consultants in palliative care for the county. These appointments had resulted in an increase in the involvement of end of life and palliative care from below 20% (2015) to above 40% (2018) for dying patients. The trust now provided the highest level of end of life and palliative care involvement to dying patients in the region.

The training fellows supported the palliative care specialist nurses and non-palliative teams in the hospital and community. The service had been recognised as more cohesive and comprehensible as a result. Continued support for the training fellows had been identified to prepare applications to join the palliative medicine specialist (consultant) register.

The trust was now able to provide an end of life and palliative care service 24 hours a day, supported by continued funding of out of hours palliative care advice for all clinicians (including hospices and care homes) in the county, delivered by a local hospice.

The trust had worked with CCGs to adopt and fund the 'six steps' programme for palliative care in care homes to facilitate discharge. Community matrons and the community specialist palliative care service continued to improve palliative planning. To help community discharge the trust funded consultant and middle grade medical posts at local hospices and prisons.

The trust had developed the cardiac arrest prevention (CAP) team in response to research that identified cardiopulmonary resuscitation (CPR) is only successful in a proportion of previously well people and does not work when people are naturally approaching the end of their lives. The team and palliative care consultant worked collaboratively to review CPR attempts in the trust and identify attempts that might have been avoided by better advance planning. The number of overall CPR attempts (total cardiac arrests) and proportion where CPR could have been avoided with better planning had both decreased over recent years.

A trust plan for improvement in capacity assessment and best interest decision making had been developed supported by a palliative care mandatory education programme in decision making for all staff.

Learning from complaints and concerns

Summary of complaints

Trust level

From April 2018 to March 2019, the trust received three complaints in relation to end of life care at the trust (0.5% of total complaints received by the trust). The trust took an average of 23.3 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed in 40 working days.

A breakdown of the three complaints by location and type is shown below:

Location/site	Type of complaint
Darlington Memorial Hospital	Facilities
Darlington Memorial Hospital	End of life care
University Hospital of North Durham	Patient care

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

A combined incident and complaint analysis had been developed to identify issues that require improvement. This has been used with national audit data and the responses from VOICES to inform the action plan for end of life and palliative care.

Number of compliments made to the trust

From April 2018 to March 2019, there were 11 compliments about end of life care at the trust. One of these was for trust wide end of life care and the other ten were for Darlington Memorial Hospital bereavement office. All compliments were recorded in March 2019.

The main themes relate to staff going above and beyond what a patient expects them to do, supporting the patient and family during difficult times and taking the time to listen and explain things to patients.

All compliments received from a patient or family are shared with named staff and their managers, along with the chief executive, if requested. Managers were encouraged to share compliments with staff on wards.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills, knowledge, experience and integrity to run a service providing high-quality sustainable care.

The end of life care service reported to the executive director of nursing and had a direct link into the trust board. The board received progress reports from the end of life care services team led by a consultant in palliative care. A designated non-executive director ensured independent scrutiny to the end of life care service.

The team spoke positively about the impetus and motivation the restructuring of end of life care services within the trust had received since our last inspection. The team was well established with experienced staff that provided clinical and professional leadership. This included a clinical director, palliative care lead consultant, associate director of nursing, associate director of operations, clinical services manager, lead nurses and lead clinicians.

Staff were well supported in their roles and had a clear understanding of their responsibilities and told us leaders were visible and approachable. Ward staff told us that the specialist end of life and palliative care team were well known, accessible and provided expertise and advice when needed.

Clinical leadership in the specialist palliative care service had been strengthened by the appointment of two new consultants (one shared with a local hospice) in 2018. Senior clinicians had engaged with other non-palliative teams (within and outside the organisation) to enhance the understanding of end of life and palliative care and supported improvements in the service for patients and families.

The end of life steering and palliative care group had delivered improvements and continued to provide direction and vision for end of life and palliative care improvement. For example, the group had appointed two consultants, improved clinical working relationships with local hospices with joint meetings and shared appointments and was developing mechanisms for communicating more effectively with the health and wellbeing board.

The steering group was also developing plans for the following:

- next end of life and palliative care strategy;
- improvements to governance links between specialist end of life and palliative care and trust care groups;
- increases to end of life and palliative care support for bereavement and mortuary services;
- creation of mechanisms for bereaved relatives to have the opportunity to share their stories in staff education.

Meetings were attended by the executive director of nursing, consultants in palliative care, lead nurses, clinical services manager and Macmillan educator. The steering group met every two months and minutes showed it discussed operational issues (for example, modification of discharge letter, funeral costs, palliative care calls and response times, palliative care and end of life dashboard, palliative care telephone advice, mortuary signage), education and training (for example, syringe driver training, end of life education, opioid and driving patient information) and strategy (for example, end of life strategy, NACEL, dying matters awareness 2019, VOICES report and actions).

Vision and strategy

The service had a strategy in place for providing end of life care.

The trust 'End of life and Palliative Care Strategy 2016 – 2019' recognised that the trust is the largest provider of end of life and palliative care services in the county and provided care to most of the people who die in the county and specific palliative care to about a third. The strategy aimed to implement improvements identified by national audit and recommendations from regulators to improve care for patients and families. The strategy aimed to use advances in information, quantitative measures and feedback from incidents and surveys, to identify areas for improvement and demonstrate excellent care for patients at the end of their lives.

The end of life steering and palliative care group annual progress report (2018-2019) acknowledged that the strategy had facilitated '...substantial improvements in the palliative care of patients and helped our staff to be more confident and able to care effectively'.

The trust vision, strategy and work plan were based upon the national Palliative and End of Life Partnership framework '...for local action to achieve for everyone what we would want for our own families' and its eight key foundations:

- personalised care planning;
- education and training;
- evidence and information;
- co-design;
- shared records;
- 24/7 access;
- involving, supporting and caring for those important to the dying person; and
- leadership.

Culture

Staff promoted a positive culture of providing quality end of life care which was reflected by leaders in the trust.

We met with the senior leadership team and separately with members of the end of life and palliative care team, hospital and community nurses and healthcare assistants and palliative care consultants. Everyone was positive about the leadership, strategy and organization of end of life and palliative care services at the hospital and throughout the trust. There was universal recognition that the trust had made improvements to end of life and palliative care since our previous inspection. Staff told us the trust was now a rewarding place to work in end of life care and recognised the contributions made by clinical leadership.

Ward staff articulated that end of life and palliative care was the responsibility of every member of staff. This was supported by the availability of the palliative care team, the acute intervention team and the out of hours advice line. This support was underpinned by end of life champions, education and training. Culture centred on the needs and experience of people who used the end of life and palliative care service.

Staff working in the mortuary and bereavement services had positive attitudes to their role and respected the service they gave to families and carers at a sensitive time. They told us the trust

had listened to their concerns about the mortuary and bereavement office at the hospital and provided funds to ensure an appropriate environment.

Porters had received training in moving and handling deceased patients and had developed good relationships with ward and mortuary staff to ensure the deceased patient was moved with respect and dignity.

Governance

There was a governance structure in place with processes and systems of accountability to support a sustainable service.

The end of life and palliative care team used audits to give oversight of their progress and position against strategy and targets. Audits of prescribing, use of the 'care of the dying patient' document, recording of patients' preferred place of death and rapid response discharge planning were all regularly completed.

The end of life steering and palliative care group provided direction and vision for end of life and palliative care improvement. Meetings were attended by the executive director of nursing, consultants in palliative care, lead nurses, clinical services manager and Macmillan educator.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and a good quality sustainable service. End of life and palliative care services was part of the community services care group and reported to the board through the care group's governance structure. The steering group met every two months and minutes showed it discussed operational issues, education and training and strategy. The group provided their minutes and an annual progress report to the trust board. The group was chaired by the executive director of nursing.

Improvement in the understanding of palliative care among hospital staff and increased input from the specialist palliative care team was demonstrated through coding of palliative care now being the highest in the region (previously second last).

Staff were clear about the service vision and their role in delivering the strategy. Leaders were aware of priorities for the service, such as achieving preferred place of care for patients, identifying patients who require end of life care and personalised care planning.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and demonstrated the ability to cope with both the expected and unexpected.

The trust used the board assurance framework (BAF) to capture and monitor action plans for board and executive level risks ('strategic risks'). In addition, each directorate and care group had its own operational risk register.

The trust did not maintain a separate 'corporate risk register'. All risks were managed by care groups and directorates on a risk management system. When reporting to the risk management committee, risks were reported by those where the current score was outside the trust's risk tolerance level set by the board.

The end of life and palliative care team did not hold its own separate risk register, and risks were held on the wider Community Services Risk Register. There were two risks related to end of life on

the directorate/care group risk register, i.e. gaps in compliance around the application of the MCA, and mortuary facilities not up to the required standard.

End of life and palliative care services had been asked to input into increased compliance of the former, and mortuary facilities were being updated at the time of inspection. At the time of inspection both these risks had reduced through mitigating actions from moderate assessment to unlikely and rare.

The hospital mortuary risk register demonstrated focus on improvements, such as viewing room refurbishment, temperature logging, and cold store redevelopment.

Information management

Appropriate and accurate information was being effectively processed, challenged and acted upon.

End of life and palliative care resources were available on the trust intranet site, as well as relevant policies and guidelines. We saw information regarding end of life and palliative care information and contacts displayed on wards. Information systems were secured through password only access. Securely held patient identification and registration system were used to transfer patients to the mortuary.

An electronic notification system was used to alert the end of life and palliative care team, the acute intervention team and chaplaincy services to the needs of patients. Urgent referrals were made directly to the respective teams by ward staff.

The trust had developed a specific dashboard for recording end of life and palliative care patient information and the content reflected preferred place of care (PPC) and preferred place of death (PPD). The dashboard identified the number of referrals (UHND: 969 in 2018/19), incidents, rapid discharges (trust: 172 in 2018/19), training compliance, compliments and complaints, coding, deaths occurring at usual residence and achievement of PPD.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Ward staff told us there was now more awareness of end of life and palliative care services and the support they provided. Staff said they were aware of the range of information and support from the palliative care team, the acute intervention team and the out of hours service provided by a local hospice. End of life link nurses on wards were engaged to give feedback to the specialist teams.

This was complemented by education and training by the teams including mouth care and syringe driver competences. The teams raised awareness of their roles during 'dying matters' week and gathered views on how their service could improve and inform staff how they could access the comprehensive end of life care training on offer.

The trust had used the national VOICES postal questionnaire of bereaved relatives to understand about people's experience of end of life care. The trust had worked jointly with the public health department of the local council and a local university to conduct a survey to provide more specific results.

A full report, published in September 2018, was shared with key stakeholders prior to a half day event in November 2018 and generated insight to services provided. Following this, the trust agreed an action plan based on the results. The local survey provided evidence and motivation for making change.

Quality of care by setting/staff group: Excellent or good	2018 local	2015 national	Diff (%)
<i>Urgent and emergency care</i>	63	63	0
<i>District and Community Nurses</i>	85	81	+4
<i>Hospital doctors</i>	81	76	+5
<i>Hospital nurses</i>	78	74	+4

Dignity and respect by setting: Always or most of the time	2018 local	2015 national	Diff (%)
<i>District and Community Nurses</i>	80	77	+3
<i>Hospital doctors</i>	65	60	+5
<i>Hospital nurses</i>	65	54	+11

In response to patient and relatives feedback the palliative care service had made changes to provide specific training to nurses to recognise dying patients and enable them to have discussions with medical staff and families, and developed a cross-specialty (acute medicine, intensive care and palliative care) group of senior clinicians to explore ways to improve earlier recognition. Following discussion with bereaved relatives the end of life and palliative care team had revised the information leaflet given to all relatives of a dying patient.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The inspection identified the following learning, continuous and innovative practices within palliative and end of life care:

- Referrals to the specialist palliative care team were made directly to the team or identified through the trust's electronic systems. The system enabled ward staff to submit electronic referral to the palliative care team, acute intervention team, mental health and chaplains.
- Automatic alerts were sent to the chaplaincy staff to inform them when a predetermined selection of medicines order set was accessed by ward staff and alerts were monitored by the palliative care team.
- The trust had developed an electronic care plan which supported nursing staff to select bespoke outcomes for patients reaching end of life.

- The trust funded out of hours palliative care advice for all clinicians in the county, delivered by a local hospice.
- Palliative care discharge co-ordinators had been appointed and had developed rapid palliative discharge guidance for effective discharge when the co-ordinators were not on duty.
- The trust had worked with CCGs to adopt and fund the 'six steps' programme for palliative care in care homes to facilitate discharge.
- The palliative care team was available five days a week and their role complemented by the acute intervention team in the evenings and at night. At weekends and out of hours a telephone service was available to provide consultant advice and support from a local hospice.
- The trust had developed prescribing sets for anticipatory medicines, combined with the discharge process to ensure more palliative patients were discharged with medicines for symptom control at home.
- The mortuary management team had developed a multi-agency mortuary group.
- Palliative care training fellows had been recruited to support palliative care specialist nurses and non-palliative teams in the hospital and community.
- Families were provided with free parking passes, syringe driver bags to maintain privacy and dignity, and memory bags to hold important jewellery to hand over to families when their relative dies.
- There had been an increase in the involvement of end of life and palliative care from below 20% (2015) to above 40% (2018) for dying patients. The trust now provided the highest level of end of life and palliative care involvement to dying patients in the region.
- The trust had developed a specific dashboard for recording end of life and palliative care patient information including preferred place of care and preferred place of death.
- The trust had increased the levels of achievement of preferred place of death.
- The trust had developed the cardiac arrest prevention team in response to research that identified cardiopulmonary resuscitation does not work when people are naturally approaching the end of their lives.
- The end of life steering and palliative care group had delivered improvements and continued to provide direction and vision for end of life and palliative care improvement.
- The trust had developed a cross-specialty (acute medicine, intensive care and palliative care) group of senior clinicians to explore ways to improve earlier recognition of dying patients.

Darlington Memorial Hospital

Surgery

Facts and data about this service

The service operates at three main sites, with elective and emergency surgery being undertaken at two main sites, Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND), and elective (general surgery, orthopaedics, chronic pain, ophthalmology, dental, endoscopy, ear nose and throat/ head and neck, and dermatology) is undertaken at Bishop Auckland Hospital (BAH). In addition, day surgery, plastic surgery, general surgery and orthopaedics are undertaken at Shotley Bridge Hospital (SBH).

Surgery and ophthalmology services have close working relationships with other NHS Trusts within the north east.

From July 2018 the provision of the urology was transferred from CDDFT to South Tees Hospitals NHS FT, this service can be accessed at the DMH site.

We inspected Darlington Memorial Hospital as part of the comprehensive inspection of County Durham & Darlington NHS Foundation Trust, which included this hospital, the University Hospital of North Durham and Shotley Bridge Hospital. We inspected Darlington Memorial Hospital (DMH) between 12 and 15 September 2017.

At that time, surgical services at DMH received an overall rating of requires improvement, with the key domains rated as requires improvement in safe and well led, good in effective, caring and responsive.

Following our inspection of the service in 2017, requirement notices were issued for surgical services at DMH.

Actions that we said the trust **MUST** take to improve:

- The trust must ensure that operating theatres are fully established against the 'Association for Perioperative Practice' (AfPP) staffing recommendations. Staffing levels at night and on late shifts fell below recommended guidance.
- The trust must continue to embed the theatres culture review action plan.
- Following never events the trust must ensure that improvements in practice are effectively embedded and maintained.
- The trust must ensure that checks of the difficult intubation trolley in recovery at UHND take place as per trust policy.
- The trust must ensure there is compliance with safeguarding adults and children training where staff are required to have this training.

Actions we said the hospital **SHOULD** consider taking to improve, were:

- The trust should ensure that equipment is stored in designated areas and boxes of equipment are stored off the floor where appropriate.
- The trust should ensure patient records are complete and staff names legible.
- The trust should ensure that protected time is available for theatre staff to attend regular training.
- The trust should assure themselves that relevant staff have access to sepsis training.
- The trust should ensure that patients discharge plans are completed.
- The trust should ensure increased visibility of the executive team at University Hospital North Durham as staff feedback identified limited visibility on this site in surgery.

- The trust should ensure ongoing engagement from senior management with theatre staff.
- The trust should improve engagement with staff particularly those with protected characteristics.

At our most recent unannounced inspection on 2 to 4 July 2019, we followed key lines of enquiry and rated all five key domains; safe, effective, caring, responsive and well led.

On this inspection we visited the surgical service areas on ward 11 (day surgery), ward 23 (ophthalmology), ward 31 (surgical ward), ward 33 (trauma & orthopaedics), ward 32, (general surgery & colorectal) and theatres.

We observed care and treatment, looked at 16 complete patient records (and specific documentation in four others, including consent, mental capacity and deprivation of liberty safeguards documents). We also interviewed key members of staff, medical staff and the senior management team who were responsible for leadership and oversight of the service. We spoke with nine patients, six relatives and 38 members of staff.

We observed patient care, the environment within wards, handovers and safety briefings. We also reviewed the hospital's performance data in respect of surgical services.

A breakdown of location, services provided, and number of beds is below.

Location/Site	Ward/Unit	Services provided	Number of beds
Darlington Memorial Hospital	Oral Surgery	Undertakes oral surgery	0
Darlington Memorial Hospital	Theatres	Theatres for all surgical wards at DMH	0
Darlington Memorial Hospital	Ward 11	Undertakes day surgery procedures	22
Darlington Memorial Hospital	Ward 23	Ophthalmology ward	-
Darlington Memorial Hospital	Ward 32	General surgery and colorectal ward.	25
Darlington Memorial Hospital	Ward 33	Elective and trauma ward	31
Darlington Memorial Hospital	Ward 31	Surgical ward (Community)	24
Darlington Memorial Hospital	Day Surgery	Team providing day surgery only procedures.	12
University Hospital of North Durham	Day Surgery	Team providing day surgery only procedures.	25
University Hospital of North Durham	Surgical Admissions Unit	Surgical admissions ward	10
University Hospital of North Durham	Theatres	Theatres for all surgical wards at UHND	30

University Hospital of North Durham	Ward 12	Orthopaedics/Plastics	33
University Hospital of North Durham	Ward 13	Vascular surgery, general surgery	10
University Hospital of North Durham	Ward 15	Ortho/plastics Elective	20
University Hospital of North Durham	Ward 16	General surgery and colorectal	23
Bishop Auckland Hospital	Day Surgery	Small team providing day surgery only procedures	23
Bishop Auckland Hospital	Theatres	Planned day case and inpatient theatre cases	20
Bishop Auckland Hospital	Ward 18	Elective orthopaedic ward specialising in primary arthroplasty	22

(Source: Routine Provider Information Request (RPIR) – Sites tab / Context acute tab)

The trust had 33,338 surgical admissions from February 2018 to January 2019. Emergency admissions accounted for 12,460 (37.4%), 16,672 (50.0%) were day case, and the remaining 4,206 (12.6%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff.

Mandatory training completion rates

The trust set targets ranging between 50% to 95% for completion of mandatory training.

Darlington Memorial Hospital surgery department

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in surgery at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Immediate Life Support (ILS)	26	40	65.0%	50%	Yes

Paediatric Immediate Life Support (PILS)	23	36	63.9%	50%	Yes
Immediate Life Support Re-Certification (ILS) - 1 Year	21	40	52.5%	50%	Yes
Information Governance	153	165	92.7%	95%	No
Deteriorating Patient and Resuscitation	148	175	84.6%	85%	No
Conflict Resolution	144	173	83.2%	85%	No
Equality & Diversity	140	176	79.5%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	70	176	39.8%	85%	No
Paediatric Immediate Life Support Re-Certification (PILS Re-Cert) - 1 Year	14	36	38.9%	50%	No

In surgery, the targets were met for three of the nine mandatory training modules for which qualified nursing staff at Darlington Memorial Hospital were eligible.

We received updated figures from the trust post inspection up to June 2019

Training module name	As at June 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Deteriorating Patient & Resuscitation - 2 Years	150	167	89.8%	85%	Yes
Hand Hygiene - 2 Years	159	169	94.1%	95%	No
Immediate Life Support (ILS) - 3 Years	27	33	81.8%	85%	No
Dementia awareness - No Specified Renewal	115	169	68.0%	85%	No
Dementia identification, assessment and diagnosis - Tier 2 - No Specified Renewal	53	79	67.1%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	101	169	59.8%	85%	No

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in surgery at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality & Diversity	109	112	97.3%	85%	Yes
Immediate Life Support (ILS)	5	7	71.4%	50%	Yes
Immediate Life Support Re-Certification (ILS) - 1 Year	5	7	71.4%	50%	Yes
Information Governance	76	83	91.6%	95%	No
Deteriorating Patient and Resuscitation	76	97	78.4%	85%	No
Conflict Resolution	76	99	76.8%	85%	No

Infection Prevention and Control - Level 2 - 1 Year	55	112	49.1%	85%	No
Advanced Life Support (ALS) - 4 Years	20	44	45.5%	50%	No
Advanced Trauma Life Support (ATLS) - 4 Years	4	12	33.3%	85%	No
European Paediatric Advanced Life Support (EPALS)	4	32	12.5%	50%	No
Acute Illness Management - No Specific Renewal	0	2	0.0%	50%	No

In surgery, the targets were met for three of the 11 mandatory training modules for which medical staff at Darlington Memorial Hospital were eligible.

We received updated figures from the trust post inspection up to June 2019

Training module name	As at June 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Immediate Life Support (ILS) - 3 Years	7	7	100%	85%	Yes
Deteriorating Patient & Resuscitation for Senior Medical Staff - 2 Years	69	80	86.3%	85%	Yes
Advanced Life Support (ALS) - 4 Years	13	17	76.5%	70%	Yes
Hand Hygiene - 2 Years	104	112	92.9%	95%	No
Deteriorating Patient & Resuscitation - 2 Years	12	16	75.0%	85%	No
Dementia identification, assessment and diagnosis - Tier 2 - No Specified Renewal	53	79	67.1%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	65	112	58.0%	85%	No
Dementia awareness - No Specified Renewal	58	112	51.8%	85%	No

(Source: Routine Provider Information Request (RPIR) – Training tab)

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. We discussed non-compliance results with the leaders of the surgery care group who told us that training was a priority within the care group. Staff were given time to complete training in order to drive improvement. The care group were aware of low compliance and intended to take a pragmatic approach moving forward to increase compliance.

Some staff we spoke with said that classroom-based training for sepsis was undertaken two-yearly and covered in the deteriorating patient and resuscitation training platform. Nursing and medical staff training overall compliance for Darlington Memorial Hospital was 61% with a trust target of 85%. This was an improvement since the last inspection where overall training compliance for nursing and medical staff was 53% against a trust target of 95%. Post inspection the trust confirmed sepsis was taught on all essential training programmes. They told us all staff who attended two-yearly deteriorating patient and resuscitation training programme received this training. The acute

intervention team also delivered ward-based education on sepsis to meet individual clinical area needs.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff training was provided on how to recognise and report abuse, and staff knew how to apply it.

Safeguarding training completion rates

The trust set targets ranging from 33% to 85% for completion of safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse.

Darlington Memorial Hospital surgery department

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in surgery at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 2	1	1	100%	85%	Yes
Safeguarding Adults Level 3	5	5	100%	85%	Yes
Safeguarding Adults Level 1	105	176	59.7%	33%	Yes
Safeguarding Children Level 2	61	162	37.7%	85%	No

The targets were met for three of the four safeguarding training modules for which qualified nursing staff in surgery at Darlington Memorial Hospital were eligible. Safeguarding children level two training module did not meet the trust target of 85%, with a 37.7% completion rate.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in surgery at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	57	106	53.8%	33%	Yes
Safeguarding Children Level 2	49	96	51.0%	85%	No

The targets were met for one of the two safeguarding training modules for which medical staff in surgery at Darlington Memorial Hospital were eligible. Safeguarding children level two training module did not meet the trust target of 85%, with a 51.0% completion rate.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We asked the trust to share updated figures with us showing safeguarding training compliance for the full year from April 2018 to March 2019. We received updated figures; however, these figures were not split by site, so we were unable to review safeguarding training compliance at Darlington Memorial Hospital (DMH) specifically.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Medical staff received training specific for their role on how to recognise and report abuse.

Staff followed safe procedures for children visiting the ward. They informed accompanying adults to supervise their children at all times and not to leave them unsupervised on the wards.

The surgery care group had raised 11 safeguarding concerns in the last six months. This demonstrated a good understanding and recognition of potential safeguarding concerns including domestic violence and abuse. The issues raised were surrounding discharge and communication. As well as the appropriate local actions being taken, these actions were also routinely fed into the trust discharge work stream 'next step home'.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained.

Staff completed infection prevention and control training; compliance for nursing staff was 59.8% and 49.1% for medical staff. (See mandatory training breakdown for Darlington Memorial Hospital).

The Patient Led Audit of the Care Environment (PLACE) assessment, which was patient led, assessed the quality of the patient environment on a yearly basis. The assessment did not cover clinical care provision or evaluate how well staff were doing their jobs. The assessments involved members of the public, former and current patients and members of Healthwatch, who looked at a selection of wards and departments against different criteria which was comprised of:

- Cleanliness
- Condition, appearance and maintenance
- Privacy, dignity and wellbeing
- Dementia
- Access
- Disability
- Food

The results highlighted how the trust was performing individually and nationally to drive improvement across hospital sites, enhance services and better the patient experience.

The PLACE assessment results for cleanliness scored 98.97% which was higher than the national average of 98.47%. For condition, appearance and maintenance the trust scored 95.13% which was higher than the national average of 94.3%.

We reviewed the Darlington Memorial Hospitals cleaning audits scores from April to June 2019 which evidenced a site average of 94%.

In most areas we found equipment was visibly clean and labels were used to identify 'cleaned and ready for use', sharps were disposed of correctly and were signed for. There were cleaning schedules in place and daily cleaning records showed these were adhered to. Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

There were side rooms available on each ward to care for patients who required isolation. Staff told us they identified patients requiring isolation with a sign on their door and we observed this in practice.

Wards we visited reported low or no cases of clostridium difficile (C. diff) and Methicillin Resistant Staphylococcus Aureus (MRSA), audit information was evident on ward dashboards. Staff described how they worked with the trust's infection prevention control team on a programme of quality improvement at ward level.

We asked the surgery care group for updated information surrounding the following:

There had been no cases of MRSA bacteraemia reported for the last 2 years within the Surgery Care Group

There had been two cases of MSSA reported during 2019/20.

- The first case was deemed hospital onset and attributed to pneumonia
- The second case was community onset in a patient who had a pacemaker inserted at another Trust

There had been four hospital onset clostridium difficile infections reported during 2019/20 within the surgery care group. We reviewed three of the root cause analysis reports made available to us following the inspection. The root cause analyses evidenced a clear time line of events, actions taken, lessons learned and a robust dissemination through governance. The fourth root cause analysis was ongoing.

When infections occurred, the trust had a system for investigation, including a peer review or post infection review, following which an action plan was produced.

We saw posters displayed around the wards we visited about infection prevention and handwashing. Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and throughout ward corridors.

We observed staff using personal protective equipment (PPE) when required, and they adhered to 'bare below the elbow' guidance. Staff followed infection control principles including the use of PPE.

Patients we spoke with confirmed staff were washing their hands before and after treating them. Hand hygiene audits were completed. We saw hand hygiene audit compliance results on each ward we visited. The trust also had an action plan for infection control which included hand hygiene campaigns.

We reviewed hand hygiene audits for May 2019 on all surgical wards at DMH. All wards scored 100%. We were assured by the senior management team any concerns in respect of compliance were addressed immediately at the time of assessment and at source. In addition to this, hand hygiene results were included in the specialty governance reports and care group governance meetings for shared learning. Specialty representatives provided assurance of immediate management through the care group governance and quality meeting with escalation to care group board as needed.

The care group had achieved 100% compliance in all clinical areas in the most recent commode audit (June 2019). We were assured by the senior management team that the trust was ranked second in the North East for cleanliness audit data analysis and action.

To support staff in maintaining levels of infection control, wards benefited from dedicated housekeepers. Waste was separated and disposed of in appropriate colour coded bags. We observed the use of tiger striped bags for the safe disposal of offensive clinical waste at Darlington Memorial Hospital. In order to reduce the cost and impact of waste on the environment surrounding clinical waste, the trust had instigated a review of the use of the clinical waste streams.

Post inspection we received information to support the roll out across sites of the disposal of offensive waste.

We were told that this was a key part of the trust's response surrounding collection of healthcare environmental services, primarily because it enabled the trust to be more resilient by using companies outside of the clinical waste industry and also because it had the potential to reduce the escalating costs. Currently, the orange bags (clinical waste) were still being transported up to 250 miles for disposal whereas the offensive waste (tiger bags) were going to an energy incinerator in Stockton. Since March this had eliminated around 25 clinical waste truck journeys, which had saved around £50,000 and prevented around 20 tonnes of waste and carbon dioxide emissions.

Each ward we visited conducted monthly infection prevention and control audits. These covered clean commodes, hand hygiene, cannula care and urinary catheter care audits. We saw results on display on each ward we visited highlighting compliance.

The wards had a link nurse for infection control. Single patient rooms were available on all wards. We saw notices displayed on doors where patients with infections were being cared for and doors were closed in line with policy for managing infectious patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

The design, maintenance and use of facilities, premises and equipment kept people safe. Patients could reach call bells and staff responded quickly when called. The design of the environment followed national guidance.

Emergency resuscitation equipment on each ward had daily and weekly checks completed in line with the trust policy. We checked the resuscitation policy which had a named author, version control and review date in place. We saw that daily checks were recorded as being completed. We checked consumable items, such as medicines, gloves, oxygen masks and suction equipment and did not find any items that were out of date on the trollies. We observed a tamper proof lock on a resuscitation trolley which was broken on ward 31. We escalated this at the time of inspection and the matron agreed to take action immediately.

The difficult intubation trolley within the recovery area in theatre was fully stocked and equipment stored on the trolley was within expiry date. The trolley was checked daily and a record of these checks was available as evidence. This was an improvement since the last inspection.

Sharps bins were properly assembled, stored off the floor, not over full and signed and dated. Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients. Staff disposed of clinical waste safely.

All matrons received updates in respect of environmental audits. We were told by the matrons that frequent informal environmental checks were instigated. Matrons told us that they liaised with domestic colleagues to rectify any non-compliance.

During the inspection we observed that equipment was stored in designated areas and storage of this equipment was stored off floor level. This was an improvement since the last inspection.

Equipment such as medical devices and general equipment items were managed for correct operation, safety and performance results data was tracked through the information technology database for routine and corrective maintenance work. This also formed part of the key performance indicators (KPIs) measures for the supplied service.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Assessment of Mental Health Services in Acute Trusts (AMSAT).

Ward staff told us that the psychiatric liaison team provided support to clinical staff supporting patients with mental health. Ward staff were able to access the team through a telephone referral and all staff we spoke with told us that the team responded quickly to their requests. In addition, ward staff were able to utilise the crisis team based with the hospital. Ward staff told us that high risk patients such as those experiencing suicidal behaviours were often known to the crisis team before they arrived at the ward and therefore clinical support was swift.

In addition, the trust engaged with the local mental health trust, which provided specific consultant advice to ward staff. For example, patients whom required a mental health section.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. (AMSAT)

Ward staff were able to utilise the crisis team based at the hospital. Ward staff told us that high risk patients such as those experiencing suicidal behaviours were often known to the crisis team before they arrived to the ward and therefore clinical support and risk identification was swift. Ward staff told us that if they required additional staff to safely support these patients, a request was made through their specific matrons.

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on admission, arrival and updated them when necessary and used recognised tools.

Risks associated with falls, pressure ulcers, venous thromboembolism (VTE), catheter and urinary infections were assessed monthly using the National Health Service (NHS) safety thermometer. Wards displayed the number of falls and pressure ulcers which had occurred on the ward for that month.

The electronic patient record automatically and continuously cross-referenced patients' vital signs, laboratory results and clinical notes, identifying potential sepsis, acute kidney injury and other conditions as soon as results were available, with the aim of eliminating delays and errors that could be associated with manual checking of results. It initiated automated workflows for time-critical actions such as beginning antibiotic treatment for patients with suspected sepsis and sent alerts to the relevant clinician.

The trust had implemented a deteriorating patient algorithm to guide staff about how and when to escalate patient care. This was clearly displayed throughout wards in the form of a flow chart next to the screen displaying the electronic patient record, so the guidance was readily available to staff. Patients with an escalated national early warning score (NEWS2) were monitored closely. All staff we spoke with could describe the algorithm and give examples of using it to inform their practice. We observed this system during inspection, staff were able to explain how and why they accessed the tool to record patient associated risk on admission and ongoing assessment.

The trust had introduced an acute intervention team consisting of nurse practitioners who instigated training, monitored deteriorating patients and were part of the emergency resuscitation team. Ward staff spoke positively about the acute intervention team and found them to be responsive and accessible.

The trust had a sepsis policy and treatment pathway in place to provide best practice guidance to all staff involved in the care of patients presenting with sepsis. The pathway incorporated the sepsis six treatment bundle. The policy covered initial management of patients with sepsis and was based on recommended research-based evidence. Emphasis was placed on actions within the first hour and reflected National Institute for Health and Care Excellence (NICE) guidance (July 2016). We saw wards displayed posters about the risks of sepsis.

Measures were put in place for patients deemed to be at risk of pressure damage. These included the provision of pressure relieving equipment, regular position change and nutritional assessments. The service had a tissue viability lead nurse with link nurses on each ward.

On admission, all patients had an initial skin integrity body map assessment as part of the adult nursing care pathway. A Waterlow risk assessment tool was used to record mobility, sensory perception, moisture, nutrition, friction and shear risks for all patients. The service had a pressure categorisation tool available to staff to identify high, medium and low risks. Staff could refer patients to the tissue viability nurse if they had concerns. We observed intentional rounding being completed by individual staff and observations recorded in individual patient care pathways.

To enable effective observation of patients at the risk of falls, the trust was implementing a dedicated cohort team. Training was ongoing for the health care assistants in distraction techniques and engagement with patients who required one to one support. The scheme facilitated protected and uninterrupted time for staff to carry out observations surrounding patients at risks of falls. The nominated staff member was given protected time and responsibility of patients deemed at risk of falls. We observed that staff were able to carry out this duty without being asked to attend to other matters. Patients deemed to be at risk of falls were cared for in high risk bays.

If a patient required assistance with equipment to mobilise, we saw that physiotherapists displayed clearly visible signs on patients' doors with instructions about which equipment was required.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Ward staff told us that the trust employed both a named learning disability nurse and named dementia nurse which covered both hospital sites. Ward staff told us that ward visits were made each day and these nurses could be contacted easily for support and advice. We saw the 'passport' system was used for patients with learning disabilities. This provided clinical staff with clear consistent information regarding the patient, each time they visited the hospital.

Dementia link nurses were identified to support staff to deliver appropriate care and support across the wards

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. We observed two safety huddles which were attended by the multidisciplinary team. The huddles included events of the day, do not attempt cardiopulmonary resuscitation (DNACPR) orders, completed audits and any other risk or safety issues raised.

The trust had taken action to address the historic problems in embedding the World Health Organisation (WHO) checklists. The five steps to Safer Surgery, WHO surgical safety checklist should be completed for patients prior to and following surgical intervention. The trust monitored completion of the WHO checklists monthly and took action where checklists were not fully completed. There had been one never event reported at Darlington Memorial Hospital between April 2018 to March 2019. This never event was in May 2018 reported following a surgical, invasive procedure which met serious incident criteria. An old ureteric stent had been reinserted instead of a new one at the point of surgery.

The care group had historically collected quantitative data in respect of completion of WHO checklists. The care group had revised the WHO checklist as a difference between the checklist and the audit tool had been identified. Alongside the quantitative information, following never events and as part of theatre matters work, the care group had developed and implemented an observational audit tool.

There had been a trust wide programme to support learning from never events. There had been joint working with NHS Improvement and the Clinical Commissioning group (CCG). The safety culture had been reinforced; training and raising awareness had taken place. The trust had commenced a mandated training video of the World Health Organisation the five steps to Safer Surgery for all staff members.

There was a plan to further embed and audit the use of Local Safety Standards for Invasive Procedures (LocSSIPs) and further reinforce the WHO checklist to reduce risks of harm to patients and to help prevent recurrence of the never events.

We reviewed recent audits of the WHO checklist post inspection.

Compliance rates evidenced score rates of:

- March 2019 - 99%
- April 2019 – 98%
- May 2019 – 96%

We observed two patient's journeys through theatre. Staff signed the patient in, performed the WHO checks and signed the patient out of theatre following surgery. Both sign outs were audible within theatre, the sign out was completed and signed appropriately on the WHO check sheet document.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

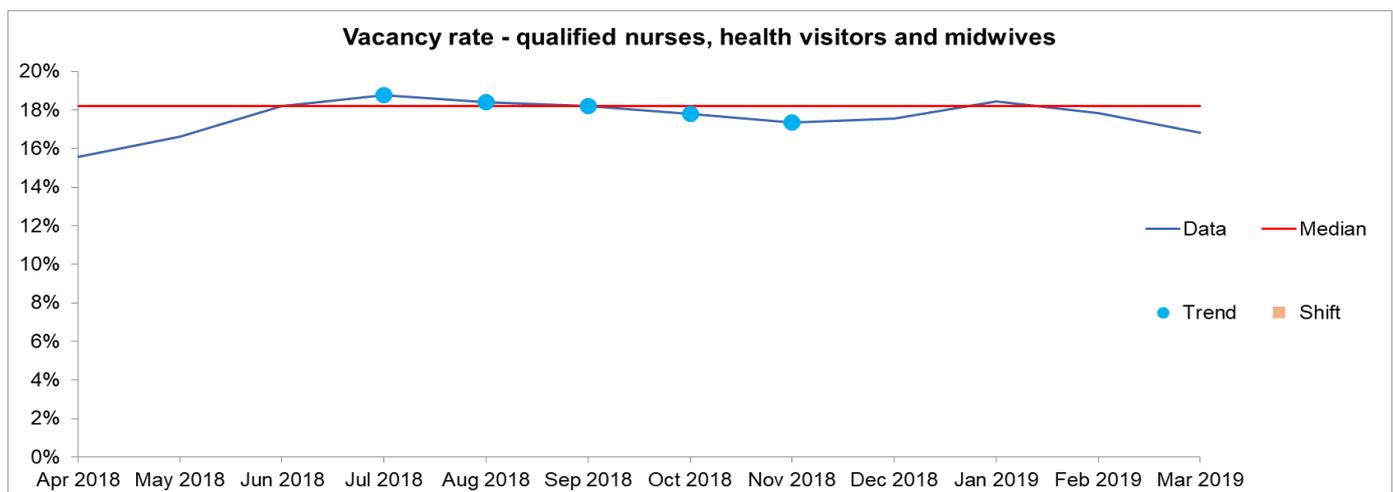
Operating theatres were fully established against the 'Association for Perioperative Practice (AfPP) staffing recommendations. During inspection we saw this guidance was met on early, night and late shifts.

We visited seven clinical areas including main theatres. We spoke with a selection of nursing staff that either were new to the trust or had worked at the trust for many years. The nursing staff we spoke with all said that staffing levels were safe. Where there were vacancies, the majority were recruited into. New staff had either recently started in post or were about to start.

Darlington Memorial Hospital surgery department

Nurse staffing rates within this core service at Darlington Memorial Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and sickness.

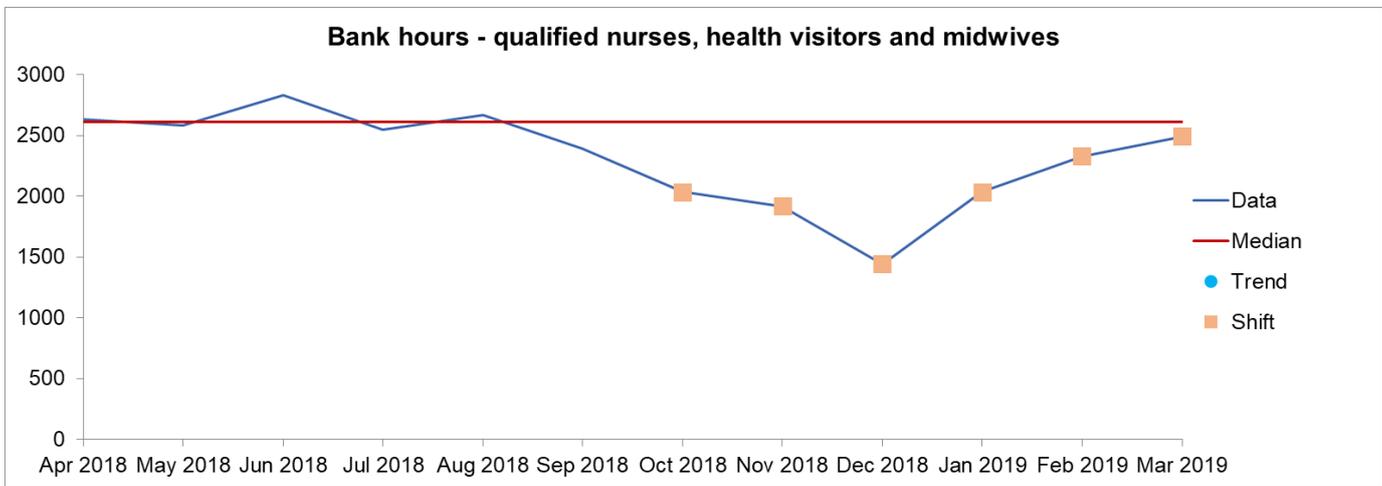
Vacancy rates



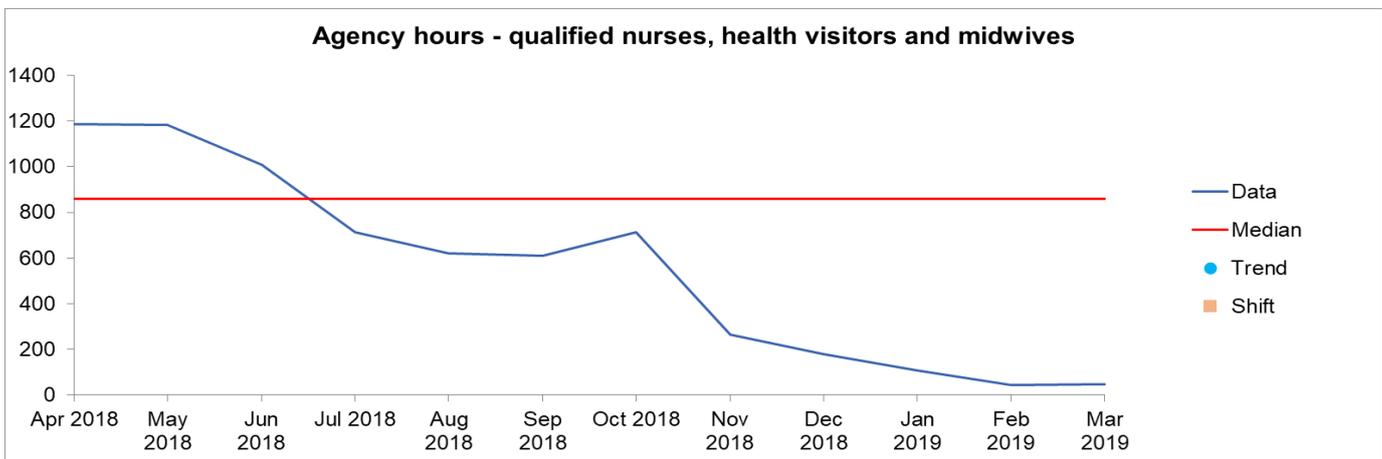
Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a downward trend from July 2018 to November 2018. On all wards that we visited staff vacancies had reduced due to successful recruitment campaigns. Each ward had vacancy rates at or below the trust target. Ward managers told us that regular staff appraisals, ongoing continual professional development and clear lines of communication were key to retaining staff and maintaining a positive staff culture.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Bank and agency staff usage



Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives show a shift from October 2018 to March 2019. Ward managers put the shifts out to the Trust bank, this means that shifts were often filled by CDDFT substantive staff reducing the need for agency staff.

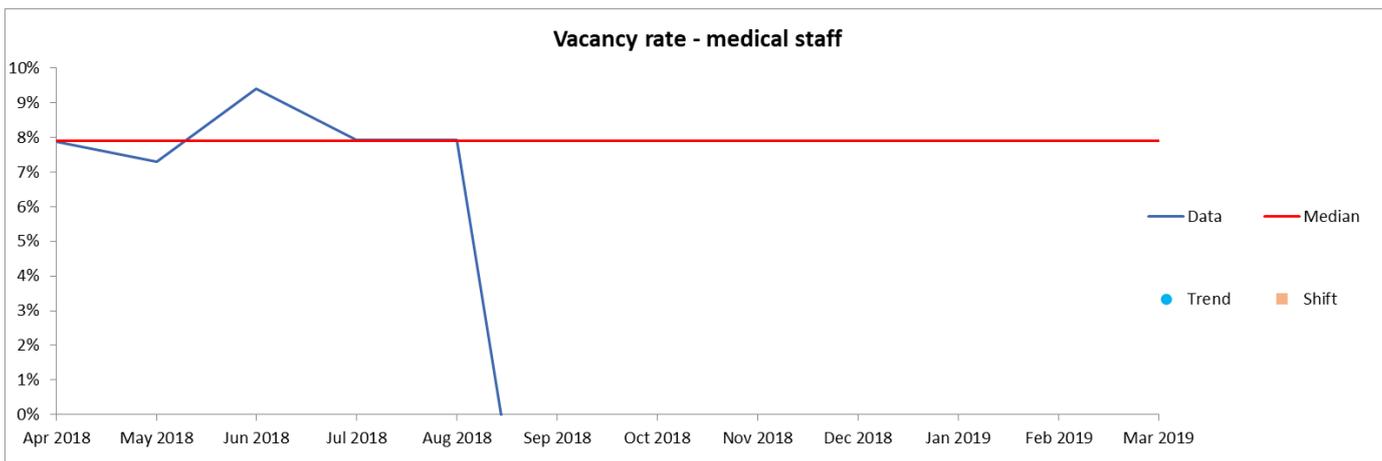


Monthly agency hours over the last 12 months for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change. (Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)

Darlington Memorial Hospital surgery department

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site

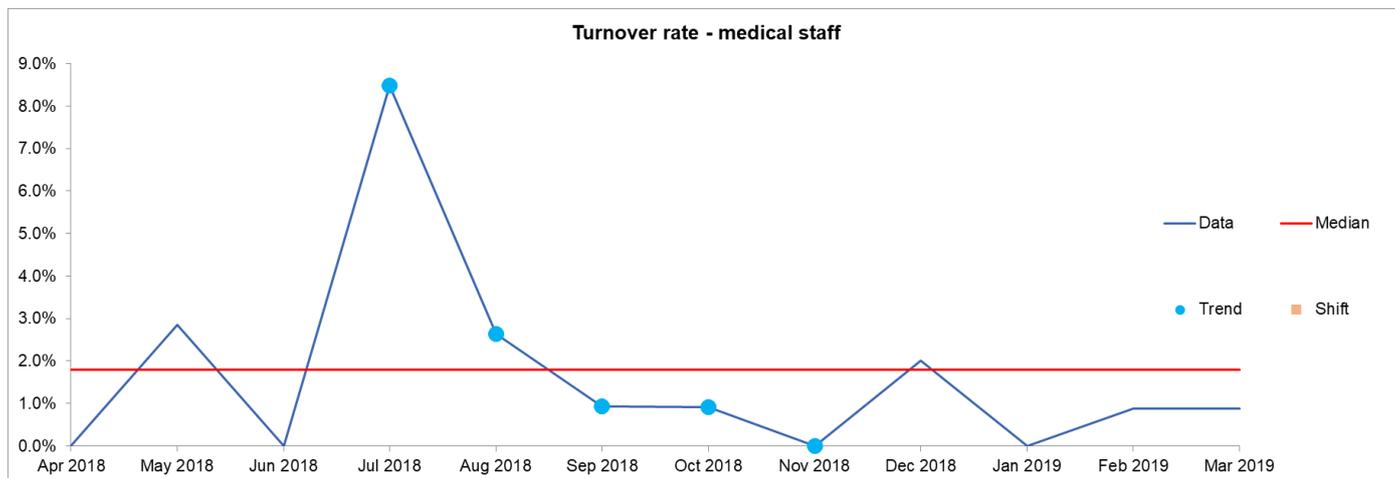
Vacancy rates



Monthly vacancy rates over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provide Information Request (RPIR) – Vacancy tab)

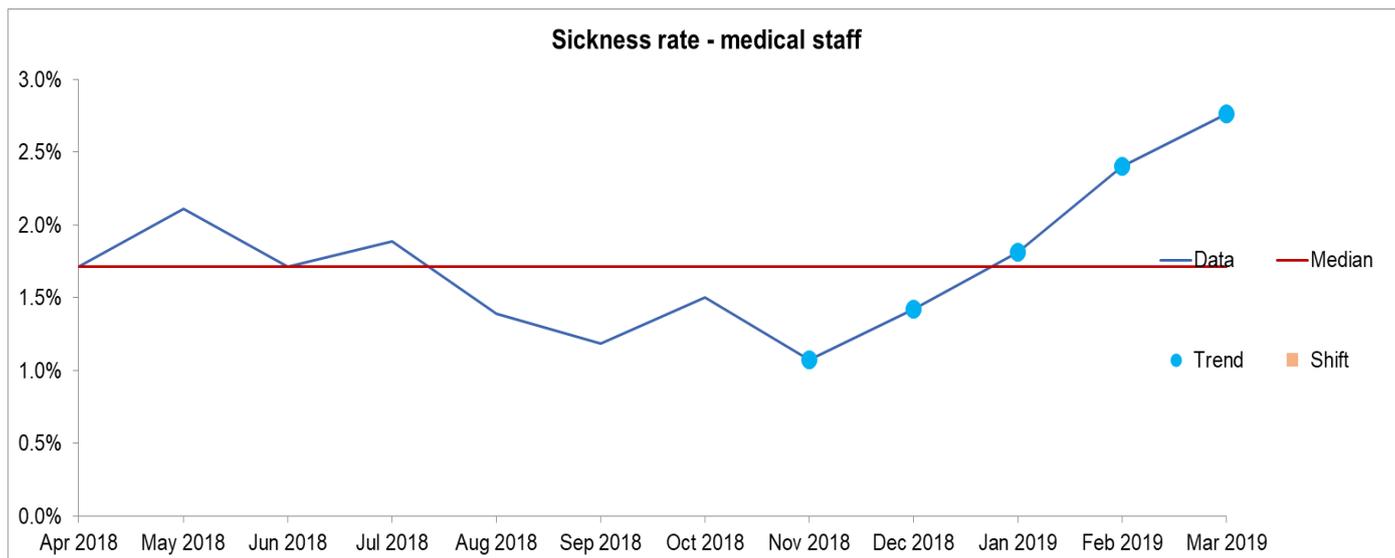
Turnover rates



Monthly turnover rates over the last 12 months for medical staff shows a downward trend from July 2018 to November 2018.

(Source: Routine Provide Information Request (RPIR) – Turnover tab)

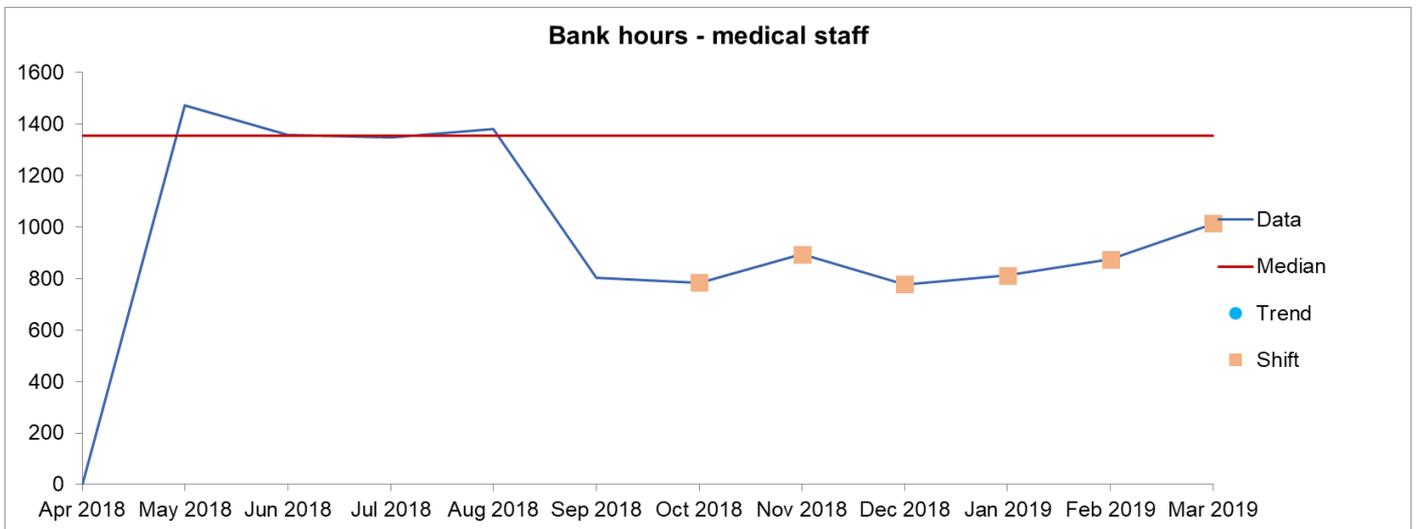
Sickness rates



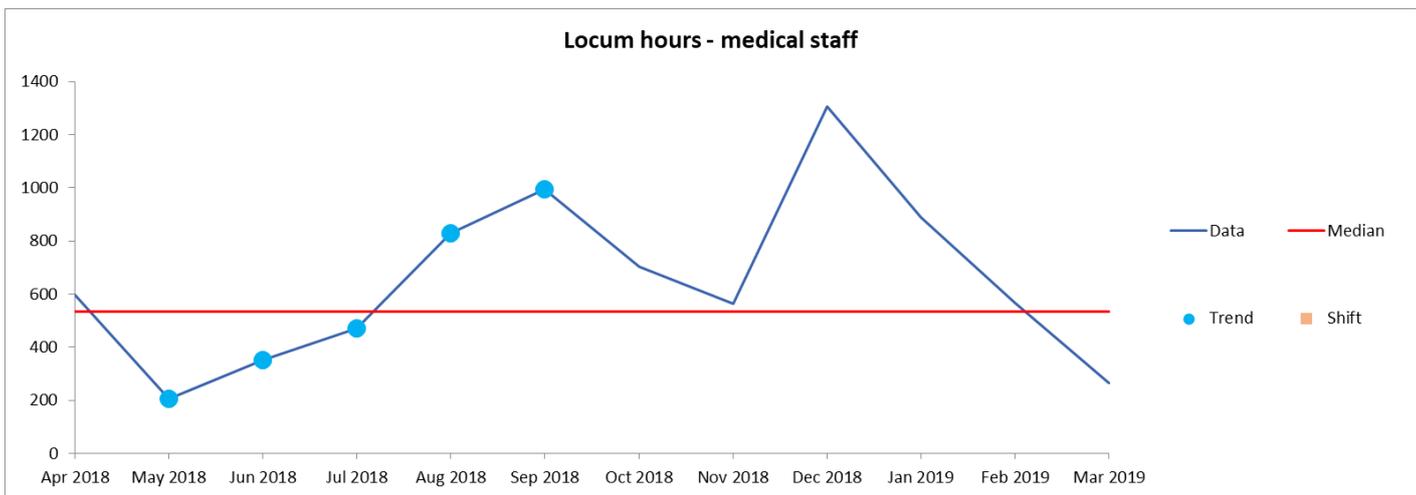
Monthly sickness rates over the last 12 months for medical staff shows an upward trend from November 2018 to March 2019.

(Source: Routine Provide Information Request (RPIR) – Sickness tab)

Bank and locum staff usage



Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.



Monthly agency hours over the last 12 months for medical staff shows an upward trend from May 2018 to September 2018.

(Source: Routine Provide Information Request (RPIR) – Medical bank and locum tab)

Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provide Information Request (RPIR) – Medical bank and locum tab)

The service had enough nursing staff of all grades to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Ward managers regularly reviewed nurse staffing. They used the Safer Nursing Care acuity tool (SNCT), along with professional judgement, to plan and flexibly adjust staffing levels accordingly. Staffing numbers were collected twice daily and staff were reallocated to ensure safe staffing. Patient numbers were reviewed regularly, and bed numbers were adjusted as demands required.

Daily nurse staffing levels were displayed on all wards. We saw that actual staffing levels met

planned staffing levels on all wards we visited for early, late and night shifts. The ward manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers.

Staffing skill mix

In January 2019, the proportion of consultant staff, middle career staff and the proportion of junior (foundation year 1-2) staff reported to be working at the trust were all higher than the England average. The proportion of registrar staff group reported to be working at the trust was lower than the England average by almost half.

Staffing skill mix for the whole time equivalent staff working at County Durham and Darlington NHS Foundation Trust



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Staff used an electronic patient record supported by paper records for each patient. Electronic patient records were secure and could only be accessed by logging in to the digital system.

We reviewed a sample of nursing and medical records across all wards we visited and checked care plans and risk assessments. We found they contained comprehensive information, were updated regularly and included sepsis checks, nutrition and hydration records, appropriate frequency of observations, pressure care, falls assessments and DNACPR forms where appropriate.

Staff had recorded outcomes following reviews and discussions with the multidisciplinary team, patients and their families. We saw good evidence of individualised care plans, appropriate risk assessments and discharge planning for patients. Patient notes were comprehensive, and all staff could access them easily.

The service used systems and processes to manage the storage of patient records. However, the management of obtaining patient consent for storage of contemporaneous records at the patient's bedside was not robust. The trust had instigated a process for obtaining patient consent; however, on inspection out of 16 patient consent forms inspected only one consent form had been signed by the patient. The clinical record keeping and healthcare records management policy for accessing contemporaneous records clearly stated the need for a patient signature. This was a deterioration since the last inspection, where the trust had received a should do action requiring that the trust should ensure patient records are complete. We were advised by the senior team that this was not recorded on the surgical risk register as an identified risk.

We noted good examples of DNACPR with evidence of discussion with patients and family. DNACPR records were consistently completed according to trust policy.

Data provided by the trust showed that 91.6% of medical staff and 92% of nursing staff had completed information governance training; the trust target was 95%.

When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Ward pharmacy cover was available Monday to Friday with an on-call system at weekends. We reviewed prescription charts and found no gaps in the recording of administration of medicines; we were assured medicines had been given on time.

Staff said they had good access to pharmacy support and could easily access medicines out of hours. At weekends, drugs were obtained through emergency stocks. We were told that a medicine locator was commissioned for staff to access in out of hours periods.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

We reviewed 16 patient prescription records and spoke with four patients about medication management and found that pharmacists checked (reconciled) patients' medicines on admission to hospital.

Medicines, including controlled drugs and intravenous fluids, were stored securely and access was restricted to authorised staff. We also checked the medicines fridges and saw daily minimum and maximum temperature checks were mostly completed on all wards and action taken when readings were outside of the 2-8° range.

The trust policy was to follow the British Thoracic Societies (BTS) guidance for the administration of oxygen. We observed during the inspection that oxygen was not prescribed or recorded in line with BTS guidance on all wards that we inspected. This increased the risk of harm to patients as clear records of administration and use were not maintained. We escalated this to the trust at the time of inspection.

Post inspection we raised concerns surrounding the prescribing of oxygen with the trust. The trust had an ongoing programme of improvement work taking place with respect to oxygen therapy, being overseen by the clinical effectiveness committee. The committee instigated the improvement

programme following evidence of variable compliance from audits undertaken by the acute intervention team. A key improvement action was the implementation of a system prompt, on the electronic prescription management and administration system (EPMA), which required the clinician to state whether the patient was to have oxygen therapy when the prescribing record is set up.

If the patient was to be placed on oxygen therapy the system would force the clinician to enter the prescription details before allowing further entries to take place. This work had been approved and was scheduled to go live by 22 July 2019. As an interim measure, the acute intervention team checked all patients on oxygen therapy on the digital platform for a corresponding prescription on EPMA, each night and where a patient did not have a prescription, an electronic task would be raised to the medical staff on duty to ensure that the prescription was entered.

This practice, in effect, ensured that there was full compliance for the patients admitted during that day; however, until the EPMA functionality is in place, there may be a delay in the prescription being raised. The trust gave assurance that they will continue to monitor compliance, via the acute intervention team after the new functionality goes live, to ensure that the associated practice becomes embedded.

We saw evidence on all wards we visited that nurses checked controlled drugs (CDs) in line with policy. There were separate CD registers for patients own medicines, registers were completed correctly. Ward managers were responsible for ensuring that CD checks were completed on a daily basis. The surgery care group had worked with pharmacy colleagues to ensure that CD cupboards had been risk assessed. Pharmacy teams completed six monthly audits of CD cupboards and surgery ward managers supported this work.

Post inspection we reviewed the controlled drugs (CD) audits from April to May 2019. The audit highlighted non-compliance (low risk) surrounding the safe storage of CD keys within a key safe which had been risk assessed and also non-compliance surrounding CD cupboards which did not conform with British Standard Reference BS2881 and the Misuse of Drugs Regulation 1973 (metal, lockable, have internal rag bolts and are fixed to an internal wall or floor). The trust had taken action to review this non-compliance and had planned remedial works to implement risk assessment and replace non-compliant cupboards moving forward.

We saw trust policies that were regularly reviewed, covered most aspects of medicines management and were accessible through the hospital intranet to all staff.

We checked medicines and equipment for emergency use and found they were readily available; staff carried out regular checks to ensure these were fit for use in line with the trust policy. We found that fluids and medications were within their use-by-date on all wards that we inspected.

Staff told us that patients wanting to self-administer medicines had a risk assessment performed and recorded before this was initiated, however, we did not see any examples of patients self-medicating. We found that all patients we reviewed had been prescribed appropriate prophylaxis for venous thromboembolism (blood clots) where this was indicated.

The introduction of an electronic medications management system (eMeds) had ensured that the trusts approach to medicines management had been further improved. The EPMA system supported the improved quality, safety and effectiveness of medication management within the hospital. This included providing support for doctors, nurses and pharmacists to digitally prescribe, order, check, reconcile, dispense and record the administration of medicines.

Medicines management was regularly audited across the trust and included antibiotic management, missed critical medicines doses, controlled drugs and the storage of medicines. We

reviewed these audit results and noted that actions resulting from the audits were fed back by lead clinical pharmacists and matrons through individual dashboards.

Both hard and electronic copies of the medicine dashboards were sent directly to ward managers, matrons and clinical pharmacy teams. Ward managers were expected to share the results with the ward teams. Staff assured us on inspection that the medicines dashboard data was discussed at hand over meetings.

We saw evidence of the dashboards on display on all wards inspected. This increased awareness of results at ward level, had encouraged ward staff to understand the value of medicines reconciliation, and therefore encouraged and prompted pharmacy staff to undertake medicines reconciliation when on the wards.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

There were systems in place for reporting, monitoring and learning from incidents. Staff reported incidents using an electronic system. Staff we spoke with could describe when and how they would report an incident. Staff told us they received feedback from incidents and could give examples of learning from incidents shared at team meetings and during daily safety huddles. We attended the weekly incident report meeting at this hospital. All incidents reported during the previous week were discussed. Matrons and managers from all surgical wards attended and discussed incidents pertaining to their areas of responsibility, including detailing the actions that had been implemented as a result. Matrons advised of any further requirements and provided updates for any ongoing incidents. We saw minutes from previous incident report meetings which were comprehensive.

There was an open culture around incident reporting. Staff told us they felt comfortable about reporting incidents and received positive feedback from their managers for doing so. Staff described receiving emails about quality and safety updates and learning from incidents.

Staff could describe the process they used in relation to the duty of candour and gave examples such as a patient falling and resulting in harm.

Mortality and morbidity were discussed at regular mortality sub-committee meetings.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to March 2019, the trust reported one never event for surgery. This was in May 2018, for a surgical invasive procedure meeting serious incident criteria where an old ureteric stent was reinserted instead of a new one. The duty of candour was adhered to, the patient was informed of the incident and agreed to a second anaesthetic procedure to replace the old stent and replace with a new one.

The service instigated an immediate root cause analysis investigation into the incident. The findings were disseminated through governance streams and all relevant staff informed in order to reduce risk and prevent further incidents. Learning was evident following this never event, staff could explain the incident and the actions taken to prevent recurrence. Improvements in practice were effectively embedded with continuous development to support continued awareness and learning. This was an improvement since the last inspection.

The surgery care group had been instrumental in the development of procedural Local Safety Standards for Invasive procedures (LocSSIPs) and safety protocols. The service had developed an educational video, observational audits in respect of completion of safety checks within theatre and posters highlighting the learning from never events. We saw evidence of this during inspection.

The Trust had a comprehensive LocSSIP development programme; this had been running for the last two years and was now supported by a programme of audit that was currently being rolled out. The trust was seen as an exemplar in this field and had been recognised and shared this work regionally, nationally and internationally.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from April 2018 to March 2019.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Slips/trips/falls meeting SI criteria	5	50.0%
Surgical/invasive procedure incident meeting SI criteria	1	10.0%
Treatment delay meeting SI criteria	1	10.0%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	10.0%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	10.0%
Medication incident meeting SI criteria	1	10.0%
Total	10	100.0%

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

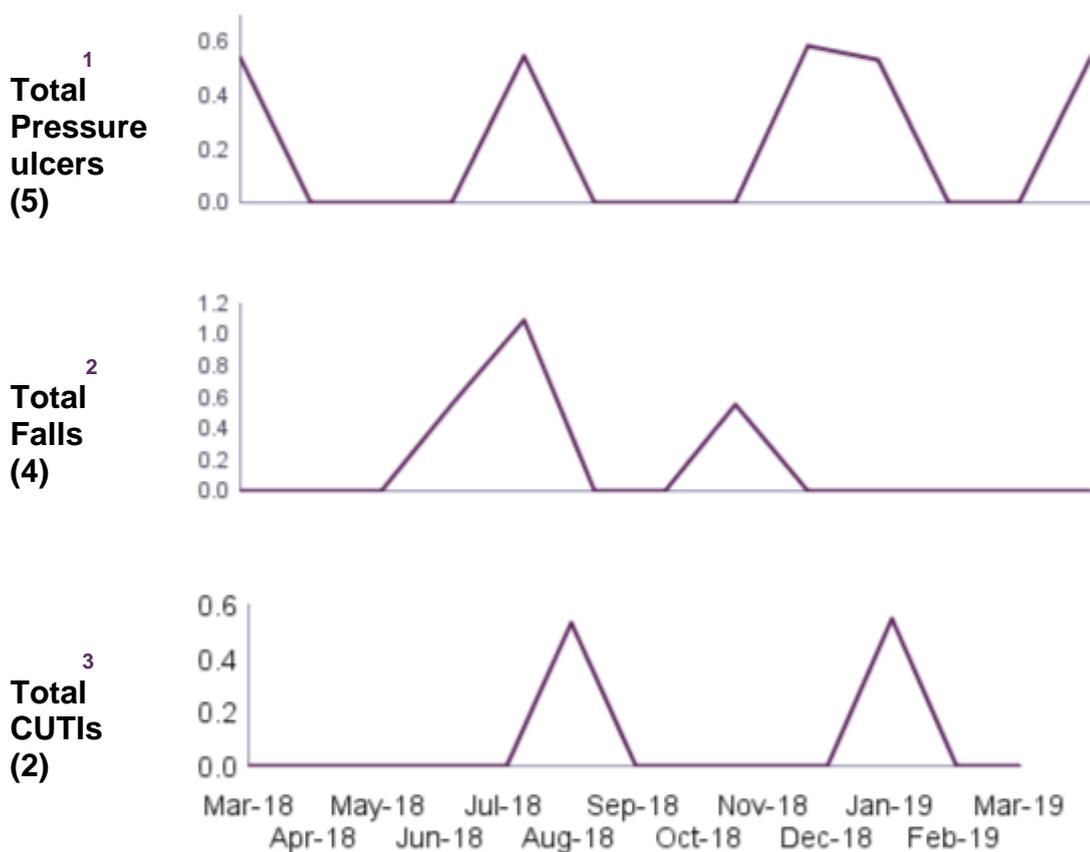
Safety thermometer data was displayed on wards for staff and patients to see. For services where they don't use the safety thermometer use, 'The service continually monitored safety performance'.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers, four falls with harm and two new catheter urinary tract infections from March 2018 to March 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter acquired urinary tract infections at County Durham and Darlington NHS Foundation Trust



- 1 Pressure ulcers levels 2, 3 and 4
- 2 Falls with harm levels 3 to 6
- 3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of patient's subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

The trust had a robust structure to support the identification, dissemination, implementation and monitoring of recommendations and quality standards from NICE. New guidance was disseminated monthly to each area of the trust, including surgery, to review and assess for relevance and level of implementation through their governance arrangements. Quarterly reports on status with meeting NICE guidance was presented to the safety and quality committee.

Staff had access to trust policies via the intranet. Patient records showed staff used standardised care pathways to plan care for patients. We looked at some of the trust's clinical protocols and patient pathways used for patients on surgical wards. We found these followed nationally recognised best practice and current evidence base. For example, staff used a sepsis screening tool and placed patients who met the criteria on the sepsis pathway. This pathway included the 'Sepsis Six', designed by the 'UK Sepsis Trust', which consists of diagnostic and therapeutic steps to be taken within one hour of diagnosis to improve patient outcomes, including up to a 50% reduction in mortality.

The trust participated in the 'Getting It Right First Time' (GIRFT) project, commissioned by the Department of Health. This is a national programme designed to improve the quality of care within the NHS by reduction of unwanted variations and or divergence from the best evidence. Senior leaders within surgery told us about GIRFT quality improvement projects in orthopaedics and general surgery.

Risks associated with falls, pressure ulcers, catheter-acquired urinary infections, and surgical site infections were monitored monthly using the National Health Service Safety Thermometer.

Audits were undertaken for the completion and accuracy of care bundles, deteriorating patient, medication and documentation such as those which related to infection prevention and control. Results showed good levels of compliance. Ward sisters completed trust-wide nursing audit programmes and we saw results and action plans.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

The trust used a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that staff followed MUST scoring for nutrition and hydration appropriately. Nutrition and hydration needs were identified and managed as part of the electronic care plan system.

The surgery care group had instigated MUST audits which showed that compliance was variable. The surgical triumvirate told us that this was due to results of transcription error (not applicable being recorded as a no) with quality data collection (prior to perfect ward – May 2019). The recent move to perfect ward data collection evidenced that the audit was collected and stored in real time. Compliance for MUST screening was consistently above 94% (June 2019) against every patient record in surgery.

The ward dietitians and nutrition nurse specialist continued to support the ward staff and management where required. In addition to this, there had been the creation of a project dietitian post to help support the implementation of nutrition related digital platform objectives and nutrition related perfect ward issues.

We reviewed care plan documentation, risk assessments were fully completed and fluid, food and rounding charts were completed appropriately. Patients waiting to have surgery were not left nil by mouth for long periods.

Specialist support from staff such as dieticians was available for patients who needed it.

We observed protected meal times were in place and saw patients supported to eat and drink. Systems were in place to identify patients who needed additional support with eating and drinking. Patients who required assistance were given a water jug with a red lid and a red placemat at meal times to highlight assistance was required. Drinks were readily available and were in easy reach of patients.

Most patients said food was good, menus were varied. The quality and quantity of food was monitored through patient led assessments of the care environment (PLACE) which showed an overall satisfaction with food provided. The PLACE scores for ward food was 96.57% which was higher than the national average of 90.17%.

Individual multicultural patient needs were catered for including, vegetarian, vegan and halal choices.

Policies were in place regarding fasting times and intravenous fluids in line with best practice. We saw records in notes for patients who received nutrition via nasogastric tubes, including the day and reason for insertion, the type of tube, measurement, aspirate pH and a confirmation that consent had been obtained.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We reviewed care plans related to pain management. Staff assessed patients regularly to see if they were in pain. Pain relief was provided as prescribed and there were systems to make sure additional pain relief was accessed through medical staff and advanced nurse pain specialists if required. The trust adhered to the Royal College of Anaesthetists (RCOA), faculty of pain medicine: Core Standards for Pain Management Services in the UK – October 2015.

We reviewed the trusts adherence against the standards and were assured that the trust had a robust pain management process in place. The Darlington Memorial Hospital site had a consultant, leading pain management and a consultant rota for consultants with acute pain rounds factored into

their job-plan. Out of hours calls for assistance with pain problems were directed to the first on call anaesthetist which was someone working at CT2 (first or second year doctor level).

Advanced nurse pain specialists were available Monday to Friday during the day and Saturdays, 8 - 2pm at DMH. Telephone advice was also available for staff. At the Darlington Memorial Hospital site, the nurse specialist pain team consisted of three nurses; one whole time equivalent (WTE) band seven and two WTE band 6 nurses

The surgery care group conducted a patient experience survey. This evidenced that 94% of respondents rated their overall experience of the acute pain service as being good to excellent

Pain assessments were completed during the admission process within the trust. If required, ongoing assessment was continued on paper subsequently during the admission period. The surgery care group were evaluating whether the admission pain assessment document could be utilised for ongoing monitoring meaning pain assessments for the duration of the patient stay would be captured within the digital platform. We were told if this was agreed through the governance process, then the group would expect to be in a position to roll this out within the next three months.

We saw pain assessments were not documented consistently across the wards we visited. We saw documentation specific to pain assessments were used on some wards and on others we saw no evidence of pain assessment. We reviewed the electronic pain care plan and saw that the guidance stated, 'administer medication and monitor'.

Ward staff told us that patients experiencing pain and subsequently prescribed PRN (as and when required) analgesia should have pain levels reviewed and assessed each time medication was due to be dispensed, or at least four hourly. Ward staff told us that a care plan for pain management would be activated on the electronic pathway if patients required regularly analgesia and subsequently assessment of pain should be logged within the electronic system. However, we saw that paper pain assessment documents were still used across some of the wards. We reviewed four patients receiving PRN analgesia and saw that two did have a paper pain assessment and two did not. The two patients who did not have a paper pain assessment record had been assessed using the electronic pain care plan seven days previously but had not been reviewed since. However, we saw PRN analgesia had been dispensed.

We were not assured that all patients experiencing pain were consistently monitored in accordance with the trust policy. Ward staff told us that paper records were discouraged, and staff were proactively supported to record pain assessment scores on the electric pathway.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The service used nursing quality indicators and each ward participated in the audit programme. We reviewed the quality indicators for June 2019. The results for the wards that we inspected evidenced a compliance range from 86 - 99%. We saw the results of the indicators on the performance boards on each ward we visited, which were discussed at team briefs to raise awareness and drive improvement.

The trust continued to use a wide range of mechanisms to monitor and measure patient and clinical outcomes and performance. There was a robust local clinical audit programme in place

with active participation in the national programme of audits. Implementation of NICE guidance and other professional guidelines was monitored and reviewed and incorporated into trust policies and clinical guidelines wherever appropriate.

Following the instigation of the digital platform for National Early Warning Score (NEWS2) in adult inpatient areas, the trust no longer completed the traditional monthly observation chart audit. In surgery, the observations overdue performance scored 19.5% in June 2019. Compliance was reviewed through governance meetings and escalated through clinical team meetings for shared learning. The compliance data was also shared in a number of ways with care groups and clinical teams via the ward performance report shared with senior nurses.

The surgery care group undertook audit of sepsis. All staff were familiar with the sepsis screening tool within the digital platform. The current audit that was completed was in line with the Commissioning for Quality and Innovation (CQUIN) for sepsis management which was a random trust sample of patients with confirmed sepsis. Most recent data was for quarter four where 100% sepsis screens were completed and compliance for antibiotics within 1 hour was 94%. Surgery care group patients were included in this audit.

The surgery care group worked collaboratively with the infection control team to support the ongoing monitoring of surgical site infection.

In line with surveillance of surgical site infection (SSI) in orthopaedic surgery which became mandatory for all English NHS trusts; the trust complied with a minimum requirement of one, three-month period of surveillance being performed in at least one of the following orthopaedic procedures:

- Total hip replacement
- Total knee replacement
- Repair of neck of femur
- Internal fixation of long bones

From January to March 2019 the total number of repair of neck of femur procedures across both sites at Darlington Memorial Hospital and the University Hospital of North Durham was 158. The trust reported two inpatient/readmission infections and 0% post discharge infection. The trust reported a total of two infections in that timeframe which equated to 1.26% infection rate.

Multidisciplinary surgical site infection (SSI) and hip fracture steering groups were instigated monthly to review the hip fracture data and hip fracture pathway. A number of changes had resulted in the reduction of infection rates at Darlington memorial hospital including:

- Polymerase chain reaction (PCR) testing of patients for multi resistant staphylococcus Aureus (MRSA)
- Patient specific antibiotic policy
- Pre-warming of patients prior to surgery
- Transfer of patients to theatre on trolley versus bed, no linen.
- Standardisation of bear hugger use

- Use of copal cement in hemi arthroplasty surgery

This had reduced infection rates from 4% to 1.2% or less over the last four years.

The care group instigated audit surrounding the insertion and management of naso gastric tubes. The audit demonstrated that there were some deficits in documentation at the time of the audit and a re-audit was planned for August 2018. The trust had introduced a Local Safety Standards for Invasive Procedures (LocSSIP) for nasogastric tube (NG) insertion and had also recently changed the NG tubes used within the trust. The re-audit had been re-scheduled later in 2019.

We discussed naso gastric tube insertion with nursing staff during inspection. They were aware of the trust naso gastric check list and process surrounding the insertion and management of naso gastric tubes. Registered nurses informed us that they were required to meet the competency framework for the insertion and management of nasogastric tubes.

Following our inspection, the trust provided venous thromboembolism (VTE) risk assessment audit data at trust level. The information department identified all patients that have had a VTE and if they have been receiving care within the organisation within 90 days prior to the event. Details were sent to the care groups so that an RCA was instigated as appropriate. The care group leads for VTE received the names and identification details, so a review took place. The safety committee received a copy of this report.

The care group reported in quarter 4, January to March 2019, that the trust had reported and investigated 17 venous thromboembolisms. The trust no longer had a VTE group, there was a lead clinician who reviewed the policy and drug regimens and this was approved through the clinical standards and therapeutics committee.

The associate director of nursing reviewed the monthly data of new VTE and those who had been within the surgery care group prior to the VTE being identified. This information was collated through the patient safety team and reported to the commissioners on a quarterly basis.

We reviewed theatre utilisation rates at Darlington Memorial Hospital which evidenced in quarter 1 (April, May and June) theatre utilisation was 77.23% and overall sessions for that quarter evidenced 776.

The Pharmacy team conducted bi-monthly audits on surgical wards. The trust provided data which indicated that monthly antimicrobial care bundle audits were undertaken. The results of these audits showed that surgical wards were predominantly compliant with most aspects of the audit. There were some areas of non-compliance in daily reviews of intravenous antimicrobial prescribing, patients switching to oral antibiotics once they were deemed to be clinically appropriate to do so and a review date or duration being documented. The lowest documented compliance score was 67% for review date recorded on ward 31.

We reviewed the surgery care groups audit compliance for medicines reconciliation, critical missed doses and controlled drugs audits post inspection. Pharmacy delivered surgical medicines reconciliation in line with priorities agreed with the surgical clinical directors. In orthopaedics, this involved focusing on the patients most at risk of post-operative complications (e.g. hip and knee replacement, patients with a fractured neck of femur). The audit undertaken in January 2019 evidenced low compliance rates on the four wards audited (see table below)

Medicines reconciliation, Darlington Memorial Hospital (January 2019)

Site	Ward	Speciality	MR completed	MR completed <24hrs	Comment
DMH	SSU	Short Stay Unit	0%	0%	No pharmacy service provided
	31	Surgical Admission/ENT	5%	5%	No pharmacy service provided
	32	General Surgery / Bariatrics	32%	29%	Only bariatric patients seen
	33	Orthopaedics	83%	66%	Aim to see all patients with priority to fractured neck of femur

As part of the pharmacy operational plan for 2019/2020 a number of work streams were underway in relation to medicines reconciliation. These included:

- 4) Review of medicines reconciliation processes to streamline based on lean principles. Lean is a set of operating philosophies and methods that help create a maximum value for patients by reducing waste and patient waits at point of discharge.
- 5) Front-loading of pharmacy technicians to admissions areas (implemented May 2019) assisting with medicines reconciliation, missed doses and adherence to policy.
- 6) Identification of patients for review on high risk medicines (via ePMA) in areas without a regular pharmacy service.

The data for missed doses was not available at surgery care group level. A recent audit of the ePMA data and incident data identified that 14 of 18 omitted dose incidents in April 2019 related to critical medicines.

In response to this the Pharmacy team implemented the following actions:

- 5) The Pharmacy team developed a critical medications site on the intranet site. This allowed staff to search for medication that was unavailable and identified the action to be taken.
- 6) The team added specific warnings to critical medicines in the additional information on ePMA electronic system.
- 7) The team delivered a presentation to all clinical staff in a number of forums including care group governance meetings, senior nurse forum and sisters away day.
- 8) The team publicised it through "the week ahead" and "medicines bulletins".

Relative risk of readmission

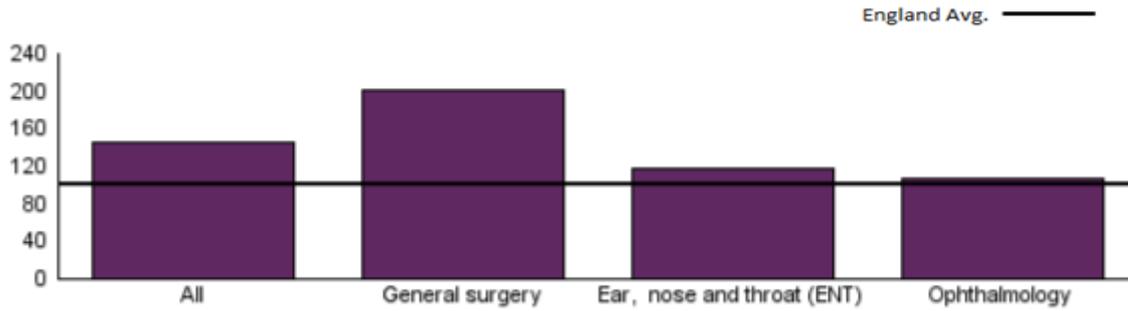
Darlington Memorial Hospital

From January 2018 to December 2018, all patients at Darlington Memorial Hospital had a higher than expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients and Ear, nose and throat (ENT) patients at Darlington Memorial Hospital both had a higher than expected risk of readmission for elective admissions when compared to the England average.

- Ophthalmology patients at Darlington Memorial Hospital had a similar to expected risk of readmission for elective admissions when compared to the England average.

Elective Admissions - Darlington Memorial Hospital

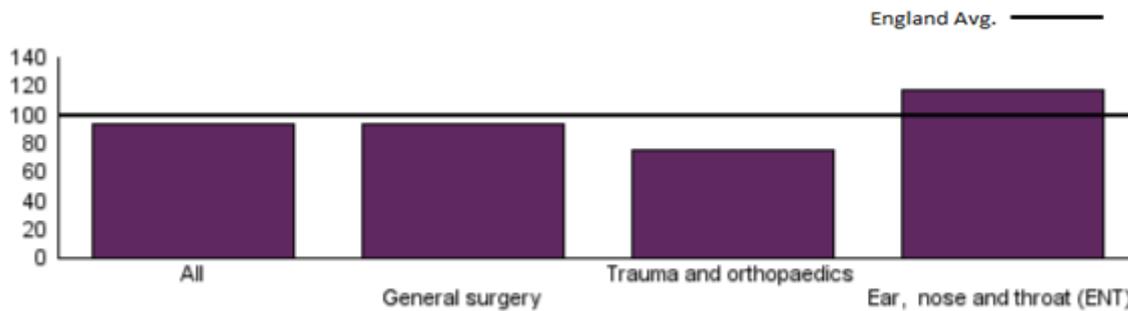


Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

All patients at Darlington Memorial Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients and trauma and orthopaedics patients at Darlington Memorial Hospital both had a lower than expected risk of readmission for non-elective admissions when compared to the England average.
- Ear, nose and throat (ENT) patients at Darlington Memorial Hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - Darlington Memorial Hospital



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity

Post inspection the surgery care group senior management team provided an update on readmission rates within the surgical division across the trust. This information was not split by site to investigate specific site readmission rates:

General Surgery

A review of the data demonstrated that 40% of the readmitted patients had returned to the clinical decisions unit (CDU) which was the surgical assessment unit for ambulatory patients, 50% of these had returned within one week. These patients would have initially been assessed in the CDU and then returned for results of diagnostic investigations or treatment, but these were not true readmissions. If these figures were removed from the data this would reduce the readmission rate to below 9%, which was in line with other regional providers.

Ear, nose and throat

Over 25% of ENT readmissions were to CDU, of which just under 80% were within a week. As with general surgery patients these patients would be returning for results or treatments and were not true readmissions. If these were removed from the readmission figures then the readmission rate would drop to 6%, which was in line with the regional average.

Plastics

Almost 25% of patients recorded were readmissions who attended the plastics dressing clinic which would indicate that they were attending for treatment and as such not true readmissions. If these figures were removed from the numbers, then the readmission rate reduces to 3% which was in line with regional organisations.

It was recognised that there were issues with data quality which the surgery care group agreed to address. There had been no specific issues raised by external reviews (e.g. GIRFT) around readmission rates for any of these services.

National Hip Fracture Database

Darlington Memorial Hospital

The table below summarises Darlington Memorial Hospital's performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, 'similar' means that the trust's performance fell within the middle 50% of results nationally.

Metrics (<i>Audit indicators</i>)	Hospital performance	Comparison to other Trusts	Meets national standard?
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	104.4%	Similar	✓
Crude proportion of patients having surgery on the day or day after admission <i>(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)</i>	78.3%	Similar	✗
Crude peri-operative medical assessment rate <i>(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome)</i>	81.2%	Bottom 25%	✗
Crude proportion of patients documented as not developing a pressure ulcer <i>(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient's</i>	99.2%	Top 25%	✗

<i>admission); this measures an organisation's ability to report 'documented as no pressure ulcer' for a patient</i>			
Crude overall hospital length of stay <i>(A longer overall length of stay may indicate that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)</i>	17.8 days	Similar	No current standard
Risk-adjusted 30-day mortality rate <i>(Adjusted scores take into account the differences in the case-mix of patients treated)</i>	4.7%	Within expected range	No current standard

(Source: National Hip Fracture Database 2018)

Post inspection the surgery care group provided an update with regard the above data. The 2017/18 report demonstrated a number of areas of good practice including prompt surgery, National Institute of Clinical Excellence (NICE) compliance, return to original residence and no evidence of delirium when assessed post operatively, which the service had sustained. There were two main areas of non-compliance identified; ortho geriatric review at Darlington Memorial Hospital and prompt mobilisation at University Hospital of North Durham. The Trust had recruited an additional consultant ortho-geriatrician at Darlington Memorial Hospital. This had provided a more consistent approach, with performance dashboard shared three times a year at governance meetings and the hip fracture steering group. Currently physiotherapy staff attended ward huddles and rounds, prioritising patients for first day post-operative mobilisation.

Bowel Cancer Audit

The table below summarises County Durham and Darlington NHS Foundation Trust's performance in the 2018 National Bowel Cancer Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Meets national standard?
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	114.4%	Good	Good is over 80%
Risk-adjusted post-operative length of stay >5 days after major resection <i>(A prolonged length of stay can pose risks to patients)</i>	71.3%	Worse than national aggregate	No current standard
Risk-adjusted 90-day post-operative mortality rate <i>(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure)</i>	1.7%	Within expected range	No current standard
Risk-adjusted 2-year post-operative mortality rate <i>(Variation in two-year mortality may reflect, at</i>	27.9%	Worse than expected	No current standard

<i>least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy)</i>			
Risk-adjusted 30-day unplanned readmission rate <i>(A potential risk for early/inappropriate discharge is the need for unplanned readmission)</i>	9.7%	Within expected range	No current standard
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection <i>(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases, it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)</i>	53.8%	Within expected range	No current standard

(Source: National Bowel Cancer Audit 2018)

Post inspection the surgery care group provided an update with regard the above data. The 2018 annual report contained data from the 2017/2018 reporting period covering patients in England and Wales with a date of diagnosis from 01 April 2016 to 31 March 2017. In December 2017 the trust implemented the Somerset Cancer Registry (SCR) which was a more robust national data collection system. Following this, the team cancer services team carried out a review of data collection strategies and implemented a number of changes as to how the trust collected and nationally reported key data items.

The following actions had been implemented:

- Performance status was discussed at all treatment planning multi-disciplinary team meetings (MDT's) and recorded on the corresponding MDT module within the summary care records (SCR) database.
- Cancer outcomes and services data set (COSD), data reports were validated prior to the monthly data submission deadlines and where, as far as possible, missing data items were located within the patient's digital record and the summary care record updated.
- National bowel cancer audit (NBCA) data compliance reports (available via the Health and Social Care Information Centre (HSCIC) portal) were utilised to identify any missing data, missing items and gaps filled where possible.

The results from the national bowel screening audit were discussed by the colorectal clinical lead at the general surgery clinical governance meeting on 29th January 2019 and it was highlighted that County Durham and Darlington Foundation Trust, was an outlier for recording performance status.

National Vascular Registry

The table below summarises County Durham and Darlington NHS Foundation Trust's performance in the 2018 National Vascular Registry.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Meets national standard?
Abdominal Aortic Aneurysm Surgery			

<i>(Surgical procedure performed on an enlarged major blood vessel in the abdomen)</i>			
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	108.0%	Not applicable	✓
Risk-adjusted post-operative in-hospital mortality rate <i>(Proportion of patients who die in hospital after having had an operation)</i>	3.0%	Within the expected range	No current standard
Carotid endarterectomy <i>(Surgical procedure performed to reduce the risk of stroke; by correcting a narrowing in the main artery in the neck that supplies blood to the brain)</i>			
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	100.0%	Not applicable	✓
Crude median time from symptom to surgery <i>(Average amount of time patients wait to have surgery after the onset of their symptoms)</i>	17 days	Not applicable	✗
Risk adjusted 30 day mortality and stroke rate <i>(Proportion of patients who die or have a stroke within 30 days of their operation)</i>	4.6%	Within the expected range	No current standard

(Source: National Vascular Registry 2018)

National Oesophago-gastric Cancer Audit

(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises County Durham and Darlington NHS Foundation Trust's performance in the 2018 National Oesophago-gastric Cancer Audit.

Metrics <i>(Audit measures)</i>	Trust performance	Comparison to other Trusts	Meets national standard?
Trust-level metrics <i>(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)</i>			
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	>90%	Better	No current standard
Age and sex adjusted proportion of patients diagnosed after an emergency admission <i>(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)</i>	15.7%	Similar	No current standard
Risk adjusted 90-day post-operative mortality rate <i>(Proportion of patients who die within 90 days of their operation)</i>	Not eligible	N/A	No current standard
Cancer Alliance level metrics			

(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.

Crude proportion of patients treated with curative intent in the Cancer Alliance <i>(Proportion of patients receiving treatment intended to cure their cancer)</i>	38.3%	Similar	No current standard
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(Source: National Oesophago-Gastric Cancer Audit 2018)

National Emergency Laparotomy Audit

Darlington Memorial Hospital

The table below summarises Darlington Memorial Hospital's performance in the 2018 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard).

Metrics <i>(Audit measures)</i>	Hospital performance	Audit's Rating	Meets national standard?
Case ascertainment <i>(Proportion of eligible cases included in the audit)</i>	73.5%	Amber	✗
Crude proportion of cases with pre-operative documentation of risk of death <i>(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)</i>	69.1%	Amber	✗
Crude proportion of cases with access to theatres within clinically appropriate time frames <i>(Proportion of patients who were operated on within recommended times)</i>	86.2%	Green	✓
Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre <i>(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)</i>	100.0%	Green	✓
Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively <i>(Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation)</i>	85.4%	Green	✓
Risk-adjusted 30-day mortality rate <i>(Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)</i>	6.5%	Within expected range	No current standard

Post inspection the surgery care group provided an update with regard the above data. The trust had exceeded the national target for surgical and anaesthetic consultant presence in theatre and the mortality figures were 6% at the University Hospital of North Durham and 6.5% at Darlington Memorial Hospital against a national mortality of 9.5%. County Durham and Darlington Foundation Trust had been approached to share best practice in relation to ortho-geriatrician input at Darlington Memorial Hospital.

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The table below summarises County Durham and Darlington NHS Foundation Trust's performance in the 2018 National Ophthalmology Database Audit.

Metrics (Audit measures)	Trust performance	Comparison to other Trusts	Meets national standard?
Trust-level metrics (Measures of hospital performance in the treatment of cataracts)			
Case ascertainment (Proportion of eligible cases included in the audit)	100.0%	N/A	No current standard
Risk-adjusted posterior capsule rupture rate (Posterior capsule rupture (PCR) is the index of complication of cataract surgery. PCR is the only potentially modifiable predictor of visual harm from surgery and is widely accepted by surgeons as a marker of surgical skill.)	1.5%	Within expected range	No current standard
Risk adjusted visual acuity loss (The most important outcome following cataract surgery is the clarity of vision)	0.8%	Within expected range	No current standard

(Source: National Ophthalmology Database Audit 2018)

National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

Darlington Memorial Hospital

The table below summarises Darlington Memorial Hospital's performance in the 2018 National Joint Registry.

	Metrics (Audit measures)	Hospital performance	Comparison to other hospitals	Meets national standard?
Trust-level	Proportion of patients consented to have personal details included (hips, knees, ankles and elbows) (Patient details help 'track and trace' prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)	56.5%	Within expected range	x
Hospital level:	Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of	0.67	Within expected	x

	femur fracture) <i>(Proportion of patients who need their hip replacement 're-doing')</i>		range	
	Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) <i>(Proportion of patients who die within 90 days of their operation)</i>	0.50	Within expected range	x
Hospital level: Knees	Risk-adjusted 5 year revision ratio (for knees excluding tumours) <i>(Proportion of patients who need their knee replacement 're-doing')</i>	0.63	Within expected range	x
	Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) <i>(Proportion of patients who die within 90 days of their operation)</i>	1.00	Within expected range	✓

Post inspection the surgery care group provided an update with regard to the above data. Darlington Memorial Hospital was within expected range for the performance of knee replacement when compared to other trusts. Consent documentation was identified as an area for improvement. The trust had implemented a new system in early 2018, the report correlated data until March 2018 so it was expected that an improvement would be seen in the next report.

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

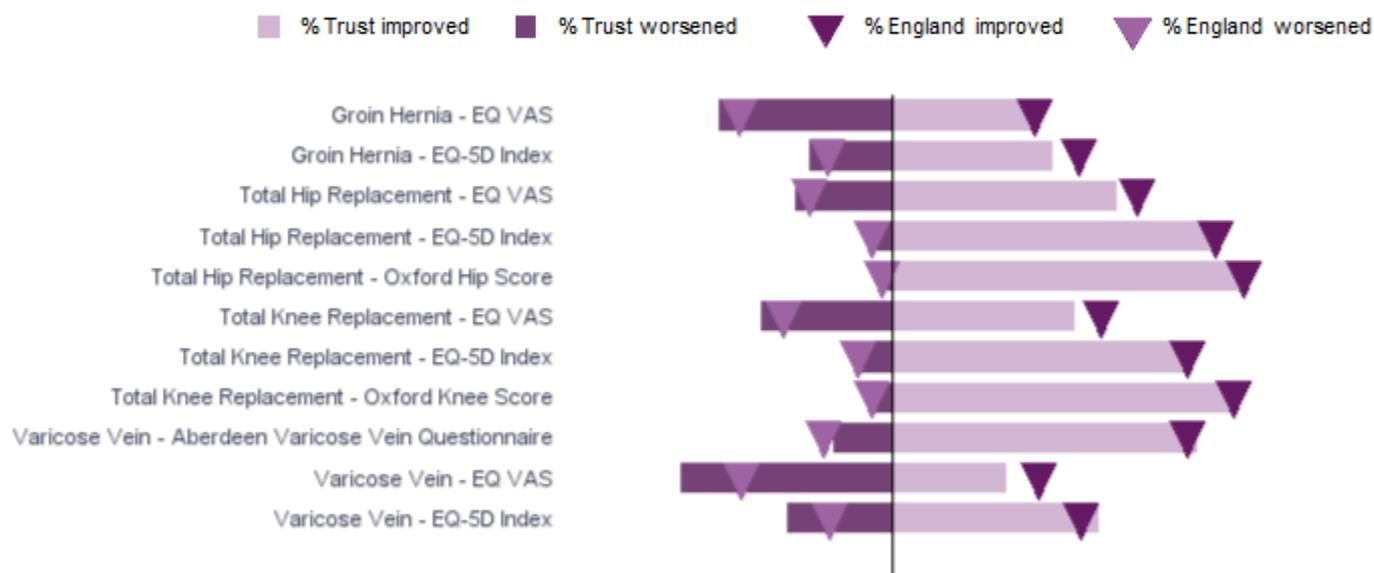
Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)

Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific Issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.



In 2016/17 performance on groin hernias was slightly worse than as the England average

For varicose veins, performance was worse than the England average.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was slightly worse than the England average.

The surgery care groups journey through PROMS had led to essentially a move from 75% uptake of form one to 100% uptake of questionnaire one. There has been year on year improvement in PROMS data in knee replacement with a whole two-point increase on the Oxford score over five years (above the national average).

The surgery care group had identified that hip replacement PROMS was skewed because patients were not correctly recording their co-morbidities and so the data currently says the trust were operating on patients who were fitter than average, when in fact the reverse was the case. The care group had introduced policies to correct this.

The surgery care group had also identified patients who were not getting their operation within three months of their questionnaire one. The care group should see an improvement through questionnaire two uptake.

(Source: NHS Digital)

Surgery outcomes (mortality and complications) were within or better than expected range using retrospective clinical audit (CRAB) data. Getting it right first time (GIRFT) visits had commended elective orthopaedics and some aspects of the ophthalmology service. The national emergency laparotomy audit (NELA) results were ahead of average on a number of indicators and the Durham multi-disciplinary team functional bowel service was an award winning nationally recognised service.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There were daily multidisciplinary meetings on some of the wards we inspected, attended by nursing and medical staff, clinical support workers, pharmacists and pharmacy technicians, occupational therapists and physiotherapists. These meetings included patient condition, clinical care and discharge planning. We observed a multidisciplinary meeting and saw that all staff had good shared knowledge of the patients under their care.

Multidisciplinary team input was recorded in patient records, demonstrating their involvement in care and treatment planning, discharge processes and social considerations.

There were clear internal referral pathways to therapy and psychiatric services.

There were specialist nurses and link nurses available for support on all wards to provide a wider skill set.

Specialist nurses were available to review patients in specialties, such as acute pain, acute intervention team (deteriorating patients), pharmacy and adult mental health liaison. Specialists were also available to support staff groups with training and to participate in multidisciplinary meetings to discuss patient care and treatment.

Allied health professionals confirmed there was good multidisciplinary working and offered training to nursing staff where appropriate. Dieticians completed reviews of patients referred for their input.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. We saw consultants on the ward conducting ward rounds with other healthcare professionals. We examined nursing records and saw that consultants had written legibly in blank ink their assessment of patients and the recommended course of treatment.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The trust monitored its current working scheme against National Health Services (NHS), seven days a week clinical standard. The surgery care group provided evidence to address the four priority clinical standards, which included time to first consultant review, diagnostics, interventions and ongoing review.

The trust submitted its board assessment of seven-day standards in June 2019. The trust declared compliance with all four standards. The report demonstrated an improvement in the percentage of emergency admissions receiving a consultant review within 14 hours from 80% in the previous audit to 92% in June 2019. The trust was 100% compliant with patients receiving a daily or twice daily review as appropriate. Both standards relating to seven-day access to appropriate diagnostics were met.

Patients had seven day a week access to consultant led acute surgical care, diagnostic services, pharmacy and emergency therapies and interventions such as those for emergency surgery. The

trust provided this through on-call services, rotas and working with other providers across clinical networks.

There was regular availability of physiotherapy, occupational therapy and speech and language therapy from Monday to Friday. Therapists (occupational health and physiotherapists) supported the service with seven day working apart from speech and language which was a six-day service.

The psychiatric liaison team were available to provide support for patients in mental health crisis 24 hours a day, seven days and week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff told us they offered health promotion advice to patients relating to smoking, weight loss and healthy lifestyles as well as specific advice about the patient's condition.

Staff could refer patients to support services if they thought patients needed additional help or support.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Patient leaflets were available and displayed at the service including preventing falls and alcohol awareness. There was also a poster labelled 'End PJ Paralysis' encouraging patients to get dressed and out of bed as evidence showed that such patients recovered quicker and felt better. All patients were asked about smoking and alcohol consumption as part of their pre-assessment.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. We examined eight nursing records and saw that patients were assessed for falls, moving and handling, pressure damage, malnutrition, bed rails, VTE, smoking and alcohol consumption. Where appropriate, patients were referred to relevant healthcare professionals such as physiotherapist and dieticians.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personal measures that limit patient's liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The care group had policy and procedures for consent which were aligned to Mental Capacity Act 2005 (MCA) which the staff had access to. Staff told capacity assessments started at the pre-admission assessment stage to ensure patients met their admission criteria. Staff understood the consent to care and best interest process. Staff could identify other situations when capacity assessments would be necessary.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff used the trust's policy as a guidance to make decisions in the patient's best interests. Staff told us that mental capacity and deprivation of liberty safeguards referrals were made through an electronic referral pathway.

Staff made sure patients consented to treatment based on all the information available. Patients told us that the consent process was explained to them when they first saw the consultant. The consultant explained the benefits and risks of their surgical procedure and they had the right to change their mind.

Staff clearly recorded consent in the patients' records. We examined care records, and these showed that consent for treatment was clearly recorded with the signature of the healthcare professional seeking consent clearly written in the records.

Mental Capacity Act and Deprivation of Liberty training completion

Darlington Memorial Hospital surgery department

The trust set a target of 33% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training modules from April 2018 to March 2019 for qualified nursing staff in surgery at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	12	34	35%	33%	Yes

In surgery the target was met for the MCA/DOLS training module for which qualified nursing staff at Darlington Memorial Hospital were eligible.

A breakdown of compliance for MCA/DOLS training modules from April 2018 to March 2019 for medical staff in surgery at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	13	78	17%	33%	No

In surgery the target was not met for the MCA/DOLS training module for which medical staff at Darlington Memorial Hospital were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Competent staff

The Trust had a support in practice (preceptorship, mentorship, clinical supervision) policy that described the support available for clinical staff in the organisation.

All nurses received support with their clinical personal and professional development leading to revalidation through appraisal meetings.

Appraisal rates

Darlington Memorial Hospital surgery department

Staff group	April 2018 to March 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Estates and Ancillary	3	3	100.0%	95%	Yes
Administrative and Clerical	43	45	95.6%	95%	Yes
Additional Clinical Services	83	90	92.2%	95%	No
Medical and Dental	72	84	85.7%	95%	No
Add Prof Scientific and Technic	25	30	83.3%	95%	No
Nursing and Midwifery Registered	128	155	82.6%	95%	No
Total	354	407	87.0%	95%	No

From April 2018 to March 2019, 87.0% of required staff in surgery at Darlington Memorial Hospital received an appraisal compared to the trust target of 95%.

Nursing staff did not meet the trust target of 95% with 82.6%, and medical staff did not meet the target with 85.7%.

Post inspection we received additional data to support appraisal compliance for the surgery care group. The surgery care group had ensured a robust focus on appraisals and role specific training. Individual ward management had supported staff to ensure they had protected free time to undertake training and appraisal. We were told by the surgery care group that they were keen to invest in staff as part of the journey on cultural improvement.

Role specific training had been a journey of improvement, understanding the areas of low compliance, an improvement trajectory was put in place for each domain, and this had shown improvements over the last 12 months.

Post inspection the senior management team provided an update to confirm appraisal compliance to date.

- Year-end appraisal rates for surgery confirmed as 92% overall; however, following a closed down data entry the close down position within the surgery care group was 94% across the trust. The data provided was not split by site.
- The care group had submitted a comprehensive data set which outlined the work that theatres were undertaking, it was recognised that the appraisal rate within this area required further work; however, there was a detailed plan in place to ensure compliance within this area.
- A data capture error had been identified within the medical and dental staff group. Year-end figure for medical staff showed that two doctors remained non-compliant for valid exemption reasons; therefore 100% of all doctors eligible for appraisal completed this within the specified timescales.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff cared for patients with compassion. We saw staff respond quickly to call bells and requests for assistance. Staff introduced themselves to patients, explained care and treatment and we saw them accommodating patient choices. Nursing staff were visible in patient bays.

Patients we spoke with told us that staff treated them with compassion, responded to them quickly and maintained their privacy and dignity. Discussions between staff and patients was carried out in a caring way.

Staff reported good teamwork and said people looked after each other. They said staff were kind to each other and patient focussed. This included staff at all management levels to staff delivering care.

We saw staff from all roles speaking to patients in a caring and courteous manner, displaying a genuine desire to help. We saw confused patients being cared for with kindness and compassion, providing distraction whilst keeping them safe. We saw staff treating patients with kindness, respect and preserving their dignity, sometimes in difficult circumstances.

Patients told us they received good care and were called by their preferred name.

The Patient Led Assessment of the Care Environment (PLACE) score for privacy, dignity and wellbeing was 92.8%, which was above the national average of 84.16%.

Friends and Family test performance

The Friends and Family Test response rate for surgery at County Durham and Darlington NHS Foundation Trust was 35%, which was better than the England average of 25% from April 2018 to March 2019.

A breakdown of response rate by site can be viewed below.

Location/Site	Response rate	Total responses
Darlington Memorial Hospital	22%	2,730
University Hospital of North Durham	49%	5,378
Bishop Auckland Hospital	37%	1,227
Shotley Bridge Hospital	108%	315

A breakdown of response rate by ward can be viewed below.

Ward name	Total Resp ^{1,2}	Resp. Rate	Percentage recommended ³												Annual perf ¹
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	
DC Day Surgery - UHND	3,583	60%	99%	98%	100%	97%	99%	98%	99%	100%	100%	100%	99%	98%	99%
DC Day Surgery - DMH	853	17%	98%	98%	100%	100%	96%	100%	99%	99%	99%	100%	100%	98%	99%
Ward 18 - BAH	724	79%	98%	100%	100%	100%	100%	100%	98%	96%	100%	100%	100%	100%	99%
Ward 33 - DMH	637	50%	100%	100%	98%	100%	95%	99%	95%	98%	98%	100%	100%	98%	98%
Ward 16 - UHND	632	63%	96%	97%	97%	100%	93%	98%	100%	98%	100%	93%	95%	97%	97%
DC Ward 20 - BAH	500	25%	N/A	N/A	98%	100%	100%	98%	100%	100%	100%	100%	100%	100%	99%
Ward 32 - DMH	482	38%	89%	95%	85%	92%	92%	88%	98%	90%	98%	93%	100%	96%	93%
SSU - DMH	397	20%	98%	100%	100%	100%	100%	100%	100%	95%	97%	100%	100%	100%	99%
SAU - UHND	379	62%	100%	100%	97%	100%	95%	100%	100%	100%	94%	100%	97%	100%	98%
Ward 15 - UHND	374	30%	100%	100%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%
DC Day Surgery - SBH	315	118%	100%	98%	100%	100%	N/A	97%	N/A	100%	100%	100%	100%	100%	83%
Ward 31 - DMH	297	14%	86%	83%	95%	92%	98%	94%	100%	97%	93%	94%	96%	100%	95%
Ward 12 - UHND	240	21%	100%	95%	96%	100%	92%	91%	N/A	90%	N/A	100%	N/A	100%	95%
NEVU (Ophthalmology) - UHND	170	31%	100%	91%	95%	93%	93%	100%	100%	100%	100%	100%	100%	100%	89%

Highest score to lowest score

Key 100% 50% 0%

- The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
- Sorted by total response.
- The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Across the care group, ward 31 at Darlington Memorial Hospital had the lowest response rate with 14%, whilst day surgery at Shotley Bridge Hospital had the highest response rate with 118%.

(Source: NHS England Friends and Family Test)

Staff Friends and Family

Improvement was evident between Q1 18/19 and Q1 19/20 where significantly more staff reported that they would recommend services to friends and family who needed treatment and care.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.

We saw that patients were well supported emotionally, and staff were caring and empathetic. There was a room available on wards visited for the use of patients and families and for staff to hold discussions with patients if they were distressed.

Spiritual and pastoral support was available to patients, relatives, carers and staff. Chaplains were available 24 hours a day to provide services for different faiths in the chapel or at the patient's bedside. The chaplaincy held a list of local faith group contacts which could be called upon if there was a specific need that could not be met from within the team.

Staff knew of active support groups for patients that provided emotional support as well as practical advice. There was a range of clinical nurse specialists at the trust and patients and staff spoke positively about their input. For example, pain management specialist nurses provided a high level of emotional support and practical advice.

Patients we spoke with said staff supported them throughout their hospital admission.

The hospital worked with outside organisations who could provide emotional support for patients with addictions. Bereavement services were available that patients and those that were close to them could access.

Staff spoke about patients with mental health needs/learning disabilities/dementia in a compassionate and kind manner.

Staff spoke of the importance of maintaining a person's privacy and dignity whilst managing their safety. They used rooms closest to the nursing station to enable closer monitoring of patients who required this.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

The wards worked with relatives, different services and staff to organise and manage discharges safely and effectively.

Wards had extended visiting hours to allow relatives and those close to patients to visit throughout the day. We saw relatives comforting distressed patients and assisting with their feeding.

Staff involved patients and those close to them in decisions about their care and treatment.

We heard patients being given clear instructions in a caring manner. We spoke with patients who had a good understanding and involvement in their plan of care.

Patients told us they and their families had been involved in care decisions and we saw that conversations with patients and families, including questions and decision-making, were recorded in patient notes. Patients said they felt staff listened to their preferences or concerns and acted appropriately to support them

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people. Surgical services were available to meet the needs of the local population and the service worked in partnership with local clinical commissioning groups (CCGs) and other providers across clinical networks to deliver them.

The service ensured that there were enough staff on duty during each shift. We saw this on display boards which showed the planned and actual number of different grades of staff on each shift.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff ensured that separate bays were allocated for patients of different sex. Staff we spoke with explained that they never allowed mix sex accommodation.

Facilities and premises were appropriate for the services being delivered. The premises had step-free access at the main entrance and there was a reception desk to assist patients and families that needed assistance.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had dementia and learning and disability link nurses. The service had dementia link nurses on each ward we visited. The trust had a dementia strategy in place which

described how staff would be trained in dementia awareness and the identification of dementia champions in each department and service.

The service had an acute surgical admissions unit (ward 31) which received referrals directly from the accident and emergency department. The unit was an acute short stay ward where service users were assessed, treated and commenced on dedicated surgical pathways. The unit had a dedicated ear nose and throat clinical treatment room. Service users were transferred to long stay surgical wards if required. Discharge was planned as part of the surgical pathway.

The service had a clinical decisions unit based on ward 31 (acute surgical admissions) which was nurse led using a specific nurse led pathway. The service was designed to meet the needs of service users referred into the hospital by general practitioners and the accident and emergency service. Following referral, service users were triaged by an advanced nurse practitioner (band 7) who had the autonomy to instigate computerised tomography (CT) scans alongside, phlebotomy testing, intravenous antibiotic therapy with onward referral to a specialist registrar for ongoing review if required.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had dementia and learning and disability link nurses. Where staff suspected patients were living with dementia they were referred to the link nurse for an assessment. There was also a dementia team in the hospital. Patients with learning disabilities usually brought their own carer with them but they could also use the support of the learning disability link nurse.

Wards were designed to meet the needs of patients living with dementia. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Patients with carers could bring their carer on to the wards to stay with the patient and offer the required support.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that interpreters could be booked through the hospital switchboard and they either attended the hospital or could provide interpretation through the telephone.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

A standard operating policy was in place for surgical emergency admissions via the clinical decision unit, surgical assessment units (SAU) or direct admissions to ward areas. This

supported staff in the flow of patients through the service. Patients attended the clinical decision unit. Following assessment people were either discharged or admitted to inpatient wards. The clinical decision unit was nurse led.

GPs referred patients to the trauma clinic for assessment if their case was urgent. The emergency department could refer to the trauma clinic for ongoing management.

The trust had clear arrangements for ensuring surgical outliers on non-surgical wards were seen daily by a relevant consultant or specialist registrar. We discussed the management of these patients and were assured that a robust process was in place. We tracked an outlier report which listed surgical outliers on non-surgical wards. On the day of inspection (02/07/2019) there was no surgical outlying patients at Darlington Memorial Hospital.

Staff told us there were occasions when surgery cancellations including on the day cancellations had occurred. Reasons for these cancellations were due to bed pressures, patient sickness, or bed capacity problems within surgery.

To ensure ongoing performance, weekly reviews of cancer targets took place, colorectal and general surgery planned to support delivery of cancer targets by consultant staff undertaking a mix of general and cancer work.

A consultant led all day trauma list from Monday to Friday. Weekend 9am to 5pm trauma lists were shared with plastic surgery specialty at the hospital.

The discharge management team worked Monday to Friday from 9am to 7pm. On alternate Saturdays, a trained nurse worked a bank shift to provide this service. The discharge team visited wards daily and liaised with the community to help facilitate complex discharges. On ward 14 (surgical day case unit) we spoke to the discharge liaison nurse. This service met the gold standard framework for discharging patients and liaising with community networks for ongoing care and treatment.

The patient flow team visited wards to ascertain bed availability and potential patient discharges each day. Staff told us patients discharges were planned from admission into the service. We reviewed people's discharge plans on the surgical admissions ward (ward 14) which showed the discharge plans had been completed with planned ongoing care in the community.

Average length of stay

Darlington Memorial Hospital - elective patients

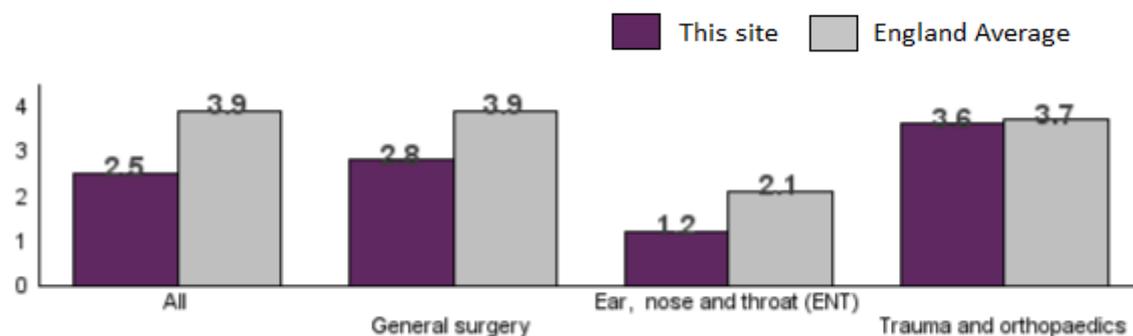
From February 2018 to January 2019, the average length of stay for patients having elective all surgery at Darlington Memorial Hospital was 2.5 days. The average for England was 3.9 days.

The average length of stay for patients having elective general surgery at Darlington Memorial Hospital was 2.8 days. The average for England was 3.9 days.

The average length of stay for patients having elective ear, nose and throat (ENT) surgery at Darlington Memorial Hospital was 1.2 days. The average for England was 2.1 days.

The average length of stay for patients having elective trauma and orthopaedics surgery at Darlington Memorial Hospital was 3.6 days. The average for England was 3.7 days.

Elective Average Length of Stay - Darlington Memorial Hospital



Note: Top three specialties for specific site based on count of activity.

Darlington Memorial Hospital - non-elective patients

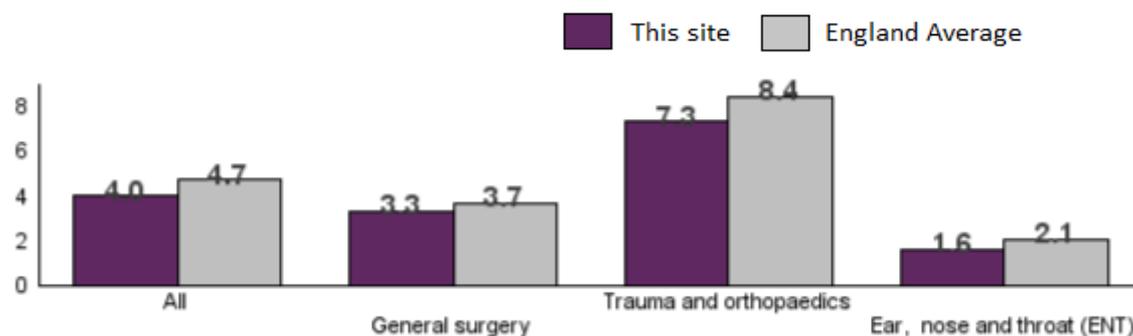
From February 2018 to January 2019, the average length of stay for patients having non-elective all surgery at Darlington Memorial Hospital was 4.0 days. The average for England was 4.7 days.

The average length of stay for patients having non-elective general surgery at Darlington Memorial Hospital was 3.3 days. The average for England was 3.7 days.

The average length of stay for patients having non-elective trauma and orthopaedics surgery at Darlington Memorial Hospital was 7.3 days. The average for England was 8.4 days.

The average length of stay for patients having non-elective ear, nose and throat (ENT) surgery at Darlington Memorial Hospital was 1.6 days. The average for England was 2.1 days.

Non-elective average length of stay - Darlington Memorial Hospital



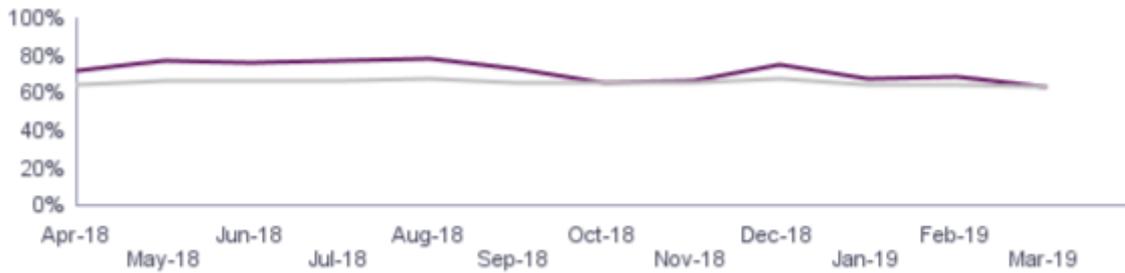
Note: Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From April 2018 to March 2019, the trust's referral to treatment time (RTT) for admitted pathways for surgery overall was better than the England average, with the exception in October 2018, November 2018 and March 2019 where performance was similar to the England average. In the latest month, March 2019, RTT for admitted pathways for surgery was 63.7%, compared to the England average of 63.3%.

— This Trust — England Avg.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Seven specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Cardiothoracic surgery	100.0%	78.4%
Urology	91.2%	75.7%
Plastic surgery	84.9%	79.4%
Ear, nose and throat (ENT)	82.1%	60.2%
Oral surgery	79.7%	56.4%
General surgery	77.0%	71.8%
Trauma and orthopaedics	63.7%	58.5%

One specialty was below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Ophthalmology	62.5%	64.3%

(Source: NHS England)

Cancelled operations

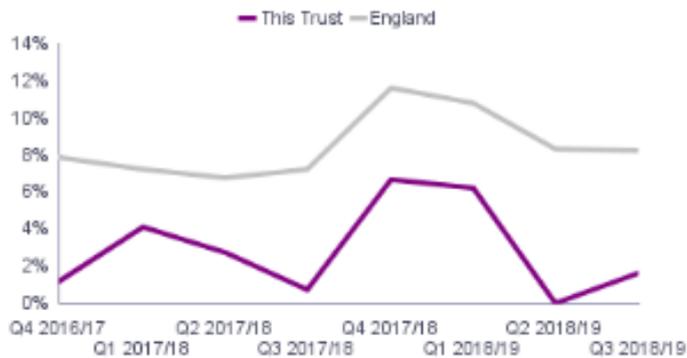
Managers worked to keep the number of cancelled operations to a minimum.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

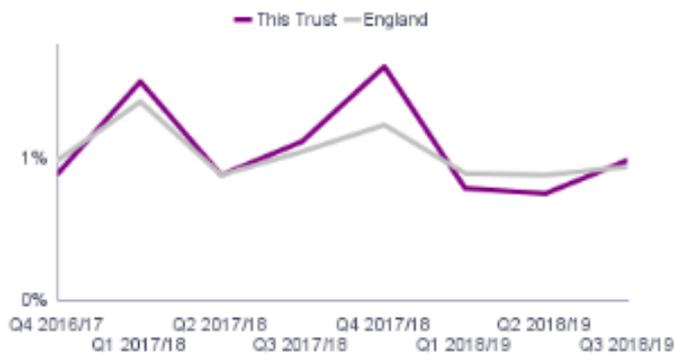
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

Over the two years, the percentage of cancelled operations at the trust was lower than the England average and showed a similar trend. In the latest period, October 2018 to December 2018, this trust cancelled 121 surgeries. Of the 121 cancellations 2% weren't treated within 28 days. The period from January to March 2018 saw the highest number of cancellations (195). Of these cancellations, 7% of patients weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - County Durham and Darlington NHS Foundation Trust



Cancelled Operations as a percentage of elective admissions - County Durham and Darlington NHS Foundation Trust



Over the two years, the percentage of cancelled operations at the trust showed a similar performance and trend to the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Patient moving wards at night

From April 2018 to March 2019, there were 3,555 patient moving wards at night within surgery. Across all surgery wards, January 2019 saw the highest number patient ward moves at night (408).

Location/Site	Number of patient moving wards at night	Proportion of total (%)
Darlington Memorial Hospital	2,821	79.3%
University Hospital of North Durham	728	20.5%
Bishop Auckland Hospital	6	0.2%
Total	3,555	100%

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The surgery care group had developed a sustainable and robust mechanism for timely and appropriate management of complaints. Complaint leads were identified following identification of the key issues, an identified lead either a matron, consultant or service manager. The median time to respond to complaints from the care group was 29 - 35 days which was within the trusts internal 40-day timescale. Overall in 2018/19 the trust achieved an average of 30 days on all responses.

We reviewed three complaints pertaining to the surgery care group. The responses were in line with trust policy and evidenced duty of candour.

Summary of complaints

The service clearly displayed information about how to raise a concern in patient areas. In the corridor on the wards there were patient information racks. These contained a leaflet titled how to raise compliments, concerns, comments and complaints. The trust had a complaints and concerns policy which had been approved in April 2018 and was due for a review in February 2020.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. We saw from the complaints analysis tool that managers logged all complaints with the date that complaints were received and the date they were closed. This log also recorded the number of days that complaints remained open as well as the final outcome of the complaint. Managers also logged the themes of complaints to identify any trends so that appropriate action could be implemented to improve care for patients.

Darlington Memorial Hospital

From April 2018 to March 2019, the trust received 39 complaints in relation to surgery at Darlington Memorial Hospital. The trust took an average of 32.8 working days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be completed in 40 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Patient Care including nutrition / hydration	20	51.3%
Patient Care	7	18.0%
Access to treatment or drugs	4	10.3%
Values & behaviours (staff)	3	7.7%
Appointments	2	5.1%
Communications	2	5.1%
Facilities	1	2.6%
Total	39	100%

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2018 to March 2019, there were 969 compliments received for surgery at the trust

(5.0% of all received trust wide).

A breakdown of compliments by site is shown below:

Site	Number of compliments	Percentage of total
University Hospital of North Durham	506	52.2%
Bishop Auckland Hospital	278	28.7%
Darlington Memorial Hospital	185	19.1%
Total	969	100%

The main themes that run through the compliments relate to the staff going above and beyond what a patient expects them to do, supporting the patient and family during difficult times for them and taking the time to listen and explain things to patients.

All compliments that the trust receive from a patient or the family are all shared with the staff named and their managers, along with the chief executive officer (CEO) if requested to or if it is from a staff member. Senior managers on individual departments shared the compliment with the staff on the ward or in the department.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The trust surgical nursing hierarchy included an associate director of nursing, matrons and band 7 ward managers supported by band 6 nursing sisters. The ward manager reported to a matron, who reported to the associate director of nursing. Staff said they felt supported by their individual matrons.

We saw that senior leaders within the surgery care group were aware of the challenges to quality, risk and safe care. Responses to never events had been proactive with dissemination and learning to reduce risk and prevent recurrence.

Frontline staff were aware of leadership development or succession planning. The leadership structure comprised of a care group triumvirate team, a medical director, associate director of nursing and associate director of operations. Staff said that senior managers were supportive. Senior staff told us the surgery care group triumvirate structure worked well within the service.

We saw good local leadership on surgical wards. Front line staff told us their immediate line managers were visible and approachable.

Clinical staff told us engagement from senior management within theatres had improved since the last inspection. They said senior managers were visible and attended theatres or were involved in departmental meetings. Staff felt that managers had listened to concerns and had involved staff in decision making surrounding planning of the service, risks and continued professional development.

A comprehensive improvement programme covering all aspects of theatre operations (safety, staffing, training and education, scheduling, operational efficiency, staff and patient experience), with local leadership and support from executive directors and the full board which had helped to achieve improved results and team morale. Staff we spoke with spoke positively of the improvement in culture and leadership within the theatre setting since the last inspection.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn in to action, which it developed with staff

Strategic planning for surgery ensured that the surgery care group used a top down and bottom up approach to meet and align local clinical need while ensuring orientation to the trust strategy.

The local clinical teams developed a plan which then fed into a care group plan. The care group plans had been synthesised into the care group plan which ensured alignment of clinical services to the care group and trust priorities.

The care group plan was distilled into easy read posters and plans so each service could understand the priorities and how they fed through the organisation to the trust objectives. This strategic link was supported through appraisals and the “golden thread” to ensure all staff members could understand how they played a part in the wider care group and trust.

Regular strategy and planning workshops with clinical services ensured that all members of the teams at all levels could have a regular touchpoint with senior leaders and ensure their service was on track for improvements and delivery against agreed objectives and plans.

Quality Matters’ was the clinical quality and safety improvement strategy for the trust. The purpose of the strategy was to support the delivery of the organisation’s vision, which is ‘Right First Time, Every Time’. The trusts strategy was ‘our patients matter’.

Staff were not always able to articulate this or say how they would contribute to the strategy, although they told us their aim was to do their best for patients.

The trust vision and strategy was displayed in flow chart format throughout the ward and theatre areas. The four strategic aims were best outcomes, best experience, best efficiency and best employer.

It was the surgery care group’s intention to have the trust’s mission statement as a core platform of all activities to ensure the highest level of quality of services, the minimisation of waste and maximisation of efficiency and the highest standards possible for the workforce environment.

The 2019/20 financial year presented a lot of change and challenge to the care group, but the surgery care group was striving to be as prepared as possible to ensure objectives were met and key changes delivered in a high quality and minimally disruptive way all while working with colleagues in the other care groups and the corporate departments to ensure the best experience for patients and staff.

The three top priorities for the surgery care group were:

- Sustainability and assurance from theatre observational audit
- Development of the University Hospital of North Durham (UHND) front of house model
- Development and implementation of orthopaedic strategy

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values

A significant journey of staff culture, support and improvement had been undertaken within the surgery care group over the last 15 months to help improve the work environment and make surgery an area of choice for staff.

Staff survey results highlighted a number of improvement areas, the care group had worked hard to improve the working life of staff, with the last staff survey being undertaken in 2018 at the start of this journey the group expected significant improvements to be made in the recent survey.

The NHS staff survey 2017 asked staff about equality and diversity. The trust told us there were relatively low numbers of black and minority ethnic employees which reflected the local population demographic. Although the numbers of respondents were not high (53 in surgery and 18 in theatres), of those that did respond, the results demonstrated that some staff with protected characteristics felt they had been treated equitably. This was an improvement since the last inspection.

The care group had focused on a number of key areas highlighted in the staff matters action plan to help ensure staff were proud and happy to work at County Durham and Darlington Foundation Trust (CDDFT) in Surgery.

We saw the staff survey indicated a mixed response from staff. Some felt supported by senior staff and would recommend their area as a place to work, whereas others did not. Some staff were able to tell us how the staff survey was being used to make improvements to culture at work.

We reviewed the 'staff matter – people strategy' action plan 2017-2020 which listed a strategic theme, objectives, action, owner and timeframe. The plan was rag rated and listed a number of key strategic themes including: staff recruitment (nursing and medical), staff retention and turnover, reduce agency staffing, leadership development, staff development, appraisal, core essential training and staff engagement.

The theatres, anaesthetic and critical care team, with support from the surgery care group triumvirate had developed and implemented the theatre matters action plan year 2. This consolidated all the findings of the theatre culture review that was undertaken in 2016. The key findings and associated work streams had been pulled into one project and action plan that was closely monitored. The management teams had worked closely with key stakeholders and support staff working within the theatre environment to proactively manage the change process to ensure sustainability.

We reviewed the theatre matters update on year two progress (January 2019). The update included; work stream never events review, skills matrix, leadership, embedding behaviour, staffing review and recruitment, retention, team development and communication. The update was robust and evidenced clear progress made to date within each key area.

Governance

The service systematically improved service quality and safeguarded high standards of care

The trust had a governance handbook in place which described the governance structures, framework, responsibilities, standards, behaviours and reporting requirements. This handbook

described the different types of governance; for example, corporate, clinical and information. On a day to day basis, management of operations took place within care groups and corporate directorates. Associate directors and clinical directors were expected to take action to achieve care group objectives and to manage risk and escalating risks where necessary to executive directors. Two committees existed to provide executive-level oversight of clinical quality and to allow issues to be escalated.

Performance in meeting objectives was monitored through the integrated performance framework, consisting of integrated reporting and a two-tier review process in which key issues were escalated to a bi-monthly performance review meeting with executive directors. Risks and issues which needed to be escalated for executive-level decisions and or action, were escalated to the executive and clinical leadership committee or depending on the extent to which issues did not require support or consensus from the clinical leadership, they could be taken to the meetings of the executive director's group.

The board had established assurance committees to enable non-executive directors to seek assurance from the directors on the achievement of core operational and strategic objectives, including the development and implementation of strategy, management of key risks and meeting of compliance obligations. These consisted of the integrated quality and assurance committee (IQAC) and the finance committee.

Senior staff confirmed the flow of information from ward level to the executive care group. Quality information flow and discussion travelled through directorate and care group level forums to executive teams.

All surgical specialties had dedicated multi-disciplinary clinical governance meetings as a minimum on a bi-monthly basis. Information from the care group governance team was provided to the specialties for wider discussion through this forum and provided in a format that replicated the care group governance and quality meetings. Any matters for escalation and minutes from the meetings were returned and tabled within the care group governance meeting agenda.

The governance committee meetings discussed aspects affecting the service, for example, serious incidents, complaints and incidents. Pharmacy feedback took place at care group quality governance meetings.

We reviewed meeting minutes from the plastic surgery care group (May 2019) which evidenced review of previous minutes, review of action log and on-going actions and concerns.

The minutes of the hospitals clinical standards and therapeutics committee confirmed ongoing review and discussion across the trusts multi-disciplinary teams in relation to clinical standards, guidelines and protocols and where necessary any changes agreed before approval.

The quality and healthcare governance committee was responsible for providing assurance to the board of directors that the trust was managing the quality of patient care, the effectiveness of clinical interventions, patient experience and patient safety.

The deteriorating patient and resuscitation trust level report, reported monthly, to all care group leads, executive director of nursing and executive medical director and resuscitation and deteriorating patient committee members.

The deteriorating patient and resuscitation care group reports were shared with the care group governance meetings. All cardiac arrest calls were followed up by the cardiac arrest prevention (CAP) team. Details of all medical emergency calls (patient with a NEWS ≤ 9 , clinical concern and uncontrolled end of life symptoms) were held in a central database.

Staff told us ward managers attended clinical governance meetings. Staff demonstrated a basic understanding of clinical governance and said that outcomes of incidents and audits were communicated to them.

The 'Quality Matters' feedback was discussed at matron's meetings, team and ward meetings where actions and discussions took place with staff.

During the inspection, we saw that each ward had a quality matters dashboard which considered audit results, learning from incidents, safety alerts, medicine alerts and 'perfect ward' metrics. These were displayed in staff areas and ward managers told us they reflected areas for improvement and actions needed. The perfect ward metrics were discussed at team meetings and were updated when improvements were made, or other areas were highlighted for focus.

Staff informed us that safety incidents and concerns as well as ward performance against various audits were discussed at staff meetings.

Ward and department sisters used multiple methods to ensure timely and effective cascade of information to individual teams. Regular updates were disseminated through the clinical governance lessons learned information and to avoid delay in sharing of information, teams used their team brief / huddle as a formal way of communicating key messages.

The multidisciplinary care group clinical governance meeting encompassed patient safety and subsequent management, there was no additional patient safety forum. The governance meeting was structured in line with the trust governance handbook and there was a clear, explicit way to be able to ensure that lessons learned were shared alongside an escalation process.

Management of risk, issues and performance

The service had good systems to identify risks, plans to eliminate or reduce them and cope with both the expected and unexpected

The trust used the board assurance framework (BAF) to capture and monitor action plans for board or executive-level risks. In addition, each directorate or care group had its own operational risk register. The trust did not maintain a separate 'corporate risk register'. All risks were managed by individual care groups and directorates on the electronic risk management system. The system could be used to report at different levels. When reporting to the risk management committee, risks were reported where the current score was outside the trust's risk tolerance level set by the trust board.

We examined the risk register for surgery and saw that risks were clearly described and numbered with the impact of each risk recorded. The register also described the mitigating actions that would be implemented if the risk materialised. Each risk had an owner, the date the risk was added to the register, the review date of each risk and the risk target date. There were actions described that would be implemented to counteract the risk with the action owner and a target date. We saw that each risk was evaluated and given a score based on its likelihood of occurring and severity of its impact.

During our visit we discussed some of these risks with staff, for example, staffing, never events, referral to treatment access targets and discharge planning and processes. Our findings are documented throughout the relevant sections of this report.

One risk identified on the risk register was the increased risk surrounding patient safety incidents within the theatre environment. The risk had been added to the risk register in December 2016 with

a risk review date and a risk target date of December 2019. The risk included a recent never event that had highlighted not all new staff had, had sight of the training video regarding the World Health Organisation (WHO), Stop Before You Block (SBYB), Prosthetic Pause. The action was to ensure all staff had sight of this. This was currently a priority to ensure that all staff were aware of correct procedures and had a target date of 31 July 2019. We were assured by the senior management team in theatre that this was given high priority and that staff were given protected time to complete this.

The care group risk register was able to be viewed by the whole senior management team. Risks were identified through specialty (directorates / governance) and care group meeting forums. The care group robustly reviewed the red risks and risks outside of tolerance formally on a monthly basis in the multi-disciplinary care group governance and quality meeting. A full risk register review was undertaken quarterly through this forum. Any staff member through their service specialty meetings had the opportunity to highlight and escalate risks and concerns.

We reviewed two sets of meeting minutes of the surgery care group, integrated governance report (April and May 2019) which confirmed that trust risks were presented to the trust integrated quality and assurance committee.

Trust board meeting minutes confirmed trust board updates and discussions in relation to risks to services.

The surgery care group had rolled out and embedded the use of Local Safety Standards for Invasive Procedures (LocSSIPs) and further reinforced the World Health Organisation (WHO) checklist to reduce risks of harm to patients and to help prevent recurrence of never events. The Trust formed a LocSSIPs implementation and governance group (LIGG). This group brought together members of the corporate governance body with care group representatives in order to develop LocSSIPs. The NatSSIPs were fully implemented in theatres. Safety issues were highlighted to staff groups through the monthly team brief and newsletters. Monthly reports were submitted by pharmacy to the safety group.

We observed that lessons learnt were identified throughout the governance minutes against specific areas, for example, 'matters for escalation and lessons learnt'.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards

All designated staff had access to patients' nursing, therapy and medical records which included assessments, test results, current medicines, consent forms and clinic notes. The nursing and therapy records were paper based and held at the end of patient's beds. This was a security risk as visitors could read this confidential information.

The service used systems and processes to manage the storage of patient records. However, the management of obtaining patient consent for storage of contemporaneous records at the patient's bedside was not robust. The trust had instigated a process for obtaining patient consent; however, on inspection out of 16 patient consent forms inspected only one consent form had been signed for by the patient. The clinical record keeping and healthcare records management policy, consent for accessing contemporaneous records clearly stated the need for a patient signature. This was a deterioration since the last inspection, where the trust had received a should do action requiring that

the trust should ensure patient records are complete. We were advised by the senior team that this was not recorded on the surgical risk register as an identified risk.

The medical records had been transferred to an electronic system that was accessed through a hand-held mobile device. This device was password protected with different levels of access given to staff based on their role within the service. The trust were in the process of moving more assessments and care plans on to the digital platform

Engagement

The service engaged well with patients and staff to plan and manage appropriate services

People using the service were encouraged to provide feedback on the quality of care and service they received. We saw the friends and family test for Darlington Memorial Hospital had a response rate of 35% which was better than the England average of 25% from April 2018 to March 2019. The test showed that for the majority of the wards at University Hospital North Durham, 100% of patients would recommend it to others for treatment, this recommendation did not fall below 83% from April 2018 to March 2019.

Staff told us that an annual staff survey was conducted, and the results of the survey were published on the intranet. The trust had an 'excellence reporting' scheme where staff could nominate colleagues that had gone beyond the call of duty. Nominated staff received certificates. On an annual basis, the trust had recognition awards where staff that went beyond the call of duty received certificates from senior management at an evening award ceremony.

Learning, continuous improvement and innovation

The surgery care group had made improvements, innovations and ensured safe and sustainable services across the care group.

The surgery care group had instigated a bespoke surgical nursing preceptorship support programme. This was developed to be a national leader in support and preceptorship to help sustain and improve recruitment, retention and staff satisfaction.

Some examples of learning, continuous improvement and innovation within surgery care group were as follows:

Waste Management

The trust was in the process of rolling out the use of offensive waste bags (tiger striped) at the Darlington Memorial hospital site, with a view to trust wide moving forward. Waste management was a key part of the trust's response to the collapse of healthcare environmental services, primarily because it enabled the trust to be more resilient by using companies outside of the clinical waste industry and also because it had the potential to reduce the greatly escalating costs. Currently, the orange bags (clinical waste) were still being transported up to 250 miles for disposal whereas the offensive waste bags (tiger striped bags) were going to an energy incinerator in Stockton. Since March this had eliminated around 25 clinical waste truck journeys, which had saved around £50,000 and prevented around 20 tonnes of waste and carbon dioxide emissions.

Trauma and orthopaedics

6. The care group had recruited an ortho-geriatrician to help ensure top tier outcomes and length of stay.

7. The multidisciplinary team and physiotherapy leads were now included in the hip fracture strategy group to ensure an encompassing review for patients.
8. The care group had improved coding to ensure more accurate data for the National Joint Register (NJR) / hip and Patient Reported Outcome Measures (PROMS).
9. The surgery care group had instigated a virtual fracture clinic
10. Musculoskeletal (MSK) triage service introduced to review every orthopaedic referral ensuring best use of resources.

General Surgery

13. National Emergency laparotomy Audit (NELA). Outcomes were better than the national average for CDDFT for mortality and length of stay. Percentage of patients with geriatrician input at UHND commended as best in region/ country, funding agreed to introduce geriatrician support at DMH to replicate good practice at UHND
14. Funding and recruitment approved for an ortho-geriatrician to improve as above
15. Durham Functional Bowel Service – multidisciplinary, award winning and nationally renowned service – strong clinical research links with other NHS and commercial providers
16. HALO technology for treatment of haemorrhoids funded and introduced to improve patient experience and length of stay.
17. Twice daily consultant emergency ward rounds across surgical wards on both acute sites.
18. Clinical decision units on both acute sites – nurse practitioner led surgical assessment for ambulatory patients (supported by on call surgical team). Metrics and outcomes discharging 80% same day.
19. Plans in place for implementation of faecal immunochemical test (FIT) from June 2019 in line with NHS England recommendations.
20. Introduction of coblation for tonsillectomy. Improved patient experience and reduced length of stay (increased day case rates).
21. Introduction of clinician led ultrasound for head and neck cancer clinic to reduce delays at front end of pathway
22. Successful bid for three whole time equivalent cancer care co-ordinators via Macmillan funding for three years to support cancer patients across the organisation.
23. Increased number of consultants, investment in an additional three consultants to help with demand and develop a centre of excellence.

Theatres and anaesthetics

6. Organ donation team – trust ranks as outstanding for referrals and 100% compliant for assessing potential donors
7. Getting It Right First Time (GIRFT). Highlighted as one of the best performers with regards to diabetic patients.
8. Post anaesthesia care unit (PACU). Enhanced care implemented, and all training and support given to help ensure patient safety and experience.
9. Digital platform programme specific to PACU to allow the flow of observations from recovery to PACU area.
10. World Health Organisation (WHO) video rolled out to assist with staff development to train and inform staff on the correct process of the safety check lists within the WHO pathway. The surgery care group was moving towards having this as part of role specific training.

Dermatology and plastics

4. Tele-dermatology triage service was implemented allowing rapid review of suspected cancer and a quick implementation of appointments through innovative telemedicine.
5. Implementation of dermatoscopes in primary care across all areas had allowed community colleagues to refer high quality photos of suspected abnormalities to the trust meaning improved speed and accuracy.
6. Agreed five clinical pathways where patients currently seen in secondary care but could be managed in community implementing referral pro-forma to ensure patients were seen in the right place (acne, psoriasis, eczema, paediatric eczema, rosacea). This joint work with community and primary care had ensured patients are actively managed in a timely way in the correct setting.

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

At County Durham and Darlington NHS Foundation Trust (CDDFT), there are Emergency Departments at Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND).

CDDFT manages five Urgent Treatment Centres (UTC):

- Darlington Memorial Hospital operate a 24/7 GP-led UTC, with GP provision at all times.
- Bishop Auckland and Peterlee UTC operate as a practitioner-led minor injuries unit 08:00-20:00 Monday to Friday and GP-led UTC at all other times.
- Shotley Bridge operates as a practitioner-led UTC service Monday to Friday 08:00-18:00 treating both minor injury and illness and revert to GP-led UTC at all other times.
- North Durham UTC operate 18:00-08:00 Monday to Friday as a GP-led UTC and 24/7 weekends and Bank Holidays.

(Source: Routine Provider Information Request (RPIR) – AC1 Context acute)

Following inspection in September 2018 urgent and emergency care at Darlington Memorial hospital received an overall rating of requires improvement with the key domains of safe and well led as requires improvement with ratings of good in effective, caring and responsive.

Following our inspection in 2018, the following issues were highlighted:

The department was having difficulty meeting the four hour target. Between October 2016 and September 2017 the department had only met the monthly 95% four hour target once.

The room used to assess patients with mental health needs, did not fully conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.

The service did not always have enough staff of the right level to keep patients safe from avoidable harm.

The service did not always manage medicines well.

Clinicians did not update or review care pathways regularly.

The access was blocked to the major incident store cupboard.

The children's resuscitation room doors were not closed or locked allowing easy access from the main corridor, which could be a potential security risk.

The layout of the main reception desk did not provide privacy as patients booked in.

Staff did not always record patients' blood sugar levels when necessary

Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered.

At our most recent unannounced inspection on 2 to 4 July 2019, we followed key lines of enquiry and rated all five key domains; safe, effective, caring, responsive and well led.

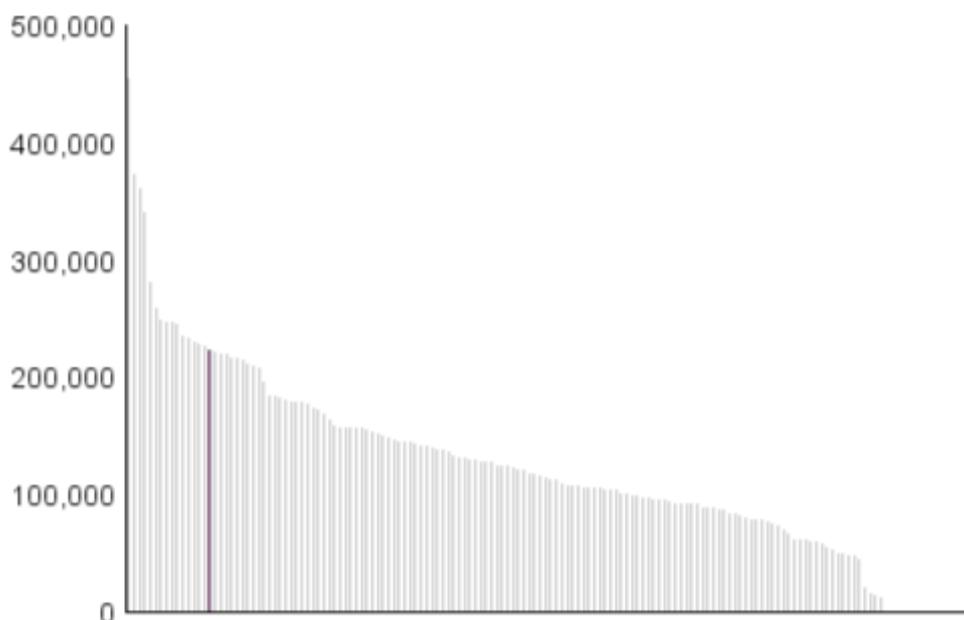
On this inspection we visited the emergency department at Darlington Memorial Hospital

We observed care and treatment, looked at 20 complete patient records, 20 medication prescription charts. We also interviewed key members of staff, medical staff, ambulance personnel and the senior management team who were responsible for leadership and oversight of the service. We spoke with 25 patients, five relatives and 42 members of staff.

We observed patient care, the environment within the department, handovers and safety briefings. We also reviewed the hospital's performance data in respect of the emergency department.

Activity and patient throughput

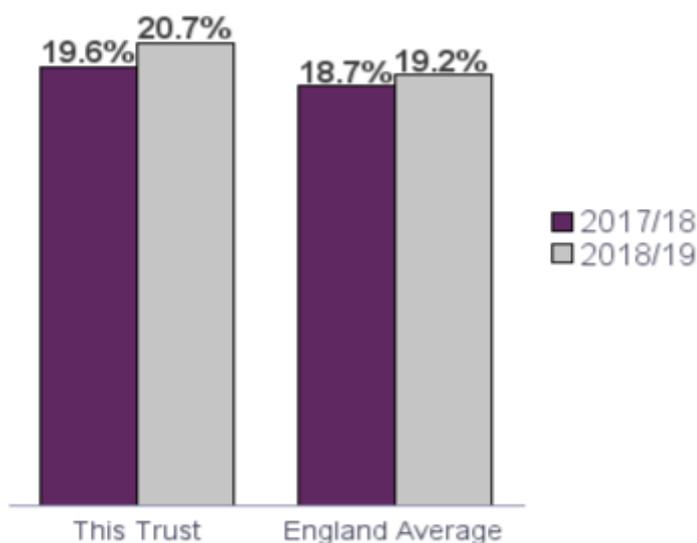
Total number of urgent and emergency care attendances at County Durham and Darlington NHS Foundation Trust compared to all acute trusts in England, February 2018 to January 2019



From February 2018 to January 2019 there were 222,185 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

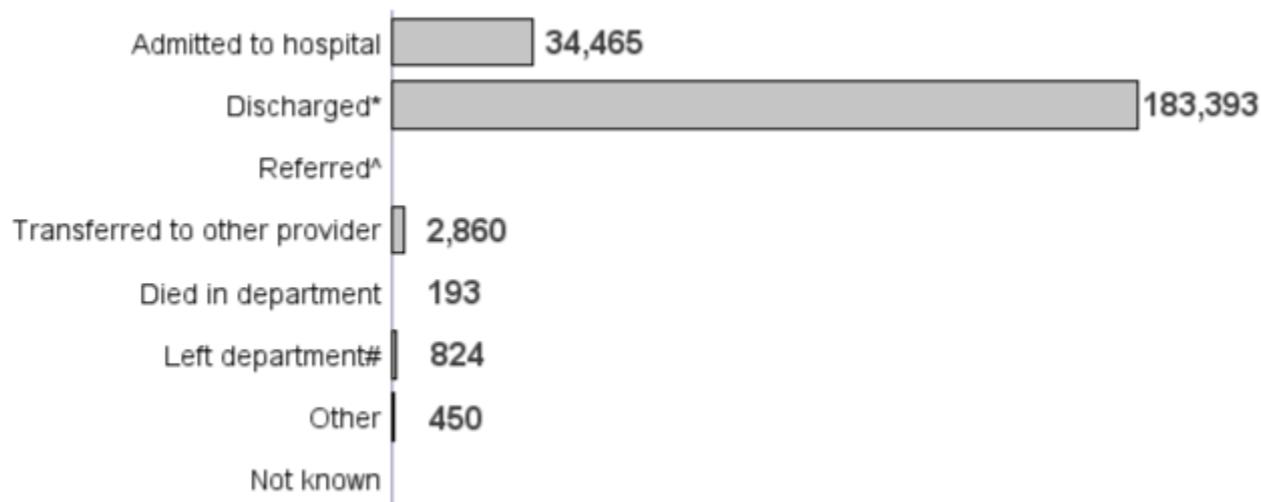
Urgent and emergency care attendances resulting in an admission



The percentage of urgent and emergency care attendances at this trust that resulted in an admission increased in 2018/19 compared to 2017/18. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from February 2018 to January 2019



* Discharged includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or

discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and had introduced systems to ensure everyone completed it.

Mandatory training completion rates

The trust set targets ranging from 50 to 95% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Deteriorating Patient and Resuscitation	1	1	100%	85%	Yes
Information Governance	101	106	95.3%	95%	Yes
Conflict Resolution	93	109	85.3%	85%	Yes
Equality & Diversity	95	112	84.8%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	54	112	48.2%	85%	No
Immediate Life Support (ILS)	0	1	0.0%	50%	No
Immediate Life Support Re-Certification (ILS) - 1 Year	0	1	0.0%	50%	No
Paediatric Immediate Life Support (PILS)	0	1	0.0%	50%	No
Paediatric Immediate Life Support Re-Certification (PILS Re-Cert) - 1 Year	0	1	0.0%	50%	No

In urgent and emergency care the targets were met for three of the nine mandatory training modules for which qualified nursing staff were eligible. Four of the courses had 0.0% completion rate due to only one eligible nursing staff not completing the courses.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Acute Illness Management - No Specific Renewal	2	2	100%	50%	Yes
Immediate Life Support (ILS)	2	2	100%	50%	Yes
Immediate Life Support Re-Certification (ILS) - 1 Year	2	2	100%	50%	Yes

European Paediatric Advanced Life Support (EPALS)	14	15	93.3%	50%	Yes
Equality & Diversity	40	45	88.9%	85%	Yes
Advanced Life Support (ALS) - 4 Years	27	31	87.1%	50%	Yes
Advanced Trauma Life Support (ATLS) - 4 Years	13	17	76.5%	85%	No
Deteriorating Patient and Resuscitation	16	22	72.7%	85%	No
Information Governance	21	32	65.6%	95%	No
Conflict Resolution	21	35	60.0%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	22	45	48.9%	85%	No
Paediatric Immediate Life Support (PILS)	0	5	0.0%	50%	No
Paediatric Immediate Life Support Re-Certification (PILS Re-Cert) - 1 Year	0	5	0.0%	50%	No

In urgent and emergency care the targets were met for six of the 13 mandatory training modules for which medical staff were eligible. Two of the courses had 0.0% completion rate due to only five eligible medical staff not completing the courses. Care should be taken when interpreting low staffing numbers.

Darlington Memorial Hospital urgent and emergency care department

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for qualified nursing staff in the urgent and emergency care department at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Deteriorating Patient and Resuscitation	1	1	100%	85%	Yes
Information Governance	47	47	100%	95%	Yes
Equality & Diversity	44	50	88.0%	85%	Yes
Conflict Resolution	39	49	79.6%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	22	50	44.0%	85%	No
Immediate Life Support (ILS)	0	1	0.0%	50%	No
Immediate Life Support Re-Certification (ILS) - 1 Year	0	1	0.0%	50%	No
Paediatric Immediate Life Support (PILS)	0	1	0.0%	50%	No
Paediatric Immediate Life Support Re-Certification (PILS Re-Cert) - 1 Year	0	1	0.0%	50%	No

At Darlington Memorial Hospital urgent and emergency care department the targets were met for three of the nine mandatory training modules for which qualified nursing staff were eligible.

Four of the courses had 0.0% completion rate due to only one eligible nursing staff not completing the courses.

A breakdown of compliance for mandatory training courses from April 2018 to March 2019 for medical staff in the urgent and emergency care department at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Acute Illness Management - No Specific Renewal	1	1	100%	50%	Yes
Immediate Life Support (ILS)	1	1	100%	50%	Yes
Immediate Life Support Re-Certification (ILS) - 1 Year	1	1	100%	50%	Yes
Equality & Diversity	19	22	86.4%	85%	Yes
European Paediatric Advanced Life Support (EPALS)	5	6	83.3%	50%	Yes
Advanced Life Support (ALS) - 4 Years	11	15	73.3%	50%	Yes
Information Governance	12	16	75.0%	95%	No
Conflict Resolution	13	21	61.9%	85%	No
Advanced Trauma Life Support (ATLS) - 4 Years	6	10	60.0%	85%	No
Infection Prevention and Control - Level 2 - 1 Year	12	22	54.5%	85%	No
Deteriorating Patient and Resuscitation	3	6	50.0%	85%	No
Paediatric Immediate Life Support (PILS)	0	5	0.0%	50%	No
Paediatric Immediate Life Support Re-Certification (PILS Re-Cert) - 1 Year	0	5	0.0%	50%	No

At Darlington Memorial Hospital urgent and emergency care department the targets were met for six of the 13 mandatory training modules for which medical staff were eligible. Two of the courses had 0.0% completion rate due to only five eligible medical staff not completing the courses.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. (AMSAT)

Staff also reported that they received annual training in sepsis management which included the use of sepsis screening tools and the use of sepsis care bundles. We saw examples of the sepsis screening tool throughout all areas of the department.

Managers monitored mandatory training and alerted staff when they needed to update their training. The care group were aware of low compliance and we saw ongoing action plans during our inspection which mitigated the low compliance. We reviewed further training data post

inspection which demonstrated an improving picture across all training modules that had not met the trust target.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff training was provided on how to recognise and report abuse, and staff knew how to apply it.

Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training, with the exception of safeguarding adults level one where the target is 33%.

Nursing staff received training specific for their role on how to recognise and report abuse.

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	90	111	81.1%	33%	Yes
Safeguarding Children Level 3 Roles and Responsibilities	87	109	79.8%	85%	No

In urgent and emergency care the targets were met for one of the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Children Level 3 Specialist	1	1	100%	85%	Yes
Safeguarding Adults Level 1	16	40	40.0%	33%	Yes
Safeguarding Children Level 3 Roles and Responsibilities	11	19	57.9%	85%	No
Safeguarding Children Level 2	0	14	0.0%	85%	No

In urgent and emergency care the targets were met for two of the four safeguarding training modules for which medical staff were eligible.

Darlington Memorial Hospital urgent and emergency care department

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for qualified nursing staff in the urgent and emergency care department at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	41	49	83.7%	33%	Yes
Safeguarding Children Level 3 Roles and Responsibilities	38	49	77.6%	85%	No

At Darlington Memorial Hospital urgent and emergency care department the targets were met for one of the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 for medical staff in the urgent and emergency care department at Darlington Memorial Hospital is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Level 1	10	21	47.6%	33%	Yes
Safeguarding Children Level 3 Roles and Responsibilities	5	11	45.5%	85%	No
Safeguarding Children Level 2	0	5	0.0%	85%	No

At Darlington Memorial Hospital urgent and emergency care department the targets were met for one of the three safeguarding training modules for which medical staff were eligible.

We asked the trust to share updated figures with us showing safeguarding training compliance following inspection. The month end compliance rate for June 2019 demonstrated that the nursing staff group had improved to 83% and to 75% in the medical staff group.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Medical staff received training specific for their role on how to recognise and report abuse.

The department used a screening tool to assess risk of physical abuse in children presenting with an injury.

Staff told us about the child protection information sharing system.

Staff knew about arrangements to safeguard women and children with, or at risk of female genital mutilation (FGM).

Staff knew about child sexual exploitation (CSE) and all staff had undertaken PREVENT training.

All staff within the department were required to complete safeguarding children level one, the current level of compliance was 75% for medical staff and 87% for nursing staff. 100% of paediatric nurses were trained to level three in safeguarding children

The department had access to a senior paediatrician 24 hours per day for child welfare issues.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas within the department were clean and had suitable furnishings which were clean and well-maintained.

Staff completed infection prevention and control training; compliance for nursing staff was 100% and 75% for medical staff.

The Patient Led Audit of the Care Environment (PLACE) assessment, which was patient led, assessed the quality of the patient environment on a yearly basis. The assessment did not cover clinical care provision or evaluate how well staff were doing their jobs. The assessments involved members of the public, former and current patients and members of Healthwatch, who looked at a selection of wards and departments against different criteria which was comprised of:

- Cleanliness
- Condition, appearance and maintenance
- Privacy, dignity and wellbeing
- Dementia
- Access
- Disability
- Food

The results highlighted how the trust was performing individually and nationally to drive improvement across hospital sites, enhance services and better the patient experience. The PLACE assessment results for cleanliness scored 98.97% which was higher than the national average of 98.47%. For condition, appearance and maintenance the trust scored 95.13% which was higher than the national average of 94.3%.

We found equipment was visibly clean and labels were used to identify 'cleaned and ready for use', sharps were disposed of correctly and were signed for. Disposable curtains were in use and had recently been changed in some areas. There were cleaning schedules in place and daily cleaning records showed these were adhered to. Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

We saw posters displayed around the wards we visited about infection prevention and handwashing. Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and throughout ward corridors.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. This included the toys available in the paediatric waiting room.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Patients we spoke with confirmed staff were washing their hands before and after treating them. Hand hygiene audits were completed. We saw hand hygiene audit compliance within the department which demonstrated 100% compliance. The trust also had an action plan for infection

control which included hand hygiene campaigns.

The care group had achieved 100% compliance in all clinical areas in the most recent commode audit (June 2019). We were assured by the senior management team that the trust was ranked second in the North East for cleanliness audit data analysis and action.

To support staff in maintaining levels of infection control waste was separated and disposed of in appropriate colour coded bags. We observed the use of tiger striped bags for the safe disposal of offensive clinical waste at Darlington Memorial Hospital. In order to reduce the cost and impact of waste on the environment surrounding clinical waste, the trust had instigated a review of the use of the clinical waste streams.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

The layout of the department was suitable, and it supported good patient flow. There was easy access to the main hospital from the department.

The children's waiting room within the department had audio and visual separation from the adult section.

There was a separate designated resuscitation room for children, we saw that it had a full range of sizes of equipment and evidence that it was reviewed regularly. We saw daily checklists completed without omission. At the previous inspection we saw that this area was not secured, we saw that the room was secured when not in use.

All resuscitation equipment was available and fit for purpose. All electrical items had evidence of regular checks and none were found to be out of date.

There are facilities for bariatric and dementia patients and internal decontamination facilities.

At the previous inspection it was found that the mental health assessment room was not PLAN (psychiatric liaison accreditation network) compliant. At this inspection the mental health assessment room was fully PLAN compliant.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all of the five Emergency Department Survey questions relevant to safety.

Question	Score	RAG
Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	8.2	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or	6.4	About the same

doctor?		as other trusts
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.5	About the same as other trusts
Q33. In your opinion, how clean was the emergency department?	8.6	About the same as other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.7	About the same as other trusts

(Source: Emergency Department Survey (October 2016 - March 2017; published October 2017))

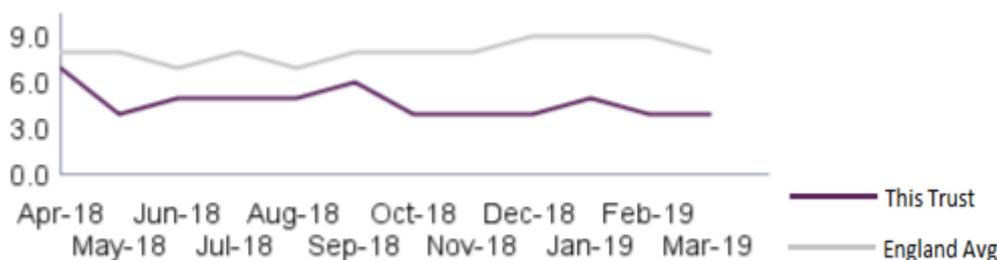
Median time from arrival to initial assessment (emergency ambulance cases only)

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools.

The median time from arrival to initial assessment was better than the overall England median in each month over the 12 month period from April 2018 to March 2019. In the last month, the median time to initial assessment was four minutes compared to the England average of eight minutes.

Ambulance – Time to initial assessment from April 2018 to March 2019 at County Durham and Darlington NHS Foundation Trust



(Source: NHS Digital – Urgent and emergency care quality indicators)

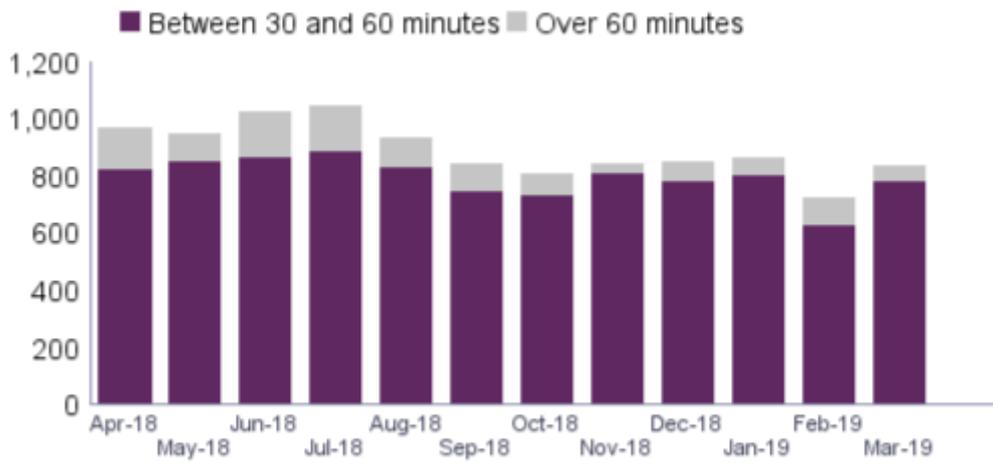
Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Darlington Memorial Hospital urgent and emergency care

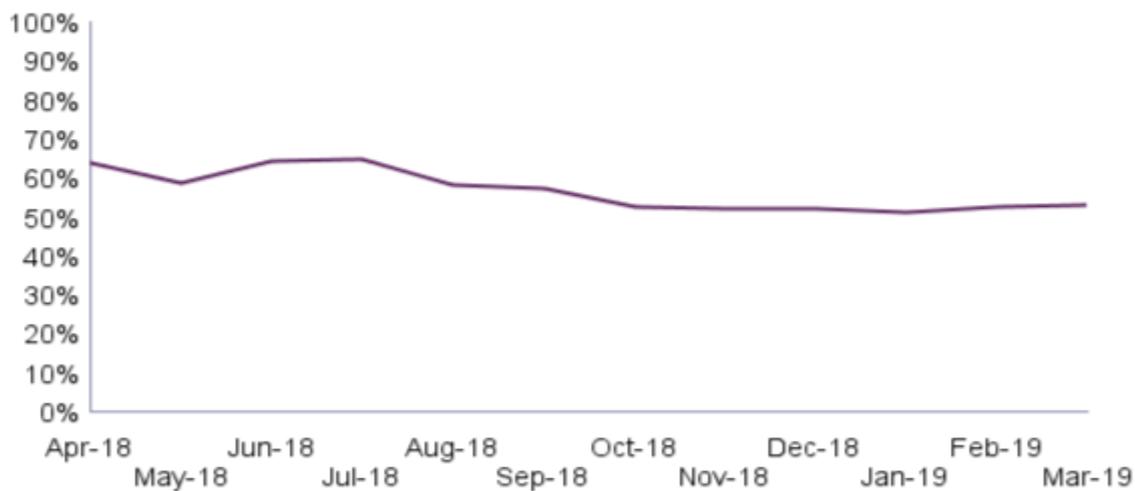
From April 2018 to March 2019 there was a positive downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Darlington Memorial Hospital urgent and emergency care.

In the period of April 2018 to March 2019, July 2018 had the highest monthly percentage of journeys with turnaround times over 30 minutes, with 65.0%. In the latest period, March 2019, 53.2% of ambulance journeys had turnaround times over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes - Darlington Memorial Hospital urgent and emergency care



Ambulance: Percentage of journeys with turnaround times over 30 minutes - Darlington Memorial urgent and emergency care



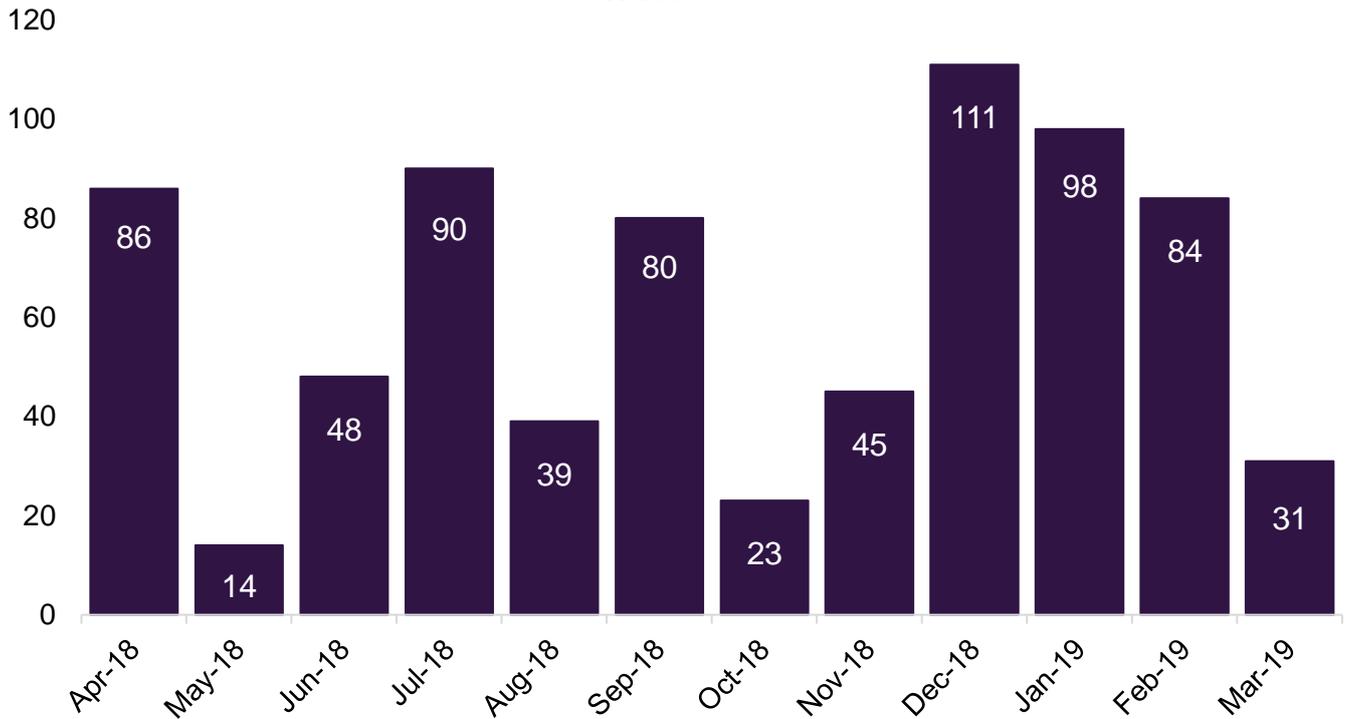
(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From April 2018 to March 2019, the trust reported 749 “black breaches”, with a fluctuating trend over the period. December 2018 saw the highest number of black breaches (111).

Black Breaches - County Durham and Darlington NHS Foundation Trust



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

It was noted at inspection that the trust had participated in a national trial where the four hour standard was not being recorded. This was an ongoing process and the results were not available.

Since the previous inspection a new ambulance handover system had been introduced. There was a designated team of qualified and healthcare support staff to take direct ambulance handovers within a designated area within the department.

Staff from the ambulance service report that the system is working well and reported a reduction in time to handover patients with reduced time spent in the department.

There is a clear streaming and triage process in place with all patients receiving an initial clinical assessment by a healthcare practitioner within 15 minutes of arrival.

Staff shared key information to keep patients safe when handing over their care to others. We observed staff using a standard process when patient details were being handed over.

Shift changes and handovers included all necessary key information to keep patients safe. We observed patient handovers with all relevant information being shared.

We saw evidence of appropriate screening tools for sepsis throughout the department, these also included specific paediatric, maternal, obstetric and neonatal tools. All staff were able to tell us about their use and we observed it's use. We saw that there was an escalation policy in place for patients with presumed or confirmed sepsis who required immediate review.

We saw examples of patients receiving antibiotics within the recommended sepsis pathway times.

There were established links between the paediatric team within the department and the paediatric medical team based elsewhere in the hospital. We saw examples of cross disciplinary working between the two departments.

Staff had access to the mental health liaison team. Staff knew where they were based and how to make urgent referrals. Staff told us that they get timely response to referrals.

Staff told us about recognition of cancer patients and any other patients at risk of infection and how they ensure the patient's safety-examples given included isolation from the department for patients with increased infection risks.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of relevant grades to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

We were told that Baseline Staffing Tools (BEST) were used to inform staffing requirements. Staffing was planned to meet hourly, daily and seasonal variations in demand. We saw examples of proactive staffing changes during inspection, we saw staff being rotated to cover areas within the department with higher patient numbers.

The department was able to staff its paediatric bays with one registered children's nurse per shift as per national guidance, but did not have enough staff to cover any sickness or other absence such as planned leave. The department mitigated this by offering appropriate training to adult nurses to enable them to build the appropriate skills and experience to treat children. We spoke to a number of adult trained nurses who had undertaken this training and who provided paediatric cover when required.

The children's ward within the hospital supported their colleagues in the emergency department and provided additional staff to assist within the department when necessary. Staff we spoke with confirmed this.

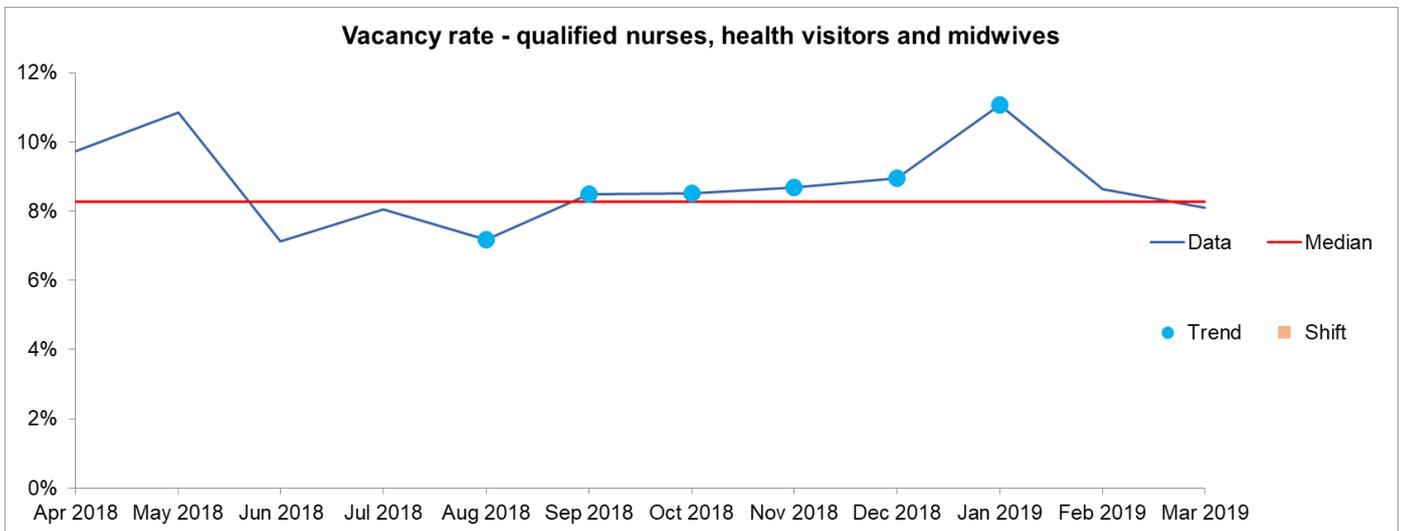
We observed handovers at the beginning of shifts and between changes in staffing. The handovers were detailed and robust with all pertinent information being shared. The staff were observed to use Situation, Background, Assessment, Recommendation (SBAR).

All bank staff complete the same departmental induction process as permanent staff which included observed practice to assess competency. Only when had this been completed could staff work unsupervised.

Trust level

Nurse staffing rates within this core service at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank/agency staff use.

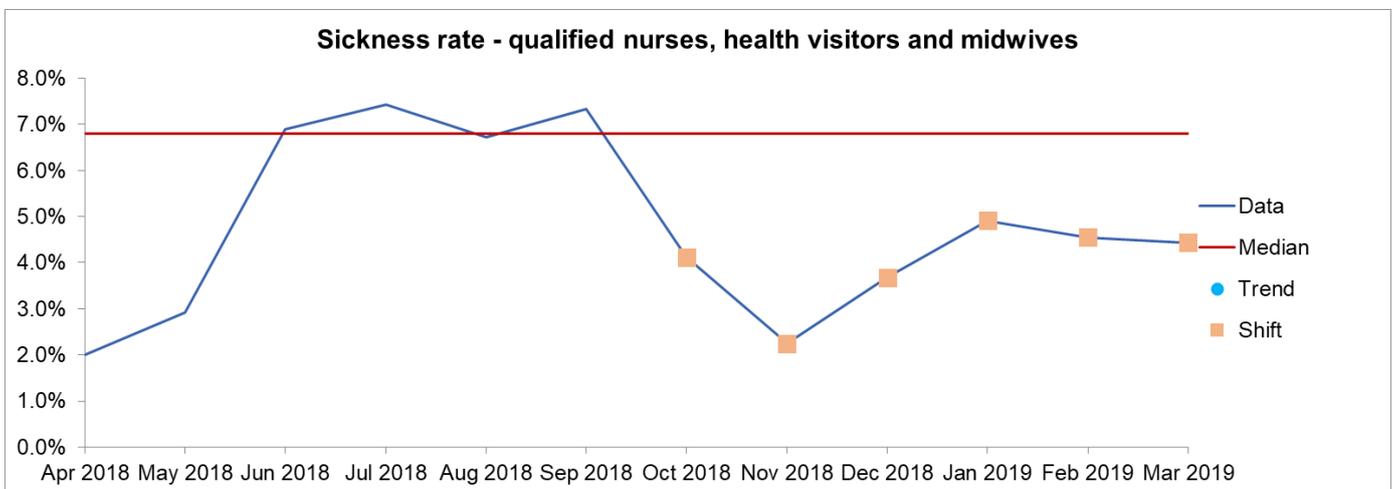
Vacancy rates



Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives shows an upward trend from August 2018 to January 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates



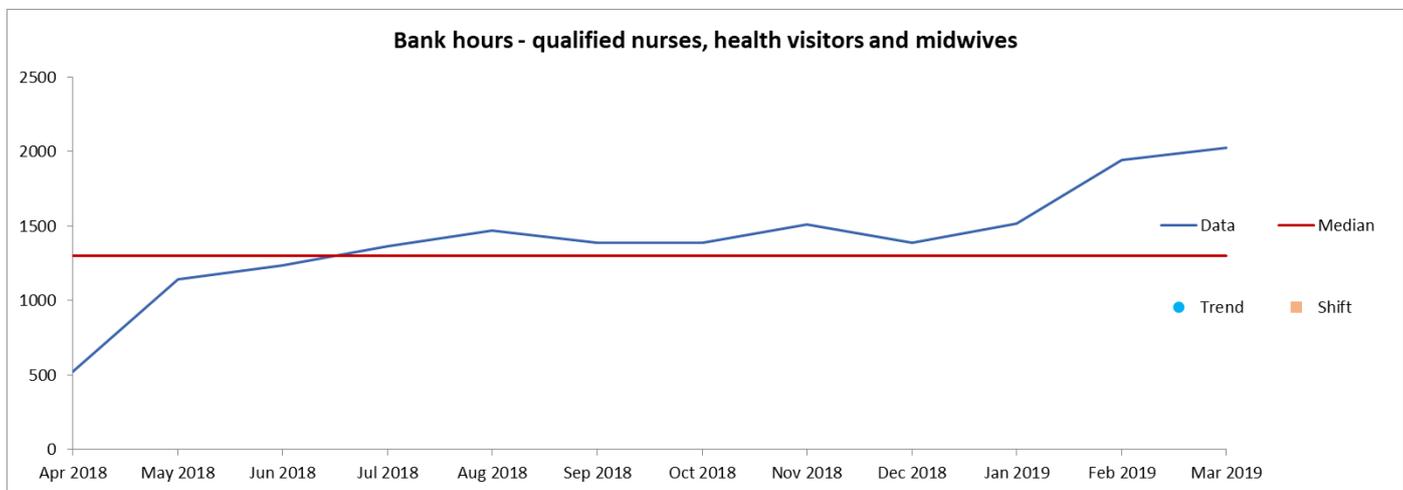
Monthly sickness rates over the last 12 months for qualified nurses, health visitors and midwives shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Darlington Memorial Hospital

Nurse staffing rates within this core service at Darlington Memorial Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and agency staff use.

Bank and locum staff usage



Monthly bank hours over the last 12 months for qualified nurses, health visitors and midwives are not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Nursing Bank Agency tab)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Staffing was planned to meet hourly, daily and seasonal variations in demand. We saw examples of proactive staffing changes during inspection, we saw medical staff being rotated to cover areas with higher patient numbers.

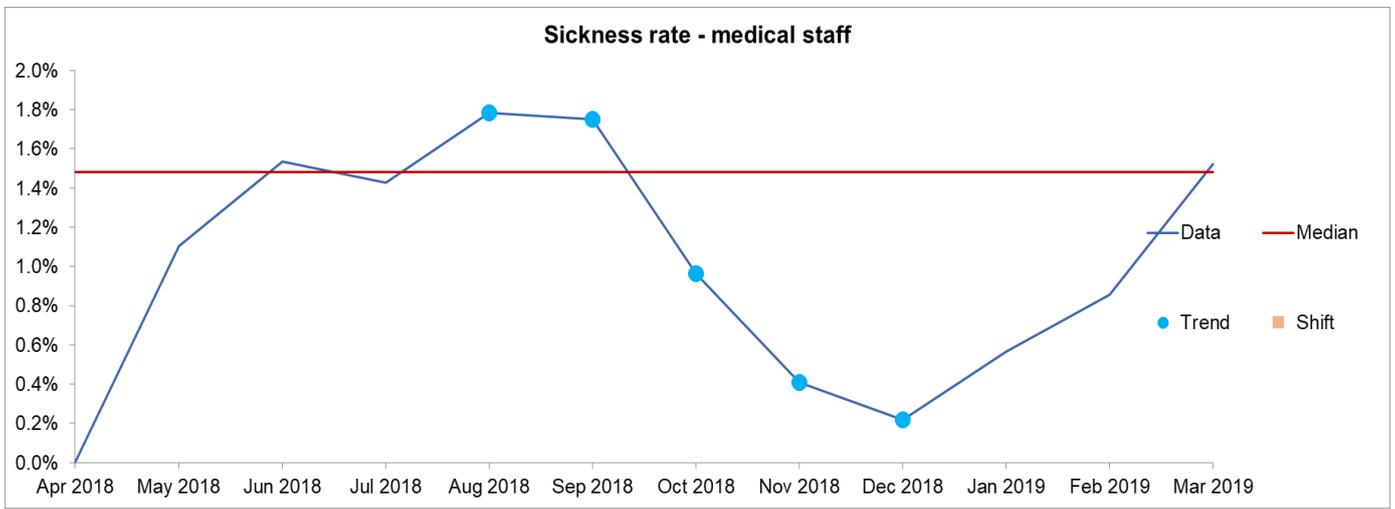
We reviewed medical rotas and saw that there was consultant cover 16 hours per day as a minimum which was in line with national guidelines for emergency departments of this size.

All locum staff completed the same department induction process as permanent staff which included observed practice to assess competency. Only when completed could staff work unsupervised

Trust level

Medical staffing rates within this core service at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy and turnover.

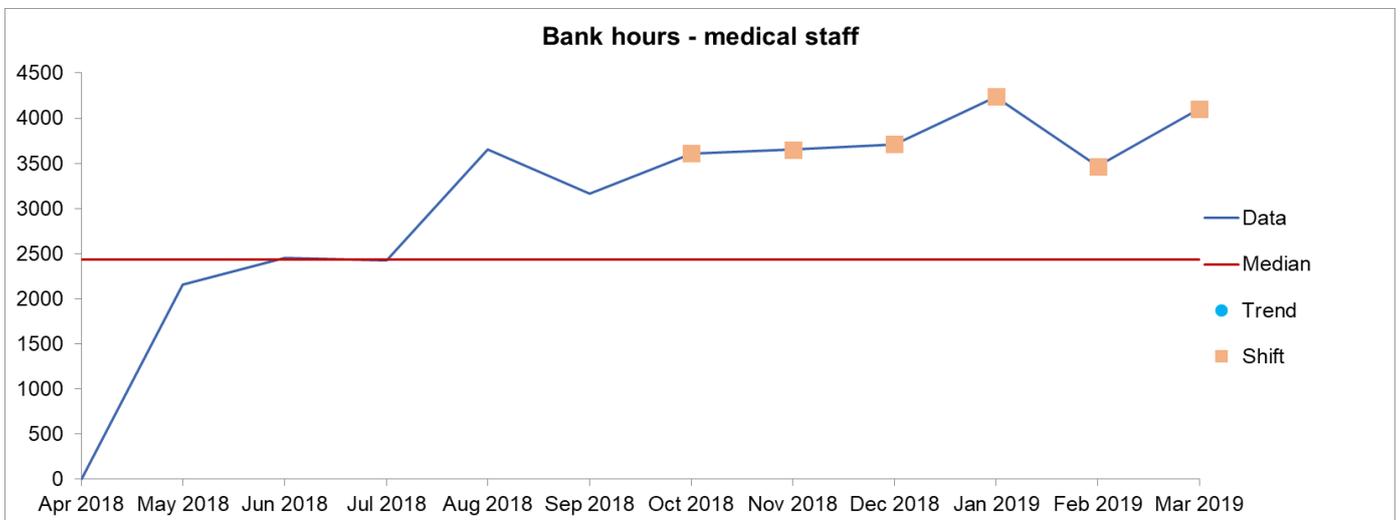
Sickness rates



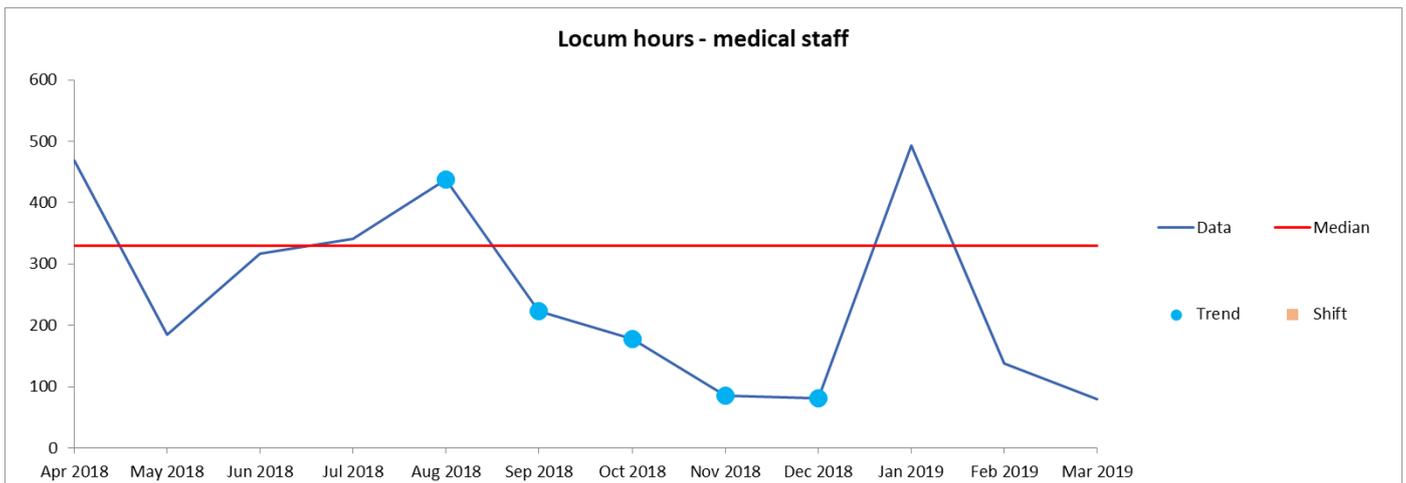
Monthly sickness rates over the last 12 months for medical staff shows a downward trend from August 2018 to December 2018.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage



Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019. We reviewed medical rotas and saw that more bank staff were being used, we were told that any gaps in the rota were being filled by permanent staff undertaking more hours rather than relying on agency staff.



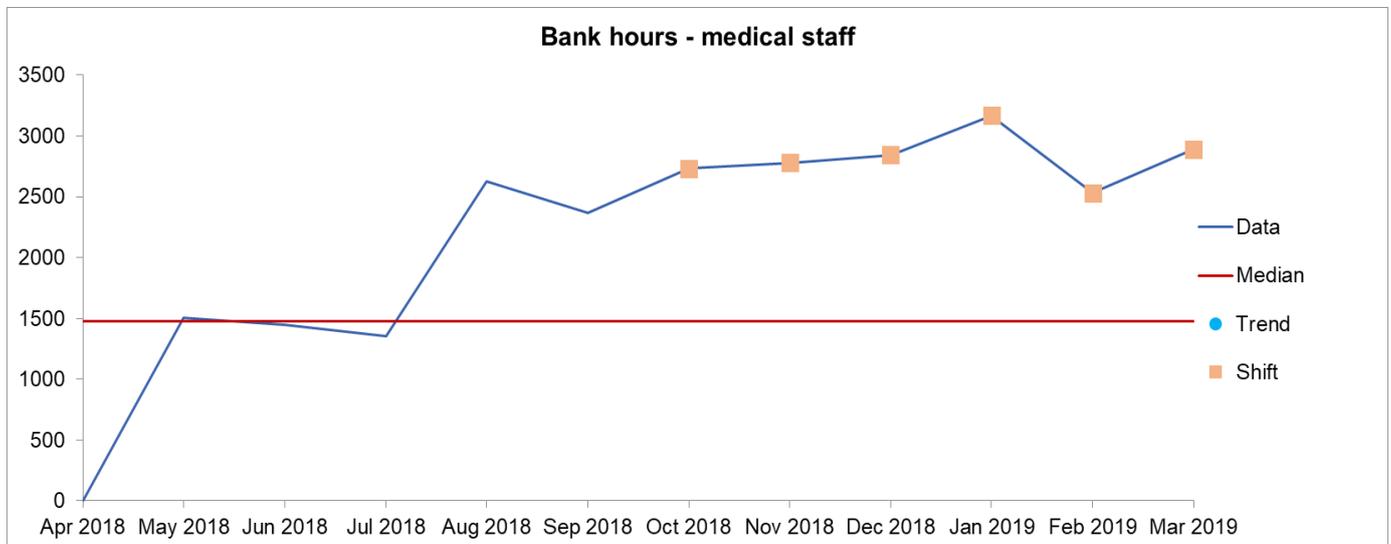
Monthly agency hours over the last 12 months for medical staff shows a downward trend from August 2018 to December 2018. We reviewed medical rotas and saw that less agency staff were being used, we were told that any gaps in the rota were being filled by permanent staff undertaking more hours.

(Source: Routine Provider Information Request (RPIR) – Medical Locum tab)

Darlington Memorial Hospital

Medical staffing rates within this core service at Darlington Memorial Hospital were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and locum staff use.

Bank and locum staff usage



Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical Locum tabs)

Staffing skill mix

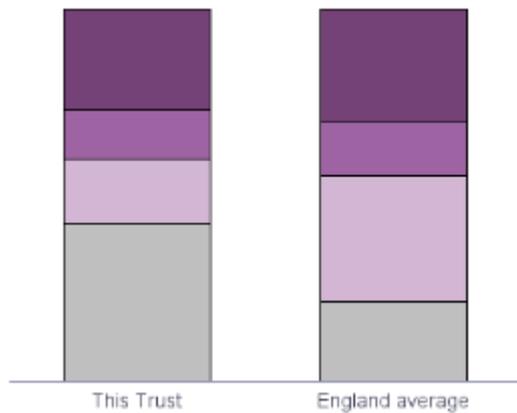
The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In January 2019, the proportion of consultant staff reported to be working at the trust were slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

We saw that the department provided consultant cover for 16 hours per day which was in keeping with the national standards for a department of its size.

Staffing skill mix for the 48 whole time equivalent staff working in urgent and emergency care at County Durham and Darlington NHS Foundation Trust.

	This Trust	England average
Consultant	27%	30%
Middle career^	13%	15%
Registrar group~	18%	34%
Junior*	42%	21%



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
 ~ Registrar Group = Specialist Registrar (StR) 1-6
 * Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

All patient records within the department were available electronically which ensured timely access when required. We observed staff logging out appropriately between patients. This meant that other specialities were able to access them in a timely manner.

We saw risk assessments such as early warning scores and pressure area care being completed appropriately and within the required timescales.

We saw antimicrobials being prescribed with clinical indications, dose and duration of treatment within the clinical record.

We reviewed patient discharge summaries and all were comprehensive. Discharge summaries were shared by the provider with other relevant professional such as GPs and care homes.

Staff were able to tell us that they would communicate information such as a patient requiring end of life care to the GP, but we saw no examples of this. Staff told us that they would telephone and follow up with emails to the patient's GP.

We saw that patient records contained details of other nonphysical conditions such as mental health needs and hidden disabilities. Staff were confident patient records contained all the information they required.

We saw an example of staff using a patient's health passport which contained important information that the patient was unable to convey to staff themselves. Staff told us of occasions when they used communication aids such as communication boards.

The department completed monthly record audits to ensure compliance and to maintain oversight. The audits for June 2019 to August 2019 saw compliance in excess of 90%.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw pharmacy staff within the department reviewing prescriptions.

Staff stored and managed medicines and prescribing documents in line with the trust policy.

We reviewed patient group directives (PGDs) and all were up to date with evidence of review. There was a comprehensive staff signature list that was also up to date.

Staff followed current national practice to check patients had the correct medicines. We saw staff checking prescriptions with pharmacy staff.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff told us about previous examples of patients being prescribed medication to assist in withdrawal and associated side effects. We saw one patient during inspection being assisted with alcohol dependency.

We saw allergy status recorded in all records that we reviewed. This is best practice to ensure patient safety.

We saw local microbiology protocols and we saw that staff followed them.

We saw all medication being stored appropriately. All controlled drug checks had been completed without omission. We observed appropriate disposal of medicines in designated waste receptacles.

At the last inspection we saw the oxygen prescribing was inconsistent. During this inspection we saw oxygen being prescribed correctly in 14 out of 16 cases. This showed improvement which was supported by the departmental action plan for oxygen prescribing.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

We saw that incidents were a standard agenda item for all staff meetings across the multidisciplinary team where learning from incidents discussed was shared.

Staff knew what incidents to report and how to report them. Staff were able to describe what constituted an incident and they used an electronic system for all incident reporting. Staff told us they received feedback following incident reporting. We saw examples of feedback in team meeting minutes. Staff told us there was a no blame culture and incident reporting was encouraged by senior leaders. All staff we spoke with were aware of the duty of candour regulation and how it should be applied. Duty of candour means the service must be open and honest with patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. We saw that staff had apologised when appropriate.

We requested results from the duty of candour audit, it demonstrated 100% compliance with the standard.

We reviewed five incidents and duty of candour had been applied in all cases. All incidents had been handled in accordance with trust policy.

Staff told us about lessons learnt and changes that had occurred following incidents.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to March 2019, the trust did not report any never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. This was evidenced in a recent incident where there was lack of escalation.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from April 2018 to March 2019.

One serious incident was for a treatment delay and the other was pending review. Both incidents occurred at Darlington Memorial Hospital.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide

immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from March 2018 to March 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

We saw evidence that all patient's where appropriate had an assessment for VTE (Venous thromboembolism) and bleeding risk on admission.

We saw a range of early warning risk assessments including paediatrics. We also saw that appropriate action was taken as a result of the findings.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

We were provided with a copy of the departmental action plan which had been introduced to support and monitor implementation of NICE guidance.

The action plan also demonstrated participation in national benchmarking clinical audits.

There was a consultant lead for all departmental audits to ensure regular monitoring and to ensure objectives had been set to ensure progression or completion.

We saw that VTE prophylaxis was offered in accordance with NICE guidance.

Sepsis screening was completed in line with national guidance.

All staff are trained to deal with violence or aggression in the appropriate way. All staff complete conflict resolution as part of their mandatory training.

Staff told us that any older person who may be frail or vulnerable would be referred for a comprehensive assessment of their needs, however, we saw no examples of this during inspection.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.(AMSAT)

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

There was drinking water available in reception but no vending machines to buy food, however the location of the department was close to hospital shops and the cafeteria where a selection of food which included healthy options could be bought.

Staff told us that if a patient was in the department for a longer period of time then food would be provided from the hospital cafeteria where religious and cultural preferences would be accommodated.

We observed patients with vomiting and diarrhoea being encouraged to drink on arrival to the department.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Emergency Department Survey 2017

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff prescribed, administered and recorded pain relief accurately.

All children were offered appropriate and prompt pain analgesia.

We saw records that demonstrated that children in moderate to severe pain had received analgesia within 20 minutes and had their pain reviewed within 60 minutes.

We saw pain scores had been recorded when appropriate in all notes that we reviewed with further evidence of pain scale tools being used such as Wong Baker faces pain tool.

All patients we spoke to told us they had been asked about pain and analgesia given if required

Emergency Department Survey 2017

In the CQC Emergency Department Survey, the trust scored 6.4 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts.

The trust scored 7.4 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 - March 2017; published October 2017))

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in all relevant national clinical audits. The service participated in national clinical outcome audits and managers used the results to improve services further.

RCEM Audit: Moderate and acute severe asthma 2016/17

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Darlington Memorial Hospital emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for five standards:

- Standard 3 (fundamental): High dose nebulised β 2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 10.6%; UK: 25%.
 - Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β 2 agonist bronchodilator therapy. This department: 18.7%; UK: 77%.
 - Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
 - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
 - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
 - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
 - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 2.7%; UK: 19%.
 - Standard 5b (fundamental): within 4 hours (moderate). This department: 8.3%; UK: 28%.
 - Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
 - Adults 16 years and over: 40-50mg prednisolone for 5 days
 - Children 6-15 years: 30-40mg prednisolone for 3 days
 - Children 2-5 years: 20mg prednisolone for 3 days
- This department: 15.1%; UK: 52%.

The department's results for the remaining two standards were both within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, Darlington Memorial Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for two standards:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 34.5%; UK: 11%.
- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 28.0%; UK: 10%.

The department was in the lower UK quartile for one standard:

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 0.0%; UK: 8%.

The department's results for the remaining standard was within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Darlington Memorial Hospital emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for four standards:

- Standard 4: Serum lactate measured within one hour of arrival. This department: 8.0%; UK: 60.0%.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 11.0%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 10.0%; UK: 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 8.0%; UK: 44.4%.

The department's results for the remaining four standards were all within the middle 50% of results.

Trauma Audit and Research Network (TARN)

Darlington Memorial Hospital

The table below summarises Darlington Memorial Hospital's performance in the 2016 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

Metrics (Audit measures)	Hospital performance	Audit Rating	Meets national standard?
Case Ascertainment (Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)	100+%	Good	✓
Crude median time from arrival to CT scan of the head for patients with traumatic brain injury (Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)	93 minutes	Takes longer than the TARN aggregate	✗
Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury	Not eligible	N/A	N/A

Metrics (Audit measures)	Hospital performance	Audit Rating	Meets national standard?
<i>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</i>			
Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care <i>(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</i>	100.0%	Higher than the TARN aggregate	✓
Risk-adjusted in-hospital survival rate following injury <i>(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)</i>	2.2 additional survivors	Similar to expected	✓

Managers used information from the audits to improve care and treatment. We saw that this information was shared with all staff.

There were engagement meetings and follow up of audit outliers. We saw meeting minutes which detailed this.

Managers shared and made sure staff understood information from the audits.

Improvement was checked and monitored.

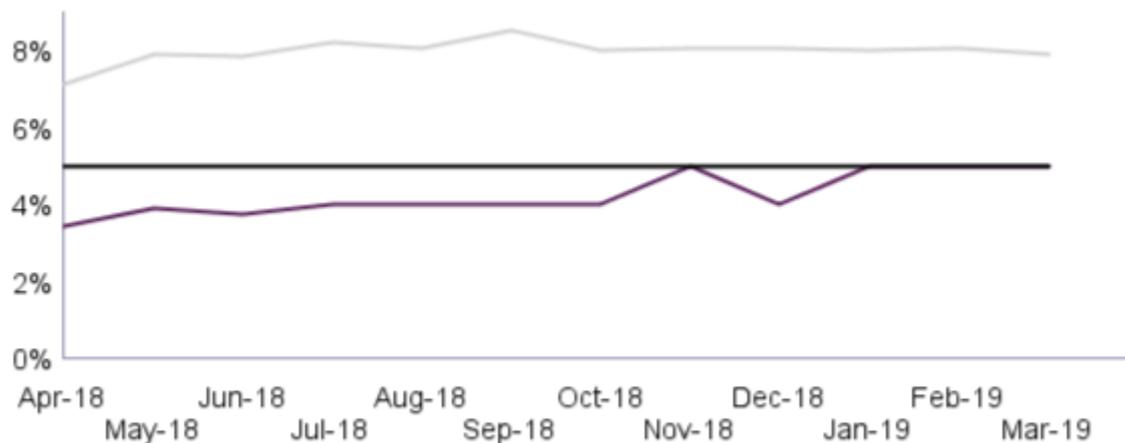
Unplanned re-attendance rate within seven days

The service had a lower than expected risk of re-attendance than the England average.

From April 2018 to March 2019, the trust's unplanned re-attendance rate to urgent and emergency care within seven days was better than or the same as the national standard of 5% and better than the England average. In the latest month, March 2019, trust performance was 5.0% compared to an England average of 7.9%.

Unplanned re-attendance rate within seven days - County Durham and Darlington NHS Foundation Trust

— This Trust — England Avg. — Standard



(Source: NHS Digital)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

All staff are given opportunities to complete non mandatory training to improve their skills and experience. We spoke with two staff members who were waiting to commence enhanced practice courses.

Staff had opportunities for one to one meetings, appraisals and support with revalidation.

Senior staff were able to describe the performance management process which allowed opportunities for staff to improve. Examples of support were the allocation of a mentor, supernumerary work and observed practice.

There was an expectation that some training would be completed in the staff's own time but where possible time was given off rota to complete mandatory training.

Arrangements were in place to ensure local healthcare providers are informed in cases where staff are suspended from duty. Senior staff were able to give recent examples of this.

Staff triaging children had the appropriate paediatric competence to provide immediate assessment.

Qualified staff were trained in infant and child basic life support.

Paediatric staff were able to attend annual learning events that are specific to paediatric emergency medicine.

A member of staff with APLS (or equivalent) training was on duty at all times. Within the department 87% of all qualified staff had completed the required level of training. Within the paediatric team in the department this was 100%.

Staff told us they had the skills and knowledge to identify and manage issues arising from mental health conditions, learning disability, autism and dementia. During inspection we saw staff managing patients with these issues with skill and understanding.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

From April 2018 to March 2019, 91.8% of staff within the urgent and emergency care department at the trust received an appraisal compared to a trust target of 95%. Nursing and midwifery registered staff met the trust target with 95.1%, whilst medical and dental staff did not meet the target with 72.7%.

We raised the lower rate of appraisal with senior leaders and it had been highlighted as a priority to address. We saw that all medical staff had either received an appraisal since March 2019 or one had been booked in.

Trust level

Staff group	April 2018 to March 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional clinical services	35	36	97.2%	95%	Yes
Administrative and Clerical	24	25	96.0%	95%	Yes
Nursing and Midwifery Registered	97	102	95.1%	95%	Yes
Medical and Dental	24	33	72.7%	95%	No
Total	180	196	91.8%	95%	No

Darlington Memorial Hospital urgent and emergency care department

Staff group	April 2018 to March 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Administrative and Clerical	10	10	100%	95%	Yes
Nursing and Midwifery Registered	44	45	97.8%	95%	Yes
Additional Clinical Services	13	14	92.9%	95%	No
Medical and Dental	14	16	87.5%	95%	No
Total	81	85	95.3%	95%	Yes

At Darlington Memorial Hospital, 95.3% of staff within the urgent and emergency care department at the trust received an appraisal compared to a trust target of 95%. Nursing and midwifery registered staff met the trust target with 97.8%, whilst medical and dental staff did not meet the target with 87.5%.

Further up to date information provided after the inspection showed that compliance for medical appraisals had increased to 100%.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

We saw that the assessment, planning and delivering of care was through a cohesive multidisciplinary team.

Staff told us that discharge was at appropriate times and with the appropriate support in place. Clinicians most competent to identify the appropriate care pathway are utilised especially in cases of frailty.

Department staff were largely complimentary of the specialist teams and that there was an overall sense of one larger team working towards excellent patient care.

Staff worked across health care disciplines and with other agencies when required to care for patients. (AMSAT)

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. (AMSAT)

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every ward/unit.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle

We observed staff giving health promotion advice to patients and we saw examples being documented within paediatric notes.

We saw examples of health promotion literature on display within the department such as smoking cessation, however we only saw literature in English. Staff told us that information was available in other languages and formats but were used too infrequently to display.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Senior staff confirmed that they followed recommendations in relation to section 136 (the removal of a person by the police to a place of safety).

All episodes of care where restraint was used were reported under incident reporting guidance to ensure that it was safe, proportionate and monitored.

Mental Capacity Act and Deprivation of Liberty training completion

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Trust level

The trust set a target of 33% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	14	42	33.3%	33%	Yes

In urgent and emergency care the target was met for the MCA/DOLS training module for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	3	21	14.3%	33%	No

In urgent and emergency care the target was not met for the MCA/DOLS training module for which medical staff were eligible.

Darlington Memorial Hospital urgent and emergency care department

The trust set a target of 33% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DOLS training courses from April 2018 to March 2019 at Darlington Memorial Hospital for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	8	19	42.1%	33%	Yes

In urgent and emergency care the target was met for the MCA/DOLS training module for which

qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at Darlington Memorial Hospital for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	1	12	8.3%	33%	No

In urgent and emergency care, the target was not met for the MCA/DOLS training module for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We reviewed further training documentation regarding MCA and Deprivation of Liberties Safeguards and we saw an improving picture of completion. We saw that all eligible staff who had not completed the training had been booked onto upcoming courses.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice(AMSAT).

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented DoL safeguards in line with approved documentation.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed good practice when a patient informed staff that they were needle phobic.

We observed staff dealing with a challenging patient with a caring and non-judgemental approach.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

There was a comfort rounding routine within the department and we saw completed documentation regarding this within the patient notes.

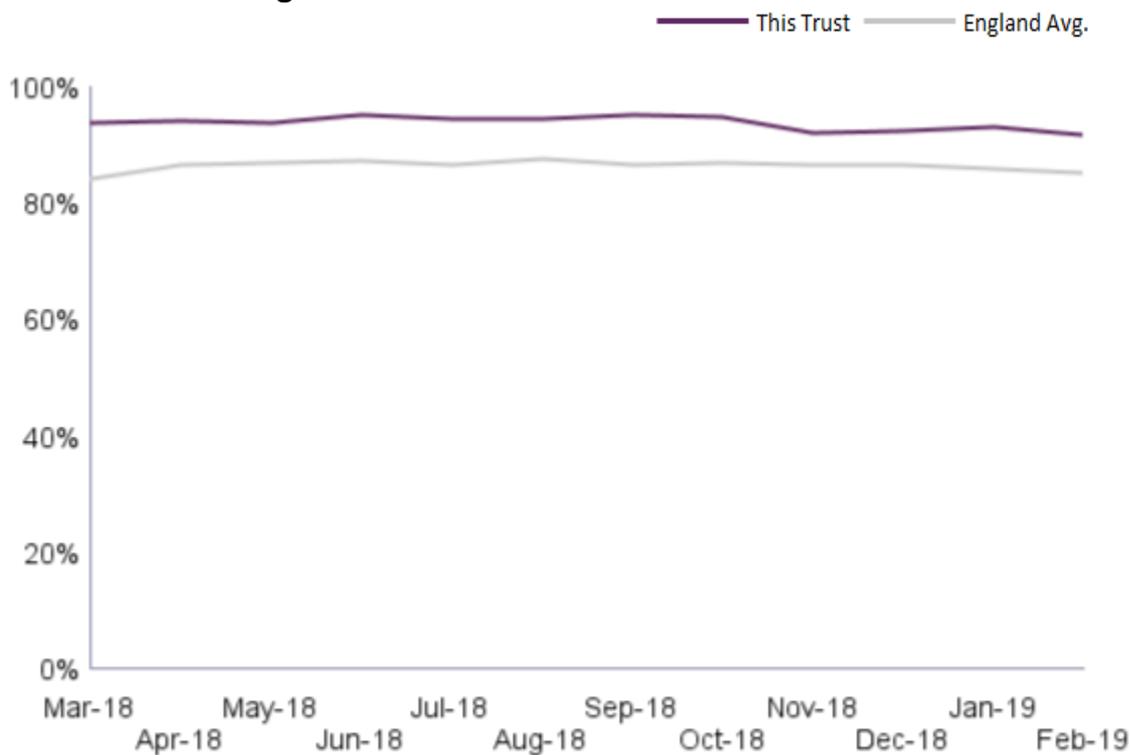
All staff introduced themselves to patients which included their position within the department. We saw staff wearing 'Hello my name is' badges and lanyards.

The trust's urgent and emergency care Friends and Family Test performance 91.6% was consistently better than the England average from March 2018 to February 2019.

Friends and Family test performance

The trust's urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from March 2018 to February 2019. In the latest month, February 2019, performance was 91.6%, compared to the England average of 85.3%.

Urgent and emergency care department Friends and Family Test performance - County Durham and Darlington NHS Foundation Trust



(Source: Friends and Family Test – NHS England)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. (AMSAT)

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

Emergency Department Survey 2017

The feedback from the Emergency department survey test was positive.

The trust scored better than other trusts for one of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 21 questions.

The question where the trust scored better than other trusts concerned medication.

The trust scored better than other trusts for one of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored worse than other trusts for one question and about the same as other trusts for the remaining 22 questions.

The question that scored better than other trusts was "Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?" and the question that scored worse than other trusts was "Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?".

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	3.5	About the same as other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.4	About the same as other trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	7.8	About the same as other trusts
Q14. Did the doctors and nurses listen to what you had to say?	8.6	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.7	About the same as other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	9.3	About the same as

Question	Trust 2016	2016 RAG
		other trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	7.7	About the same as other trusts
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?	8.7	About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.3	About the same as other trusts
Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?	9.1	About the same as other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.0	About the same as other trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	8.9	About the same as other trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	6.8	About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	6.2	About the same as other trusts
Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.7	About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests?	8.2	About the same as other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	8.9	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.8	Better than other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	5.1	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	4.2	Worse than other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	4.7	About the same as other trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	5.5	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.3	About the same as other trusts
Q45. Overall	8.0	About the same as other trusts

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population..

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia (AMSAT).

The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. (AMSAT)

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community. Alternative languages were not displayed but were available when required.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment. (AMSAT)

Emergency Department Survey 2017

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

Question – Responsive	Score	RAG
Q7. Were you given enough privacy when discussing your	7.5	About the same as

condition with the receptionist?		other trusts
Q11. Overall, how long did your visit to the emergency department last?	7.4	About the same as other trusts
Q20. Were you given enough privacy when being examined or treated?	9.3	About the same as other trusts

(Source: Emergency Department Survey (October 2016 - March 2017; published October 2017))

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

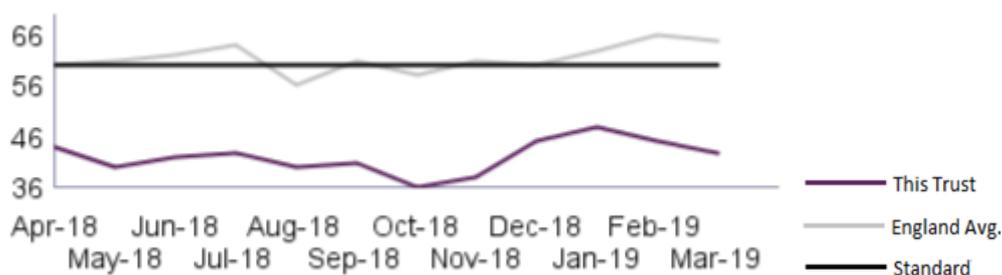
Median time from arrival to treatment (all patients)

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. From April 2018 to March 2019, the trust met the standard for all months over the 12 month period and was better than the England average.

From April 2018 to March 2019, performance against this standard was better than the England average and followed a similar trend. In the latest month, March 2019, the median time to treatment was 43 minutes compared to the England average of 65 minutes.

Median time from arrival to treatment from April 2018 to March 2019 at County Durham and Darlington NHS Foundation Trust



(Source: NHS Digital – Urgent and emergency care quality indicators)

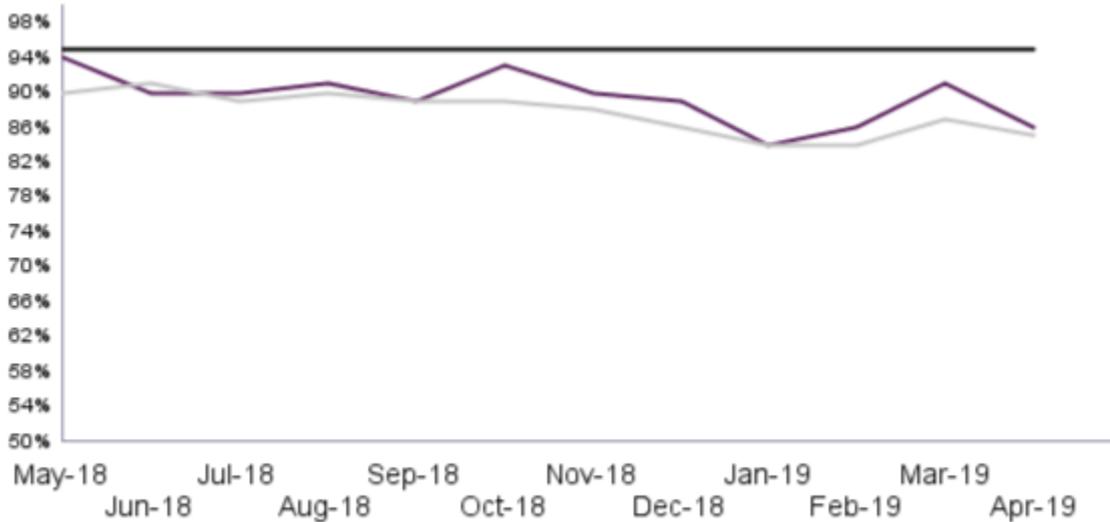
Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From May 2018 to April 2019, the trust failed to meet the standard and performed similar or better than the England average.

Four hour target performance - County Durham and Darlington NHS Foundation Trust

— This Trust — England Avg. — Standard



(Source: NHS England – Urgent and emergency care waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From May 2018 to April 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average, with the exception of May 2018 where this was similar.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - County Durham and Darlington NHS Foundation Trust



The table below shows the number of patients waiting more than four hours to admission:

Month	Number of patients waiting more than four hours to admission
May 2018	354
June 2018	685
July 2018	523
August 18	438
September 2018	664
October 2018	546
November 2018	619
December 2018	724
January 2019	1,177

February 2019	763
March 2019	678
April 2019	940

January 2019 saw the highest number of patients (1,177) waiting more than four hours to admission and May 2018 saw the lowest (354).

(Source: NHS England - Urgent and emergency care SitReps).

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from May 2018 to April 2019, no patients waited more than 12 hours from the decision to admit until being admitted.

(Source: NHS England – Urgent and emergency care waiting times)

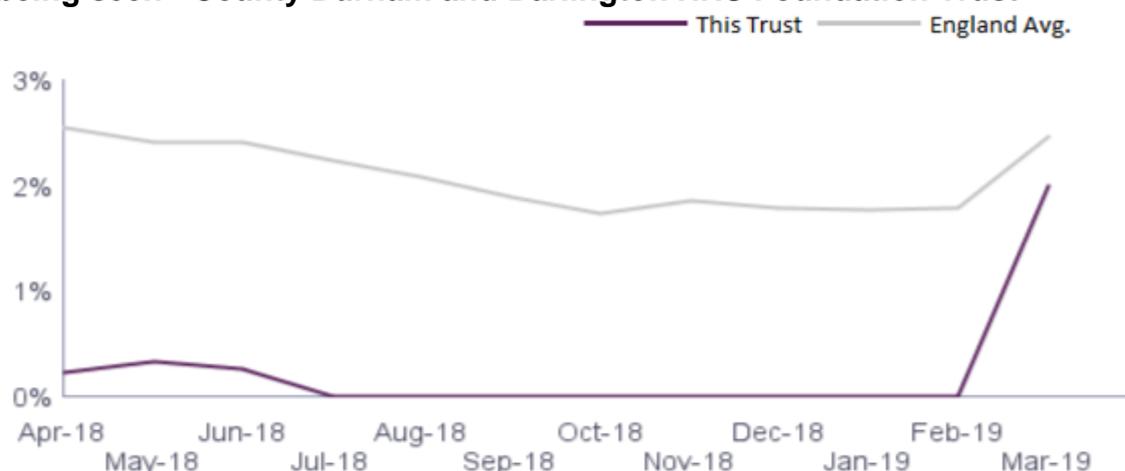
Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment

The number of patients leaving the service before being seen for treatments was low.

From April 2018 to March 2019, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was better than the England average.

From July 2018 to February 2019, the percentage of patients leaving the trust’s urgent and emergency care services before being seen was 0.0% and increased in the latest month, March 2019, to 2.0%, compared to the England average which was 2.5%.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - County Durham and Darlington NHS Foundation Trust

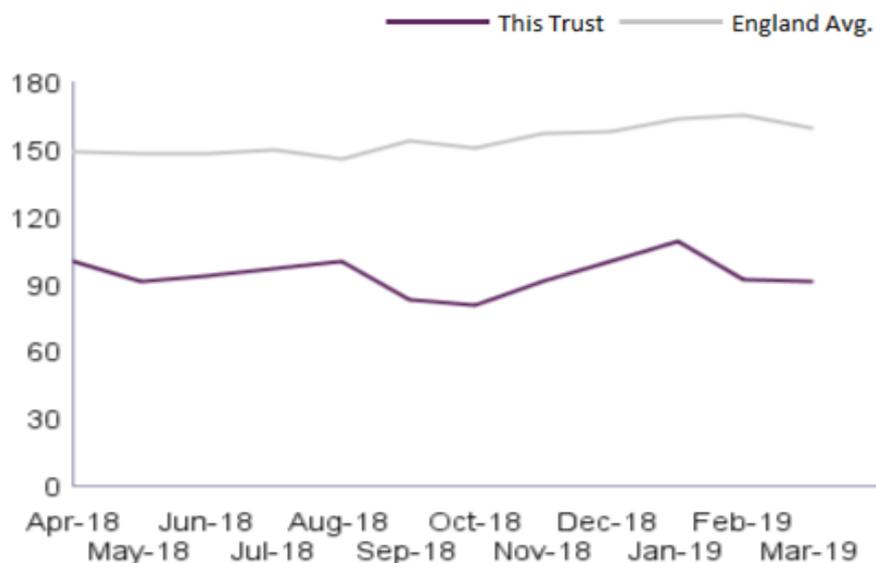


(Source: NHS Digital – Urgent and emergency care quality indicators)

Median total time in urgent and emergency care per patient (all patients)

From May 2018 to April 2019 the trust’s monthly median total time in urgent and emergency care for all patients was lower than the England average. In the latest month, March 2019, the trust’s monthly median total time in urgent and emergency care for all patients was 91 minutes compared to the England average of 160 minutes.

Median total time in urgent and emergency care per patient - County Durham and Darlington NHS Foundation Trust



(Source: NHS Digital - Urgent and emergency care quality indicators)

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs (AMSAT).

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Summary of complaints

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

We reviewed five complaints and saw all five had followed trust policy.

We saw complaints being used in staff training to improve practice and patient care.

Trust level

From April 2018 to March 2019, the trust received 93 complaints in relation to urgent and emergency care at the trust (16.2% of total complaints received by the trust). The trust took an average of 33.2 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed within 40 working days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Patient Care including Nutrition / Hydration	40	43.0%
Access to treatment or drugs	29	31.2%
Values & behaviours (staff)	13	14.0%

Patient Care	6	6.5%
Facilities	3	3.2%
Communications	1	1.1%
Appointments	1	1.1%
Total	93	100%

Darlington Memorial Hospital urgent and emergency care department

From April 2018 to March 2019, there were 37 complaints about urgent and emergency care at Darlington Memorial Hospital. The trust took an average of 33.1 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed in 40 working days.

A breakdown of complaints by type is below:

Type of complaint	Number of complaints	Percentage of total
Patient Care including Nutrition / Hydration	14	37.9%
Access to treatment or drugs	9	24.3%
Values & behaviours (staff)	8	21.6%
Facilities	3	8.1%
Patient Care	3	8.1%
Total	37	100%

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2018 to March 2019, there were 203 compliments about urgent and emergency care at the trust. A breakdown of compliments by site is below.

Site	Number of compliments	Percentage of total
University Hospital of North Durham	127	62.6%
Darlington Memorial Hospital	51	25.1%
Bishop Auckland Hospital (UCC)	10	4.9%
Peterlee Community Hospital	8	3.9%
Shotley Bridge Hospital (UCC)	7	3.5%
Total	203	100%

The main themes that run through the compliments relate to the staff going above and beyond what a patient expects them to do, supporting the patient and family during difficult times for them and taking the time to listen and explain things to patients.

All compliments that the trust receive from a patient or the family are all shared with the staff named and their managers, along with the CEO if requested to or if it is from a staff member. The trust ask that managers share the compliment with the staff on the ward or in the department.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

All senior leaders were able to articulate their understanding of the challenges to quality and sustainability. They had identified the actions required to address them.

Effective leadership was a clear priority and all senior managers told us about their leadership strategy.

All staff told us that the senior leadership was visible and approachable. We observed senior managers working within the department at times of high pressure.

Staff reported that all senior medical and nursing staff were approachable and available.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

We saw results from the vision and strategy reported at the last inspection. A new ambulance handover area had been created within the department and we also saw that the mental health room had become compliant to the national standards.

All staff were aware of the department's vision and strategy and fully supported it.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We found the culture of the department open and inclusive. Staff that we spoke to felt that they were valued and respected by their peers and leaders. We asked staff at all levels about the morale of the department and they all said that morale was good and they worked as a team. Staff felt supported in their work and there were opportunities to develop their skills and competencies, which were encouraged by senior staff.

There was a desire from all staff we spoke with to provide effective care and treatment to patients. We observed staff working well together and there were positive working relationships with the multidisciplinary teams.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were regular governance meetings. The agenda items of the governance meetings included clinical outcomes/effectiveness, mortality, patient safety, patient experience and clinical risk

management. These meetings fed into the acute emergency care group meetings and key messages from these meetings were cascaded to staff using various communication channels, such as email, notices and handover.

There were monthly staff meetings and two weekly senior meetings that included doctors, senior sisters and a matron.

A monthly high intensity user meeting took place to discuss the frequent attenders to the department. This meeting included the wider multidisciplinary team such as GP's, mental health liaison team, ambulance service, police and fire service.

We reviewed meeting minutes from recent frequent attenders meeting which specifically discussed children. Representatives from the children's and adolescent mental health team attended these to discuss what support and services could be offered to prevent re-occurrence of mental health patients attending the department.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Regular performance meetings are held and representatives from other specialities are invited to attend to discuss issues around performance and what actions could be taken to prevent reoccurrence.

Governance meetings were held on a monthly basis and we saw that risk, incidents, performance and complaints were fixed agenda points.

All staff participated in local, regional and national staff meetings with any issues or concerns escalated to board level. We saw meeting minutes with incidents, complaints and feedback as fixed agenda points.

We saw an up to date risk register which utilised the red, amber, green (RAG) system, however at the time of inspection there were no specific risks on the risk register concerning Darlington.

The department has a full capacity protocol but there have been no reported instances of it being repeatedly used.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

All staff complete information governance training as part of their trust induction.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patient feedback is sought and acted upon, we saw that comment cards and complaint information was available throughout all areas of the department.

We reviewed positive and negative feedback received by the department. The feedback was largely positive.

The department participated in the friends and family test (FFT) and consistently scored high levels of patient satisfaction.

All staff were encouraged to attend the monthly department meetings. Staff felt communication within the trust and the department was good. Methods of communication included a trust wide weekly e-bulletin to staff, staff emails, posters and information was passed to them during handover.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The department was trialling a new analgesia which would replace sedation with the objective of reducing the amount of time a patient would spend in department post procedure. The trial was not completed at the time of inspection, but early data was positive.

End of life care

Facts and data about this service

The trust provides end of life care at two of its sites, Darlington Memorial Hospital (DMH) and University Hospital of North Durham (UHND). End of life (EOL) care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

EOL care is provided across the organisation by nurses, consultants, health care assistants, mortuary and clerical staff across all care groups 365 days per year. Ward staff are supported by the acute specialist palliative care team who assisted staff to deliver end of life care across acute settings, through education, training, documentation, and clinical availability.

In addition ward staff have access to the acute intervention team who offered guidance and clinical support with complex symptom management for all patients. The acute intervention team is an innovative service providing assessment and input to critically ill patients in acute hospitals with the recognition that many of these patients will have palliative care needs. They work closely with the palliative care team and receive ongoing education and support in palliative and end of life care.

Both teams also provide support to patients with a life limiting/progressive illness, not limited to those with cancer. Ward staff are able to refer to both teams using the electronic patient database or by telephone.

In DMH and UHND there are specialist palliative care teams who work 09:00-17:00 Monday to Friday to provide advice and support to ward teams, patients and families. The focus is on complex symptom management, end of life discharge and effective end of life care.

A Macmillan Educator for palliative and EoLC supported the development of an EoLC education strategy and delivers mandatory end of life education training. For registered nurses (RNs) there is a full training day 'Providing care and support to the dying person in the last days and hours'.

The community specialist palliative care service operates seven days a week, 09:00-17:00. They receive about 2,000 referrals per year. The team is located in three bases across the county.

The trust has commissioned 24/7 specialist palliative care advice from the consultant led palliative care service at Marie Curie Hospice Newcastle.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The trust commissioned 24/7 specialist palliative care advice from the consultant led palliative care service at Marie Curie Hospice Newcastle.

The trust had 2,032 deaths from February 2018 to January 2019.

(Source: Hospital Episode Statistics)

This report focuses on the inspection of end of life and palliative care services (medical, nursing, mortuary, chaplaincy and bereavement). Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

We observed daily practice and viewed six sets of patient records and 'do not attempt cardiopulmonary resuscitation' (DNACPR) records and nine prescription charts. During the inspection we visited surgical, medical and care of the elderly wards, and also visited the mortuary and the hospital chapel. We spoke to patients who were receiving end of life care and patients' relatives.

We spoke with 41 members of staff, which included medical and nursing staff, the specialist palliative care team, the leadership team for end of life care, chaplaincy, mortuary and bereavement staff.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills and ensured all staff had completed it.

Mandatory training data was collated centrally and staff received alerts when they were due to complete mandatory training. Ward staff told us they were informed by their managers when training was due.

At our previous inspection in 2015, end of life care training was not part of the trust's mandatory training programme.

During the most recent inspection, senior managers told us that end of life training was to become mandatory in the next six months following inspection.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training, with the exception of information governance module where the target is 95%.

Darlington Memorial Hospital end of life care department

A breakdown of compliance for mandatory training courses as at June 2019 for qualified nursing staff in the end of life care department at Darlington Memorial Hospital is shown below:

Training module name	As at June 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Information Governance and Data Security - 1 Year	3	3	100%	95%	Yes

A breakdown of compliance for mandatory training courses as at June 2019 for medical staff in the end of life care department at Darlington Memorial Hospital is shown below:

Training module name	As at June 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire Safety - 1 Year	2	2	100%	95%	Yes
Health, Safety and Welfare - 3 Years	2	2	100%	95%	Yes
Moving and Handling - Level 1 - 3 Years	2	2	100%	95%	Yes
Hand Hygiene - 2 Years	2	2	100%	95%	Yes

At Darlington Memorial Hospital end of life care department, the targets were met for four of the five mandatory training modules for which medical staff were eligible. Information governance and data security training module did not meet the target with a 50% completion rate, compared to the 95% target. However, this is based on only two eligible medical staff members. Care should be taken when interpreting low eligible staff numbers.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)

Conflict Resolution	1	1	100%	85%	Yes
Deteriorating Patient and Resuscitation	1	1	100%	85%	Yes
Equality & Diversity	1	1	100%	85%	Yes
Infection Prevention and Control - Level 2 - 1 Year	1	1	100%	85%	Yes
Information Governance	1	1	100%	95%	Yes

At Darlington Memorial Hospital end of life care department, the targets were met with 100% completion for all of the five mandatory training modules for which the one medical staff was eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning, disabilities, autism and dementia.

The Macmillan palliative care educator and members of the specialist palliative care service had developed a comprehensive training programme enabling staff to be trained in a three-year cycle. On line learning had been developed including mental capacity assessment and best interest decision making modules from the national e-learning programme ('End of Life Care for All'). Latest figures available showed 48.2% of nurses across the trust had received specific end of life and palliative care training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics. We saw staff shared information during huddles and multi-disciplinary meetings to ensure safe discharge planning.

In addition, mortuary staff shared examples of safeguards that had been raised following some concerns regarding the transportation of the deceased from a specific ward.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to describe the safeguarding process and could name the adult safeguarding lead who they would contact if they had any concerns.

Safeguarding training completion rates

We spoke with ward nursing, medical and mortuary staff who were able to clearly explain their responsibilities in relation to safeguarding patients. They were able to share examples of when

they had needed to submit safeguarding concerns for patients in their care. They told us that they had not experienced any difficulties in obtaining advice, and that this was available 24 hours a day.

We saw contact details for safeguarding teams clearly displayed in ward areas.

The trust set targets of 85% and 95% for completion of the safeguarding training modules.

Darlington Memorial Hospital end of life care department

A breakdown of compliance for safeguarding training courses as at June 2019 for qualified nursing staff in the end of life care department at Darlington Memorial Hospital is shown below:

Training module name	As at June 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Awareness - 3 Years	3	3	100%	95%	Yes
Safeguarding Adults - Level 1 - 3 Years	3	3	100%	85%	Yes
Safeguarding Children - Level 2 - 3 Years	3	3	100%	85%	Yes
Safeguarding Children (Version 2) - Level 1 - 3 Years	3	3	100%	95%	Yes

At Darlington Memorial Hospital end of life care department, the targets were met for all of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as at June 2019 for medical staff in the end of life care department at Darlington Memorial Hospital is shown below:

Training module name	As at June 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding Adults Awareness - 3 Years	2	2	100%	95%	Yes
Safeguarding Children (Version 2) - Level 1 - 3 Years	2	2	100%	95%	Yes
Safeguarding Adults - Level 1 - 3 Years	1	1	100%	85%	Yes
Safeguarding Children - Level 2 - 3 Years	2	2	100%	85%	Yes

At Darlington Memorial Hospital end of life care department, the targets were met for all of the four safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

All areas where palliative and end of life care were provided appeared clean, tidy and well maintained.

We observed staff using PPE such as gloves and aprons, adhering to the 'bare below the elbow' guidance and washing their hands between reviewing different patients to help prevent the spread of infection.

We visited several areas in which palliative and end of life care were provided, including hospital wards, the mortuary and bereavement offices. All ward areas appeared clean, tidy and well maintained. We saw that personal protective equipment, including gloves and aprons, was readily available, and there were appropriate handwashing and hand decontamination facilities in all areas.

Cleaning records for the mortuary were up to date and demonstrated that it was cleaned regularly. Staff identified what had been cleaned and signed their name once it was completed.

The mortuary had systems and processes in place to manage the risk of infection. Staff would ensure the deceased patient was appropriately covered. They would also complete a label to indicate the infection risk. Mortuary staff ensured deceased patients who had been confirmed to be an infection control risk were kept in a designated area.

In addition the provider had purchased a lead lined coffin, in the specific event of death due to toxic chemical poisoning.

Environment and equipment

Staff we spoke with told us they had no problems accessing equipment for patients at the end of life in the hospital.

Side rooms were limited on the wards and ward managers told us demand for side rooms was high when also dealing with infection control issues. Side room provision for end of life care was prioritised where possible.

The hospital had suitable facilities to meet the needs of patients' families. The wards we visited had private rooms where sensitive or private discussions could take place.

Syringe drivers were readily available and obtained from a trust wide central equipment library.

The trust developed guidelines in accordance with the NPSA Rapid Response Report; Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010, which advised that ambulatory syringe drivers should change over to devices with specific safety features. We saw all syringe drivers in use adhered to this report.

Staff told us that syringe driver safety checks were completed for all patients with a driver in use. We reviewed six sets of syringe driver documentation and saw that these checks were not completed in accordance with the trust policy 'Policy for the administration of subcutaneous medication via the T43 syringe pump' which states safety check must be completed every four hours in the inpatient setting. In all records we reviewed, all syringe drivers were checked between 5 and 6 hourly intervals. This is a reoccurring breach following the last inspection in 2015.

The trust provided us with data to show that 482 qualified nurses had received training in syringe devices. We were told ward, department and line managers of staff who used medical devices were responsible for '...reviewing current competencies, identifying any training needs and ensuring that staff receive instruction and guidance on the use of equipment as part of the local induction process and followed by annual reviews thereafter'. However, we were not assured that this training was followed up or monitored at ward level or ongoing review of clinical competencies for nursing staff managing syringe drivers was completed.

The mortuary housed several bespoke bereavement rooms which were available for families and bereavement support staff. The environment was light and spacious with the design situated alongside a private garden area.

We saw the mortuary was well equipped and that the capacity was adequate. There was a 22 unit body store. We saw specialist equipment that included bariatric trolleys and four specific bariatric body stores.

The temperature of the mortuary fridges was recorded on a daily basis and the fridges were alarmed with alerts directly to the estates department should the temperature fall outside of the normal range.

The mortuary staff told us that they had not experienced any difficulties involving capacity but they could access the mortuary at the University Hospital of North Durham if they experienced problems.

We visited the chapel which was a calm tranquil environment. It provided information and a place of worship for a variety of faiths.

Staff disposed of clinical waste safely. We observed that waste was segregated appropriately between clinical and non-clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Risk assessments for each patient were completed on admission and updated when necessary. Staff shared key information to keep patients safe when handing over their care to others.

Ward staff provided care to patients requiring palliative and end of life care. Staff referred patients to the acute specialist palliative care team or the acute intervention team for patients who experienced complex symptoms or additional support was required to meet patient needs. Risk assessment tools were in place covering nutrition and hydration, falls and pressure care.

Referrals to the specialist palliative care team were made directly to the team or identified through the trust's electronic systems. The team had given training and education on wards that meant staff were clear when to make a referral. Visits to the individual patient and wards were arranged and advice given.

Ward staff told us that both teams had a visible presence on the wards and support and guidance was readily available for all ward staff.

Huddles were conducted twice daily and key patient information such as care interventions, risk management and goal setting for each patient was discussed.

We reviewed the risk register for the mortuary and saw that staff had raised concerns in relation to the post mortem of super bariatric patients, due to the height of the examination table. We saw a recent risk assessment mitigated specific risks to staff and was managed through effective standard operating procedures which outlined safe working limits.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The specialist palliative care team consisted 21 staff trust wide. We were told that staff recruitment was not usually an issue, and turnover and sickness rates were low.

End of life care annual staffing metrics							
April 2018 – March 2019							
Staff Group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours	Annual agency hours	Annual unfilled hours
Target	N/A	5%	None	4.0%			
All staff	21.0	0.1%	9.7%	5.7%			
Qualified Nurses	5.5	-5.9%	16.9%	3.1%	N/A	N/A	N/A

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

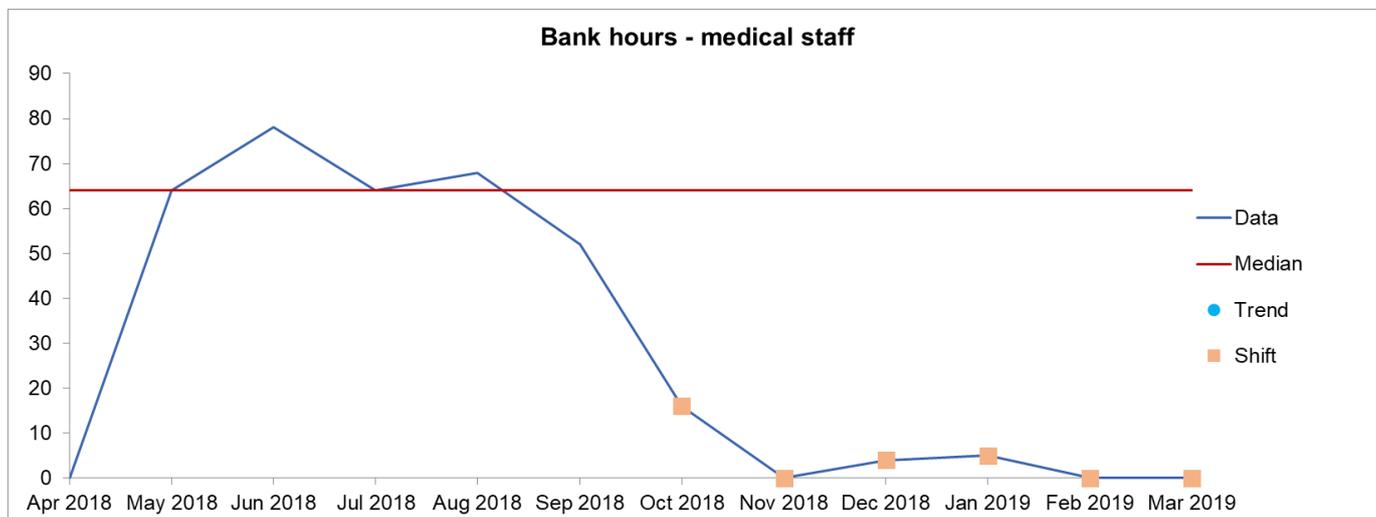
Nurse staffing rates within this core service at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and bank/agency staff use.

Darlington Memorial Hospital end of life care department

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Bank and locum staff usage



Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical Bank Locum tabs)

Darlington Memorial Hospital end of life care department

End of life care annual staffing metrics

April 2018 – March 2019

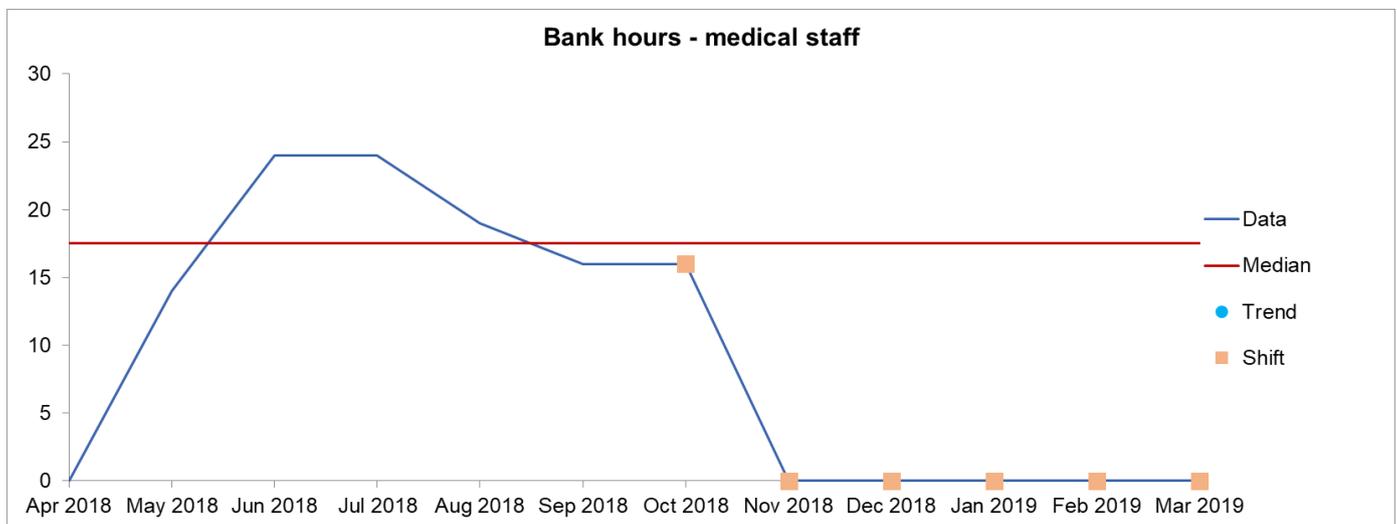
Staff Group	Annual average establishment	Annual vacancy rate	Annual turnover rate	Annual sickness rate	Annual bank hours	Annual agency hours	Annual unfilled hours
Target	N/A	5%	None	4.0%			
All staff	11.4	-1.9%	16.9%	5.9%			
Medical staff	N/A	100.0%	N/A	N/A	113	0	14

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Nurse staffing rates within this core service at trust level were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for vacancy, turnover, sickness and locum staff use.

The following information and charts highlight specific staffing areas where there is noteworthy evidence that may prompt further investigation on site.

Bank and locum staff usage



Monthly bank hours over the last 12 months for medical staff shows a shift from October 2018 to March 2019.

(Source: Routine Provider Information Request (RPIR) – Medical Bank Locum tabs)

Records

Staff kept detailed records of patients’ care and treatment. Records were not consistently clear and up to date up-to-date or easily available to all staff providing care.

Care plans developed by the trust included the ‘Five Priorities for Care of the Dying Person’ identified in ‘One Chance to Get It Right’ (Leadership Alliance for the Care of Dying People, 2014).

These prioritised:

- the possibility that a person may die within the next few days or hours is recognised and communicated clearly decisions made and actions taken in accordance with the person’s needs and wishes are regularly reviewed and decisions revised accordingly;
- sensitive communication takes place between staff and the dying person, and those identified as important to them;
- the dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants;
- the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible; and
- an individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

In line with these priorities the trust was following principles of advance care planning and recorded patients and relatives wishes and preferences, preferred place of care, do not attempt cardio-pulmonary resuscitation (DNACPR) discussions in patients’ notes.

The trust utilised both electronic and paper based records. Ward staff told us that a new electronic end of life care plan had recently been introduced as part of the nerve centre electronic recording. This care plan enabled clinical staff to record patient goals, treatment and outcomes in relation to physical and emotional wellbeing, ongoing place of care, and discharge planning. Preferred place of death could not be included within this care plan.

We saw developments with the electronic system facilitated options for individualised care planning. Ward staff were positive about the new care plan options and were becoming more confident at navigation between paper based and electronic records. Staff told us that over time they felt the system would become easier to use and proactively sought to activate all electronic care plans applicable for EoLC patients.

Within four of the six patient records we reviewed, we saw the electronic end of life care plan option was not selected. We were therefore not assured that this system was consistently used by all clinicians and therefore some care plan and risk were not identified. Some staff told us the combination of paper and electronic records made navigation of care difficult to follow.

In addition to care plans we reviewed patient records relating to syringe drivers, hydration and intentional patient rounding. We saw inconsistent use of records across these specific areas.

The hospital had systems in place to identify and prioritise EoLC patients out of hours and between primary and secondary care settings. We observed effective correspondence between primary and secondary care through the use of common documentation.

The trust participated in the regional 'Electronic Palliative Care Co-ordination Systems (EPaCCS)' enabling the recording and sharing of people's care preferences and key details about their care at the end of life. This identified quality improvement to emergency health care plans (EHCPs) to enable better patient care and outcomes. The aim was to improve the number, quality and access to EHCPs, better support patients with complex medical needs and/or a life limiting condition, ensure patients have the care and treatment they need in the right place and reduce the risk of inappropriate clinical decisions being made.

EHCPs are the regional document for communicating key information including advance decisions. The clinical lead for palliative care was chairing a task and finish group to improve the creation and communication of EHCPs across the trust area. Key actions included systems for creating EHCPs electronically within the acute and community sites, a standing operating procedure for EHCPs and clarity on competencies and training for staff.

Medicines

The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines.

Prescribers on wards used pre-defined order sets for end of life prescribing anticipatory medicines. These order sets contained a predetermined selection of medicines in line with trust policy and were listed on a red kardex to aid universal recognition. When these order sets were accessed by ward staff, the patient's status was updated to EOL. This triggered an alert to the chaplaincy team. The palliative care team proactively monitored the system for patients with this status.

Although care plans were selected on the electronic recording system, nursing staff did not consistently record outcomes in nursing and medical notes in line with the trust 'Medicine Policy' (2019).

Nursing staff did not consistently record outcomes in nursing and medical notes. For example the pain care plan says administer medication and monitor but we reviewed six sets of patient records and saw no record of monitoring was found in either the paper based or electronic records

Records of pain assessments and re-assessments were not consistent. We saw a document was available but was not consistently used across wards visited.

We saw medicines was a regular agenda topic at the end of life steering group meetings and the availability of community pharmacy medicines for patients whom were discharged back home.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff delivering end of life and palliative care understood their responsibilities with regard to reporting incidents and they knew how to report them. We saw good evidence of incident sharing between ward staff and end of life teams and lessons learnt because of this.

We reviewed the last four incidents recorded which were specific to end of life and palliative care and saw there were no trends or re-occurring themes. Incidents were unrelated in nature.

In addition we saw the trust had recently produced a report to show the total number of incidents within end of life and palliative care. The trust reported 179 incidents across a twelve month period in 2018 to 2019. There were six main themes identified including; education and training, personalised care planning and involving, supporting and caring for those important to the dying person. These results correlated with the National Audit Of The End Of Life Care (NACEL) audit results and subsequent trust action plan.

Staff told us that serious incidents were investigated with the involvement of relevant staff. We saw discussion of serious incidents within the minutes of end of life care governance minutes. Staff we spoke with showed some understanding about the duty of candour regulations, they understood their responsibility to be open and transparent. They gave us verbal examples of when they had used duty of candour. We saw duty of candour was included in the incident reporting policy.

The mortuary gave an example of learning following an incident, in which the policy relating to the preparation of the deceased was reviewed to improve staff safety.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to March 2019, the trust did not report any never events for end of life care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from April 2018 to March 2019.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Ward managers told us that electronic dashboards were maintained to collate key data for each ward. We reviewed these dashboards and saw monthly specialist palliative care referrals were collated, incident numbers, rapid discharge, complaints and compliments, end of life training targets and coding accuracy.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Policies used by the service were available for staff to access on the trust intranet. These included a range of pathways and guidance which reflected national evidence based best practice and guidelines.

The trust end of life care strategy was developed in line with The National Palliative and End of Life Partnership and National Ambitions for Palliative and End of Life Care, which outlined eight ambitions of care. Two of the foundations for ambitions included education and training and personalised care planning. The trust responded to personalised care planning with the development of an electronic care plan, which recently implemented supported nursing staff to select bespoke outcomes for patients reaching end of life. The care plan was developed in line with the Deciding Right initiative and the 5 priorities of care within the One Chance to get it Right publication.

In addition, the trust used 'Guidance for care of patients ill enough to die' to guide clinical teams in the priorities for end of life care. This document was introduced in 2014 following the discontinuation of the Liverpool Care pathway.

The guidance is aligned to the National Institute for Health and Clinical Excellence (NICE) quality standards for care of the dying in the last days of life. This consists of four quality statements which relate to assessing signs and symptoms, individualised care, anticipatory prescribing and hydration. These quality standards are used by the trust to audit clinical practice and outcomes in care settings within County Durham and Darlington.

In addition, guidance relating to mental health and specifically capacity and consent during end of life care was provided by trust policies. We reviewed these policies and saw they were developed in line with the Mental Health Act.

Staff conducted multi-disciplinary team huddles in which key clinical information was shared to drive individualised outcome planning for patients.

The end of life steering group participated in the ratification of clinical policies and the review and development of new guidance for end of life and palliative care.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

The trust used a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that staff followed MUST scoring for nutrition and hydration appropriately. Nutrition and hydration needs at the end of life were identified and managed as part of the electronic care plan system.

However, we saw inconsistencies in the use of fluid balance charts across all wards we visited. Some ward staff told us that electronic fluid balance charts were now in use with no paper records to be completed. Other ward staff told us they used a combination of both formats. None of the six fluid balance charts we reviewed showed an outcome goal for either intake or output of fluids.

In addition we reviewed fluid balance charts for two patients receiving IV fluids at the time of inspection and saw that only two intake and output entries had been made in a 24 hour period.

We saw evidence of mouth care for those patients unable to tolerate fluids. In addition we saw the acute specialist palliative care team provided training sessions throughout the year regarding mouth care, which was available to all clinical staff. However, we did not see evidence of evaluation of care planning in this area.

We reviewed the results of the most recent bereaved relative's survey which showed that 70% of respondents felt that there was enough support with nutrition.

We saw within the results of the first round of the 2019 National Audit of Care at the End of Life that Care of the Dying audit that the trust scored lower at 39% when compared to 61% nationally in relation to documented assessments of nutrition in-between recognition and time of death. Hydration was also lower at 55% compared to 75% nationally.

The trust has subsequently produced an action plan to ensure quality outcomes are monitored but it did not show agreed timescales for action.

Pain relief

Staff did not consistently assess and monitor patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We saw pain assessments were inconsistently documented for palliative and end of life care patients across the wards we visited. We saw documentation specific to pain assessments were used on some wards and on others we saw no evidence of pain assessment. We reviewed the

electronic pain care plan and saw that guidance was to ‘... *administer medication and monitor*’. Records reviewed showed no evidence of monitoring specific to pain management and we were not assured monitoring of syringe drivers (every four hours) was taking place in line with trust policy (‘Policy for the administration of subcutaneous medication’, 2017).

We reviewed the results of the most recent bereaved relative’s survey which found that only 26% of relatives stated that pain relief was received all of the time.

However, during inspection we saw ward staff administering pain relieving medication in a timely manner.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers used information from the audits to improve care and treatment

End of Life Care Audit: Dying in Hospital (2016)

The trust did not participate in the End of Life Care Audit: Dying in Hospital 2016.

(Source: EoLCA – End of Life Care Audit – Dying in Hospital)

National Audit of Care at the End of Life (2019)

The trust took part in the National Audit for Care at the End of Life (NACEL), a three-year project commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

The audit focused on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales. The audit changed from the End of Life Care Audit: Dying in Hospital.

Summary scores for the trust were calculated against recognising the possibility of imminent death 9.2 (national summary score 9.2), communication with the dying person 6.1 (6.9), communication with families and others 5.0 (6.6), involvement in decision making 8.2 (8.4), needs of families and others 5.0 (6.1), individual plan of care 6.3 (7.4), families and others experience of care 6.4 (7.1), governance 10.0 (9.5) and workforce/specialist palliative care 5.0 (7.6).

The results from the first round of the audit indicated that the trust performed better than the national summary score in two out of nine areas and worse in the other seven areas. The following actions had been identified:

- Guidelines developed to support clinical staff in assessment, discussion and documentation of hydration and nutrition requirements of individual dying patients.
- Palliative care service will ensure all wards are using ‘Care of Dying Guidance’ and will support ward doctors and nurses to improve conversations and documentation.
- Guidelines developed to support clinicians in what should be said and documented in relation to common side effects of medications used at end of life.
- Electronic care plans developed to support end of life care.

- Development of end of life ('comfort') observations on electronic system.
- The palliative care service will work with the new medical examiner to identify cases where the possibility of dying was not recognised early enough or where there was a lack of escalation planning which had a negative impact on care.
- The palliative care service will work with the new medical examiner to create a process for rapid feedback and support for staff

The 'Palliative Care Annual Report' (2019) acknowledged the audit results '...will be used as a focus for education and to guide system improvements. Several changes have already been made and others will follow over 2019'.

These included:

- increase in the involvement of end of life and palliative care from below 20% (2015) to above 40% (2018) for dying patients, the highest rate of care involvement in the north east region;
- fewer patients dying each year in the hospital. Public Health England uses 'death in usual place of residence' (DIUPR) as a high-level marker of effective palliative care provision (51.8%, England average 46.8%);
- worked jointly with the Public Health Department of the local council and local university to conduct a postal questionnaire (views of informal carers, evaluation of services (VOICES)) of bereaved relatives that is used nationally to understand more about people's experience of end of life care;
- developed a palliative care dashboard for key elements of data to be monitored monthly;
- developed combined incident and complaint analyses to provide insight into the issues that require improvement. This has been used in conjunction with the national audit data and the responses from VOICES to inform the action plan for palliative care.

We saw at the last inspection in 2015 that the trust did not routinely capture preferred place of death. We saw that data was now collated and recent data showed preferred place of death was recorded in 99% of the documentation that was checked across the last five months trust wide.

Specialist nursing staff told us they were well equipped to treat patients with a mental health condition and liaised with the psychiatry team daily in such cases. Staff knew how to refer to the drug and alcohol service, should they need to do so.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

From April 2018 to March 2019, 100% of staff within end of life care department at the trust received an appraisal compared to a trust target of 95%.

Darlington Memorial Hospital end of life care department

Staff group	April 2018 to March 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Nursing and Midwifery Registered	7	7	100%	95%	Yes

From April 2018 to March 2019, 100% of staff within end of life care department at Darlington Memorial Hospital received an appraisal compared to a trust target of 95%.

The Macmillan palliative care educator and members of the specialist palliative care service had developed a comprehensive training programme enabling staff to be trained in a three-year cycle. On line learning had been developed including capacity assessment and best interest decision making modules from the national e-learning programme ('End of Life Care for All').

The end of life and palliative care education strategy identified competence levels for four distinct groups of staff - those working entirely focused on the care and support to the dying person, staff who frequently deal with the care and support for the dying person, staff working within other services who are infrequently involved with the care and support to the dying person, and staff working within ancillary and non-clinical support services who are infrequently involved with the care and support for the dying person.

The palliative care team had attended advanced symptom management (two-day conference, 2018 and 2019), advanced communication course, non-medical prescribing and clinical skills. The palliative care team participated in quarterly Macmillan countywide meetings. The strategy also identified competences for staff who frequently deal with the care and support for the dying person involving role specific training designed to be delivered to 85% of staff by 2021.

Training to the other identified groups of staff was delivered through core mandatory training. In addition, education was provided around principles and competences for the care and support for the dying person and those closest to them as part of 'Deteriorating Patient and Resuscitation' and 'Acute Illness Management'. The Acute Intervention Team had delivered 124 hours of teaching on wards to 819 staff since April 2019 on palliative care, including the rapid discharge flow chart, who to escalate to in and out of hours, symptom control and management, the contents of support files on wards and the 'Care of the Dying' and 'Care after Death policy' (2018).

Latest figures available showed 48.2% of nurses across the trust had received specific end of life and palliative care training. Link staff had completed specific end of life training enabling them to support staff on the wards. In addition, the trust had plans to include end of life training as part of mandatory training. There was a rolling education programme with 24 palliative care link nurses across UHND and community hospitals with four sessions each across the year. This forum was used to disseminate information and offer shadowing opportunities within the specialist palliative care team.

Specialist palliative care and acute intervention staff provided ward staff with complex symptom control advice and end of life care planning and nursing care. End of life and palliative care training sessions were held on wards visited. Ward staff were encouraged to attend these events which included symptom management and presentations for professional colleagues such as hospice and ambulance providers.

The medical devices team had also delivered trust wide training for the competent use of syringe drivers. Although large numbers of staff had attended the training, staff competence was not monitored or re-validated.

The chaplaincy team were all appropriately experienced, including specialist knowledge in areas such as child and adult death and bereavement, issues around faith and ethical issues. They also provided training to staff and external organisations including ethics and bereavement and contributed to trust induction.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The electronic database system enabled ward staff to submit electronic referral to colleagues within the hospital. This included the palliative care team, acute intervention team, mental health and chaplains. Ward staff told us these professional colleagues were visible on the wards and we saw teams working together to proactively support effective care planning and treatment delivery.

Ward staff told us that all referrals and requests for patient's reviews were addressed, even if the patients had not been identified as approaching the last days of life. We saw teams supported each other to ensure the needs of each patient were met.

We saw examples of effective multidisciplinary working on wards: ward staff told us that, discussions and treatment planning was a collaboration of different professionals working together to enhance patient care.

Ward 'huddles' were used at the start of each shift to discuss individual patient care planning. We saw discharge co coordinators, were integral to these meetings specifically at the end of life when patients preferred place of death was home.

Acute and community colleagues worked together to ensure the patients' needs and wishes were met. For example, palliative medicines in community pharmacies were routinely reviewed to ensure smooth discharge planning.

We saw palliative and end of life steering group meetings involved staff from other areas, such as safeguarding, pharmacy, and local ambulance providers. Learning and consistent practice was shared and policies reviewed with consideration for other professional colleagues.

Seven-day services

Key services were available seven days a week to support timely patient care.

Although seven-day services for the acute specialist palliative care team were not in place, ward staff could access additional support services. These included the acute intervention team which were available seven days a week and an end of life and palliative care advice line which was provided by a local hospice.

During weekdays, consultants, doctors and nurse specialists reviewed patients daily. At weekends, reviews were conducted by nurse specialists.

Following the last inspection in 2015, community specialist palliative care teams had been extended to provided seven day support services.

Ward staff told us that an additional ward huddle was held on a Friday to ensure patients requesting to die at home were clearly identified and appropriate discharge arrangements were made.

Mortuary staff did not work at evenings or weekends but were on call to come in if a body needed to be released during these periods. They told us they did not have any problems releasing a body in a timely manner if all paperwork was complete, and were therefore able to meet the needs of those faiths requiring prompt burial.

The chaplaincy service provided 24-hour cover and, out of hours, aimed to respond within one hour.

Radiology and pharmacy services were available out of hours, either directly or on an on-call basis, and allied health professionals such as physiotherapists were available at the weekend.

Ward staff told us that an additional ward huddle was held on a Friday to ensure patients requesting to die at home were clearly identified and appropriate discharge arrangements were made.

Health promotion

Staff gave patients practical support to help them live well until they died.

We saw relevant information promoting healthy lifestyles and support on every ward and staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The service promoted the National Dying Matters weeks once a year. The team told us that last year they held events at hospital sites, encouraging both patients and staff to discuss death and dying, and also highlighting the work of other services such as local hospices.

We saw Macmillan support centres were based in both hospital sites and were staffed by volunteers offering leaflets and guidance for patients and their relatives in a range of subjects, including emotional, financial and therapy information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 33% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

A breakdown of compliance for MCA/DoLS training courses from April 2018 to March 2019 at University Hospital of North Durham for qualified nursing staff in end of life care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	1	3	33.3%	33%	Yes

In end of life care, the target was met for the MCA/DOLS training module for which qualified nursing staff were eligible. Care should be taken when interpreting low eligible staffing numbers.

A breakdown of compliance for safeguarding training courses from April 2018 to March 2019 at University Hospital of North Durham for medical staff in end of life care is shown below:

Training module name	April 2018 to March 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Mental Capacity Act	1	1	100%	33%	Yes

In end of life care, the target was met for the MCA/DOLS training module for which medical staff were eligible. Care should be taken when interpreting low eligible staffing numbers.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLs). DoLs can only be used if the person will be deprived of their liberty in a care home or hospital.

We looked at the trust's policies for consent and mental capacity act, including DoLs. We found that these were in date and contained appropriate references to legislation such as the mental capacity act, equality and diversity and the human rights act.

Specialist end of life care staff told us that mental capacity act and deprivation of liberty safeguards training was part of a mandatory training programme which was managed centrally.

At the time of inspection mental capacity assessments and decision making tools were not part of the electronic records system. Staff recorded assessments using the designated MCA 1 and MCA 2 forms, which are nationally recognised documents.

We reviewed four capacity assessment forms and saw these were appropriately completed and reviewed.

We checked four 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms at this hospital and saw that these were appropriately completed and reviewed.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Ritual washing facilities were available for those families wishing to use them.

We observed patients being treated with dignity and respect. We observed a number of interactions between staff, patients and relatives. We observed staff responding compassionately to patients' pain, discomfort and emotional distress in a timely and appropriate way.

Confidentiality was respected in staff discussions with people and those close to them. Staff spoke about patients with complex needs in a respectful way and demonstrated a non-judgemental attitude.

Patients we spoke to told us their care had been good and felt involved in their care. Social and cultural needs were considered and information was discussed in an open but sensitive manner.

The chapel contained a ritual washing room so that families who wished to wash and prepare their loved one could do so. East was marked on the floor to aid orientation for prayer.

Bereavement services staff offered practical advice would be given regarding the death certificate, funeral services, mortuary services and administration procedures. Patient's property was returned through the bereavement services team when necessary, to avoid relatives having a potentially upsetting visit to the ward.

Bereavement staff told us there had been some recent delays experienced by families obtaining death certificates, however we did not see any complaints relating to this.

Emotional support

Staff did not always provide emotional support to patients, families and carers to minimise their distress. They did not always understand patient's personal, cultural and religious needs.

Families and patients we spoke described a caring and compassionate workforce. Feedback we received during inspection was very positive and families told us that the ward staff were 'amazing' and 'could not do enough'.

Nursing staff told us that side room availability was limited but where possible patients reaching end of life were prioritised. Where side rooms were not available patient's families told us care was delivered in a sensitive and dignified manner.

We saw across several wards that comfort packs were provided for families visiting the wards. These included free parking permits, overnight provision if families wished to stay at the hospital and refreshments. In addition, on two wards we saw small gift bags which contained forget me knot seeds, a memories card and bereavement support booklets.

Results from the most recent bereaved relatives survey carried out between between January and July 2017 were mixed. We saw 66% of families felt that dignity and respect was always provided and 93% felt that family were supported after death in a sensitive manner.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

The trust collated information specifically in relation to patient and family involvement and decision making. Patients said the ward and palliative care teams were very supportive and answered concerns thoroughly. Wards did not limit visitor access for patients nearing the end of life, open visiting times were in place.

Results from the most recent bereaved relative's survey showed 86% of respondents felt that they were involved in decisions about their care. We saw 90% of respondents felt that death occurred in the right place and 81% felt as involved as possible in the decisions regarding end of life care.

In addition we saw that 92% of respondents stated they had received support regarding feelings about illness and death from other services such as bereavement services.

We spoke with two patients who were being cared for on a general ward with oversight from the palliative care team. We were told that the team and the ward staff had been very caring and had involved the patient's family at every opportunity.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

End of life services were planned to meet the needs of the local population and ensure patients received co-ordinated care accessible and responsive to people's needs. There was good partnership working between the hospital and community teams, local hospices, primary care providers and the ambulance service.

The trust had developed integration of the community and acute palliative care teams to ensure a seamless flow between settings with trust systems identifying palliative patients newly admitted to the acute setting. Medical palliative care staff worked across hospital, hospice and community settings. 'Deciding Right' documentation was used within both the acute and community settings to support patients and their families to make decisions right for them. There was recognition that sharing information to appropriate services, for example ambulance services, was crucial for an effective service.

The mortuary management team was accountable for securing services for the deceased throughout the trust and across agency boundaries and had developed a multi-agency mortuary group. The primary responsibility of the group was to ensure effective end-to-end care for the deceased and their family were in place and monitored. The group included representatives of coroner's officers, funeral directors, the patient reference group, crematoria and the registry office.

The second trust annual palliative care symposium was held in May 2019 attended by 129 delegates. Emphasis was placed on the end of life care strategy, the ambitions to achieve the strategy (each person seen as an individual, fair access to care, maximum comfort and wellbeing, co-ordination, all staff prepared to care and each community prepared to help) and included input from chaplaincy services. Evaluation showed 96% of attendees recommended the event.

The trust was working with the local clinical commissioning group (CCG) to improve the creation and delivery of emergency health care plans as well as exploring the use of treatment escalation plans to support individualised care plans for patients nearing the end of life. The development of protocols to improve the sharing of advance care planning with the local ambulance service for patients at home and in care homes was progressing.

The trust was continuing to reduce the number and proportion of cardiac resuscitation attempts that could have been avoided with better assessment and care planning. This had been improved through the initial introduction of the new format for end of life care planning on the electronic record system. These were supported through the trust promoting guidance for the care of the dying patient with an education and communications programme.

The trust provided end of life care in all ward settings with medical, nursing and allied health professional teams supported by the specialist palliative care team (SPCT) and the acute intervention team to deliver the best possible end of life care.

The trust had appointed a lead medical examiner to create a more effective and robust mechanism for death certification in the hospital. The palliative care service will work with the examiner to develop ways for more immediate feedback from bereaved relatives and more directed service improvement.

There were no visiting restrictions on the wards for friends or family of those receiving end of life care, arrangements were made for relatives who wished to stay overnight.

The service had worked to improve delays in the completion of death certificates and mortuary staff investigated any delays and documented actions taken.

The trust was a member of the regional palliative care partnership and had improved the implementation of the 'care of the dying patient' document and training and dissemination of information for the 'Deciding Right' initiative.

The trust continued to fund out of hours palliative care advice for all clinicians (including hospices and care homes) in the county, delivered by a local hospice.

Three palliative care training fellows were in post (two new consultants joined the palliative care service in 2018) providing increased capacity in end of life and palliative medicine and developing potential future consultants in palliative care for the county. The training fellows supported the palliative care specialist nurses and non-palliative teams in the hospital and community. The service had been recognised as more cohesive and comprehensible as a result. Continued support for the training fellows had been identified to prepare applications to join the palliative medicine specialist (consultant) register.

The acute intervention team provided assessment and support to deteriorating patients in hospital. Trust figures showed 50% of patients seen by the team had palliative care needs and where needed, acute treatments were delivered to make people better. The acute intervention team were trained to recognise and manage end of life and palliative care needs and worked closely with ward staff to deliver these, especially during the out of hours.

There had been an increase in the involvement of end of life and palliative care from below 20% (2015) to above 40% (2018) for dying patients. The trust now provided the highest level of end of life and palliative care involvement to dying patients in the region.

Public Health England uses 'death in usual place of residence' (DIUPR) as a high-level marker of effective end of life and palliative care provision (51.8%, England average 46.8%). The trust was

improving on this measure, each year fewer patients were dying in the hospital and better than the England average.

Staff told us they found it easy to refer a patient to the palliative care team who visited new patients the same day. The team provided specialist advice, either on the ward or through telephone advice. The team's assessment of a patient covered physical issues such as pain relief, nausea and mobility, their reaction to the deterioration of their condition, where they might prefer to die and how they were coming to terms with their prognosis.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff moved dying patients to a single room as soon as possible to ensure patients' privacy and dignity and to enable relative's overnight accommodation if needed.

The chaplaincy team visited patients when notified by ward staff or the trust electronic record system. During visits, the team spoke to patients and their families about the support they offered, left them contact details and recorded their visit in the patient's notes. Chaplaincy staff supported people's spiritual needs regardless of faith, including the needs of staff. The chapel had facilities for many faiths including, amongst others, Christian, Islam (Wuḍū' and ablution) and identified the Qibla (the direction that should be faced when a Muslim prays during ṣalāh).

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Trust electronic record systems identified patients with needs related to patients with mental health problems, learning disabilities and dementia. Staff contacted a specialist learning disabilities nurse when needed.

The trust had developed a mental capacity act team to provide support to staff to understand their duty of care within the principles of the MCA. Full day training on the principle of the Mental Capacity Act and Deprivation of Liberty safeguards (DoLs) had been provided to build staff understanding.

The trust had developed a clinic-based service accessible to patients with lymphoedema who may or may not have end of life or palliative/diagnoses.

Ward staff told us there was a learning disabilities team who were available for support and guidance, and who would work alongside patients and relatives, for example to support with communication needs. Members of the learning disabilities team attended monthly multi-disciplinary team meetings.

Staff understood their responsibilities on meeting the information and communication needs of patients with a disability or sensory loss. Individual mobility and communication needs were assessed within an initial nursing assessment which all patients received and documented in an individual care plan. Staff, patients, relatives and carers received help from interpreters through telephone or direct contact.

Bereavement services staff provided booklets in a range of other languages and accessed telephone or face to face translation services if needed. Computer tablets were available to them to provide an internet linked BSL signing service and they had not experienced any problems with availability of this or any other translation services.

Families were provided with free parking passes and volunteers had created syringe driver bags to maintain privacy and dignity and memory bags to hold important jewellery to hand over to families when their relative died.

There had been an increase in the involvement of end of life and palliative care from below 20% (2015) to above 40% (2018) for dying patients. The trust now provided the highest level of end of life and palliative care involvement to dying patients in the region.

Public Health England uses 'death in usual place of residence' (DIUPR) as a high-level marker of effective end of life and palliative care provision (51.8%, England average 46.8%). The trust was improving on this measure, each year fewer patients were dying in hospital which was better than the England average. The trust's unscheduled care service had improved access to palliative assessment and management for patients dying at home.

The trust had supported improvements in provision of end of life and palliative care medicines during out of hours period. This has resulted in the use of anticipatory medicines, updates to the palliative care medicine stock list, an electronic version of the palliative care alert system and the development of a palliative care pharmacy network.

Palliative care discharge coordinators had developed rapid palliative discharge guidance which enabled staff to use available resources for discharge even when the coordinators were not on duty. To support this the trust had developed prescribing sets for anticipatory medicines and combined these with the discharge process to ensure that more palliative patients were discharged with medicines for symptom control at home.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Patients for end of life and palliative care were identified through a multidisciplinary discussion involving those involved in a patient's care on the ward, either directly with the specialist palliative care team or through the trust's electronic record system.

Once a referral was received the team assessed the patient to determine the level of support required. Specialist palliative care nurses reviewed and triaged all referrals. Where necessary patients were also referred for a review by a palliative care consultant. Patient's notes were reviewed by the team and a specialist nurse reviewed the patient's pain relief and began arrangements for discharge. Ward staff said they had received good support from the palliative care team when arranging discharge. Discussions about the patient's preferred place of death took place as soon as was practicable and documented in the patient's notes.

The trust 'Audit of Documentation of Care in the Last Hours and Days of Life for Expected Deaths in CDDFT' (February 2018) showed there were high levels of achievement (76%) of preferred place of death (PPD). This had increased to more than 90% for seven of the previous twelve months before inspection. The specialist palliative care service had improved personalised care planning and supported preference for place of death for 95% of patients known to the service in 2018.

The trust had worked with CCGs to adopt and fund the 'six steps' programme for palliative care in care homes to facilitate discharge. Community matrons and the community specialist palliative

care service continued to improve palliative planning. To help community discharge the trust funded consultant and middle grade medical posts at local hospices and prisons.

The trust had developed the cardiac arrest prevention (CAP) team in response to research that identified cardiopulmonary resuscitation (CPR) is only successful in a proportion of previously well people and does not work when people are naturally approaching the end of their lives. The team and palliative care consultant worked collaboratively to review CPR attempts in the trust and identify attempts that might have been avoided by better advance planning. The number of overall CPR attempts (total cardiac arrests) and proportion where CPR could have been avoided with better planning had both decreased over recent years.

A trust plan for improvement in capacity assessment and best interest decision making had been developed supported by a palliative care mandatory education programme in decision making for all staff.

Learning from complaints and concerns

Summary of complaints

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints

Trust level

From April 2018 to March 2019, the trust received three complaints in relation to end of life care at the trust (0.5% of total complaints received by the trust). The trust took an average of 23.3 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed in 40 working days.

A breakdown of the three complaints by location and type is shown below:

Location/site	Type of complaint
Darlington Memorial Hospital	Facilities
Darlington Memorial Hospital	End of life care
University Hospital of North Durham	Patient care

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2018 to March 2019, there were 11 compliments about end of life care at the trust. One of these was for trust wide end of life care and the other 10 were for Darlington Memorial Hospital bereavement office. All compliments were recorded in March 2019.

The main themes that run through the compliments relate to the staff going above and beyond what a patient expects them to do, supporting the patient and family during difficult times for them and taking the time to listen and explain things to patients.

All compliments that the trust receive from a patient or the family are all shared with the staff named and their managers, along with the CEO if requested to or if it is from a staff member. The trust ask that managers share the compliment with the staff on the ward or in the department.

Is the service well-led?

Leadership

The end of life care service reported to the executive director of nursing and had a direct link into the trust board. The board received progress reports from the end of life care services team led by a consultant in palliative care. The team spoke positively about the impetus and motivation the restructuring of end of life care services within the trust had received since our last inspection.

The team was well established with experienced staff that provided clinical and professional leadership. This included a clinical director, palliative care lead consultant, associate director of nursing, associate director of operations, clinical services manager, lead nurses and lead clinicians.

Staff were well supported in their roles and had a clear understanding of their responsibilities and told us leaders were visible and approachable. Ward staff told us that the specialist end of life and palliative care team were well known, accessible and provided expertise and advice when needed.

Clinical leadership in the specialist palliative care service had been strengthened by the appointment of two new consultants (one shared with a local hospice) in 2018. Senior clinicians had engaged with other non-palliative teams (within and outside the organisation) to enhance the understanding of end of life and palliative care and supported improvements in the service for patients and families.

The end of life steering and palliative care group had delivered improvements and continued to provide direction and vision for end of life and palliative care improvement. For example, the group had appointed two consultants, improved clinical working relationships with local hospices with joint meetings and shared appointments and was developing mechanisms for communicating more effectively with the health and wellbeing board.

The steering group was also developing plans for the following:

- next end of life and palliative care strategy;
- improvements to governance links between specialist end of life and palliative care and trust care groups;
- increases to end of life and palliative care support for bereavement and mortuary services;
- creation of mechanisms for bereaved relatives to have the opportunity to share their stories in staff education.

Meetings were attended by the executive director of nursing, consultants in palliative care, lead nurses, clinical services manager and Macmillan educator. The steering group met every two months and minutes showed it discussed operational issues (for example, modification of discharge letter, funeral costs, palliative care calls and response times, palliative care and end of life dashboard, palliative care telephone advice, mortuary signage), education and training (for example, syringe driver training, end of life education, opioid and driving patient information) and strategy (for example, end of life strategy, NACEL, dying matters awareness 2019, VOICES report and actions).

Vision and strategy

We met with the senior leadership team and separately with members of the end of life and palliative care team, hospital and community nurses and healthcare assistants and palliative care consultants. Everyone was positive about the leadership, strategy and organisation of end of life and palliative care services at the hospital and throughout the trust. There was universal recognition that the trust had made improvements to end of life and palliative care since our previous inspection. Staff told us the trust was now a rewarding place to work in end of life care and recognised the contributions made by clinical leadership.

Ward staff articulated that end of life and palliative care was the responsibility of every member of staff. This was supported by the availability of the palliative care team, the acute intervention team and the out of hours advice line. This support was underpinned by end of life champions, education and training. Culture centred on the needs and experience of people who used the end of life and palliative care service.

Staff working in the mortuary and bereavement services had positive attitudes to their role and respected the service they gave to families and carers at a sensitive time. They told us the trust had listened to their concerns about the mortuary and bereavement office at the hospital and provided funds to ensure an appropriate environment.

Porters had received training in moving and handling deceased patients and had developed good relationships with ward and mortuary staff to ensure the deceased patient was moved with respect and dignity.

Culture

Staff promoted a positive culture of providing quality end of life care which was reflected by leaders in the trust.

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Governance

There was a governance structure in place with processes and systems of accountability to support a sustainable service.

The end of life and palliative care team used audits to give oversight of their progress and position against strategy and targets. Audits of prescribing, use of the 'care of the dying patient' document, recording of patients' preferred place of death and rapid response discharge planning were all regularly completed.

The end of life steering and palliative care group provided direction and vision for end of life and palliative care improvement. Meetings were attended by the executive director of nursing, consultants in palliative care, lead nurses, clinical services manager and Macmillan educator.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and a good quality sustainable service. End of life and palliative care services was part of the community services care group and reported to the board through the care group's governance structure. The steering group met every two months and minutes showed it discussed operational issues, education and training and strategy. The group provided their minutes and an annual progress report to the trust board. The group was chaired by the executive director of nursing.

Staff were clear about the service vision and their role in delivering the strategy. Leaders were aware of priorities for the service, such as achieving preferred place of care for patients, identifying patients who require end of life care and personalised care planning.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and demonstrated the ability to cope with both the expected and unexpected.

The trust used the board assurance framework (BAF) to capture and monitor action plans for board and executive level risks ('strategic risks'). In addition, each directorate and care group had its own operational risk register.

The trust did not maintain a separate 'corporate risk register'. All risks were managed by the care groups and directorates on an electronic risk management system. When reporting to the risk management committee, risks were reported by those where the current score was outside the trust's risk tolerance level set by the board.

The end of life and palliative care team did not hold its own separate risk register, and risks were held on the wider Community Services Risk Register. There were two risks related to end of life on the directorate/care group risk register, i.e. gaps in compliance around the application of the MCA, and mortuary facilities not up to the required standard.

End of life and palliative care services had been asked to input into increased compliance of the former, and mortuary facilities were being updated at the time of inspection. At the time of inspection both these risks had reduced through mitigating actions from moderate assessment to unlikely and rare.

The hospital mortuary risk register demonstrated focus on improvements, such as viewing room refurbishment, temperature logging, and cold store redevelopment.

Information management

Appropriate and accurate information was being effectively processed, challenged and acted upon.

End of life and palliative care resources were available on the trust intranet site, as well as relevant policies and guidelines. We saw information regarding end of life and palliative care information and contacts displayed on wards. Information systems were secured through password only access. Securely held patient identification and registration system were used to transfer patients to the mortuary.

An electronic notification system was used to alert the end of life and palliative care team, the acute intervention team and chaplaincy services to the needs of patients. Urgent referrals were made directly to the respective teams by ward staff.

The trust had developed a specific dashboard for recording end of life and palliative care patient information and the content reflected preferred place of care (PPC) and preferred place of death (PPD). The dashboard identified the number of referrals (DMH: 911 in 2018/19), incidents, rapid discharges (trust: 172 in 2018/19), training compliance, compliments and complaints, coding, deaths occurring at usual residence and achievement of PPD.

Culture

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Ward staff told us there was more awareness of end of life and palliative care services and the support they provided. Staff said they were aware of the range of information and support from the palliative care team, the acute intervention team and the out of hours service provided by a local hospice. End of life link nurses on wards were engaged to give feedback to the specialist teams.

This was complemented by education and training by the teams including mouth care and syringe driver competences. The teams raised awareness of their roles during 'dying matters' week and gathered views on how their service could improve and inform staff how they could access the comprehensive end of life care training on offer.

The trust had used the national VOICES postal questionnaire of bereaved relatives to understand about people's experience of end of life care. The trust had worked jointly with the public health department of the local council and a local university to conduct a survey to provide more specific results.

A full report, published in September 2018, was shared with key stakeholders prior to a half day event in November 2018 and generated insight to services provided. Following this, the trust agreed an action plan based on the results. The local survey provided evidence and motivation for making change.

Quality of care by setting/staff group: Excellent or good	2018 local	2015 national	Diff (%)
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<i>Urgent and emergency care</i>	63	63	0
<i>District and Community Nurses</i>	85	81	+4
<i>Hospital doctors</i>	81	76	+5
<i>Hospital nurses</i>	78	74	+4

Dignity and respect by setting: Always or most of the time	2018 local	2015 national	Diff (%)
<i>District and Community Nurses</i>	80	77	+3
<i>Hospital doctors</i>	65	60	+5
<i>Hospital nurses</i>	65	54	+11

In response to patient and relatives feedback the palliative care service had made changes to provide specific training to nurses to recognise dying patients and enable them to have discussions with medical staff and families, and developed a cross-specialty (acute medicine, intensive care and palliative care) group of senior clinicians to explore ways to improve earlier recognition. Following discussion with bereaved relatives the end of life and palliative care team had revised the information leaflet given to all relatives of a dying patient.

Learning, continuous improvement and innovation

The inspection identified the following learning, continuous and innovative practices within palliative and end of life care:

- Referrals to the specialist palliative care team were made directly to the team or identified through the trust's electronic systems. The system enabled ward staff to submit electronic referral to the palliative care team, acute intervention team, mental health and chaplains.
- Automatic alerts were sent to the palliative care team and chaplaincy staff to inform them when a predetermined selection of medicines order set was accessed by ward staff.
- The trust had developed an electronic care plan which supported nursing staff to select bespoke outcomes for patients reaching end of life.
- The trust funded out of hours palliative care advice for all clinicians in the county, delivered by a local hospice.
- Palliative care discharge co-ordinators had been appointed and had developed rapid palliative discharge guidance for effective discharge when the co-ordinators were not on duty.
- The trust had worked with CCGs to adopt and fund the 'six steps' programme for palliative care in care homes to facilitate discharge.
- The palliative care team was available five days a week and their role complemented by the acute intervention team in the evenings and at night. At weekends and out of hours a telephone service was available to provide consultant advice and support from a local hospice.

- The trust had developed prescribing sets for anticipatory medicines, combined with the discharge process to ensure more palliative patients were discharged with medicines for symptom control at home.
- The mortuary management team had developed a multi-agency mortuary group.
- Palliative care training fellows had been recruited to support palliative care specialist nurses and non-palliative teams in the hospital and community.
- Families were provided with free parking passes, syringe driver bags to maintain privacy and dignity, and memory bags to hold important jewellery to hand over to families when their relative dies.
- There had been an increase in the involvement of end of life and palliative care from below 20% (2015) to above 40% (2018) for dying patients. The trust now provided the highest level of end of life and palliative care involvement to dying patients in the region.
- The trust had developed a specific dashboard for recording end of life and palliative care patient information including preferred place of care and preferred place of death.
- The trust had increased the levels of achievement of preferred place of death.
- The trust had developed the cardiac arrest prevention team in response to research that identified cardiopulmonary resuscitation does not work when people are naturally approaching the end of their lives.
- The end of life steering and palliative care group had delivered improvements and continued to provide direction and vision for end of life and palliative care improvement.
- The trust had developed a cross-specialty (acute medicine, intensive care and palliative care) group of senior clinicians to explore ways to improve earlier recognition of dying patients.