South Tees Hospitals NHS Foundation Trust

Evidence appendix

The James Cook University Hospital
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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.

Facts and data about this trust

Acute hospital and community sites at the trust
A list of the acute hospitals and community sites at South Tees Hospitals NHS Foundation Trust is below.

Name of acute hospital site	Address	Details of any specialist services provided at the site	Geographical area served
The James Cook University Hospital	Marton Road, Middlesbrough, TS4 3BW	Neurosciences, renal medicine, spinal injuries, major trauma, cardiothoracic, vascular surgery and cancer services	Middlesbrough
Friarage Hospital	Northallerton, North Yorkshire, DL6 1JG		From the North Yorkshire moors to the central Pennines, the borders of York district (south) and the borders of Darlington.
East Cleveland Primary Care Hospital	Alford Road, Brotton, TS12 2FF	Rehabilitation and palliative care	

Guisborough Primary Care Hospital	Northgate, Guisborough TS14 6HZ		
Redcar Primary Care Hospital	West Dyke Road, Redcar, TS10 4NW		
The Friary Community Hospital	Queens Road, Richmond North Yorkshire, DL10 4AJ		

(Source: https://www.southtees.nhs.uk/hospitals/)

Is this organisation well-led?

Leadership

Not all leaders at Board/senior level had the necessary experience, knowledge, capacity, to lead effectively. The need to develop senior leaders was not always recognised or identified therefore action was not always taken. Although there was leadership training for certain roles within the organisation there was no recognised organisational development strategy to develop senior leaders and those aspiring to move into executive roles.

We had concerns about the model for medical leadership; it had led to a splintered approach with a lack of clarity in accountabilities and a lack of a collective view of the medical priorities for the organisation.

The board had seen considerable change over the last two to four years, especially with the executive members. All the executive members had been recruited since October 2015 with only two of the non-executive members in post prior to September 2015. The trust had a unique executive structure at Board level with four medical directors (MD) as voting members of the board. Other executive members were the CEO, director of nursing and the finance director.

The CEO joined the trust in April 2015 full time as a director of transformation with a focus on the transformation and financial recovery of the trust. They were appointed as permanent CEO from October 2015.

The medical directors (MD) took up post in April 2016 and worked clinically the equivalent of three days/week with two days/week each for their MD duties including each having responsibility for a specific set of clinical specialities within a clinical "centre". Board members told us that the strength of this model was the MDs' link to frontline work as they all worked clinically. The MDs were clearly passionate about patients and quality of care, however, there was a lack of capacity for the MDs to effectively deliver their leadership roles; this was compounded by a lack of leadership training and skills. There was also a view by some senior staff that the model of four MDs was not effective as there was a perceived lack of clarity in accountabilities and a lack of a collective view of the medical priorities for the organisation.

For all executive directors, apart from the finance and estates directors, this was their first position at Board level. The trust therefore had a relatively inexperienced executive leadership team when operating at board level within a unitary board. We were told by both clinical staff and some members of the board that the board did not always work together well as a unitary board.

The finance director's brief was very narrowly focussed on the financial and procurement aspects of the trust and the role did not engage with the broader trust responsibilities. We were told this was a deliberate decision to ensure there was sufficient focus on financial recovery. There was no chief operating officer (COO) post. Other directors included: interim director of HR, business development, and estates (appointed September 2016); they were not board members. We were told they did not routinely attend the board. For example, the director of HR who was also interviewed as the trust's equality and diversity lead did not attend board meetings; it was unclear how HR issues were effectively represented at the board. Following the inspection the CEO stated that board responsibility for strategic HR matters was within their portfolio. This meant that at board level both the CEO and director of nursing had a very broad portfolio / "bandwidth" which was acknowledged by the CEO. There was also a lack of experienced senior leaders supporting these roles. Some senior staff said it was hard to get quality time with the CEO as they were very busy operationally. The Trust had identified the need to appoint a COO to provide additional operational capacity thus allowing the CEO to be more strategic. This was confirmed during the inspection by the CEO. Following the inspection the trust told us they had tried to recruit in both August 2018, December 2018 and March 2019 but there had been no suitable applicants. No interim arrangements had been put in place meantime to address this identified gap.

There was a relatively new chairman who had been in post since April 2018 and prior to that had been a non-executive director at another NHS organisation. The non-executive director posts were all filled with the newest appointment being in February 2018. There was a suitable mix of skills and experience across the non-executive directors. However, the CEO told us that some of the NEDs could, on occasion, cross into the role of the executive team; due to the pressures placed upon the Board with regard to in year operational performance by regulators.

The trust had a senior manager lead for learning disability, safeguarding adults and children; they were knowledgeable, and the team was visible on the wards providing support in real time to clinical staff. There was also a nursing lead identified for dementia or frailty.

Local leadership of the core services we inspected varied however, almost all staff we spoke with felt supported within their directorate. Well led at both James Cook and Friarage hospitals required improvement for the core services of surgery, diagnostics and critical care. In particular we had concerns about well led in critical care in relation to staffing levels and prevention of patient harm.

At the time of the inspection board development activity was limited, and was topic driven rather than the development of an effective unitary board, an example given was a planned away day about the system change to take further cost out. However, following the inspection we were told that over the last three years the board had worked on board effectiveness as part of board development work required to sign off the enforcement action placed on the Trust in 2013. Since October 2015, the Board had covered a range of topics from effective board governance and the Board Assurance Framework (BAF) through to team dynamics and interpersonal skills. The chair was committed to developing a more structured programme linked to the board's self-assessment arrangements which had yet to become embedded. The CEO told us they had recognised that there was a need to develop leadership competency within their team. There was no-one on the aspiring CEO national programme.

There had been considerable changes to corporate functions, especially quality, HR and finance in 2018/19, and restructuring at all levels. There was concern from staff at all levels that the quality portfolio was not being effectively addressed following the decision to disestablish the director of quality role in December 2017.

The re-organisation of both the HR and finance functions including a reduction in posts as a cost-saving. There was an HR business partner model which, in line with other corporate functions, was developed to support the clinical centres on the front line. A de-centralised HR hub had been put in place to ensure clear HR support and accountability for performance against agreed HR metrics at a centre level. There has been a re-focusing of the priorities of the HR team and a reduction in staffing to reflect this and to bring the Trust's HR corporate costs in line with the top quartile when compared with other trusts.

The finance directorate had access to staff development activities hosted within the region. Opportunities to participate in national training and development networks were constrained by the financial position of the trust. There was currently no plan for the finance team to seek formal finance staff development accreditation.

Following the inspection the Trust confirmed that there had been a very tight vacancy control process across the Trust for the last 12 months as part of the NHSI's regulatory control and enforcement action. We were told that all centres ran a vacancy control panel and all decisions to recruit were signed off by the CEO.

The HR team were starting to work with the operational directors to develop succession planning within the Centres. We were told there had been a recent assessment centre for staff wanting to move into service management roles.

There were some programmes in place to develop leadership such as participating in an Ashridge Masters in Leadership course (for up to 15 staff, with eight participating at the time of the inspection) and consideration was being given to developing a more local MBA course with a nearby university. In addition, we were told that where performance was concerning there was a "Strengths-based approach" to improvement, an example of a clinical team using this to improve the lung cancer pathway was given. We were told that nurse leadership roles at ward level went through an assessment centre linked to the Model ward operating model which identified staff who required further development to be put in place.

There were some apprenticeship-based leadership and management programmes up to master's level for band 7 staff and above. The trust subscribed to the North East Leadership Academy (NELA) enabling leaders and managers to access NELA's workshop programme. The trust had staff who were qualified to deliver the Mary Seacole leadership programme (a six-month leadership development programme) to trust and regional staff. The trust also had an annual Schwartz round programme (Schwartz Rounds provide a structured forum where staff come together regularly to discuss the emotional and social aspects of working in healthcare). Foundation Year 1 doctors participated in a 12-month foundation leadership and management programme leading to an accredited leadership qualification. Following the inspection the Trust told us they ran the Government apprenticeship scheme and as of May 2019 had introduced 253 active apprenticeships across the Trust.

The trust was developing new workforce models and multidisciplinary roles. The trust supported by Health Education England had secured 48 places on a new advanced clinical practitioner apprenticeship programme at Teesside University. This enabled the development of staff into innovative advanced clinical practice roles for nurses, AHPs, pharmacists and scientists.

Fit and Proper Persons Requirement (FPPR)
Whilst all appropriate checks for FPPR had been carried out, we found this was not always recorded within board members' personal files.
We reviewed fifteen director's files (both non-executive and executive) to determine whether appropriate steps had been taken to complete employment checks for executive and non-

executive board members in line with the FPPR (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.

We found that the trust's policy for FPPR had been approved in September 2018 and met the requirements of the regulation. Directors completed annual self-declaration forms to confirm whether they complied with the regulation. However, there were gaps in the files we reviewed; we were not assured that the appropriate FPPR checks had been taken:

- Four of the 15 did not have evidence of a valid DBS check. The others were in place with one check dated 2013 and the remainder dated from 2017 onwards.
- Five of the fifteen had no reference checks.
- There was no insolvency of director's disqualification recorded in any of the files for 2018 or 2019.

During the factual accuracy process the trust provided us with evidence that had not been available in the files we reviewed on inspection which indicated that:

- References had been completed; in three cases references had been included on clinical personal files not the files we reviewed. Two Board Members were long standing employees and did not have references however, on review by the Trust in September 2018, the Chairman provided a letter of Good Standing to be included within their Board files.
- DBS checks were in place
- Insolvency checks had been carried out but were not routinely included in the personnel files.

An FPPR assurance paper presented to the board in March 2018 indicated that directors and non-executive directors had completed the FPPR annual paper work for the year 2017/2018 and that directors would next be asked to repeat this process in Quarter four of 2018/2019.

The diversity of the Board members is outlined in the table below:

- Of the executive board members at the trust, 14.3% were Black Minority Ethnic (BME) and 28.6% were female.
- Of the non-executive board members 0.0% were BME and 37.5% were female.

Staff group	BME %	Female %
Executive directors	14.3%	28.6%
Non-executive directors	0.0%	37.5%

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

Staff representatives told us that they felt there was good representation of females on the board, but they were concerned that there were four MDs and only one nursing representative.

The board had an understanding of the broader health challenges locally and nationally. The trust, as a tertiary centre, was aware of the key leadership role it had to play in the Tees Valley integrated care system (ICS). The ICS covered seven local authorities; five CCGs; and the local NHS trusts. The CEO had been appointed as the provider lead for the ICS.

The CEO was a member of the ICS board. There was work ongoing within the ICS region to develop a transformational strategy for the Tees region. The chief executive was the regional lead / senior responsible officer for some of the workstreams for the ICS: urgent and emergency care

and stroke provision. Other workstreams included maternity; frailty and elective care. The medical directors, some senior clinicians and managers also participated in the work streams associated with this programme. The board members recognised that there was a need to invest in senior transformational capability and strengthen operational capacity to enable them to be more externally focused and to deliver change within the organisation. A new role was being created across the ICS of transformational director to deliver the implementation of the ICS strategy for the area once it was agreed. A joint board had recently been held with local trusts about the development of the ICS.

The immediate structure below the board was the operational management board (OMB) which included the clinical and operational directors from the clinical centres. At corporate level there was the medical directors' office, nursing and quality and the corporate centre teams.

Operationally the trust was run through four clinical centres; urgent and emergency care and Friarage; planned and specialist care; community and corporate. Each centre was led by a team made up of a medical director, an assistant director of nursing, a professions' lead and an operations director who were supported by matrons and service managers. The operations directors reported to the MD leading each centre and since November 2018 were also accountable to the deputy CEO for performance. The centres had a number of specialised clinical directorates within them, each led by a clinical director on a three-yearly term of tenure. At the time of the inspection there were 40 clinical directors however there was a revised "Clinical leadership model 2019 - 2022" being developed by the CEO to realign some of the directorates into different centres and to reduce the number of clinical directors to 20 by April 2019. The plan was for this to go live from 1 April 2019. The centres had some support from finance and HR functions through a business partner model with dedicated staff assigned to each of the centres.

There was a chief pharmacist in place who reported directly to the Chief Executive as both the controlled drug local intelligence network and Pharmacy representative. They recognised that recruitment was a challenge with vacancies around 10%, however, this was indicative of the national picture. The pharmacy department were working with other local Trusts and GP practices around joint posts and with local university pharmacy departments.

Vision and strategy

The trust had a mission statement, a vision and guiding values. The values were being reviewed. The trust had an overarching "Target Operating Model 2015 – 2020" and we were told the trust was refreshing its strategy. A clinical strategy was in development.

We were told that the trust was in the process of refreshing its strategy to align with the developing integrated care system for the Tees Valley area. The immediate priority was developing an aligned clinical strategy and senior team members were involved in this process and were leading on several work programmes.

The mission was "to provide seamless, high quality, safe healthcare for all" and the vision was "to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement".

The values displayed on the trust's website and submitted by the trust were:
- Putting patients at the centre of everything we do
- Continuously improving quality
- Using our resources to the benefit of the wider community

- With an additional one in a document given to CQC at the inspection – supporting, respecting and valuing each other

However, as part of the inspection a different set of values was shared with us taken from the staff engagement action plan:
- Bold - in our ambitions, actions and thinking
- Open - to challenge, to try new ideas, to fail fast and learn from our mistakes
- Accountable - for our actions and those of our teams
- Authentic - acting with genuine and honest intent

We were told these had been developed at a "strategic dialogue day".

The trust had five strategic objectives developed in 2015:
- We will deliver excellence in patient outcomes and experience
- We will deliver excellence to be seen as an employer of choice
- We will drive operational performance to deliver responsive, cost effective care
- We will deliver long-term financial sustainability to invest in our future
- We will develop clinical and commercial strategies to ensure our long-term sustainability.

Strategy and business development was led by the CEO with support from a small transformation team. The team was now outwardly focussed upon the Integrated care system (ICS) regional work. The CEO had appointed a director of business development to lead this work focussing on clinical strategy and transformation.

The board members we spoke with stated that they prioritised quality above finances, but we heard from several staff at varying levels that decisions made were based upon financial drivers and implemented without clinical engagement (more detail is provided in the finances overview section below).

There was a plan for strategy development within the Trust. The trust had an overarching "Target Operating Model 2015 – 2020" which was launched in September 2015. Within this there were a number of "strategic imperatives" such as to "increase our patient focus to ensure clinical effectiveness and excellence in both patient outcome and patient experience". The model had a staged approach to delivery which included the change to the medical leadership model by bringing in five medical directors which has recently changed to four MDs.

A number of strategies were in development/ready for approval at the time of the inspection. They included: clinical strategies and a number of underpinning strategies such as a communication and engagement strategy and a research and innovation interim strategy.

The trust's research and innovation strategy referred to as interim was an update of an existing strategy until a jointly developed strategy was in place that would cover the newly formed Durham Tees Valley Research Alliance. This, together with the communication and engagement strategy was approved by the Board in February 2019. A staff engagement strategy was in development which was yet to be approved by the Board.

Clinical strategies were being reviewed and developed for each speciality with the clinical and business intelligence units. This was described to us by the corporate leads for strategy; the most recent were in 2018/19 for the neurosurgery and spinal directorate, cardiology directorate and the urology directorate. These contained a SWOT analysis including performance and market drivers.

We were given an example where the intelligence unit had used data to inform the change of a ward use from a traditional function to a 72 hour ward at the "front of house". Feedback from staff we spoke with indicated that they did not all understand the rationale for the changes: it seemed that they were not well engaged or informed about these developments.

In the services we inspected staffs' understanding of the vision and strategy varied.

At the time of the inspection there was no evidence of a coherent financial strategy to achieve financial balance in the medium term. The lack of a medium-term financial plan was a concern.

In addition to this the Tees Valley ICS was reviewing clinical service provision and pathways focussed on five key areas. There are some supporting enabling workstreams in place to complement the emerging whole system clinical strategy. These included bed reconfigurations and the establishment of a clinical intelligence unit with a focus on predictive analysis. However more granular work was required on workforce and financial strategies to ensure a more sustainable health system going forward. There was mixed feedback from external stakeholders as to how engaged the trust were within the wider system to improve care pathways and services for patients. On inspection, there were similar views shared by the board members we spoke with.

The Board members we spoke with were aware of the national, regional and local challenges and opportunities for the health care system and how they saw the trust operating within it.

The trust had strategies in place for meeting the needs of patients with a mental health, learning disability, autism or dementia diagnosis.

The trust had responded to the national imperative to improve the quality of care for those patients with a mental health need who required care in an acute hospital setting. "There was an ED consultant who was the lead for mental health and covered both sites. There were regular governance meetings with the local mental health trust where they reviewed breaches of waiting time targets, referral mechanisms and repeat attenders. The two trusts developed management plans for repeat attenders and worked closely to ensure a joined-up approach for these patients, along with GP's and police/probation. The trust had developed a pathway that supported those patients who were in mental health hospitals but needed to come to the acute hospital for physical healthcare. This pathway supported an initial assessment of patients so that they were correctly placed without having to come through ED and might go straight to a surgical ward for example.

There was a 'Treat as One Strategy' 2018-2021 which was also involved services in the Durham and North Tees area. The strategy focused on six key areas of service delivery with the aim of ensuring that patients with potential or pre-existing mental health disorders have their holistic needs appropriately assessed and treated by appropriately skilled staff. Staff meet monthly to review each of the six areas. Examples of progress were:

- Two-week pilot where patients in various departments were asked to participate in basic psychological screening using a validated screening tool, the PHQ-9. Of the 19 people screened during that time, six were identified as having some mental health needs and two were referred to the PLT for further work.
- MH awareness training became mandatory for staff as part of this strategy and the trust was on track to hit their 12-month target of having 40% of staff complete this training.
- The trust was also working with the local mental health trust to deliver joint modules in the preceptorship programme.

There had been a dementia strategy for 2013-2018 which had covered areas such as staff training, hospital environment and patient and carer experience. Examples of work included training over 10,000 staff within the five years. For assessment and identification, the trust had built frailty screening into the initial triage and were about to roll out a new nursing pathway and documentation that further supported this work. The lead nurse for frailty was also a nurse advisor for the National Audit of Dementia and the trust had participated in this for the last four years. In terms of assessment of patients for delirium and dementia, the trust had a target to undertake this within 72 hours; the trust has never scored below their target of achieving this in 90% of patients since the strategy launched in 2013.

The trust was working towards its Pharmacy and Medicine Management Strategy 2018 - 2021 which had been approved at Board level. In addition to this strategy the trust had a Medicines Optimisation Strategy January 2018 - March 2020 which further helped to reinforce workstreams. The strategy was developed by 15 volunteers from the pharmacy team at all grades. This was then shared with the whole pharmacy team. The focus for project development was medicines optimisation savings and IT implementation. The Pharmacy and Medicine Management Strategy and Medicines Optimisation Strategy were regularly reviewed as part of Safer Medicine Practice Group.

Culture

Staff at different levels of the organisation described the culture, at executive level, as top down and directive.

There was a deterioration in staff engagement as evidenced by the staff survey. This was also confirmed by what staff told us about the culture of the organisation.

Many medical and nursing staff told us that a 'top down' culture had developed over the last two-three years which was command and control in its nature. This was evidenced in the staff survey results (see below). Many staff expressed concerns that the actions and behaviours by some senior staff taken to address behaviour and performance was inconsistent with the vision and values. The most significant area where this varied was feedback from medical staff. Staff side representatives told us that morale and goodwill was declining and that there was a lack of engagement with clinical staff. They also reported instances of staff feeling bullied for speaking out. Staff we spoke with felt that the balancing of quality with financial performance and tipped much more towards to finance in the last 12 months.

The CEO talked of "pushing the servant leadership culture" (whereby the leader exists to provide guidance and direction, but the employees are empowered to make decisions) however, this was not reflected in what we saw or heard. When we asked other staff about the servant leadership model they were not aware of it and did not understand it.
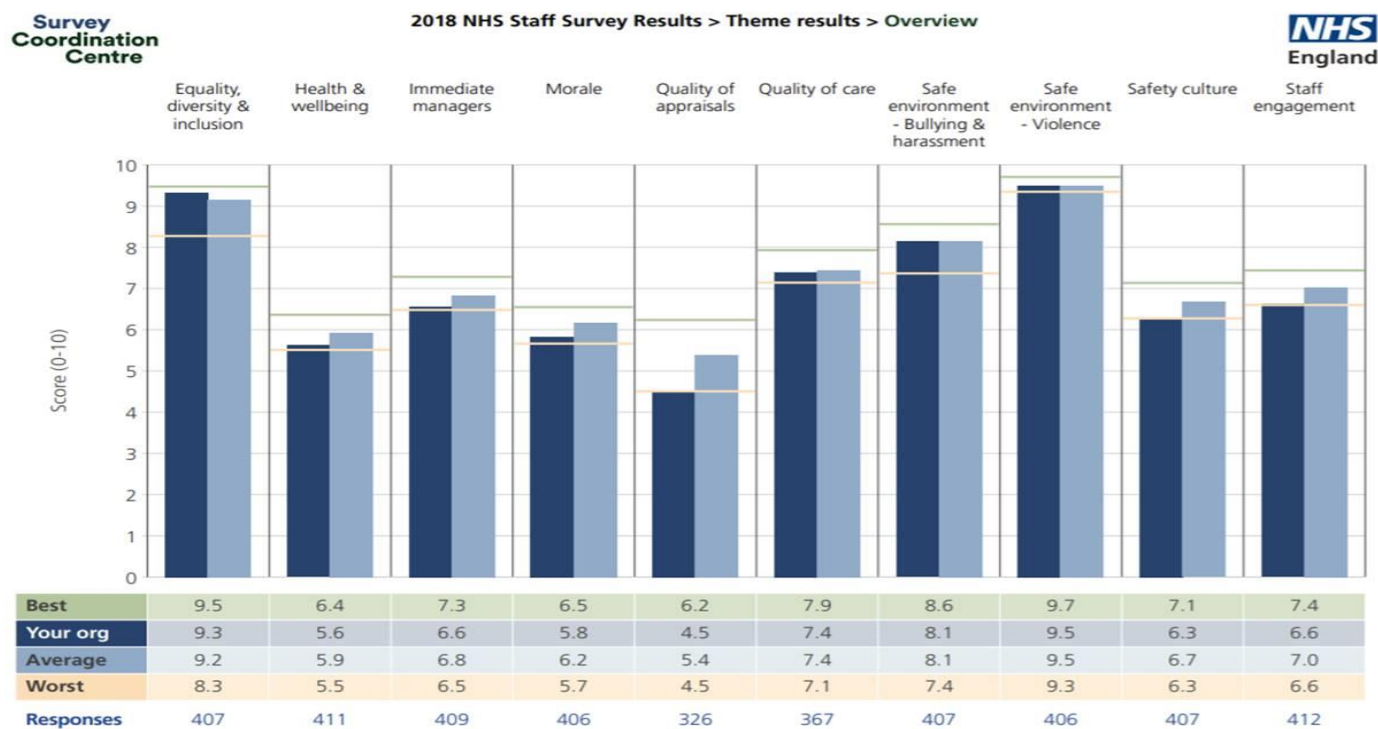
The CEO was also driving a culture of rapid change – "if it's more right than wrong; go with it and can fail fast". A number of staff expressed concern about the push for rapid change and they told us they felt they were done to rather than working with.

However, there were a lot of staff who told us they felt well supported in the trust by their colleagues and were proud to work for the organisation and their team. Consultants were supportive of one another, junior doctors felt well supported by their seniors. Many staff told us that they had worked for the trust for a long time and were loyal and positive about their colleagues and the care they provided.

NHS Staff Survey 2017 and 2018

The trust had undertaken sample staff surveys for the last three years and had recognised that there were some concerns within this. The trust's Workforce committee was recommending a full staff survey for 2019.

The following illustration shows how this provider compares with other similar providers on ten key themes from the 2018 survey. Possible scores range from one to ten – a higher score indicates a better result.

2018 NHS Staff Survey Results > Theme results > Overview

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.5	6.4	7.3	6.5	6.2	7.9	8.6	9.7	7.1	7.4
Your org	9.3	5.6	6.6	5.8	4.5	7.4	8.1	9.5	6.3	6.6
Average	9.2	5.9	6.8	6.2	5.4	7.4	8.1	9.5	6.7	7.0
Worst	8.3	5.5	6.5	5.7	4.5	7.1	7.4	9.3	6.3	6.6
Responses	407	411	409	406	326	367	407	406	407	412

The 2018 survey is based on themes rather than the key questions in the 2017 survey, therefore we cannot directly compare with the 2017 results. However, there were no themes where the trust's scores were significantly higher (better) or lower (worse) when compared to the 2017 staff survey as shown in the table below:

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	9.2	410	9.3	407	Not significant
Health & wellbeing	5.9	414	5.6	411	Not significant
Immediate managers	6.8	414	6.6	409	Not significant
Morale		0	5.8	406	N/A
Quality of appraisals	4.9	332	4.5	326	Not significant
Quality of care	7.7	355	7.4	367	Not significant
Safe environment - Bullying & harassment	8.1	410	8.1	407	Not significant
Safe environment - Violence	9.3	412	9.5	406	Not significant
Safety culture	6.4	413	6.3	407	Not significant
Staff engagement	6.8	414	6.6	412	Not significant

Source: http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Result/

Staff Diversity
There was a lack of focus on equality and diversity and at the time of the inspection there were no staff networks in place promoting the diversity of staff.

The HR director was also the trust lead for equality and diversity. We were told that there were five HR staff who operated as business partners in each centre and going forward some of these would have a specialist interest in this area. However, no extra time was allocated for this; it would be alongside their existing work load.

Senior HR staff confirmed that the trust had an equality and diversity group (Equality and inclusion: fairness Forum) which had been set up in 2018.; this had been set up at a strategic level. We were told it did not have any staff on it with these characteristics and the group had not been supported by the staff side committee. Following the inspection the trust provided notes from the meetings between February and August 2018 – there were no notes provided from September 2019 to date. Post inspection we were also that an Equality, diversity and inclusion group was being re-established in 2019.

The trust submitted an "Equality, diversity and inclusion strategy", however, it was not dated. There was a 2018/19 equality and diversity action plan in place. However, only two of the 16 actions due to be finished by October 2018 had been completed. We were told that the draft equality, inclusion and diversity strategy would be presented to the March 2019 workforce committee then through to board for ratification. The draft strategy indicated that an equality and diversity action plan would be developed and that progress against this plan would be monitored by the trust's equality and diversity lead and reported annually to the Workforce Committee.

The 2018 staff survey indicated that the trust was slightly better than average on the equality, diversity and inclusion responses.

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

Ethnic group	Medical and dental staff (%)	Nursing staff (%)	Nursing midwifery staff (%)
White	5.6%	26.4%	2.5%
BME- British	2.5%	1.3%	0.0%
BME- Non-British	1.2%	0.5%	0.0%
Unknown / Not Stated	0.7%	1.6%	0.2%

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

Workforce race equality standard (WRES)
The trust had reviewed the national WRES and submitted a report in August 2018 to the NHS England WRES team identifying compliance against the standards, where the gaps were and actions to address this. However, on the action plan we reviewed there were no timescales for achievement of the actions and no evidence was provided as to the progress of the plan. The report stated that the action plan was reviewed by the trust's Workforce committee with progress to be reviewed on a bi-annual basis. We were told that the trust had recently (from September

2018) started to analyse recruitment data in detail from initial application to recruitment with a monthly report being generated.

There were statistically significant differences between BME and white staff scores for all four of the WRES questions in the 2017 staff survey for this trust. The 2017 staff survey results indicated that the percentage of BME staff experiencing harassment, bullying or abuse from staff at this trust significantly deteriorated from 21% to 35% which was also worse than the England average of 29%. However, the 2017 staff survey results indicated that the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public at this trust was the same as 2016 and was better than the England average. The percentage of staff believing that the organisation provided equal opportunities for career progression (70%) had deteriorated for BME staff at the trust and remained worse than for white staff (88%). The percentage of staff who had personally experienced discrimination at work was similar to the national average. There was an "Addressing Bullying Action Plan" which had been developed in 2018 and was ongoing at the time of the inspection.

The scores presented below are questions relating to bullying and harassment from the NHS staff survey, they are question 17b and key findings 25, 26 and 21 split between white, black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Notes:
• These scores are un-weighted, or not adjusted.
• For question 17b, the percentage featured is that of 'Yes' responses to the question.
• Key finding and question numbers have changed since 2014.
• In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	28%	26%	22%
		BME	23%	27%	23%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	25%	23%	21%
		BME	35%	29%	21%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	88%	88%	88%
		BME	70%	73%	74%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5%	6%	5%
		BME	14%	15%	15%

(Source: NHS Staff Survey 2017)

Friends and Family test
The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored above the England average for recommending the trust as a place to receive care from October 2017 to September 2018. However, the number of people participating was low, at only 6.8%.in October 2018 compared to the national average was 12.5%.
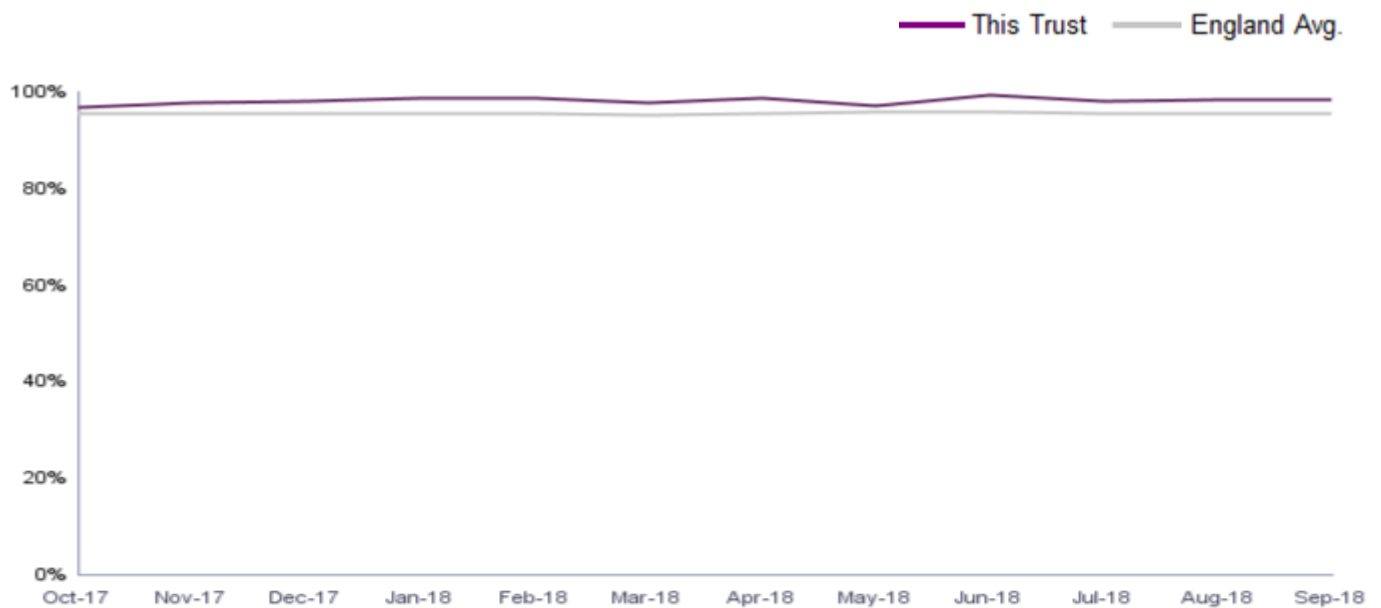
(Source: Friends and Family Test)

Sickness absence rates

Sickness was being managed down to ward level; every ward had a trigger report to show absence by ward. The sickness policy had not changed, however, staff now aware that they would be managed effectively with return to work interviews held. Managers told us that most staff accepted this as they were the ones who were left to pick up the work when others were absent. Winter months had higher levels with 4.9% in September 2018 and in January 2019 they were 4.89 against the trust target of 3.5. The graph below shows the sickness rate from August 2017 – July 2018. The trust's sickness absence levels in August 2017 were lower than the England average. From September 2017 to July 2018 the trust's sickness absence levels were higher than England average.
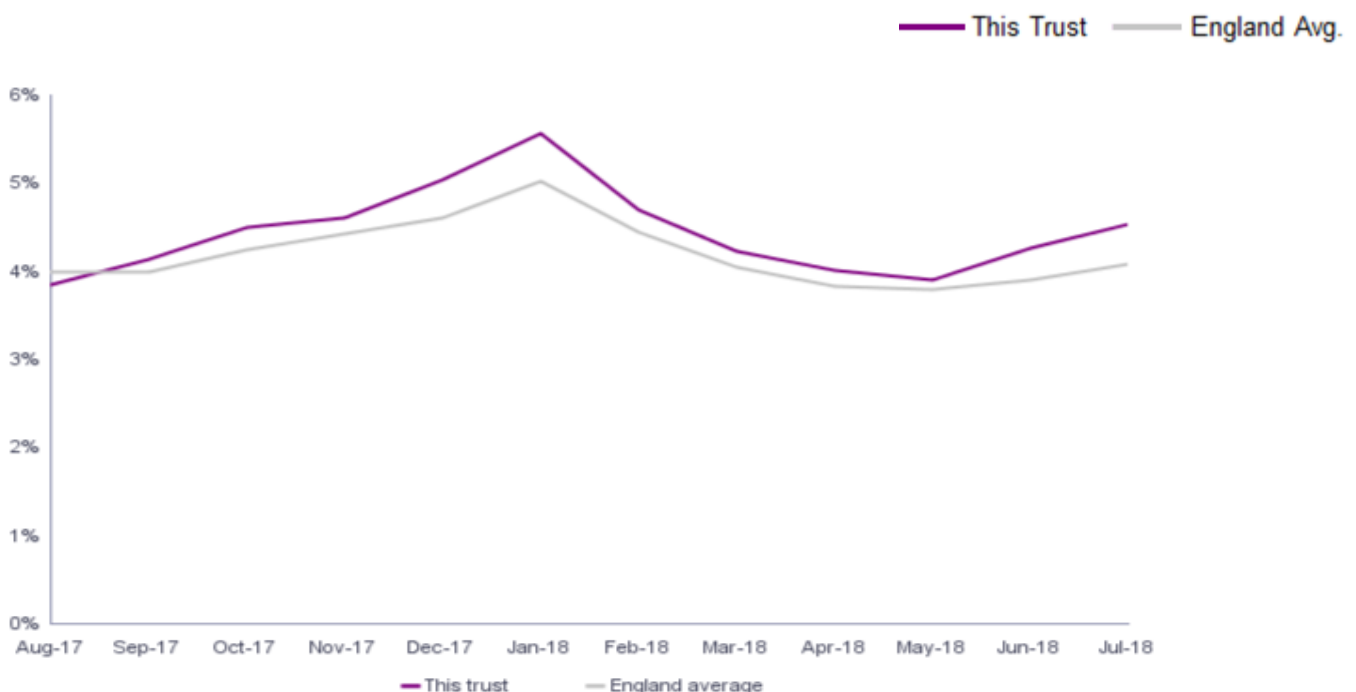
(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for all the 13 indicators.

● Better than expected   ○ Same as expected   ◆ Worse than expected

Survey area	RAG
Overall satisfaction	○
Clinical Supervision	○
Clinical Supervision out of hours	○
Handover	○
Induction	○
Adequate Experience	○
Supportive environment	○
Work Load	○
Educational Supervision	○
Feedback	○
Local Teaching	○
Regional Teaching	○
Study Leave	○

(Source: General Medical Council National Training Scheme Survey)

It was not clear from the incidents we reviewed if Duty of candour was fully applied as there was a lack of evidence of written notification of an apology and whether any investigation outcomes were routinely sent.

There was a duty of candour section at the end of the 24/72 hour reports we reviewed asking if the affected person or relatives had been informed of the incident. Within each serious incident route cause analysis investigation report there was a section called "Involvement and support of patients and relatives" with reference to the trust's "Being Open" policy. The text included whether the patient /carer/family had been informed of the incident and whether an apology had been given. In one of the three pressure ulcer incidents which we reviewed there was also an initial discussion sheet which recorded who the trust had met with; patient and /or relatives, a summary of what was said and whether they wished to receive written notification of the investigation. It was not clear in the other two what information was given to the patient or their family. None of the incidents we reviewed indicated that the patient, family or carers had helped set the terms of reference for the investigation. A number of staff we spoke with said they did not always raise concerns as they felt that nothing happened when they did and there was no or limited feedback. Within the 2017 staff survey the percentage of staff reporting errors, near misses or incidents witnessed in the last month was 80% which was worse than the national figure of 94% and the staff confidence and security in reporting unsafe clinical practice (3.57) was worse than the national average (3.84).

Following the inspection the trust provided us with details of audit they had undertaken which indicated that of the 11 incidents reviewed there were: seven that recorded both a verbal and written discussion, three were verbal only and one was not achieved as they were unable to contact next of kin.

The trust had a "Freedom to Speak Up: Raising Concerns (Whistleblowing)" policy issued in December 2016. At this time the trust Freedom to Speak Up Guardian was the company

secretary, this was later transferred to the director of human resources. Where staff felt unable to raise their concerns with their line manager/supervisor they were advised to contact an external independent company. An external phone line had been set up for staff to use to raise concerns. Since its inception in December 2016 until end June 2018 the company had dealt with four incidents of staff raising concerns. Compared with other trusts this was a very low figure; it was not clear if this was because staff had other mechanisms to raise concerns. The management acknowledged lack of utilisation of the independent service and the need for a review, refresh and relaunch of organisational approach.

There were two nominated Freedom to speak up guardians in place at the time of the inspection. They had received training in November 2018; this role was in addition to their full time operational roles within the trust; there was no dedicated time allocated to these roles. We were told that the role of guardian had been relaunched in October 2018. The two guardians had developed their own reporting tool with support from IT and a separate email system. To promote the service they had developed a screen saver and there was information in the trust magazine and staff magazine. They were supported by the director of nursing and a non-executive and met with the chair and CEO. The trust had recently recruited 26 champions for freedom to speak up and these were across both the JCUH and FHN sites. We were told there had been three referrals since the 6 January 2019; however, it was too early to identify the effectiveness of the relaunch of the role.

The chair of the quality assurance committee acknowledged that the trust was only just starting to effectively develop the freedom to speak up guardian process. An action plan had been developed to relaunch the role with completion dates to December 2018.

At the time of the inspection the guardian of safe working had been in place since 2016 with four hours/week allocated to the role. There was evidence that junior doctors were using the guardian and reporting issues to them. However, exception reporting submissions continued to be at a lower level (11 raised between 1 October 2018 and 31 December 2018) than was originally anticipated. A recent survey conducted by the GMC at the Trust provided some insight into potential reasons for this. These included that 50% of respondents reported that they had felt under pressure not to exception report in their current post; 25% were concerned about the potential impact of reporting on their career and reputation and; 32% of respondents said they had not reported as exceptions were 'every day' occurrences. Examples of how the trust had responded to concerns raised were shared with us. Quarterly and annual reports were presented to the board. A junior doctor's forum had been set up as a platform for formally raising problems.

There was an appraisal / staff development review (SDR) system in place. From the February 2019 board papers, it was noted that the rate for 2018/19 was 74.3 which was short of the trust's target of 80%. There had been a sustained improvement over the last three years with 2015/16 being 68.6%; 2016/17 was 71.3% and 2017/18 was 84.7%.

Staff appraisal data showed 96% of the medicines management and pharmacy staff had received their annual appraisal. The remaining 4% was due to long term sickness or maternity leave. Engagement with pharmacy staff was felt to have improved and the "likely to recommend" score had improved in the last staff satisfaction survey. Staff engagement was through a variety of methods; regular 'huddles', monthly 1:1 meetings with line manager. All pharmacy staff had training on Duty of Candour as part of mandatory training. Some staff had used it recently with an incident around IV fluids.

Governance

There were structures, processes and systems of accountability for governance in place which had been reviewed although there was a lack of capacity for clinical governance leadership and management.

There had been previously a director of quality; this role and some supporting roles had not been replaced and the functions had been incorporated into the director of nursing's portfolio. The director of nursing was chair of most of the clinical committees; there were concerns about capacity to deliver on all these areas.

Leaders had reviewed governance structures. There had been an external review of the governance arrangements which had identified a number of concerns and actions required to strengthen governance. There had also been a review of the board function and the implementation of a board assurance framework. Further board committees had been put in place including a Finance and investment committee and a workforce committee.

The board met ten times per year with five of these meetings in public. Arrangements for board committees had recently been reviewed and the reporting sub committees streamlined which included provision for an annual review of effectiveness albeit this has not been completed for the current reporting year. These changes provided improved clarity on the governance arrangements although they were not yet fully embedded.

There were seven board committees in place: audit; remuneration; charitable funds; quality assurance; finance and investment; workforce and; risk. There was also the operational management board (OMG). There were working groups under each of the committees. For example, the Clinical standards group, Mortality surveillance sub group and the Patient safety group (including IPC and complaints) were managed through the Quality assurance committee. Each committee had a non-executive chair with two other non-executives and executive members. The committees had a "Chair's log" which was used to report back to board a summary of the key points from each meeting.

There was cross cover in executive membership of the quality, finance and audit committees and there were appropriate mechanisms for the committees to report to the board. However, there was no cross over in non-executive membership between quality assurance and the finance and investment committee. This would have reduced the non-executive oversight of the key challenges the trust was facing.

The terms of reference for the QAC, Finance and investment committee and Audit committee were reviewed at the February 2019 meeting.

The quality assurance committee was chaired by a non-executive director with two other non-executives; the executive lead was the director of nursing. A committee member commented that the QAC was not always assured that feedback loops on frontline learning were complete for SIs and this was an area they were working to improve. The key points from the quality assurance committee were reported to each board meeting.

The Trust had a medication safety officer (MSO) who was included in the governance structure. The ward dashboard which was introduced in 2018 enabled a robust view of medicines management at an operational level, results were fed into action plans at ward level and were escalated when needed through the Safer Medicine Practice group. Pharmacy audit was part of the quality team workstream within the trust. The Drug and Therapeutics group was a well-established multidisciplinary group and provided clear terms of reference for its members.

Board Assurance Framework

The board have worked to reshape the board assurance framework to ensure it was aligned to the trust`s five strategic objectives and with the trust's risk management process. A draft was presented to the September 2018 private board meeting. These changes were at an early stage of implementation. We were told that it was planned that the board assurance framework would be reviewed quarterly by the board alongside the corporate risk register. Relevant sections of the board assurance framework were allocated to each of the board committees for review.

We reviewed a copy of the board assurance framework presented to us at the Well led inspection. There were risks identified against each of the strategic objectives with the most (seven) sitting under the strategic objective: deliver long term financial sustainability to invest in our future. In total, eleven other risks had been identified across the other four strategic objectives. Seven risks were rated as high risk and scored 15 or above. These were:

- Delivery of a sustainable future for the Friarage hospital – scored 16
- Regulatory compliance with the Health and Social Care Act 2008 and Regulations 2014 – scored 15 - with the principle risk of not achieving the requirements of the single oversight framework
- Ensure an open and transparent safety culture that supports organisational learning and quality improvement – scored 16 - which related to the under reporting of incidents
- Delivery of annual plan including the 2018/19 financial control total – scored 15
- IT infrastructure fir for current and future organisational needs – scored 16
- Ensuring IT infrastructure is in place – scored 16
- Trust estate developed and maintained to meet regulatory requirements and aligned to strategic plans – scored 15

(Source: Trust Board Assurance Framework – February 2019)

Management of risk, issues and performance

Whilst leaders were aware of some of the risks, issues and challenges they were not always acted upon in an effective or timely manner,, such as those we identified within critical care services and urgent and emergency care.

Following the inspection, we formally wrote to the trust under our powers requesting evidence that key patient safety risks identified by CQC specifically in relation to critical care were being effectively managed and mitigated.

The trust responded and provided information about how they were now managing elective and emergency demand of critical care beds and how they were now ensuring appropriate staffing levels to meet this demand.

There was a lack of assurance in financial governance within the trust therefore quality priorities were not always being addressed in a timely manner. We found examples of payment for vital supplies not being prioritised and pieces of medical equipment being delayed which could potentially have compromised the treatment and care of patients.

Whilst there were systems in place to identify risks these were not embedded. There was both a lack of reporting by some staff and a lack of timely action at board level for some of the issues which we identified at inspection. A risk committee had been set up in 2018 following an external review of governance which was chaired by a non-executive. Risk review and escalation mechanisms had been created from ward to board. However, these were not always followed or effective.

There was variability in whether staff reported incidents or learnt from them. For example, staff within diagnostic services told us that they did not always report incidents or receive feedback/learning whilst staff in medical services were mainly positive about reporting and learning from incidents.

The operational challenges at the Friarage hospital due to shortages of clinical staff had been identified at least 18 months prior to the inspection and work had commenced on a more sustainable model of services at the hospital. The board had approved a preferred clinical model on 5 September 2019 and submitted this to the local commissioners. However, a decision to implement it, on a temporary basis, was taken by the board on the 5 February 2019 with a delivery date of the 27 March 2019 which was due to safety concerns. This was a major reconfiguration, affecting most services at the Friarage, and provided a significant challenge to the trust to implement it safely in such a short space of time. This implementation was ongoing at the time of the inspection.

We had also identified a lack of staff with the competencies to immediately assess any children who might walk into the urgent and emergency care service at the Friarage hospital OOHs. This was not on the risk register.

Considerable work had gone into developing the James Cook emergency department model with investment in emergency nurse practioners, consultants seeing patients at the front of house, the "referrer decides" when an admission is required and admission avoidance schemes which had led to the trust performing well in achieving the national four-hour standard.

Decisions were made to operate on elective patients when no critical care beds were available and staff were unclear about operational pressures escalation. When we observed bed meetings and visited the ED department we were told the trust was under unprecedented pressure but there were no discussions about escalating OPEL (operational pressures escalation levels national framework) level. We also did not see that the trust followed its own standard operating procedure (SOP) in the management of the elective programme when urgent care came under pressure. Staff were unable to clarify to us how additional capacity was being utilised in times of pressure. Following the inspection, we formally wrote to the trust under our powers requesting evidence that key patient safety risks identified by CQC specifically in relation to critical care were being effectively managed and mitigated. The trust responded and provided information around how they were now managing elective and emergency demand of critical care beds and how they were now ensuring appropriate staffing levels to meet this demand.

The CEO had brought in a strong focus on performance management to deliver the key constitutional targets. This was led by the CEO and through the operational management board. Weekly "Performance management wall" meetings were held where key staff would stand in front of walls covering seven key performance areas. They would review current performance and any actions required to bring it back on track, such as the cancer waiting times standards. We were told they were well attended and have resulted in improved performance in the areas which they measured. However, it was acknowledged by senior managers, including the CEO, that the effectiveness of the walls was in part reliant on the CEO attending the walls and providing focus. An example given was the dip in the cancer waiting time standard; the CEO had not been attending the "wall" meetings, the standard had dipped; the CEO had moved the wall to near her office and it was improving. The summary points from the walls were incorporated into the trust's operational performance report which went to the operational management board and then to the trust board. There were some of these "walls" replicated at service / ward level.

Integrated quality and safety dashboards were used to provide information and manage performance at ward, centre and trust level. These included data covering infection, falls and pressure ulcer rates, patient experience feedback, complaints and incident data. Monthly medication safety dashboards, mortality and 'learning from deaths' data alongside more detailed quantitative and qualitative patient experience feedback were also used. These metrics were included in the monthly quality report monitored at the Quality assurance committee (QAC) and reported to Board.

The business intelligence unit was in the process of reviewing each directorate's performance. A data pack was developed and shared with the team prior to a meeting. The team then presented back to the corporate team including the CEO. At the time of the inspection four had been completed: cardiology; neurosurgery; orthopaedics and general surgery. We were told that if a service was deemed to be "failing" it was temporarily managed centrally to turn it round, the example given was radiology. A clinical intelligence unit was also being developed.

A winter predictor tool had been developed which was used to help plan the opening and closing of escalation beds. Further bed modelling had been completed in March/April 2018 which had resulted in a number of changes to the model of provision for some wards/specialities. This work was ongoing. From discussions with staff it was apparent that there was a lack of understanding as to why this had happened; there had not been effective engagement / consultation with staff about these changes.

Senior medicines managers regularly reviewed risk registers and a clear process was in place for risk escalation. All medicine incidents were reviewed by the Safer Medicine Practice Group. Common themes were included in Safety at South Tees Alert which was shared across all the trust sites and in a "Pharmacy Focus" memo. Medicines alerts and alerts for medical devices were dealt with by the Safe Medicine Practice Group. There was a formal process of sign off which was overseen by the MSO. Out-patient pharmacy services and homecare were delivered by an external provider under a service level agreement. There were arrangements in place to monitor the quality of the service provided.

Finances Overview
Finance and quality management were not effectively integrated to support decision making. Cost improvement planning and quality impact assessments were in need of improvement to ensure managers fully appreciated the risks relating to any service changes.
Despite the trust's challenged financial position there was no evidence of a coherent financial strategy to achieve financial balance in the medium term.

There was a perception from many staff we spoke with that the focus of the senior management had shifted from prioritising clinical quality towards achieving financial balance. It was clear from board member interviews that the trust appeared determined to achieve its control total this year to enable it to come out of NHSI enforcement measures. We were told that £130m had been "Driven out over last couple of years".

The trust has been running with an underlying deficit of circa £25m over recent years and had failed to make significant inroads into addressing this position as it had largely been reliant on non-recurrent cost improvement. The trust accepted its financial control total for 2018/19; however, there was risk to its delivery. The trust had also borrowed £113m over the last four years to back its cashflow. At the time of inspection the trust was under "Enforcement" from NHSI in relation to

the requirement to ensure financial compliance with the provider licence and was rated as a "3" which meant that mandated support was required.

As part of the committee review the membership and terms of the reference for the audit committee had been strengthened. Prior to this and unusually the audit committee was comprised of two members only. The audit committee now had improved oversight of the overall internal control environment. These changes were in line with good practice but needed to become embedded.

The finance and investment committee focussed on all aspects of financial performance and undertook the "heavy lifting" on behalf of the board. The membership of this committee comprised of three non-executive directors, director of finance, director of nursing and one of the medical directors so there was a balance in the coverage of finance and quality considerations. The committee did not engage routinely with the clinical care centres; this needed strengthening going forward. Any engagement and holding the clinical care centres to account was on a deep dive basis only if there was a perceived problem.

The Head of Internal Audit Opinion for 2017/18 was one of "substantial improvement required" with significant weaknesses in the framework of governance, risk management and control. Over the last 12 months the trust has taken several steps to improve financial governance across the trust. Indications from internal audit reporting in 2018/19 showed that progress was being made in addressing the control weaknesses previously identified.

There were challenges to the sustainable delivery of quality care due to the financial challenges the trust faced. The trust reported an improving relationship with its two local clinical commissioning groups. There were challenges however as both commissioning organisations were in special measures for finance. To better manage financial risk across the local health economy an aligned incentive contract had been agreed between the trust and the local commissioning groups.

Cost improvement planning (CIP) was in need of improvement. There was a very significant cost improvement programme in the current year which represented 6% of turnover and over half of this programme had a heavy reliance on non-recurrent measures. This was not a sustainable position and greater self-sufficiency needed to be built within the clinical care centres to develop and drive their own efficiency programmes with appropriate programme management support.

CIP was predominately top down and was led by the senior leadership team. However, the trust was making some use of benchmarking tools such as Model Hospital and Getting It Right First Time (GIRFT) in the development of its efficiency programme. We saw a GIRFT report for critical care which was dated July 2018, however actions to address this were only being developed in 2019.

There was not an effective use of quality impact assessments (QIAs) to ensure safety and quality when changes to services were proposed and delivered. Whilst there was a newly developed quality impact assessment policy that had been approved by the operational management board in August 2018; senior staff could not describe to us the decision-making process both in terms of when to do an QIA and how it progressed to completion. Some told they were only completed for strategic cost improvement programmes (CIPs) and others said that the director of nursing and an MD lead on all QIAs. We reviewed five QIAs; the documents provided had gaps and did not include costs. The policy stated that all approved QIAs were reviewed quarterly by the quality

assurance committee. However, the robustness of tracking the impact of these schemes was not well evidenced.

We were told that the trust had taken £7m out of corporate costs as part of cost improvements. However, a significant number of clinical staff we spoke with were concerned about the lack of management support to both ensure that clinical governance was effective and for the ability to make changes to improve services. Some external stakeholders told us they were also concerned about the loss of the staff whose remit had been quality and clinical governance, especially the disestablishment of the director of quality role.

We were told that the capital programme had been suspended over the last two years. This had meant that the trust had not yet invested in an electronic patient record (EPR) or the required changes to further improve the paediatric environment in the emergency department.

The trust had significant cashflow challenges and this has led to delays in paying contractors and potential threats to key clinical supplies. Hence there was obvious visibility of the difficult financial position and there were tight controls on expenditure. However, there was a lack of evidence that the trust had appropriate escalation to ensure the continuation of clinical supplies were prioritised. Instances of this were shared with us by clinicians which included a number of incidents and near misses that had the potential to significantly affect patient safety and care. Examples included non-payment/late payment to: blood and transfusion services; telephone companies; equipment providers and transport providers. These occurred mainly in quarter one of 2018 and were related to a significant cash flow issue. The achievement of the contracted payment rate to suppliers – the better payment code - was in the region of 26% at this point in time; it had since improved to over 60%. Senior staff could not describe the process for the prioritisation of payment for such clinical supplies. The non-payment of bills had previously been raised by staff directly with senior management and again with us on inspection. Cash flow had improved due to one off sales of estate in May 2018 which enabled a backlog of supplier bills to be paid.

Finances were reviewed monthly at the finance and investment committee. The finance and investment committee had been meeting monthly and was about to change to every other month. The board had a sound understanding of the current financial position and the challenges and risks to it both in this financial year and going forward for the next two to five years.

The table below provides a summary of the trust's actual and projected finances over a four-year period from 2016/17.

Financial metrics	Historical data		Projections	
	Previous Financial Year (2016/17)	**Last Financial Year (2017/18)**	**This Financial Year (2018/19)**	**Next Financial Year (2019/20)**
Income	£579.6m	£599.7m	£602.1m	£602.1m
Surplus (deficit)	(£10.9m)	(£4.4m)	£3.8m	£3.8m
Full Costs	£590.5m	£604.1m	£598.3m	£598.3m
Budget (or budget deficit)	£8.5m	£7.4m	£3.8m	£3.8m

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

Trust corporate risk register
The trust provided a document detailing their highest profile risks. There were 41 risks rated as

15 or above across the trust. Those scoring 20 were:

- Risk of delay to provision of chemotherapy treatment – scored 20
- Risk that there is insufficient equipment to monitor patients with DASH monitors in U&EC
- Risk of inadequate provision of junior doctors within obstetrics and gynaecology
- Risk of inadequate provision for transitional care on post-natal ward
- Risk to the security and availability of systems due to cyber attack
- Risk to patient safety due to inadequate midwifery and support staffing
- Risk of regulatory action by the Information Commissioners Office due to non-compliance with Freedom of Information Act
- Risk of not being able to assess patients due to number of broken trolleys in U&EC not being repaired
- Risk of delays in radiology reporting due to workforce pressures
- GPs were not receiving the full information in patient discharge letters
- Risk that the trust will be required to provide up to six years back pay leading to large financial costs
- Risk of insufficient capacity in current maternity environment to manage increasing booked activity.

Some of the risks had been identified for a considerable period of time; the oldest being from December 2014 with a further three from 2015. The robustness of the management action for each risk on the register was very variable; some had evidence of regular review and management whilst others did not.

The senior management had identified areas for improvement for the effectiveness of risk management within the trust and as such had developed the risk escalation structure and set up a separate risk committee "pushing for stronger risk escalation". There was a trust-wide risk validation group which had membership from each centre. This group fed into the Executive risk group and in turn to the trust's risk committee, the operational management board and then the trust board.

Information management

There was a focus on performance data, this sufficiently covered operational and financial information which was shared with staff from board to ward through the business intelligence unit.

The trust`s digital status was relatively poor, however the trust recognised this; there were some business cases awaiting the outcome of funding decisions to improve this.

The trust had an information technology strategy which had been approved at the November 2018 board meeting and included the move to a single electronic patient record, however we were not reassured the full scale and costs for this strategy had been considered. In addition, there was an ICS Digital Care Strategy in development which identified the electronic patient record as a priority.

The board received a summary level integrated performance dashboard which covered key metrics for quality, safety, workforce and operational performance. However more granular information was available for review by board committees and through the operational performance management arrangements.

The trust`s digital status was relatively poor, however, the trust recognised this and was developing business cases to improve this, such as for investment in an electronic patient record (EPR). The Trust was forming a strategic partnership with two other trusts to procure the EPR of choice. Despite these limitations the trust had recently developed a business intelligence unit with analytical support available to the operational teams. The trust was also developing a clinical intelligence unit under the leadership of a medical director. We were told this would directly benefit predictive modelling and the patient pathway modelling aligned to the integrated care system work programmes. There were no electronic patient record or prescribing systems.

Data provided by the trust indicated that there were a number of legacy I.T. systems used to collect and process administrative and clinical data. Data quality across these systems had been challenging which had previously led to low confidence in the data and reluctance to use it to support decision making. The Trust had adopted the approach of driving up the quality of operational data by making it visible through the use of data walls and dashboards on a weekly or daily basis. We were told that by using the data as a core part of decision-making, any inconsistencies or areas of concern were highlighted and addressed promptly, providing confidence in the data accuracy, and driving up data quality.

The trust was starting to develop real time data through its IT system and the use of e-whiteboards which had recently been installed. They held key clinical information about each patient and the information relating to the next stage of the patient's clinical pathway. Not all staff had been trained in the use of the boards.

We found that patient records were not secure in ward areas. Records were stored in open, unlocked trolleys; whilst the trolleys did have lids with locks they were not locked.

There was often a delay in reporting serious incidents to external bodies. In the incidents we reviewed there was a range of reporting to StEIS (Strategic Executive Information System) from the following day to five months later.

The trust took part in medicines NHS benchmarking review. All medicines resources were available through the IT system and this included patient group directions which were also reviewed as a standard agenda item at the safe medicine practice group. An annual audit plan was now in place. The Trust had applied for NHS digital funding for improvement in IT and was committed to matching the 50% funding. We were told that an IT-based automated medication dispensing and central pharmacy function would be operational by March 2019.

Engagement

We found little evidence of effective engagement with staff. We had a large number of senior clinicians raising concerns during our inspection process about the lack of clinical engagement in service changes within the trust, the trust's response to this was not open and receptive.

There was mixed feedback from external stakeholders as to how engaged the trust was within the wider system to improve care pathways and services for patients.

There was insufficient attention to appropriately engaging those with particular protected equality characteristics and there were no staff networks in place promoting the diversity of staff.

There was a limited approach to engagement and effectively obtaining the views of people, especially clinical staff, to support service changes and transformation which was acknowledged

by the CEO and chair during the inspection. We were told the CEO was developing plans to improve this. A Communication and engagement strategy was presented to the February 2019 trust board for approval.

Whilst the trust had strong medical director representation on the board there was an obvious disconnect between a large proportion of the consultant body and the senior leadership team. We held a focus group on site that was attended by approximately 130 consultants across most specialities and spoke with at least a further 13 consultants following our inspection. The overwhelming feedback from consultants we spoke with was their lack of engagement in decision-making within the trust and their concerns about the impact this has on patient care. Themes of concerns that were raised were as follows:

- Incident reporting not being acted upon.
- Issues with management of outliers and consultants having knowledge of where their patients were.
- Issues with the availability of critical care beds and the continuation of elective programmes without critical care capacity.
- Lack of access to equipment and clinical services due to non-payment of bills and cost saving activity.
- Lack of succession planning and capacity and capability planning when vacancies occurred.
- Lack of capacity of quality management due to director of quality not being replaced.
- Loss of key staff due to morale and inability to attract new staff to area.
- Constant change and restructuring at all levels destabilising work and development.

In response to this the trust's management told us that they had made and continued to make significant changes to improve performance by changing the way consultants worked, standardising their contracts and how they received their administration support. In some specialities this had not been well received and had affected engagement with the consultant body causing a disconnect.

We were told that clinical engagement included two "strategic dialogue days" held each year. Approximately 140 senior leaders, managers and clinicians in the Trust were invited. These days started with a presentation given by the CEO which covered a review of the last six months performance and a setting out of the strategic priorities for the next six to 12 months. The CEO told us that feedback, particularly from clinicians, was that they would like to see more information and spend more time discussing clinical effectiveness. The plan going forward would now be to use one of these two days to focus purely on patient safety, quality and clinical effectiveness and for 2019 this would be the planned date in December.

We were told that clinical engagement included two "strategic dialogue days" per year which were hosted by the CEO. Approximately 140 senior clinicians - clinical directors and matrons – were invited to the event. At these the CEO did a "state of the nation" presentation about the performance and direction of travel of the trust with the next one planned for May 2019. Staff feedback from the last one that there had not been enough focus on clinical effectiveness, however, it was unclear at the time of the inspection how this would be addressed.
Whilst we were told there were walk arounds and visits by some of the executive and non-executive directors to services throughout the trust there did not appear to be a mechanism to ensure that feedback was provided to the departments they had visited. However, we were told

that governors and non-executives attended some specific patient safety walkabout tours managed through the director of estates.

There was a very supportive culture at operational level. Staff told us they felt well supported by their colleagues and their immediate management. Staff at all levels in the urgent and emergency services felt supported by their management structure up to board level. There was a specific mention of support from the estates team around managing room capacity.

During the inspection the executive team had acknowledged that engagement was an area for improvement. There was a staff engagement plan in development for 2019/20 outlined in a set of slides which had six key strategies:

- Develop our South Tees identity and create a sense of pride and belonging in our organisation
- Review our values and define the supporting behaviours required to deliver our vision whilst holding each other to account
- Develop our employer offer and employee experience to enable us to recruit and retain the best
- Develop a culture of engaging leadership, strong management, effective communication and collective responsibility
- Develop a mindset of transformation and service improvement to drive our organisation forward
- Recognise and celebrate success and ensure our people feel valued

There was no associated action plan however, the slides indicated that a CEO Staff engagement steering group would have its first meeting on the 8 April 2019.

Prior to the inspection we asked for a copy of an action plan which addressed the concerns raised by the staff surveys. This was not provided. A plan of how they would oversee the 2018/19 survey and results was provided.

The directors acknowledged that engagement with those staff that had a protected equality characteristic could be improved. At the time of the inspection information provided to us by the trust indicated that there were no staff networks.

Each year the trust had its annual Nightingale Awards. These awards were developed by the nurse and midwife consultant team in 2004 in order for the care and compassion of nursing to be formally recognised. These awards were chaired by a non-executive.

The trust had a membership of 5,000 public and patient members and around 9,000 staff members. There was a well-established council of governors and they told us there was generally good engagement with the board which had improved over the last one to two years especially with the new chair and CEO. Governors attended as observers to board committees, visited patient areas and provided feedback to the trust executive. The council of governors met five times a year with one of these at the Friarage site. There were 33 seats on the Council with 16 representatives from the local community areas, two patient/carer representatives, three staff and 12 from partner organisations.

Patient and public engagement required further development. A patient experience committee was being set up to be chaired by the CEO. There were some patient user groups, but these were more focussed on delivery of current services. There had been consultation in 2017 about

changes to the provision at the Friarage hospital. Patient engagement was mainly focused on specific pathway issues and did not currently feature strongly on the board`s agenda.

A 1,000 voices project was established in January 2017. Face to face interviews were conducted using a structured questionnaire with approximately 400 patients per month (each ward was visited every month and real time patient experience feedback was collected on at least eight patients). In addition to feedback in real time each ward receives a monthly report of both qualitative and qualitative feedback used to drive local improvements. Patient experience was measured across 10 domains, verbatim comments recorded, and a report issued to the ward within 24 hours of the interview. The trust told us that feedback was consistently above their target of 9/10 (average across all domains) with the domain of 'kindness and compassion' scoring well - the September 2018 score was 9.89. Lower scores were noted in the domain of 'consistency and co-ordination'; although still over nine they were mostly related to inconsistent information and use of medical jargon. This had been included in the trust's quality priorities for 2018/19. 'Noise at night' was another key domain where lower scores were seen. Clinical Matrons had developed an education and poster campaign - 'Shh .... sleep helps healing' which was launched in December 2018. In December 2018 the overall score was 9.67 from 335 participants across the trust with the lowest score being cleanliness at 9.19 and the highest being 9.9 relating to medicines.

There was a patient experience committee planned to be led by the CEO which would then report to the Quality assurance committee.

For pharmacy services lay members were part of a focus group around patient information leaflets but were not routinely included on committees. The Trust did not have a specific medicine information pharmacist this was a shared responsibility. Clinical pharmacist's and pharmacy staff spoke with patients about medicines. The trust worked with local CCGs and they were represented on the Drugs and Therapeutics committee (DTC) and Area Prescribing Committee.

The trust participated in the Friends and family test to help gain the views of patients, however, in October 2018 the FFT response rate was 6.8% which was well below the national average of 12.5%.

The trust also ran a volunteer programme and had over 500 volunteers. Of these, 290 were therapeutic care workers. These volunteers were trained to support patients with specific needs such as those living with dementia or learning difficulties. As well as providing a valuable service for patients and the public visiting the trust it also provided the opportunity for some volunteers to progress into jobs within the trust or elsewhere.

We spoke with a number of stakeholders prior to the inspection, such as the local clinical commissioning groups, NHS England, NHS Improvement and Health Education England. There was mixed feedback from external stakeholders as to how engaged the trust were within the wider system to improve care pathways and services for patients. There was also some concerns raised about the proactiveness and responsiveness of the trust to quality concerns because of the loss of the staff within the quality function.

Learning, continuous improvement and innovation

We were told that the scale of the transformation required within the trust was at a pinch point at the time of the inspection. Some board members and clinical staff said that there was a lack of operational management capability and capacity for transformation work within the trust. However, the trust was recruiting to a transformational team to strengthen this.

There were limited systems and staff in place to support improvement and innovation work. There is no singular methodology of continuous improvement. The trust made some use of benchmarking tools such as Model Hospital and Getting It Right First Time (GIRFT).

A slimmed down version of rapid performance improvement workshops (RPIW) was being developed where teams could come together for four hours which was much shorter than the usual workshops and therefore may not have been as effective. An RPIW was traditionally a five-day workshop focused on a particular process in which the people who do the work are empowered to eliminate waste and reduce the burden of work. It is designed around the plan-do-study-act (PDSA) method.

South Tees Hospitals NHS Foundation Trust (South Tees) in the GMC 2017 trainee survey was ranked in the top quartile nationally and ranked second amongst acute Trusts in the North East with the North East as a whole maintaining the best trainee survey results in England. Junior doctors we spoke with all commented on a positive emphasis on education and training from the consultants.

Consultant pharmacists were driving improvement through high level clinical input into core areas. This included a regional cancer specialist pharmacist and new specialist posts in A&E. The trust pharmacy department employed a Medicine Optimisation in Care Home pharmacist to improve discharge into the community. The Friarage hospital had recently piloted a seven-day clinical pharmacy service which was in the evaluation stage at the time of inspection.

Learning from deaths
There was evidence of the strengthening of learning from internal and external reviews of mortality and individual deaths. There was a "Responding to deaths" policy in place from September 2018 which included a first and second stage care record review process. The trust had also implemented the role of medical examiner (ME) role in May 2018. It had clinical input five days per week to:

1. Improve the accuracy of the death certification process
2. Provide more consistent and appropriate referrals to the Coroner
3. Ensure direct contact with bereaved relatives to identify /address concerns at an early stage
4. Complete the second part of the cremation form
5. Perform first level mortality review

There were seven part-time MEs in post at the time of the inspection with a further two appointed who were about to start training. The MEs were consultants from a variety of clinical backgrounds who also worked at the trust. The intention was to review all the deaths that occurred at the trust through this process. As of December 2018, the MEs were reviewing about 82% of all the trust's deaths. This initial review was usually within 48 hours. The review included contacting family members to see if care had been effective and if there was anything that could have been done better. The initial review determined whether a more detailed review was required or immediate escalation to the medical director or chief nurse.

There was a clear process outlined in a flow chart as to how the trust managed it's learning from deaths process. As well as the MEs there was a trust wide Mortality surveillance sub group with terms of reference and mortality and morbidity (M&M) committees within each directorate.

Learning also went to the patient safety committee and through that to the Board's quality assurance committee. Where deaths had been deemed at least partially preventable action plans were developed. There was a quarterly Mortality learning from deaths report
which went to the board meeting. For the quarter October to December 2018 there were 102 deaths reviewed in the quarter, 75% of patients were judged to have received good care with no preventability. There were five cases judged to show strong preventability with room for improvement in care and three cases showed strong preventability with less than satisfactory care. There were 87% of the deaths which were expected. Twenty cases were highlighted as identifying learning from good care (cases can appear in more than one category) and 35 cases were highlighted as identifying learning from problems in care. Positive lessons were around communication with family around patient's wishes for treatment, advanced decision making and palliative care. Negatives reflected incomplete or unsigned DNACPR forms, lack of timings and designations in paperwork and uncompleted forms and pathway documentation.

We reviewed five second stage reviews and found that there were gaps in some of the reviews. Only one review answered the questions "Was diagnosis/differential diagnosis appropriate?" and "Were investigations appropriate?". One review was of an unexpected death and the grade of this was not answered. All five had the lessons learnt section completed in terms of whether there were any positive or negative lessons and what these were. There was evidence of discussion with the patient/next of kin in four of the five reviews we looked at.

The ME service was responsive to the needs of relatives. It was situated next to the bereavement service and the office of the Registrar at James Cook hospital. This meant that bereaved families could come to one place to collect any of their relative's belongings, register the death and if required speak with an ME (following the initial telephone call). There were plans in place to improve the service for bereaved relatives at the Friarage hospital led by the ME team. Mechanisms were in place to measure the success of the ME service. These included adding questions to the trust's bereavement survey about the ME process and a survey of junior doctors.

The SHMI (the summary hospital-level mortality indicator which reports on mortality at trust level) was 109 as of June 2018 which was within the as expected range nationally. The HSMR (Hospital Standardised Mortality Ratio) was 114 as of September 2018 which was higher than expected. The trust was a national mortality outlier for both chronic renal failure and intercranial injury. The trust provided us with their investigation of these outliers. CQC's review of the trust's action plans was ongoing at the time of the inspection.

Learning from incidents
Incidents were not consistently identified and reported on. Not all incidents were dealt with appropriately or quickly enough and there was limited thematic learning across the organisation. We saw examples of incidents that should have been reported and had not been recognised or reported as such. As a result, required data or notifications were inconsistently submitted to external organisations.

The trust remained a relatively low reporter of incidents nationally. Elements of the incident policy were out of date and had not been updated since 2014 despite changes in national guidance regarding the management of incidents.

Concerns about the management and learning from incidents had been identified by CQC in Summer of 2018 and raised with the trust. This was discussed and recorded in the trust's Board papers. However, at inspection we still had the same concerns.

The senior leadership told us they recognised that the reporting and management had been a concern; but they told us it was improving. However, evidence from our review of incidents, staff focus groups run by CQC, interviews and from speaking with staff in clinical areas, indicated otherwise. We were told on several occasions that staff felt they were discouraged to incident report and that when incidents were recorded there were delays in response or sometimes no feedback to staff reporting. Examples of concerns raised included staff shortages, lack of equipment; the amount of change within the organisation; outlier patients in medicine and management of critical care beds including the lack of appropriate escalation and management of patients. In addition, when the James Cook hospital main switchboard was cut off for six hours in May 2018, this was reported as an incident on datix but it was never declared as a serious incident. There had been at least three "near miss" incidents within the trust relating to the ligature risks and the safety of patients with mental health conditions. Whilst these incidents had been reported, they had not been fully investigated as no serious harm had occurred. This meant there was a lack of learning about how to prevent future self-harm attempts. We also found other examples of the failure to recognise similar incidents.

We reviewed six serious incident investigations (SIs) whilst on site and others as part of our ongoing monitoring of the trust. The incidents we reviewed did not provide assurance that they were addressed in a timely manner or that immediate action was taken to prevent a reoccurrence. In addition, policy and practice were not reviewed sufficiently to change future practice in order to prevent re-occurrence of the event. Investigations appeared superficial with little involvement of patient or family. Overall there was a delay in report of some incidents internally and a longer delay externally. The median time to report incidents was 40 days for this organisation compared to 30 days for all trusts (Insight 2018).

The trust had an incident reporting and investigation policy which was dated November 2014 with a review date of March 2019. We were told it was under review at the time of the inspection. Elements of the policy were out of date and had not been updated since 2014 despite changes in national guidance re the management of incidents. A patient safety incidents process to support the early identification and investigation had been developed in August 2018 which was five stages from a daily conference to review moderate and above harms through to the Patient safety group to review it.

We lacked assurance of shared learning and actions taken surrounding a serious patient safety incident in the catheter laboratory that lessons had been learned and that staff were adhering to the WHO checklist and the hospital policy surrounding swab and needle checks.
It was a view of some of the board members that the trust was some way behind on aspects of "behavioural safety"; that the trust was only looking at big issues not and not yet near misses or trends. This was apparent on our review of the management of incidents, for example, in diagnostics there were a number of similar incidents relating to repeat doses of contrast that had not been identified or acted upon.

There was a process where a summary of ongoing and new serious incidents were reported to the QAC. This did include a section a section of lessons learned from final reports of investigations.

Complaints process overview
The trust had a complaints system in place and from complaints we reviewed it was evident that most complainants were responded to in a considerate manner. The trust worked to a tiered

response time process, usually 25 or 40 days; where the timescale was determined based on the complexity of the concerns raised (40 days for complex complaints).

Data from the trust indicated that in December 2018 52% of complaints were closed within target which was an improvement on the previous two months. This figure was expected to fall to 56% in January 2019 due to the number of complaints being completed that month. The trust expected to achieve its 80% target in February 2019.

The executive director lead was the director of nursing with oversight from a named non-executive. There was a central team with responsibility for co-ordinating complaints / PALS together with the real time patient experience programme and this consisted of seven WTE equivalent posts. The central team were responsible for the administration of the process and the clinical centres were responsible for investigating and responding to the complaint. The clinical centres employed patient experience co-ordinators of which there were four WTE who focus was solely to do complaints and four WTE who had a combined role with other governance duties.

We reviewed six complaints ranging from very simple to more complex cases. We found documentation was very sparse in some cases and none we reviewed had been responded to in line with the trust target for simple or complex complaints. Response times ranged from 22 to 44 working days. Some complaint responses we reviewed had evidence of clinical involvement and contained contact details for staff who would be willing to speak with or meet the complainant. Three responses contained an action plan to show how lessons had been learned and changes made to practice, but the remaining three had no actions identified. In one response we could see a thorough investigation had been carried out and all responses showed the complaint had been investigated to some extent with details of the outcome given. Only one complaint showed any element of risk assessment being applied. Two of the complaint responses we reviewed were written very compassionately, the other four were written from more of a factual perspective.

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?	25	80%
What is your target for completing a complaint	N/A	N/A
If you have a slightly longer target for complex complaints please indicate what that is here	40	80%

From October 2017 to September 2018 the trust resolved 2,262 complaints without formal process.

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

Number of complaints made to the trust
The trust received 368 complaints from October 2017 to September 2018. Surgery received the most complaints with 142.

Core Service	Number of complaints	Percentage of total
Surgery	142	38.6%
Medical care (including older people's care)	130	35.3%
Urgent and emergency services	30	8.2%

	17	4.6%
Gynaecology	17	4.6%
Maternity	17	4.6%
Services for children and young people	11	3.0%
Outpatients	6	1.6%
Diagnostics	4	1.1%
Other	4	1.1%
Critical care	2	0.5%
Adults Community	2	0.5%
Other - PMS service	2	0.5%
Provider wide	1	0.3%

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

From October 2017 to September 2018 there was one complaint referred to the ombudsman that was fully upheld and four that were partially upheld. In 2017/18 there had been an increase in the number and rate of complaints received compared to the previous year. The percentage of complaints closed within timeframe had increased to 79.7% for the year, this was an improvement from 2016/17. The percentage of re-opened complaints has increased slightly from 23% in 2016/17 to 26% in 2017/18.

The trust had a Patient advice and liaison service which was based at the James Cook university hospital and was open Monday to Friday 9am to 4pm. They could also be contacted by phone or email.

Compliments
From October 2017 to September 2018, the trust received a total of 270 compliments. A breakdown by core service can be seen in the table below:

Core service	Number of compliments	Percentage of total
Adults Community	67	24.8%
Surgery	40	14.8%
Medical care (including older people's care)	34	12.6%
Community Inpatients	26	9.6%
Diagnostics	17	6.3%
Maternity	17	6.3%
Urgent and emergency services	17	6.3%
Services for children and young people	14	5.2%
Outpatients	13	4.8%
Other - PMS service	10	3.7%
Other	6	2.2%
Gynaecology	3	1.1%
Critical care	3	1.1%
Children, Young People and Families	2	0.7%
End of Life Care	1	0.4%

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

Accreditations
Speciality directorates participated in appropriate research projects and recognised accreditation schemes.

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 below is a list of accreditations awarded to the trust:
- Joint Advisory Group on Endoscopy (JAG)
- Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care
- Anaesthesia Clinical Services Accreditation (ACSA)
- Imaging Services Accreditation Scheme (ISAS)
- Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189
- Improving Quality in Physiological Services Accreditation Scheme (IQIPS)
- Commission for the Accreditation of Rehabilitation Facilities (CARF)
- CHKS Accreditation for radiotherapy and oncology services
- Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)
- MacMillan Quality Environment Award (MQEM)
- Accreditation for Inpatient Mental Health Services (AIMS)
- Quality Networks
- ECT Accreditation Scheme (ECTAS)
- Psychiatric Liaison Accreditation Network (PLAN)
- Memory Services National Accreditation Programme (MSNAP)
- Accreditation for Psychological Therapies Services (APPTS)

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

James Cook University Hospital

Urgent and emergency care

Facts and data about this service

The James Cook University Hospital is one of two emergency departments for South Tees hospitals NHS Foundation trust. The service provides urgent and emergency care for patients in the Middlesbrough area. It is also a regional trauma centre for the South Durham, East Cleveland, Tees Valley and North Yorkshire area. The service provides emergency treatment for patients 24 hours a day, seven days a week.

- The James Cook University Hospital- emergency department
- Friarage Hospital - emergency department

Minor injury units were available at Redcar Primary Care Hospital and a children's minor injury unit model is delivered at the Friarage Hospital.

The emergency department at The James Cook University Hospital (JCUH) was designated a major trauma centre in April 2012. The department is open seven days a week, 24 hours a day. Patients are cared for in four main areas; ambulatory care including see and treat, majors, resuscitation and paediatrics.

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

Activity and patient throughput

Total number of urgent and emergency care attendances at South Tees Hospitals NHS Foundation Trust compared to all acute trusts in England, July 2017 to June 2018
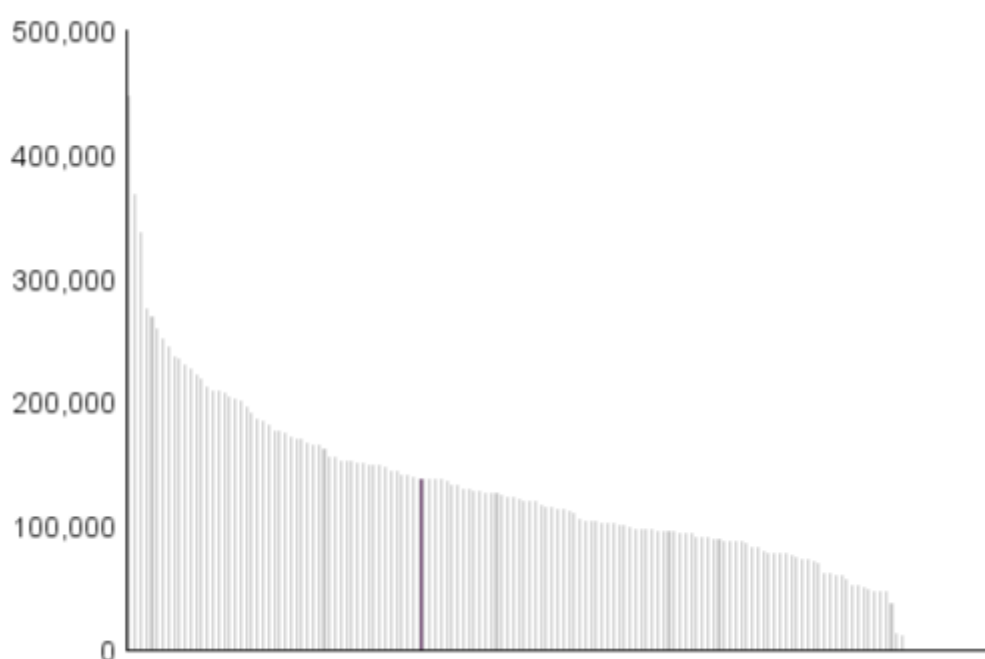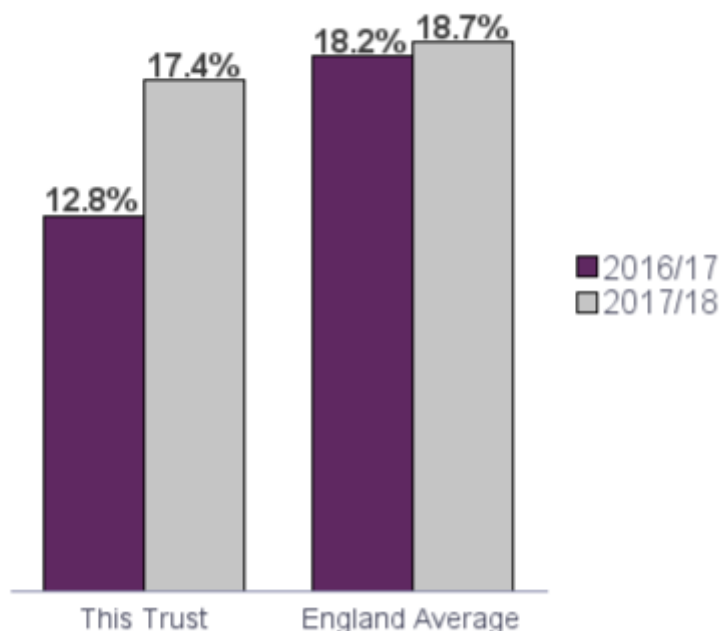

From July 2017 to June 2018 there were 137,614 attendances at the trust's urgent and emergency care services as indicated in the chart above.
(Source: Hospital Episode Statistics)

Information we reviewed showed that between July to December 2018, 55,575 patients attended the emergency department of these, 43,585 were adults and 11,990 were children and young people aged 0-18 years.
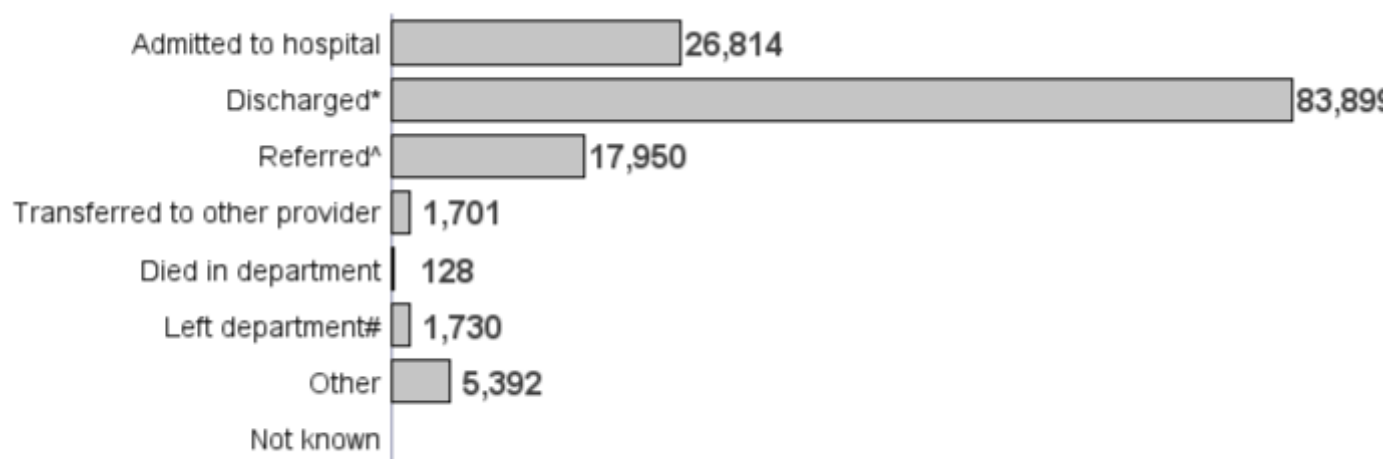
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in 2017/18 compared to 2016/17. In both years, the proportions were lower than the England averages.
(Source: NHS England)

Urgent and emergency care attendances by disposal method, from July 2017 to June 2018

* 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?

Mandatory Training

The service had systems in place to ensure all staff received mandatory training. They set a target of 90% for completion of all mandatory training modules. Data for the James Cook University urgent and emergency care department up to September 2018 indicated that the 90.0% target was met for seven of the 21 mandatory training modules for which qualified nursing staff were eligible and met for four of the 18 mandatory training modules for which medical staff were eligible. More recent data from the trust indicated an improvement in some areas however, figures for paediatric and adult life support training were low.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for qualified nursing staff in the urgent and emergency care department at the James Cook University is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Mentor Update	12	12	100.0%	90.0%	Yes
Health and Safety (Slips, Trips and Falls)	93	96	96.9%	90.0%	Yes
Falls prevention inpatient training	19	20	95.0%	90.0%	Yes
Equality and Diversity	91	96	94.8%	90.0%	Yes
Information Governance	87	96	90.6%	90.0%	Yes
Advanced paediatric life support – APLS	2	2	100.0%	90.0%	Yes
Triennial Review	12	12	100.0%	90.0%	Yes
Paediatric Immediate Life Support – PILS	34	65	52.3%	90.0%	No
Adult Basic Life Support	1	20	5.0%	90.0%	No
Advanced life support - ALS	9	13	69.2%	90.0%	No
Dementia Awareness (inc Privacy & Dignity standards)	29	35	82.9%	90.0%	No
Fire Safety 3 years	77	96	80.2%	90.0%	No
Infection Prevention (Level 1)	76	96	79.2%	90.0%	No
Anaphylaxis awareness	2	3	66.7%	90.0%	No
Immediate life support - ILS	42	71	59.2%	90.0%	No
Blood Transfusion	56	95	58.9%	90.0%	No
Conflict Resolution	13	32	40.6%	90.0%	No
Prevent -WRAP	33	96	34.4%	90.0%	No
Manual Handling - People	23	80	28.8%	90.0%	No
Basic Life Support	3	15	20.0%	90.0%	No
Learning Disability Awareness Training	0	2	0.0%	90.0%	No

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for medical staff in the urgent and emergency care department at the James Cook University is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Advanced life support - ALS	17	17	100.0%	90.0%	Yes
Immediate life support - ILS	1	1	100.0%	90.0%	Yes
Newborn Life Support - NLS	1	1	100.0%	90.0%	Yes

Advanced paediatric life support - APLS	12	12	100.0%	90.0%	Yes
Paediatric Immediate Life Support - PILS	0	1	0.0%	90.0%	No
Adult Basic Life Support	20	30	66.7%	90.0%	No
Health and Safety (Slips, Trips and Falls)	29	38	76.3%	90.0%	No
Information Governance	29	38	76.3%	90.0%	No
Equality and Diversity	27	38	71.1%	90.0%	No
Basic Life Support	17	25	68.0%	90.0%	No
Fire Safety 3 years	23	38	60.5%	90.0%	No
Infection Prevention (Level 1)	23	38	60.5%	90.0%	No
Manual Handling - People	9	15	60.0%	90.0%	No
Conflict Resolution	10	17	58.8%	90.0%	No
Blood Transfusion	16	35	45.7%	90.0%	No
Prevent -WRAP	15	38	39.5%	90.0%	No
Dementia Awareness (inc Privacy & Dignity standards)	1	4	25.0%	90.0%	No
Falls prevention inpatient training	0	3	0.0%	90.0%	No

At the James Cook University urgent and emergency care department the 90.0% target was met for four of the 18 mandatory training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Mandatory training was undertaken via e-learning and face-to-face settings. The service had recently appointed a training lead for the department. Post the inspection, the training faciliator had been given protected time to support staff with training and development requirements.

We spoke with 27 staff, who all said they had completed their mandatory training, or were booked onto outstanding courses. Staff also said that they supported to complete their mandatory training.

Post the inspection, the trust provided information which showed overall training compliance for November 2018 was we were unsure from the data provided whether this included medical and nursing staff:

Name of course	Completion rate	Trust Target	Met (Yes/No)
Health and Safety (Slips, Trips and Falls)	89.1%	90.0%	No
Equality and Diversity	88%	90.0%	No
Information Governance	83.6%	90.0%	No
Fire Safety 3 years	75.5%	90.0%	No
Infection Prevention (Level 1)	74.9%	90.0%	No

We requested to review training compliance rates for resuscitation training, these showed only 52.3% of qualified nursing staff were qualified in paediatric immediate life support, this was worse than the training compliance rate of 90%. Data we reviewed showed that 100% of staff eligible for advanced paediatric immediate life support had completed it, however; this only equated to two qualified nursing staff. For medical staff, 0% of medical staff were qualified in paediatric immediate

life support. Data we reviewed showed that 100% of staff eligible for advanced paediatric immediate life support had completed it, however; this only equated to 12 medical staff, when for other training modules there were 38 medical staff eligible.

We reviewed training in adult life support and this showed, 5% of qualified nursing staff were qualified in basic life support, this was worse than the training compliance rate of 90%. Data we reviewed showed that 69.2% of staff eligible for advanced life support had completed it, however; this only equated to 13 qualified nursing staff, when other training modules equated to 96 qualified nursing staff. For medical staff data showed 66.7% of medical staff were qualified in basic life support, this was worse than the training compliance rate of 90%. Data we reviewed showed that 100% of staff eligible for advanced life support had completed it, however; this only equated to 17 medical staff, when other training modules equated to 38 medical.

Following the inspection the trust reviewed the data and confirmed that 21/23 consultants were compliant with ALS training. However, no additional data was provided regarding nurse staffing.

Safeguarding

At this inspection, the service had systems in place for the identification and management of adults and children at risk of abuse. Staff we spoke with said that they completed adult and children's safeguarding as part of their mandatory training. They also said that the trust safeguarding team was accessible and supportive when staff needed advice about safeguarding concerns.

The service had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse, and issues which staff should report. Staff we spoke with were aware of what concerns could potentially be a safeguarding concern and knew how to raise them.

Staff we spoke with were knowledgeable with the safeguarding referral process for both adults and children. They could provide examples of safeguarding referrals they had made to ensure patients were safe. Staff were also able to confirm they received level three safeguarding training if appropriate.

The safeguarding lead for the department was the clinical director. The safeguarding lead provided support to the nursing and medical team. The safeguarding duty nurse from the trust safeguarding team, visited the emergency department daily. The triage system included a screening tool, staff used the tool to establish parental responsibility, who attended with the child and whether the child had a social worker.

We reviewed 10 paediatric care records and found that the safeguarding assessment was complete in all records reviewed.

The trust had a safeguarding duty nurse reviewed the records of children who had been through the department daily. The purpose was to ensure that any relevant organisations such as GP's, school nurses or health visitors had been informed of the visit and to make sure that no vulnerable children, or incidents had been missed.

When a child leaves an emergency department without being seen it is good practice to ensure a review of notes is undertaken by a senior clinician. During the inspection, we noticed one set of records where a young person had left the department without being seen, however the senior review had not occurred, we highlighted this at the time of the inspection. We did not receive assurance that the service had a robust procedure to ensure that a review of the notes occurred when a child left without being seen.

The service had systems in place to ensure all staff received safeguarding training. They set a target of 90% for completion of all mandatory training modules as indicated in the tables below.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for qualified nursing staff in the urgent and emergency care department at the James Cook University Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 3)	93	96	96.9%	90.0%	Yes
Safeguarding vulnerable adults	91	96	94.8%	90.0%	Yes
Safeguarding Children (Level 3 Additional)	84	93	90.3%	90.0%	Yes

At the James Cook University Hospital urgent and emergency care department the 90.0% target was met for all the three safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for medical staff in the urgent and emergency care department at the James Cook University Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 3)	28	28	100.0%	90.0%	Yes
Safeguarding Children (Level 2)	9	10	90.0%	90.0%	Yes
Safeguarding Children (Level 3 Additional)	24	28	85.7%	90.0%	No
Safeguarding vulnerable adults	29	38	76.3%	90.0%	No

At the James Cook University Hospital urgent and emergency care department the 90.0% target was met for two of the four safeguarding training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Post the inspection, the trust provided information which showed overall training compliance for November 2018 was:

Name of course	Completion rate	Trust Target	Met (Yes/No)
Safeguarding -vulnerable adults	90.7%	90.0%	Yes
Safeguarding children	93.3%	90.0%	Yes

Female genital mutilation (FGM) was included in the hospitals safeguarding training programme. Staff were aware of FGM and understood their responsibilities to report cases.

Prevent training for the service dated October 2018, showed 34.4% qualified nursing staff and 39.5% medical staff both sets of data were worse than the training compliance rate of 90%. Post the inspection, the trust shared information which showed they now had 79% compliance with Prevent training (trust wide data).

Sexual exploitation training was included as part of safeguarding training staff were aware of how

to recognise this and actions that were required.

Cleanliness, infection control and hygiene

The service had systems in place to prevent and control infections. These included staff training, audits and policies and guidance documents.

The trust had an infection, prevention and control policy, this directed staff to other policies and protocols for guidance containing information on hand hygiene, personal protective clothing and patient isolation precautions.

At this inspection, we found the department was visibly clean and tidy. Due to recent changes in the cleaning contract, domestic staff were not able to show us domestic monitoring forms but were able to verbally confirm compliance rates of 98%.

We reviewed patient led assessments of the care environment (PLACE) reports for the hospital and noted 98.3% compliance for cleanliness which was better than the England average of 98.5%.

Records we reviewed showed that that 76 out of 96 qualified nursing staff and 23 out of 38 medical staff had completed infection prevention and control training (level one).

Infection prevention and control assurance visits were carried out by the infection prevention and control team, these included specific actions for completion.

During the inspection, we observed that staff were compliant with hand hygiene policies, including 'bare arms below the elbows' and personal protective clothing policies.

Handwashing advice was clearly displayed and facilities for hand hygiene were available. We observed staff decontaminating their hands appropriately. Staff had access to "at the point of use" alcohol gel. During the inspection, we did not see hand hygiene compliance data on display.

We observed staff cleaning and disinfecting equipment between patients, which followed the trust policy. We reviewed 10 pieces of reusable equipment stored on the department, and all items appeared to be visibly clean and ready for use. We saw that staff used a specific label to identify that commodes were clean and ready for use. Toys we reviewed in the department were clean and in good condition.

Staff we spoke with were knowledge about infection prevention and control procedures within the department. Staff we spoke with confirmed that they had access to appropriate personal protective clothing (PPE). Patient we spoke with confirmed and we observed staff using gloves and aprons appropriately.

We saw processes for segregation of waste including clinical waste. Staff could segregate waste at the point of use. Sharps bins were used by staff to dispose of sharp instruments or equipment. Sharps bins in the areas visited were secure, dated signed and stored of the floor. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.

Cubicles were available for patients requiring isolation during the inspection. All patients requiring isolation were isolated appropriately and staff caring for them did this using the appropriate precautions.

The trust carried out audits of antimicrobial prescribing in the department, this also included actions taken and required to achieve the antimicrobial commissioning for quality and innovation CQUIN target. The trust had begun to work with partner organisations to improve antimicrobial prescribing across the healthcare community.

During the inspection, we asked to review water flushing records, these were not available within the unit and staff working in the unit said that they did not carry out the flushing, this did not provide assurance of compliance with water safety plans. We discussed this with the trust and post the inspection flushing records were supplied however the records supplied dated post the inspection and did not provide assurance of compliance with robust water safety plans to reduce the risk of waterborne disease. Following the inspection the trust provided limited assurance (five days of records from the 8 - 22 January 2019) that the appropriate checks were being made.

Records we reviewed from November 2018, showed there had been 31 trust attributed cases of clostridium difficile, five Methicillin Resistant Staphylococcus Aureus blood stream infections and 21 Methicillin Sensitive Staphylococcus Aureus bloodstream infections attributed to the trust. However, none of these infections were attributed to the department.

During the inspection, we saw patient blankets and sanitary products left uncovered in the department, due to the limited size of the resuscitation area staff did not have any cupboards to store these items.

Environment and equipment

Resuscitation equipment including paediatric and neonatal were available in the department. We checked these and found that they all contained the relevant equipment.

The waiting area for patients was in the main entrance and a specific children's waiting area was adjacent to this. The children's waiting area had toys available to provide distraction, but it was not separate from adult patients. The waiting areas were visible to staff.

Triage facilities were accessed in the see and treat treatment area. Ambulance patients arrived via a separate area and were rapidly assessed in the corridor.

The department had been designed to accommodate approximately 60,000 attendances per year, current figures showed approximately 100,000 attendances per year. The department had four resuscitation bays and staff we spoke with expressed concerns that these were often full and they had to prioritise which patients they placed into resuscitation and which moved into the main department, even though clinically they both should remain in resuscitation.

The department was separated into different areas for patients to be reviewed for example: paediatric, minors, majors and resuscitation.

At the last inspection, we found that the paediatric environment was not fit for purpose, as the children's waiting area was in the see and treat area, where adults were also being treated. The department had made changes since the last inspection and had refurbished some of the unit to provide a dedicated paediatric area. However due to the size of this area and the number of paediatric attendances, paediatric patients were still being seen in the "see and treat area". Staff we spoke with also said that on occasions children and young people were seen in the main department. Although both areas were child friendly, neither area was secure to ensure paediatric patients were separated from adults. Children in the emergency department were still treated with adult patients and paediatric patients had to walk through adult areas to receive treatment in the paediatric area. We did not receive assurance that the current paediatric provision in the department meet the standards for children in emergency departments. During the inspection, we discussed this with the senior management team, who acknowledged improvements could be made in both the environment and pathways. They shared with us their visions and confirmed that designs for a new paediatric area were available, these had progressed to a business case, however it had not been approved. The senior management team were in the process of completing a compliance audit in relation to current Facing the future: Standards for children in emergency settings June 2018 was due to be reported on in March 2019.

The department had access to a designated mental health room, we inspected the room and found that it did not meet the quality standards for liaison psychiatry services, it contained fixings and fittings which posed ligature and harm risks to patients, visitors and staff. Patients under a section 136 (of the Mental Health Act) who were medically fit but requiring a place of safety were transferred to a dedicated 136 suite at a neighbouring mental health trust adjacent to the hospital site.

We reviewed patient led assessments of the care environment (PLACE) reports for the hospital and noted 96.3% compliance for condition, appearance and maintenance which was better than the England average of 94.3%.

The departments waiting room was small with seating for only 44.9 patients per 100,000 admissions this was worse than the mean average of 66.4 patients when benchmarking with other emergency departments (NHS benchmarking network emergency care project November 2018). This report also showed that the number of major's cubicles was similar 18 to the mean of 18.7 per 100,000 attendances. The department had less minor's cubicles, seven, to the mean of 12 per 100,000 attendances. Overall the department had 32 available treatment spaces for patients which was worse than the mean average of 44.4 per 100,000 attendances.
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 evidence of stock rotation. Staff working in the department did express concerns to us about the availability of reusable equipment, specialist breathing machines, blood monitoring equipment and monitors and these were identified on the risk registers for the service.

It is good practice to record and change breathing circuits on anaesthetic machines daily (Association of anaesthetists) Records we reviewed provided assurance this had been completed.

Staff also had access to a difficult airway trolley, records we reviewed, provided assurance that this was checked as per the department's procedure. The department also used pre-packed central line, catheter and chest drain packs to ensure all equipment was available prior to undertaking these procedures.

A computerised asset management system was in place within the trust. We looked at six pieces of equipment and found the majority to have been safety tested within the review date.

The paediatric resuscitation area was decorated in a child friendly way, it had paintings of the local area and pictures drawn by local children, this provided a calming environment and helpful distraction to children being treated in this area.

Relatives rooms were available for relatives who were in distress or whose relative was being cared for in the resuscitation room.

Assessing and responding to patient risk

The trust scored better than other trusts for two of the five Emergency Department Survey questions relevant to safety and "about the same" as other trusts for the remaining three questions.

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?	9.4	Better than other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.9	About the same 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?	7.2	Better than other trusts
Q33. In your opinion, how clean was the emergency department?	8.8	About the same as other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.6	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

The median time from arrival to initial assessment was better than the overall England median in each month from October 2017 to September 2018. Performance was consistently four minutes. During the inspection, all patients we reviewed were assessed within four minutes

Ambulance – Time to initial assessment from October 2017 to September 2018 at South Tees Hospitals NHS Foundation Trust
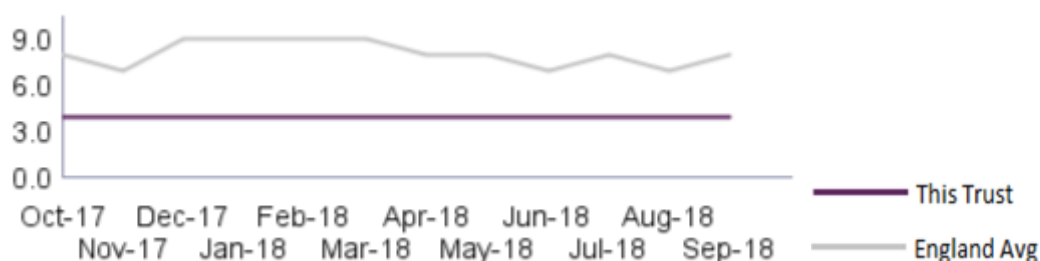

(Source: NHS Digital - A&E quality indicators)

From October 2017 to September 2018 performance of the monthly percentage of ambulance journeys with turnaround times over 30 minutes at James Cook A&E fluctuated between 55% and 64%.

Ambulance: Percentage of journeys with turnaround times over 30 minutes - James Cook A&E
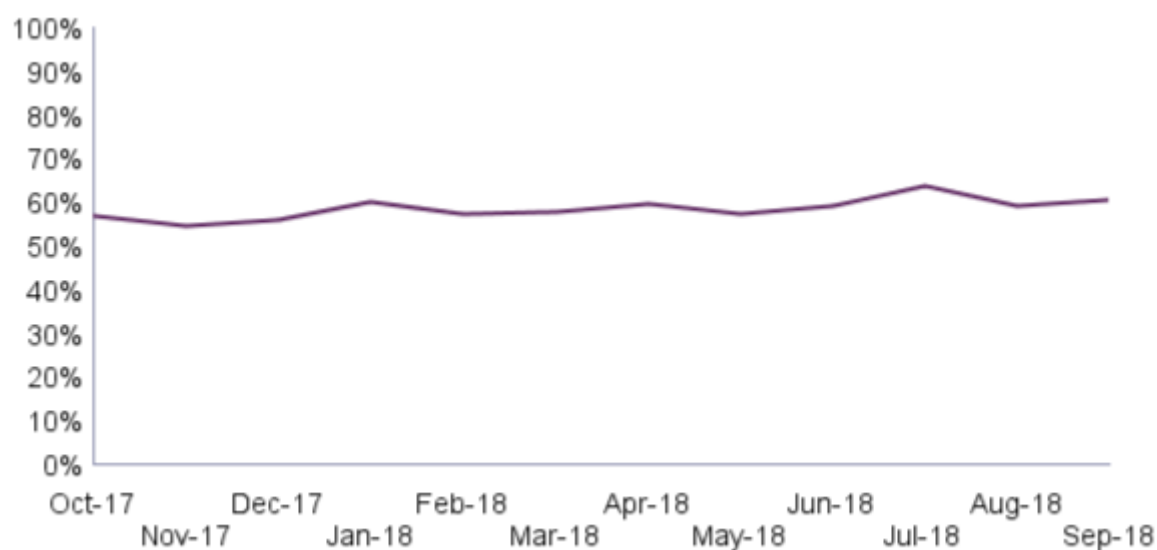

Ambulance: Number of journeys with turnaround times over 30 minutes - James Cook A&E
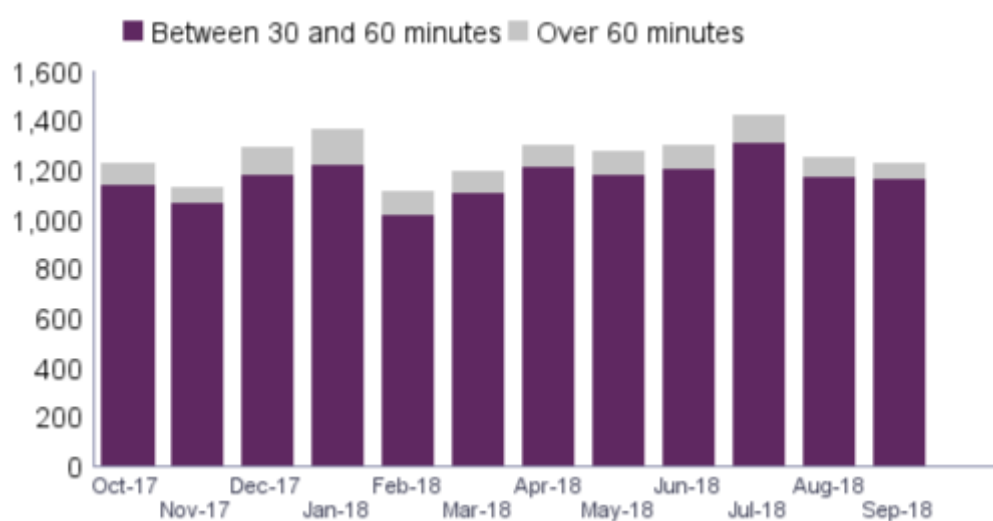
(Source: National Ambulance Information Group)

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 October 2017 to September 2018 the trust reported 48 "black breaches", with an expected increase over the winter period.
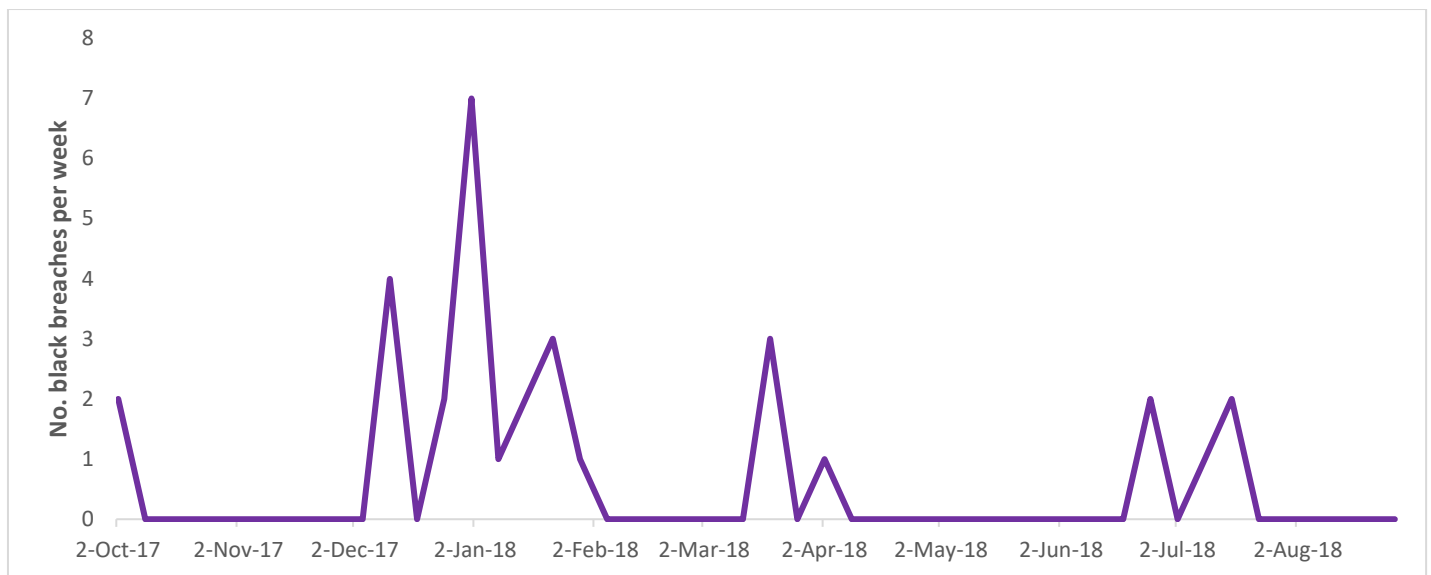
The reason for each black breach was due to the department being in escalation.
(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

It is recognised best practice in emergency departments to carryout clinical streaming, streaming is the allocation of patients to different physical areas/services to meet the needs of the patients. This should be undertaken by a trained clinician as soon as possible following admission. Within this service they called it streaming navigation. Patients who self-presented were navigated at the reception desk, by registered nurses. Navigation was dependent upon the patient's clinical presentation. Streaming of patients by reception staff was not carried out and this met best practice guidance.

Following streaming, it is recognised best practice in emergency department to carryout triage, to enable the prioritisation of patients. Triage should be delivered within 15 minutes of the arrival in the department, by staff qualified staff. We reviewed thirteen sets of admission records and triage records and saw that on the majority of occasions people waited slightly longer than the 15 minutes, from the records we reviewed we saw than on average patients waited 18 minutes for triage with the wait time ranging from 2 to 57 minutes.

Initial assessments of patients arriving by ambulance were carried out by the emergency practitioner in charge (EPIC doctor) to ensure timely decision-making; patients were then placed on specific pathways to ensure they received the correct diagnosis and treatment.

Patients where there was a concern of abnormal physiology were assessed using the national early warning system (adults-NEWS2) and for paediatrics (PEWS) this provided a baseline for staff and provided staff with an early warning of deteriorating patients, to enable them to take the appropriate action and escalate any patient of concern to medical staff. Records we reviewed showed that, on all occasions NEWS and PEWS calculations were recorded accurately, and appropriate actions were taken if scores were escalated.

Crowding in emergency departments is recognised as a risk to patients receiving good quality care, escalation policies are required to reduce overcrowding and increase the flow through the department. Within the department we saw robust escalation systems in place and governance procedures to avoid overcrowding.

The department had implemented the "fit to sit" initiative, for patients who were well enough to sit in chairs whilst awaiting treatment, rather than waiting on trolleys.

During the inspection, we saw that some patients including paediatrics waited longer than the recommended 60 minutes to see a clinician. We fed this back to the senior management team, who took immediate action to review the issues and improve monitoring of the time to treatment for paediatric patients.

We asked to review specific incidents that had occurred in the department in relation to the paediatric area, the trust supplied information, which showed that very few incidents had occurred. Following the inspection, we were made aware of a specific incident which highlighted security risks in this area, the trust had taken immediate mitigating actions, to prevent further occurrence of this type of incident.

During the inspection, we reviewed risk assessment documents on falls and skin integrity; in the majority of occasions these were not documented as completed. Intentional rounding was used in the department to check on patients at set times to manage their fundamental care needs, from the records we reviewed we did not see that staff recorded intentional rounding on the patient administration system.

There was a mental health liaison team, this was provided through a service level agreement from a neighbouring mental health trust. This service was available 24 hours per day, seven days a week. The response time for access to the liaison team was within one hour, staff working in the department confirmed that this was a very responsive service. Staff working in the emergency department also had access to child and adolescent mental health teams and community crisis teams. Staff did not use specific formal risk assessments for suicide or self-harm.

Staff we spoke with, were knowledgeable and able to talk with us about how they would manage patients in the department with mental health needs. Staff confirmed that if patients presented a risk to themselves or others they were supervised. Patients who arrived under a section 136, were observed by the police. During the inspection, we did not see any patients presenting with mental health issues in the emergency department.

All staff we spoke with confirmed that no recent incidents had occurred where patients attempting to harm themselves in the emergency department.

Security staff were used in the department if patients displayed aggressive or challenging behaviour to themselves, staff or other patients. Security staff were employed by a separate company the service provided us with information which showed that staff had received training on the use of restraint.

We were not able to observe safety huddles between staff. However, we reviewed safety huddle information file; which had gaps in recording information, staff we spoke with said that this was because the information being shared had not changed, however some of the gaps were over a number of days.

It is recognised best practice to have systems in place to identify children and young people who attend frequently. Due to different computer systems in place in the computer system used at the local minor injury unit was not integrated with the computer system within the emergency

department so the service was not able to have an accurate picture of all attendances at all units. The senior management team shared with us the plans to capture this information from April 2019.

Nurse staffing

The department had determined what number of nursing staff was required on each shift to maintain safety of patients. Planned staffing for the dayshift was 15 registered nurses, and six health care assistants. Planned staffing for the night shift was 13 registered nurses and five health care assistants.

We reviewed duty rotas over the previous three months and examined 42 shifts. Data we reviewed showed that on the majority of occasions areas were not staffed at planned levels. We reviewed qualified nurse shifts and saw that 19 out of 21 day shifts and 17 out of 21 night shifts were staffed at below planned levels. The service had recognised this and was in the process of recruiting more qualified nurses; six qualified nurses were due to commence employment in the department immediately after the inspection.

The paediatric emergency Standard states there should be sufficient RSCNs to provide one per shift. We reviewed 42 Shifts and found that a RSCN was available on every shift.

Emergency Nurse Practitioners were available every shift, these staff formed part of the junior doctor medical rotas.

In addition, the service employed a patient flow assistant on each shift to liaise with the site co-ordination team, check patient test results and complete the hourly status reports. They also employed a number of other assistant roles e.g. stock assistants.

The trust used the safer nursing care tool to monitor patients' acuity and plan staffing levels, establishment reviews had been carried out and had been recently approved at the trust management board. Staff escalated staffing issues through the site management meetings twice a day, these meetings were used to review activity, manage staffing issues and monitor capacity and demand on each site.

The trust reported the following qualified nursing staff numbers as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
The James Cook University Hospital	105.0	100.6	95.8%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From October 2017 to September 2018, the service reported a vacancy rate of 4.1% for qualified nursing staff in urgent and emergency care.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From October 2017 to September 2018, the service reported a turnover rate of 11.7% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 10%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From October 2017 to September 2018, the service reported a sickness rate of 4.9% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 3.5%.

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

From October 2017 to September 2018, the James Cook University Hospital reported an average monthly bank usage rate of 8.2%, an unfilled rate of 0.7% and no agency usage in urgent and emergency care.

Staff group	Bank rate	Agency rate	Unfilled rate
Qualified	3.1%	N/A	0.7%
Non-qualified	25.4%	N/A	0.7%

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department was similar to (77.6%) the national mean average of 78% when comparing the percentage of nursing staff that are qualified per 100,000 emergency department attendances for November 2018. Information also showed better (13.4%) than the mean average of 10.8% when comparing the percentage of advanced nurse and emergency nurse practitioners per 100,000 emergency department attendances for November 2018.

Medical staffing

The department had determined what number of medical staff was required on each shift to maintain safety of patients.

Medical staff worked shifts to meet the demands for the service for example:
- Junior medical staff were available 24 hours/seven days a week.
- Consultant medical staff were available 8am -12 midnight Tues, Wednesday and Thursday, with on-call cover available 12 midnight to 8am.
- Friday to Monday consultant medical staff were available onsite 24 hours.
- Advanced nurse practitioners were available on the medical rota 24 hours per day.

Planned staffing for the day shift was between eight and eleven doctors supported with two emergency nurse practitioners and one paediatric nurse practitioner. Planned staffing for the night shift was four or five doctors, one paediatric nurse practitioner and two emergency nurse practitioners.
Two dual trained (paediatric and adult) consultants were available in the department. Speciality paediatric support was available from the children's and young people's service.

At the time of the inspection, the trust had 24 (21 WTE) emergency department consultants, they said that they needed 24 WTE to enable them to provide 24-hour consultant cover on the James Cook site in line with the Royal College of Emergency Medicine workforce standards for delivery of services in a Major Trauma Centre.

At the time of the inspection the consultant job plans did not include onsite cover 24 hours, seven days a week.

Job plans covered Friday to Monday 24/7; Tuesday, Wednesday and Thursday were covered by a senior middle grade supported by a consultant on call. Gaps in the rota were offered as additional to consultants and some had been covered as availability allowed.

During the inspection, we reviewed the provision for major trauma within the unit as consultants were not available on site 24 hours per day/seven days a week. On-site trauma cover was available Friday to Monday, Tuesday to Thursday consultant cover was available on-call from home if the consultant lived within 20 minutes of the hospital. If the consultant lived longer than 20 minutes away they stayed within the hospital. The trust provided information which showed that on the evenings when there was no consultant present there was a higher grade middle tier doctor as the Emergency Physician in Charge, as well as the consultant on call who could respond to attend within 20 minutes of being called if necessary. The long-term plan was to appoint additional consultants in Emergency Medicine to support the 24/7 model. This did not provide overall assurance that the service was able to meet all requirements of the major trauma standards on a consistent basis.

The department had a requirement that the overnight middle grade had an in-date qualification in advanced life support (adults and paediatrics) and trauma. However, from records we reviewed we did not see that the department had a robust system to capture this.

From October 2017 to September 2018, the trust reported a vacancy rate of 27.6% for medical staff in urgent and emergency care. For the he James Cook University Hospital it was 21.7%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From October 2017 to September 2018, the trust reported a turnover rate of 20.4% for medical staff in urgent and emergency care. This was higher than the trust target of 10%. The breakdown by site for the James Cook University Hospital was 22.7%
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From October 2017 to September 2018, the trust reported a sickness rate of 0.7% for medical staff in urgent and emergency care. This was lower than the trust target of 3.5%. The breakdown by site for the James Cook University Hospital was 0.7%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From October 2017 to September 2018, the trust reported that 2.1% of medical shifts in urgent and emergency care were filled by locum staff and 0.6% of shifts were filled by agency staff.
(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department was better than (20.6) the mean average of 11.6 when comparing the number of consultants per 100,000 emergency department attendances for November 2018. Information also showed the consultant vacancy rate was better (no vacancies - 0%) than the mean average of 16.5%. When comparing the percentage of advanced nurse and emergency nurse practitioners per 100,000 emergency department attendances November 2018.

In July 2018, the proportion of consultant staff reported to be working at the trust were higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 35-whole time equivalent staff working in urgent and emergency care at South Tees Hospitals NHS Foundation Trust.

	This Trust	England average
Consultant	52%	29%
Middle career^	9%	15%
Registrar group~	27%	32%
Junior*	12%	24%
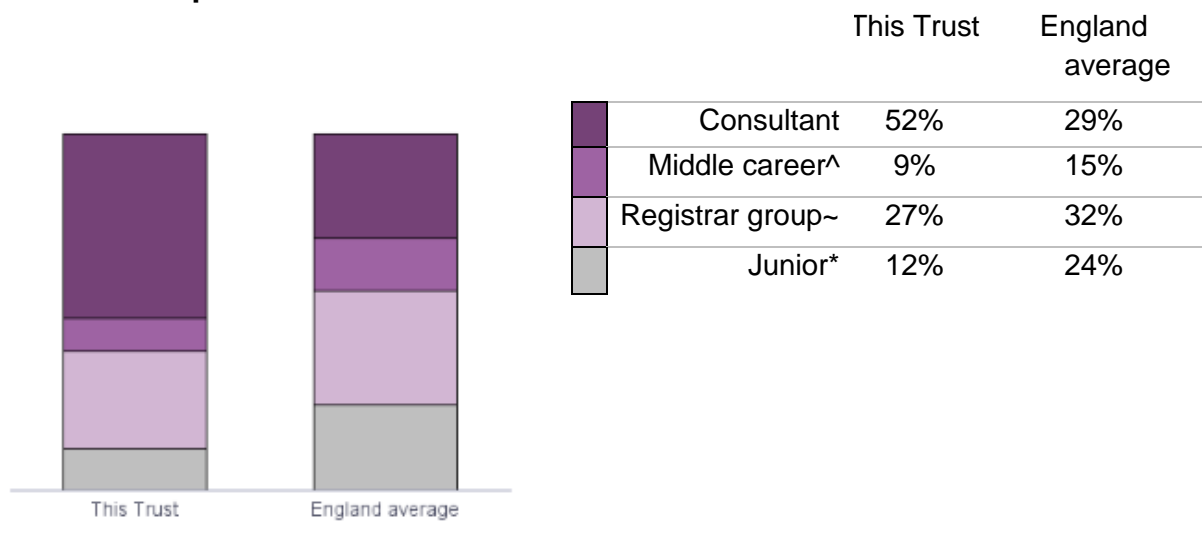
^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

Records

The service used electronic records, any written records were scanned into the electronic record system at the time of the admission.

Ambulance service records were electronic and staff received these at the time of handover, paper copies were available from other ambulance providers private or out of area, these were scanned into the electronic system at the time of admission.

We reviewed 31 sets of patients' records and found completion of documentation to be in line with professional standards, for example all writing was legible, and all entries were dated and timed.

Records were stored securely when not in use and were only accessible to appropriate people.

Individual care records were written and managed in a way that kept patients safe. The care records we reviewed showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

In seven out of seven records we reviewed mental health needs had been identified on triage documentation. Staff working in the trust did not have access to the mental health trust records system, but the psychiatric liaison team had access to both systems and would print off any vital information such as risk assessments and care plans and attach these to the trust records to enable effective sharing of vital information.

Staff we spoke with were aware of the process to take if a patient was discharging themselves against medical advice, such as undertaking capacity assessments.

All staff were required to complete information governance training every year. Training records showed 90% qualified nursing staff, and 76% of medical staff in the department had completed

information governance training, medical staff did not meet the trust overall training compliance rate of 90%.

Medicines

Medicines including controlled drugs were stored correctly with access restricted to authorised staff; they were checked in line with the policy and there were no discrepancies in controlled drug registers. Controlled drugs were audited by the nurse in charge of the unit on a twice daily basis.

We saw that staff recorded medicines refrigerator temperatures daily, we also saw action recorded if the temperatures were not within expected ranges. Staff we spoke with could describe the process for reporting if the fridge temperature went out of range.

Pharmacy services were available seven days a week, with an on-call service available out of hours and on a Sunday.

During the inspection, we noted that patient group directives (PGD) for various medicines including pain relief had been reviewed however, there was no central log of who could administer PGDs, or who had undertaken competence assessments. A PGD is a written instruction, which allows the supply and/or administration of prescription only medicines to a group of patients without individual prescriptions. Certain legal requirements are necessary including the start and end date of the PGD, a signature of a doctor and a pharmacist. Post the inspection, the trust provided information which showed that a central log was now available, and that all staff were now recorded as competent to deliver medicines via a PGD.

We reviewed medicines administration records for six patients. We saw that arrangements were in place for recording the administration of medicines and allergies were clearly documented.

An electronic medicines storage and dispensing system had recently been approved for the emergency department, it was due for fitting in the near future.

Pharmacy support to the department had recently increased, this now included a daily presence in the department.

Incidents

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 October 2017 to September 2018, the trust reported no incidents classified as never events for urgent and emergency care.
(Source: Strategic Executive Information System (STEIS))

Serious incidents (SI) are incidents that require further investigation and reporting. In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2017 to September 2018.

The breakdown of the types of incident reported were:
- Diagnostic incident including delay meeting SI criteria (including failure to act on test

results) – two (67% of total incidents)

- Treatment delay meeting SI criteria – one (33% of total incidents)

(Source: Strategic Executive Information System (STEIS))

The service had systems in place for reporting, monitoring and learning from incidents. The service had an incidents policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents. The emergency department recorded incidents in an electronic system. We spoke with staff who were knowledgeable of the incident reporting system, had confidence that incidents were being reporting and investigated correctly and confirmed that they received feedback on incidents they reported.

Lessons were learned following the investigation of incidents and learning was shared with staff via staff meetings, information displays (staff room), huddles and emails.

Duty of candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain examples of when they would use this. Staff we spoke with were aware of the duty of candour regulations, they could provide us with examples of when they would use this such as missed fractures.

For the trust we saw that the summary hospital level mortality indicator (SHIMI) and the hospital standardised mortality ratio (HSMR) were "as expected" and "higher than expected", SHIMI 111 April 2017 March and HSMR 110 February, 113 March 2018. Mortality data was discussed at the directorate meetings to share learning and improve performance.

Medical safety dashboards were used to gather information on mortality and share learning from deaths, data we reviewed showed this information was discussed at the monthly governance meetings. The trust also had medical examiner roles in place to review all deaths.

The service did not always have multi-disciplinary debrief sessions following traumatic events, debrief sessions are recognised within emergency departments to improve learning post events. Staff we spoke with understood the benefits from carrying these out and the senior management team were supportive, the team needed a further period to embed these as a consistent part of emergency medicine.

Safety Thermometer

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, three falls with harm and no new urinary tract infections in patients with a catheter from September 2017 to September 2018 within urgent and emergency care.
(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

People's needs were assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes.

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. Guidelines and policies, we reviewed were in date and based on current best practice.

Quality improving projects were being undertaken in the department, these included; improved nurse led pathways, admission avoidance pathways and innovative models of care, improving the access to patients to consultants.

The trust was using the commissioning for quality and innovation framework- improving services for people with mental health needs who present to A&E.

Nutrition and hydration

People's nutrition and hydration needs were not always met. During the inspection, we did not see any staff offer patients any food. Drinking water was available, and we heard staff offering one patient a drink, however the majority of patients we spoke with said they had not been offered food or water. Patients' we spoke with were not always sure if they could eat or drink. During the inspection, we did see signs indicating drinking water was available.

In the CQC Emergency Department Survey, the trust scored 7 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was about the same as other trusts.
(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

We reviewed patient led assessments of the care environment (PLACE) reports for the hospital and noted 85% compliance for food and hydration which was worse than the England average of 90.2 %.

The department did not have patient / carer access to a vending machine providing drinks and snacks to patients.

Pain relief

During the inspection, we saw patients being offered pain relief, we spoke with fifteen patients, the majority said that staff offered them pain relief and that staff checked that pain relief administered had been effective.

In the CQC Emergency Department Survey, the trust scored 6.7 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 7.9 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 to March 2017; published October 2017)

We observed staff using pain scoring tools to assess patients' levels of pain; staff recorded this information on the electronic patient record.

The service did not audit pain relief.

Patient outcomes

The emergency department failed to meet any of the national standards, however when compared nationally with other emergency care settings the department was in the upper quartile for some of these standards.

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, James Cook University's emergency department failed to meet any of the national standards. The department was in the lower UK quartile for three standards:
- Standard 1a (fundamental): O_2 should be given on arrival to maintain sats 94-98%. This department: 10.9%; UK: 19.0%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 1.0%; UK: 25%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 47.3%; UK: 77%.

The department's results for the remaining four standards were all within the middle 50% of results.
(Source: Royal College of Emergency Medicine)

The asthma action plan captured issues of concern within the audits and actions were in place to improve performance. However, there was no date for a re-audit to ensure improvements had been made.

In the 2016/17 Consultant sign-off audit, James Cook University Hospital's 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: 23.1%; UK: 11.0%.
- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 28.9%; UK: 12.0%.

The department's results for the remaining two standards were all within the middle 50% of results.
(Source: Royal College of Emergency Medicine)

The consultant sign off action plan we reviewed was not completed, did not have actions identified or re-audit dates included to improve performance.

In the 2016/17 Severe sepsis and septic shock audit, James Cook University's emergency department failed to meet any of the national standards. The department was in the upper UK

quartile for two standards:

- Standard 3: O_2 was initiated to maintain SaO_2 >94% (unless there is a documented reason not to) within one hour of arrival. This department: 78.0%; UK: 30.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 42.0%; UK: 18.4%.

The department's results for the remaining six standards were all within the middle 50% of results.
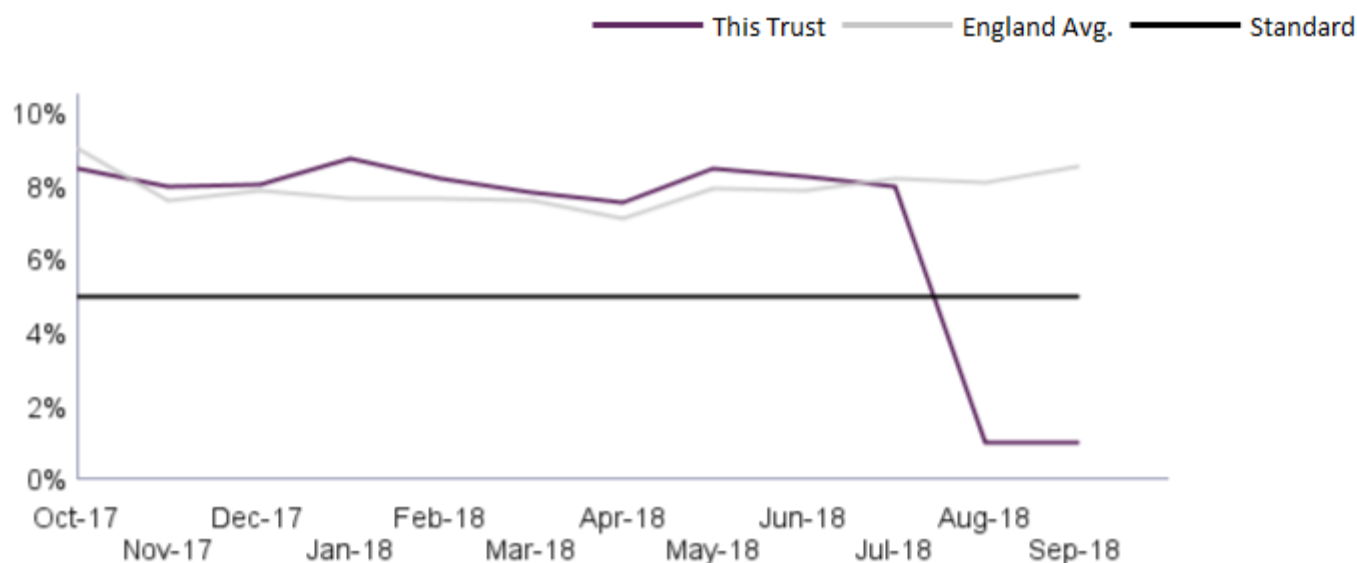*(Source: Royal College of Emergency Medicine)*

The sepsis action plans we reviewed were not completed, they did not have actions identified or re-audit dates included to improve performance.

The department participated in trauma and research network audits.

From October 2017 and July 2018, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5.0% and about the same as the England average, however for the last two months reported, performance has improved and was better than the national standard and the England average.

Unplanned re-attendance rate within seven days - South Tees Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Competent staff
From October 2017 to September 2018, 74.6% of staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 80.0%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
NHS infrastructure support	4	4	100.0%	Yes
Qualified ambulance service staff	2	2	100.0%	Yes

Qualified Allied Health Professionals (Qualified AHPs)	4	4	100.0%	Yes
Medical & Dental staff - Hospital	43	37	86.0%	Yes
Support to doctors and nursing staff	76	55	72.4%	No
Qualified nursing & health visiting staff (Qualified nurses)	131	92	70.2%	No

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

Staff described the appraisal process as a valuable experience and felt their learning needs were addressed. They were also given opportunities to attend courses to further their development.

Staff we spoke with said that the service offered a comprehensive induction programme to newly qualified or newly appointed staff, however some staff expressed concerns to us that the induction into the department for bank staff was variable.

The department had recently appointed a training lead. Post the inspection, the training faciliator had been given protected time to support staff with training and development requirements.

Staff working in the department were offered additional training to develop role specific competences and qualifications, these included triage and navigation competences.

Registered staff we spoke with that they had been supported through revalidation by the hospital.

Multidisciplinary working

We saw evidence of an effective multi-disciplinary team (MDT) approach to patient care and treatment, including seeking advice and joint decision making about patients across the emergency departments and with other medical disciplines.

Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships. Staff from outside agencies confirmed that the trust staff treated patients with mental health needs in caring, responsive and non-judgmental ways.

A commissioning agreement was in place with a neighbouring mental health trust to provide support for patients experiencing mental health conditions. Staff had 24-hour, seven days a week access to mental health liaison staff. Staff from the department held regular meetings with the staff from the mental health trust to support joint working arrangements. Staff we spoke with from both trusts described good working relationships.

Staff working in the department, worked closely with the trust frailty, physiotherapy and occupational therapy teams, to undertake assessments of patients' needs and prevent inappropriate admissions to hospital.

Staff working in the department worked effectively with members of the ambulance service, during the inspection we saw medical and nursing staff meet and greet ambulance staff with in a professional manner.

The department attended major trauma meetings. Which included members of the local trauma network.

Seven-day services

The emergency department was open 24 hours a day, seven days a week.

Consultant staff were on duty in the department seven days a week.

The mental health liaison team provided cover within the department 24 hours a day, seven days a week.

Access to emergency GP appointments in and out of hours were available via the navigation nurse.

Radiology services and diagnostic services were available within the department 24 hours a day, seven days a week.

Health Promotion

Health promotion information was not available within the department.

The department identified patients that required additional support during initial assessment. Staff worked with external agencies to provide referrals to external services when this was required for example; drug and substance misuse services and young people's service when exhibiting risky behaviour.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures and best practice and professional standards. We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients.

We did not see any records where consent was documented, even when sedation was being used patients.

Staff we spoke with were aware of Gillick competencies relating to decisions made by children and young people.

The Mental Capacity Act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, where someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests. Staff we spoke with could give a clear explanation of capacity assessment and the importance of recognising how ill health could impact on patients' capacity. However, we did not see any capacity assessments being carried out or documented.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are Deprivation of Liberty Safeguards (DoLs). DoLs can only be used if the person will be deprived of their liberty in a care home or a hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards.

The trust reported that from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 73.2% of staff in urgent and emergency care compared to the trust target of 90.0%. The breakdown by site was as follows:

Site	Training complete (YTD)	Individuals required (YTD)	Completion rate	Target met
The James Cook University Hospital	62	143	43.4%	No

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

Staff working in the department confirmed that they were expected to complete mandatory mental health awareness training as an e-learning package, they also confirmed that they were expected to complete a combined course on mental capacity act and the Deprivation of Liberty Safeguards. All staff had access to living with dementia training tier one.

We spoke with seven members of staff across the department, staff could confirm that they had received MCA and DoLs training, including capacity assessments.

Staff we spoke with said they access to mental health referral pathways and they would use these with any patients they had concerns about.

During the inspection, no patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place so we were unable to review any.

Is the service caring?

Compassionate care

We spoke with fifteen patients and seven relatives in the department, at this hospital. Patients we spoke with were happy with their care.

We observed staff caring for patients and found that they were compassionate and reassuring.

We heard staff introducing themselves by name and explaining the care and treatment they were delivering.

Patients we spoke with said that that staff were very caring and kind. Patients described their care as "great" and described the attitude of staff as "amazing, respectful" and "going the extra mile".

Patients we spoke with said that staff attended to the quickly if they required assistance, however throughout the inspection we did not see patients provided with buzzers which were within reach.

During the inspection, the majority of patients we observed were comfortable, looked well cared for and had their privacy and dignity maintained, we heard staff in the resuscitation department asking relatives to access through another set of doors to protect the privacy of other patients.

We reviewed patient led assessments of the care environment (PLACE) reports for the hospital and noted 89.6% compliance for privacy and dignity which was better than the England average of 84.2%.

The trust's urgent and emergency care Friends and Family Test performance (% recommended)

was better than the England average from September 2017 to July 2018. In August 2018 there were only four responses and in any month where there were fewer than five responses the trusts scores zero.

A&E Friends and Family Test performance - South Tees Hospitals NHS Foundation Trust
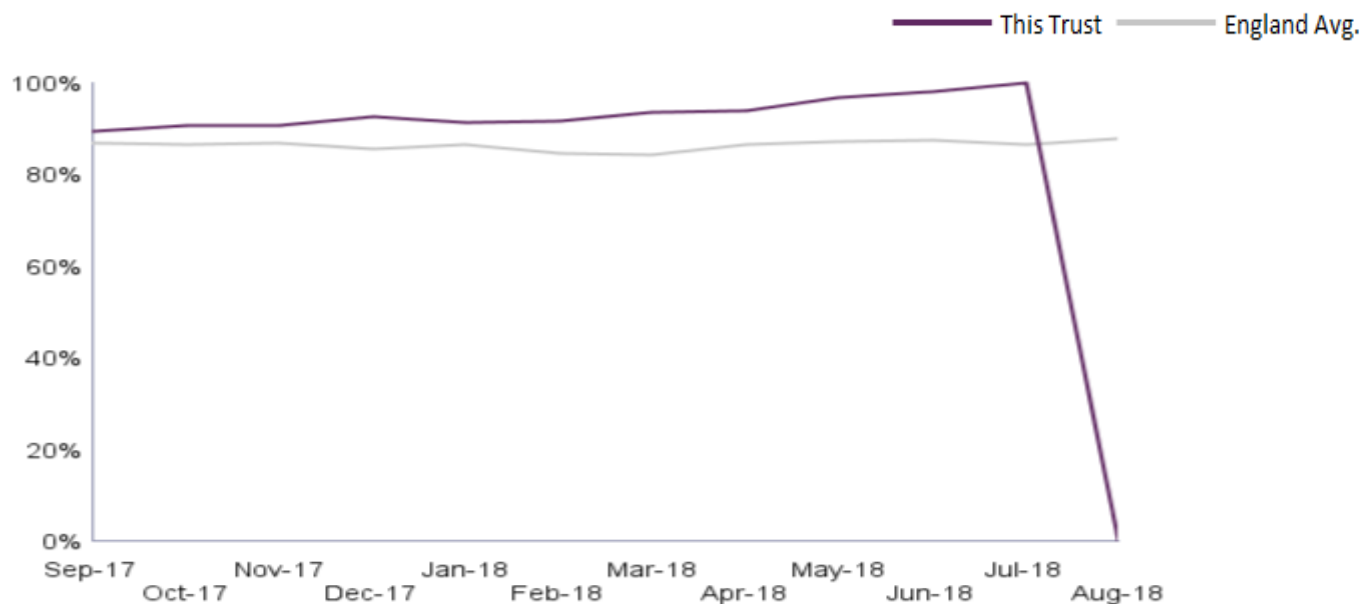
(Source: NHS England Friends and Family Test)

Emotional support

We saw that the department manager and matron were visible, and patients and relatives could speak with them.

During the inspection, when patients were distressed we saw staff provide them with support and reassurance, we also saw that staff regularly checked on relatives who were in distress or whose relative was being cared for in the resuscitation room.

We heard a conversation between patients and staff; the doctor was providing comfort and support.

Patients we spoke with said that staff had been reassuring and kind.

Staff we spoke with said that they supported patients with mental health conditions, in a non-judgmental way and provided support according to the patient need and risks that they presented with.

Understanding and involvement of patients and those close to them

We observed staff in the department as they explained to patients what they needed to do and why. Staff involved the patients in their decision making and we saw medical staff clearly explaining the next steps and providing appropriate information prior to making decisions. We also heard staff gain the patients' permission to proceed for treatment.

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 that they were aware of their plans of care and they had been given the time for questions and felt listened too.

Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions.

Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.

The trust scored better than other trusts for three of the 24 Emergency Department Survey questions relevant to the caring domain and about the same as other trusts for the remaining 21 questions.

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	4.7	Better than other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.6	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?	8.3	About the same as other trusts
Q14. Did the doctors and nurses listen to what you had to say?	8.8	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examing and treating you?	8.5	About the same as other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	9.0	About the same as 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?	7.8	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?	8.8	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?	8.6	Better than 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?	9.0	About the same as other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.9	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?	9.2	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?	7.4	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?	7.1	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?	8.8	About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests?	9.2	Better than other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	8.7	About the same as other trusts

Question	Trust 2016	2016 RAG
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.4	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	6.1	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?	6.0	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	5.7	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?	6.9	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?	7.6	About the same as other trusts
Q45. Overall... (please circle a number)	8.5	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Is the service responsive?

Service delivery to meet the needs of local people

The department worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.

The service recognised the need for improvements in the emergency pathways and had developed new build designs to accommodate these improvements.

Meeting people's individual needs

The services provided reflected the needs of the population served, including patients with protected characteristics under the Equality Act and those in vulnerable circumstances. Reasonable adjustments were made so that patients with a disability could access services on an equal basis to others. For example, the department, was accessible for patients with limited mobility and people who used a wheelchair.

We reviewed patient led assessments of the care environment (PLACE) reports for the trust and noted 91.3% compliance for disability which was better than the England average of 84.2 %.

The department provided information and facilitates to meet the needs of patients with sensory loss. A hearing loop was available in the waiting room. Staff could access services from the British sign language service.

On the electronic patient administration system bespoke patient flagging occurred for those with additional communication needs. Patients were provided with information leaflets on topics such as head injury, treatment for sprains and strains and minor illness. The leaflets were in English and staff informed us that patient advice leaflets could be requested in large print, other languages

and formats, including a 'read aloud' version. Staff we spoke with confirmed that the liaison team and therapeutic care teams had access to pictorial signs and symbols. The trust employed four specialist nurses for vision impairments.

Translation services were available for patients whose first language was not English. Staff we spoke with knew how to access these services. Staff we spoke with said this service was responsive.

The mental health liaison team provided cover within the department 24 hours a day, seven days a week. The emergency department had a dedicated consultant lead for mental health. The trust and the mental health trust had worked together on joint management plans for frequent attenders.

Patients who attended the department who were known to be living with dementia or learning disabilities were flagged on the computer system. The system identified patients with learning disabilities; this was a system used to ensure staff were aware of important patient information and requirements. Patients living with dementia were identified by a 'forget-me-not' icon was added to their notes to alert staff that extra support may be needed. The trust employed a lead nurse for frailty, they were also the lead for dementia. We saw specific 'dementia friendly' cubicles in the department however we did not see that any distraction aids were available for use by patients to help minimise agitation and anxiety. The department has single patient use twiddle blankets kept in the office until needed. Two high visibility cubicles have been decorated to support the care of patients with dementia. In light of the above information, we would respectfully invite the CQC to reconsider this statement and the draft report amended to reflect the evidence provided.

The trust employed lead nurse for learning disabilities, and staff could refer to them for advice or additional support for patients. The trust had an overall "treat as one strategy" which they had shared with staff through bulletins.

Staff we spoke with said that patients living in care homes had care home passports and those living with dementia or learning disabilities had "this is me" documents which shared vital pieces of information with care staff. During the inspection, we did not see any passports or "this is me" documents in use.

The trust had specific patient pathways to support patients with mental health needs to access the right care, for example; direct access to surgical wards rather than attending the emergency department.

Staff working in the paediatrics area had implemented a "pyjama fairies" initiative, they provided new pyjamas from the fairies when they needed to remove a child's pyjamas, due to a traumatic event. Staff in this area also had access to distraction boxes with sensory toys and bubbles.

Staff had access to specific training to improve patient experience within the department, for example, frailty, staff had identified roles as champions, including dignity, learning disabilities and fractured neck of femur. They also had dedicated consultant leads for frailty, mental health and safeguarding.

Patients we spoke with said that staff respected their privacy and dignity by closing curtains and doors as necessary.

We reviewed patient led assessments of the care environment (PLACE) reports for the hospitals and noted 85.7% compliance for dementia which was better than the England average of 78.9%.

Whilst waiting in the unit patients had access to WIFI.

The trust scored better than other trusts for one of the three Emergency Department Survey questions relevant to the responsive domain and about the same as other trusts for the remaining two questions.

Question – Responsive	Score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	7.4	About the same as other trusts
Q11. Overall, how long did your visit to the emergency department last?	8.2	Better than other trusts
Q20. Were you given enough privacy when being examined or treated?	9.4	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

A range of information leaflets and advice posters were available on wards we visited. These included discharge information, specialist services and general advice about their care and treatment.
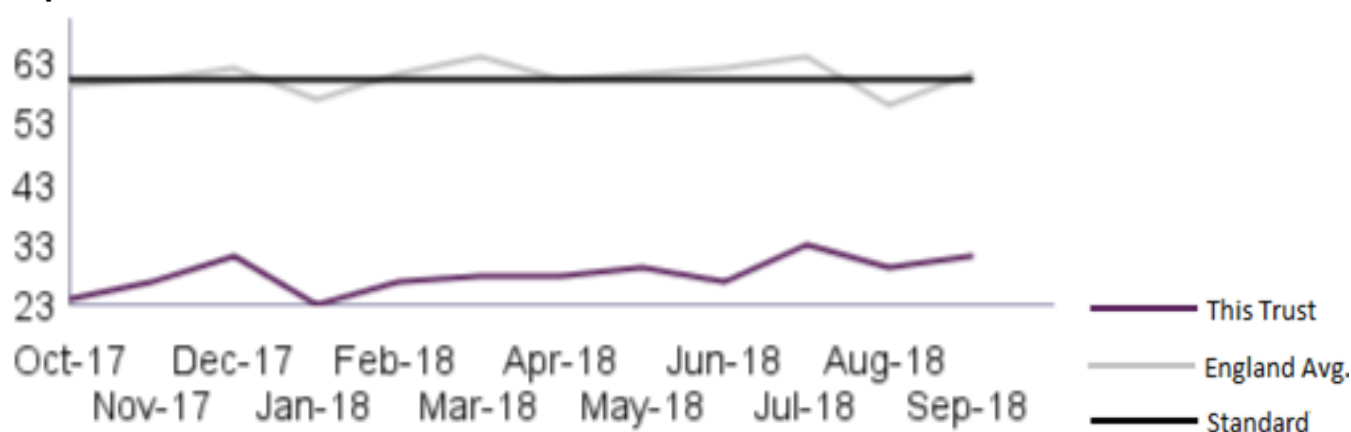
Access and flow

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. The trust met the standard for each month over the 12-month period from October 2017 to September 2018.

From October 2017 to September 2018 performance against this standard was consistently better than both the standard, and England average.

In the most recent month reported, September 2018 the median time to treatment was 31 minutes compared to the England average of 61 minutes.

Median time from arrival to treatment from October 2017 to September 2018 at South Tees Hospitals NHS Foundation Trust
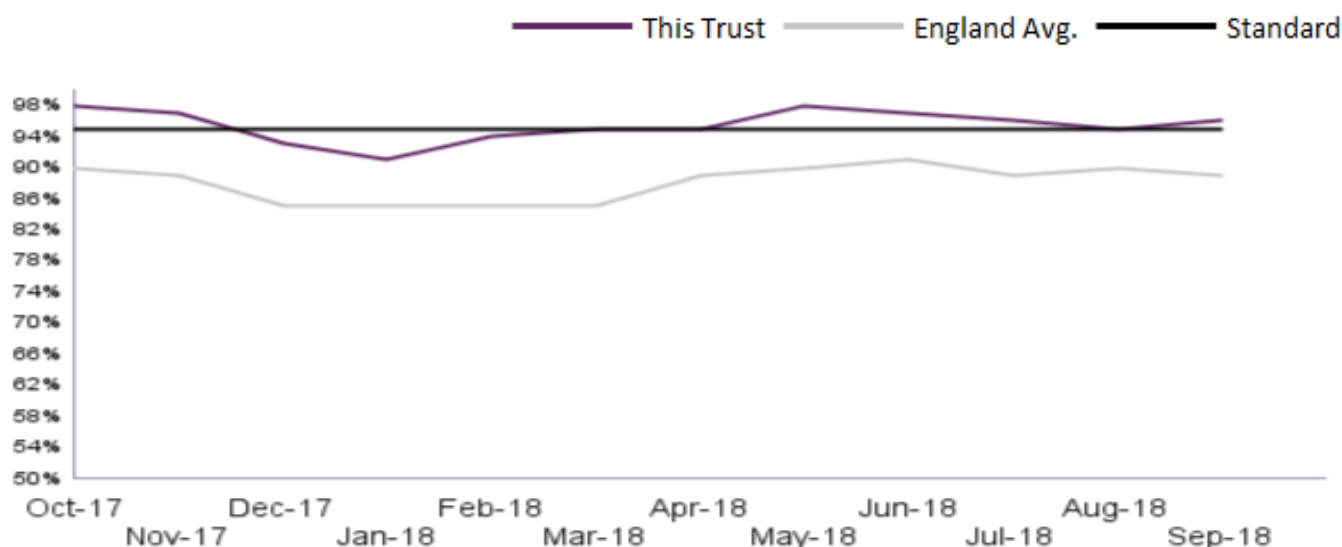

(Source: NHS Digital - A&E quality indicators)

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 October 2017 to September 2018 the trust met the standard for nine of the 12 months reported and performed better than the England average.

From October 2017 to September 2018 performance against this metric showed performance decrease over the winter period however recovered from February onwards.

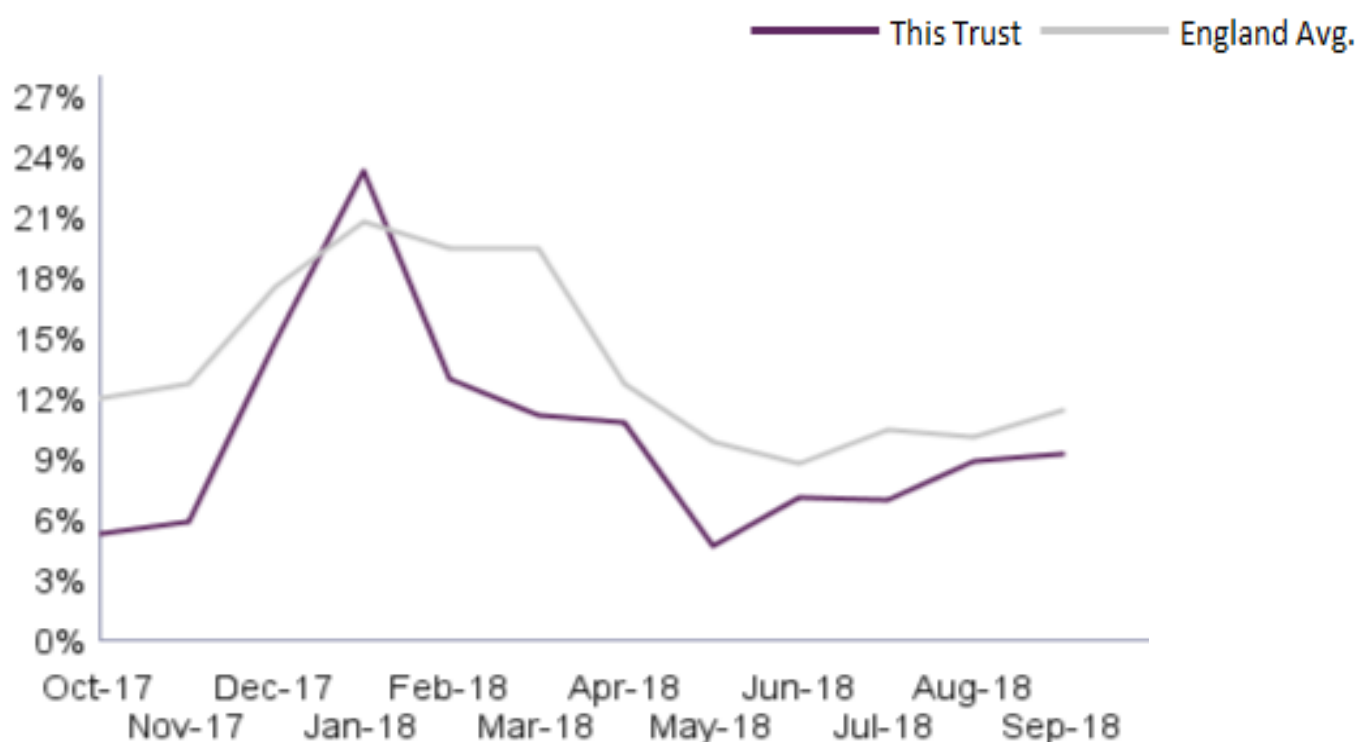**Four-hour target performance - South Tees Hospitals NHS Foundation Trust**

(Source: NHS England - A&E Waiting times)

From October 2017 to September 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.

From October 2017 to September 2018 performance against this metric showed expected worsening during the winter months however recovered and has been lower than the England average since January 2018.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - South Tees Hospitals NHS Foundation Trust
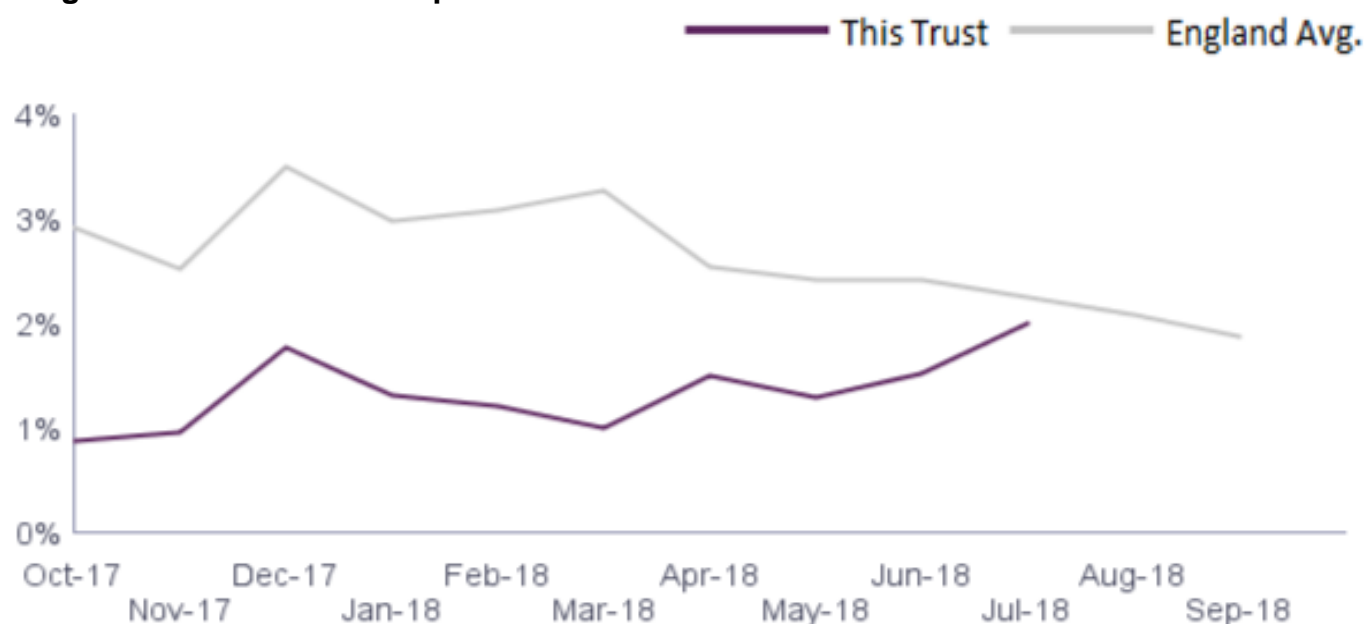
Over the 12 months from October 2017 to September 2018, eight patients waited more than 12 hours from the decision to admit until being admitted. They were all in January 2018 which is when performance was at its worst.
(Source: NHS England - A&E Waiting times)

From October 2017 to September 2018 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. For the last two months reported, the numbers leaving before being seen are classed as "small numbers" so are not reported which is why the chart has no value.

Percentage of patient that left the trust's urgent and emergency care services without being seen - South Tees Hospitals NHS Foundation Trust
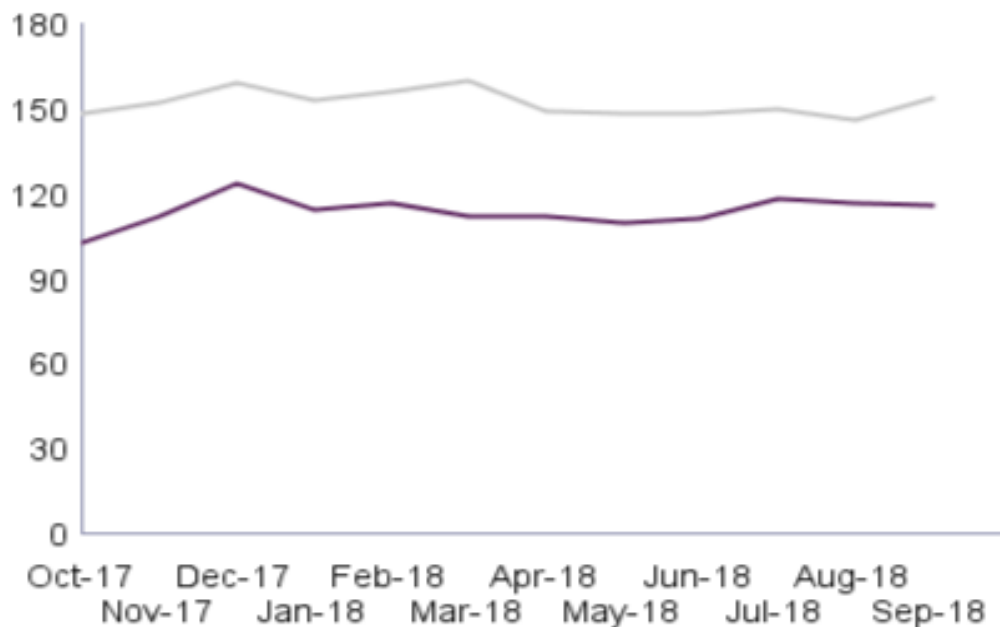

(Source: NHS Digital - A&E quality indicators)

From October 2017 to September 2018 the trust's monthly median total time in A&E for all patients was lower than the England average. In September 2018, the trust's monthly median total time in A&E for all patients was 116 minutes compared to the England average of 154 minutes.

Median total time in A&E per patient - South Tees Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

For the most recent complete month prior to our inspection (Dec 2018) the emergency department daily attendance ranged from 210 to 346 daily attendances with an average of 294 patients.

A "front door" approach was taken in the department, this was nurse and medical led assessments to support timely diagnostics, decision-making and prompt treatment. Communication about decisions was made, recorded and shared with staff via discussions, electronic records and huddles to ensure a smooth flow of patients.

The see and treat area was operational 9am to 11pm, this area allowed ambulatory patients with a variety of conditions to see a consultant early in their pathway.

As navigation was used in the department, this ensured the right person was treated in the right place at the right time. Staff did highlight to us that during periods of understaffing, navigation was postponed, staff we spoke with said that this decreased flow through the department.

The service worked effectively with other admissions areas to ensure a responsive, collaborative service was maintained.

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information, supplied by the department showed that the service attendance rate was 106,831 which was higher than the mean average of 87,099, this information also showed that the department had 383 daily attendances, with a better than average ambulance handover time and a better than average percentage of patients seen within four hours. Information also showed that patients spent less time in this emergency department 140 minutes on average compared with the mean of 209 minutes. The department was better when comparing the attendance to the admission rate (conversation rate); the trust was 22% and the national mean average was 28%.

The department used one hourly status reports to map activity in the department and identify

issues of concern such as overcrowding, long triage times etc. We reviewed information that clearly showed activity in the department and evidence of escalation.

Learning from complaints and concerns

From October 2017 to September 2018 there were 30 complaints about urgent and emergency care services. The trust took an average of 28 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 subjects of complaints are shown below:
- Patient Care: 26
- Admin/policies/procedures (inc patient record): one
- Values & behaviours (staff): one
- Appointments: one
- Communications: one

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

The trust had a process that addressed both formal and informal complaints that were raised by patients or relatives.

The service had systems in place for reporting, monitoring and learning from complaints. The service had a complaints policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating complaints. We saw information displayed in ward areas about how to complain or raise a concern.

The emergency department recorded complaints in an electronic system. Staff we spoke with said that themes and trends of complaints were shared with staff at huddles, team and directorate meetings. Staff were knowledgeable of complaints made within the department, they had confidence that complaints were being reporting and investigated correctly and that any learning was being shared to prevent the complaint from occurring again. We discussed with staff a recent compliant, staff could discuss with us themes from this complaint and changes in practice because of this complaint for example, changes in discharge procedures and improved discussion with patients and relatives.

From October 2017 to September 2018 there were 17 compliments in urgent and emergency care.
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

During the inspection, we reviewed two recent complaints, both complaints were appropriately investigated, had evidence of lessons learnt, evidence of patient/family involvement and we saw evidence of compliance with duty of candour requirements.

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department was better (total of 17) than the mean average of 80 complaints per 100,000 emergency department attendances November 2018. However, it also showed that compliments received were worse (total of nine) than the mean average of 94 compliments per 100,000 emergency department attendances November 2018.

Is the service well-led?

Leadership

We found that the unit managers and senior management were knowledgeable and approachable; they appeared visible and approachable for junior members of staff they supported. They had dedicated time for management and support of staff.

The emergency department leadership team included a clinical director, service manager and matron, together they formed a clinical delivery leadership triumvirate, staff we spoke with said they were supportive and knowledgeable. A medical director with responsibility for urgent and emergency care was appointed in 2018, Staff we spoke with said that since appointment communication within the department had improved. Staff we spoke with said the senior management team were supportive and staff felt able to raise concerns if required.

The majority of staff we spoke with were complementary about the culture and communication in the trust.

A "coaching" culture was evident in the department and staff had time out coaching sessions with their clinical teams to allow for leadership development and reflection.

Staff we spoke with said that the emergency practitioner in charge (EPIC) and emergency nurse in charge (ENIC), ensured that staff knew who the leader on shift was.

Vision and strategy

A clear vision and strategy was in place for the emergency department, the directorate strategy was prepared in April 2018 and included a number of different workstreams, for example; admission avoidance pathways, processes to support patients to access the right care, first time to achieve the best clinical outcomes and recruitment and retention strategies and plans to achieve financial viability.

Culture

Staff we talked with described the culture as positive, staff said they said they felt valued by their colleagues and the trust.

They said that morale was variable, staff we spoke with acknowledged challenges within the department, but recognised the positives of working in the department.

The senior management team were proud of staff and the care they delivered and their resilience to pressures that worked in an emergency department brought. The senior management team spoke with us about a listening culture and staff being able to influence the department and make safe changes.

Medical staff we spoke with shared with us the departments positive reputation, between doctors in training. They spoke with us about the support they received in the department.

Staff had access to a raising concerns service called "see hear speak up", staff we spoke with provided positive examples of speaking up and feeling listened too.

Governance

The emergency services department, was part of the urgent and emergency care centre. This included the directorates of emergency medicine, acute medicine and critical care. The service had clear governance structures. The triumvirate were responsible for governance within the

department, the triumvirate, the emergency department directorate and the centre board all held governance meetings monthly and then escalated to the operational management board and the quality assurance meetings. In addition, performance information was monitored weekly at performance wall meetings, where members of the operational and management teams met to review overall performance including four hour wait times.

We requested to review minutes from governance meetings; minutes we reviewed showed discussion about complaints, incidents, performance and finance.

Management of risk, issues and performance

The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services.

Staff working in the department and senior management team were knowledgeable about the about the risks within the department, however not these risks were documented in the risk register for the department. For example; senior staff within the directorate highlighted their highest risks, they identified the emergency department environment and the risks posed to paediatric and mental health patients, other risks we identified such as nurse staffing or lack of trauma consultant cover overnight were not documented on the risk registers we reviewed. Risk registers for the department, identified eight risks, three rated as high, four rated as moderate risks and one rated as low risks. Four of the eight risks related to a lack of clinical equipment, actions had been taken e.g. requesting additional resources to replace, however resources had not been secured to replace the necessary equipment. Risks had been reviewed in 2018.

The senior management team said that risk registers were shared via the directorate meetings, then escalated to the monthly centre governance committee to the operational management board. From there risks were discussed at the risk executive board assurance meeting and escalated to the board.

Quality and safety dashboard information was collected on IPC, falls, pressure ulcers, patient experience, complaints and incident reporting. This information was shared with the emergency department, at directorate meetings.

Information management

Information was used to monitor and manage operational performance of the department, and to measure improvement.

Information provided by the trust, showed that 76.3% of medical staff and 90.6% of nursing staff had completed information governance training. Compliance rates were below than the trust's target level of training of 90% for medical staff.

Computers were available on the unit. During the inspection, computers were not always locked securely when not in use.

Engagement

Staff could provide information which showed they had changed discharge procedures and improved examination processes because of patient feedback.

The patient experience team had gathered information from mental health patients experience of care at South Tees, early analysis was positive and further work was planned to provide further feedback.

The service measured patient and staff engagement through national and local surveys, concerns, complaints and compliments from patients, relatives and staff. The service carried out '1000 voices' surveys to gather feedback on services from patients and used this information to improve patient care.

Staff we spoke with were patient focused and clear about their roles and responsibilities to engage patients and families.

Learning, continuous improvement and innovation

The trust held a yearly celebrating success award ceremony, the service had been nominated on a number of occasions.

The emergency department had recently been awarded third place in a national competition for quality improvements projects and clinical team of the year.

The emergency medicine training department had recently awarded the department with a second-place award for training provision.

The department had a number of innovations in place ranging from consultant led see and treat clinics, coaching team programmes, access to phlebotomy and virtual U&E care clinics.

Medical care (including older people's care)

Facts and data about this service

James Cook University Hospital and Friarage Hospital are the two acute hospitals forming South Tees Hospitals NHS Foundation Trust. The trust provides acute hospital services to the local population as well as delivering community services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland.

The trust had 75,067 medical admissions from July 2017 to June 2018. Emergency admissions accounted for 32,360 (43.1%), 2,639 (3.5%) were elective, and the remaining 40,068 (53.4%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 27,935

- Gastroenterology: 11,412

- Clinical haematology: 8,361

(Source: Hospital Episode Statistics)

The James Cook University Hospital: 394 beds

- Ward 12

- Ward 14

- Ward 2

- Ward 26

- Ward 27

- Ward 28

- Ward 29

- Ward 3

- Ward 33

- Ward 4

- Ward 6

- Ward 9

- Ward 15 acute assessment unit

- Ward 1 Rapid Access Frailty assessment unit

- Ward 37 acute medical unit

- Ward 29 Monitored bay

- Coronary care unit

- Spinal injuries unit

The University Hospitals of South Tees (UHST) was last inspected in October 2016 to confirm whether the trust had made improvements to its services since our previous comprehensive

inspection in December 2014. At that time, medicine services at The James Cook University Hospital (JCUH) received an overall rating of good, with the key domain rated as good in safe

Following our inspection of the service in 2016, no requirement notices were issued for medical services at JCUH.

Actions we said the hospital SHOULD consider taking to improve, were:

- Ensure that the emergency nurse call bell in wards 10 and 12 is reviewed to ensure it is fit for purpose.

- Continue to review the level and frequency of support provided by pharmacists and pharmacy technicians to ensure consistency across wards.

- Ensure medication processes are followed consistently particularly 'do not disturb' procedures for staff completing medicine rounds.

- Ensure that that the frequency of controlled drug balance checks are carried out in line with national guidance.

- Ensure that the end of life strategy is approved and implemented and move to develop a seven-day palliative care service.

- Continue to develop plans to ensure appropriate staffing levels on wards, particularly in the neonatal unit to meet the British Association of Perinatal Medicine guidelines.

At our most recent unannounced inspection, 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 medical service areas on ward 1 (rapid access frailty assessment unit), ward 15 (acute assessment unit), ward 12 (geriatric medicine), ward 28 (stroke rehabilitation), ward 3 (diabetic and endocrinology unit), ward 9 (respiratory), endoscopy unit, coronary care unit and the cardiac catheter suite.

We observed care and treatment, looked at 14 complete patient records (and specific documentation in five others, including consent, mental capacity and deprivation of liberty safeguards documents) and 11 prescription charts. 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 14 patients, three relatives and 32 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 medical services.

Is the service safe?

Mandatory Training

Mandatory training completion rates

The trust set a target of 90.0% for completion of mandatory training. There was a deterioration since the last inspection in 2016 where overall compliance for both nursing and medical staff was greater than 90%.

On inspection we were told that mandatory training was discussed and planned with individual staff members to ensure that staff had capacity to complete them either on line or attend face to face training. Senior management advised us that mandatory training was taken seriously. We were told that the lead officer and the corporate team were working hard with individual

directorate areas to improve compliance at a local level to meet the target by quarter four. Additional mandatory and safeguarding training sessions had been implemented at differing times for medical staff to increase compliance.

Across the trust in medicine the 90.0% target was met for seven of the 12 mandatory training modules for which qualified nursing staff were eligible. At the James Cook University Hospital medicine departments, the 90.0% target was met for 10 of the 24 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from October 2017 and September 2018 for qualified nursing staff in the medicine departments at the James Cook University Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Clinical Risk Assessment	9	9	100.0%	90.0%	Yes
Triennial Review	58	58	100.0%	90.0%	Yes
Mentor Update	58	58	100.0%	90.0%	Yes
Equality and Diversity	557	581	95.9%	90.0%	Yes
Health and Safety (Slips, Trips and Falls)	554	581	95.4%	90.0%	Yes
Dementia Awareness (inc Privacy & Dignity standards)	334	353	94.6%	90.0%	Yes
Falls prevention inpatient training	188	199	94.5%	90.0%	Yes
Information Governance	543	581	93.5%	90.0%	Yes
Fire Safety 3 years	541	581	93.1%	90.0%	Yes
Infection Prevention (Level 1)	532	581	91.6%	90.0%	Yes
Anaphylaxis awareness	119	137	86.9%	90.0%	No
NEWS 2	37	43	86.0%	90.0%	No
Conflict Resolution	169	220	76.8%	90.0%	No
Blood Transfusion	359	480	74.8%	90.0%	No
Manual Handling - People	403	551	73.1%	90.0%	No
Basic Life Support	5	7	71.4%	90.0%	No
Adult Basic Life Support	239	350	68.3%	90.0%	No
Immediate life support - ILS	159	233	68.2%	90.0%	No
Falls prevention for community staff	4	6	66.7%	90.0%	No
Advanced life support - ALS	35	53	66.0%	90.0%	No
Prevent -WRAP	366	579	63.2%	90.0%	No
2 day Community Care Centre Development Programme	2	4	50.0%	90.0%	No

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Paediatric Immediate Life Support - PILS	1	3	33.3%	90.0%	No
Learning Disability Awareness Training	1	5	20.0%	90.0%	No

Across the trust in medicine the 90.0% target was met for none of the 11 mandatory training modules for which medical staff were eligible. At the James Cook University Hospital medicine department, the 90.0% target was met for two of the 20 mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from October 2017 and September 2018 for medical staff in the medicine department at the James Cook University Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Advanced paediatric life support – APLS	7	7	100.0%	90.0%	Yes
Paediatric Immediate Life Support - PILS	2	2	100.0%	90.0%	Yes
Health and Safety (Slips, Trips and Falls)	222	261	85.1%	90.0%	No
Advanced life support - ALS	25	30	83.3%	90.0%	No
Equality and Diversity	217	261	83.1%	90.0%	No
Information Governance	217	261	83.1%	90.0%	No
Fire Safety 3 years	204	261	78.2%	90.0%	No
Infection Prevention (Level 1)	199	261	76.2%	90.0%	No
Anaphylaxis awareness	6	8	75.0%	90.0%	No
Adult Basic Life Support	137	187	73.3%	90.0%	No
Dementia Awareness (inc Privacy & Dignity standards)	34	49	69.4%	90.0%	No
Blood Transfusion	137	211	64.9%	90.0%	No
Basic Life Support	40	65	61.5%	90.0%	No
Falls prevention inpatient training	20	35	57.1%	90.0%	No
Manual Handling - People	88	154	57.1%	90.0%	No
Prevent -WRAP	137	260	52.7%	90.0%	No
Immediate life support - ILS	2	4	50.0%	90.0%	No
Conflict Resolution	17	38	44.7%	90.0%	No
Learning Disability Awareness	0	3	0.0%	90.0%	No

Training					
Prevent - BPAT	0	1	0.0%	90.0%	No

Safeguarding

Safeguarding structures and processes were embedded and established within the organisation. We saw that the trust had 'adults at risk' and 'safeguarding children' policies in place that staff could access on the trust's intranet.

Staff were aware of safeguarding procedures, how to make referrals and access advice; there were safeguarding leads throughout wards and a head of safeguarding in place. Staff could describe circumstances when they had made a safeguarding referral.

The trust instigated monthly quality assurance rounds to audit practice and provided training and education to frontline staff in the clinical environment in both adult and children inpatient areas (adult areas on rotation).

The quarterly strategic safeguarding group reported to the quality assurance committee, chaired by the director of nursing (board lead) and attended by both Clinical Commissioning Groups (CCG's).

Safeguarding training

The trust set a target of 90.0% for completion of safeguarding training.

At trust level in medicine the 90.0% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible. At the James Cook University Hospital medicine department, the 90.0% target was also met for three of the four safeguarding training modules for which qualified nursing staff were eligible. A breakdown of compliance for safeguarding training courses from October 2017 and September 2018 for qualified nursing staff in the medicine department at the James Cook University Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 3 Additional)	4	4	100.0%	90.0%	Yes
Safeguarding vulnerable adults	558	581	96.0%	90.0%	Yes
Safeguarding Children (Level 2)	539	576	93.6%	90.0%	Yes
Safeguarding Children (Level 3)	4	5	80.0%	90.0%	No

At trust level in medicine the 90.0% target was met for three of the five safeguarding training modules for which medical staff were eligible. At the James Cook University Hospital medicine department, the 90.0% target was also met for three of the five safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 and September 2018 for medical staff in the medicine department at the James Cook University Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion	Trust	Met

	(YTD)	(YTD)	rate	Target	(Yes/No)
Safeguarding Children (Level 3 Additional)	5	5	100.0%	90.0%	Yes
Safeguarding Children (Level 1)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 3)	5	5	100.0%	90.0%	Yes
Safeguarding Children (Level 2)	219	255	85.9%	90.0%	No
Safeguarding vulnerable adults	219	261	83.9%	90.0%	No

Whist the training compliance target failed to meet trust target, the 2018 figures were an improvement from the 2016 inspection results.

Additional safeguarding training sessions had been implemented at differing times for medical staff to increase compliance. We were assured by senior management that training remained high on the agenda and would be tracked by service managers in both clinical centres for acute and general medicine.

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

South Tees staff completed mandatory mental health awareness training as an e-learning package. They also completed a mandatory combined course on the mental capacity act and deprivation of liberty safeguards and a separate course on safeguarding levels 1-4 depending on the grade of staff.

The learning disability (LD) nurse offered additional LD training, which was not mandatory but there were plans to incorporate this within the mandatory safeguarding training in the future. Conflict resolution training was mandatory within safeguard training.

Current training arrangements included a number of elements of delivered training. Safeguarding and learning from incidents was a thread that ran through other processes.

Element	Who	Mandatory	Description
ELearning	All staff	Yes	Short introductory package
Mental Capacity Act	All clinical staff	Yes	Principles of MCA/DoLs and application to clinical practice
Safeguarding adults individual training	Clinical Matrons	Yes	Individualised package for staff undertaking safeguarding enquires
MHA training	All staff who are 'Designated staff members	Yes	Delivered training on safeguarding the rights of patients detained under the Mental health act.
Mental Health Awareness training	All staff	Yes	Introduced in 2018 as part of the 'Treat as One' agenda. 70% compliance achieved within the year.
Learning Disabilities training	All staff	No	Care of adults with learning disabilities including reasonable adjustments
Safeguarding adult board training	All staff	No	Range of courses & training available
Tool box teaching	All staff	No	Safeguarding adults quality assurance rounds

Leadership day programme	B7, B6, B5 and Healthcare Assistants quarterly forum	No	Partnership perspective of safeguarding procedures explored as case studies
Individualised training programmes	Safeguarding Nurses	Yes	Individual training programmes are devised for members of the safeguarding team including local and regional training as well as self-directed study. This is monitored via the SDR process.
Core mandatory training programme	Junior medical Staff	Yes	Safeguarding cases/MCA focusing on medical practice

Cleanliness, infection control and hygiene

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene. Staff completed infection prevention and control training; compliance for nursing staff was 91.6% and 76.2% for medical staff. (See mandatory training breakdown for JCUH).

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. 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.

There were systems such as schedules and completed cleaning records in place to ensure the clinical areas and equipment were cleaned regularly and appropriately. Equipment was labelled as clean and ready for use.

Wards we visited reported low or no cases of clostridium difficile (C. diff) and Methicillin Resistant Staphylococcus Aureus (MRSA). Staff described how they worked with the trust's infection prevention control team on a programme of quality improvement at ward level.

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 on corridors.

We observed staff using personal protective equipment when required, and they adhered to 'bare below the elbow' guidance. Staff were seen using personal protective equipment and handwashing before and after patient contact.

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. The average hand hygiene self-assessment audit score between April 2017 and March 2018 was 94% and the peer review average was 93%. Peer reviews were conducted by infection prevention and control nurses (IPCNs) and clinical matrons during monthly clinical assurance rounds and independent reviews were carried out by therapeutic care volunteers. Results were submitted electronically to the matron and action plans were generated where necessary. We saw results on display on each ward that we visited highlighting compliance.

To support staff in maintaining levels of infection control, wards benefited from dedicated housekeepers and a central trust domestic team. Housekeepers kept the sluice area clean and tidy and ensured commodes were cleaned and ready for use. Waste was separated and disposed of in appropriate colour coded bags.

The wards had a link nurse for infection control. Side wards 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.

The trust had introduced an environmental support worker role on acute wards on the JCUH site since the last inspection. The role supported 12 hours per day, seven days per week to support bed and equipment cleaning, ensuring high standards of cleanliness, reducing risk and releasing nursing time.

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 does not cover clinical care provision or evaluate how well staff are doing their jobs. The assessments involve members of the public, former and current patients and members of Healthwatch, who look at a selection of wards and departments against different criteria which is 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 98.35% which was marginally higher than the national average of 98.5%. For condition, appearance and maintenance the trust scored 96.38% which was higher than the national average of 94.3%.

There were processes in place to quality assure the cleaning of scopes within the endoscopy department and a system to ensure scope use was fully traceable, through an information technology (IT) system as well as in patient records. The unit manager told us that all staff received an annual refresher regarding decontamination of equipment and that manufacturers of equipment provided training for staff when needed.

Environment and equipment

Equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. However, on inspection we observed two defibrillators in the cardiac investigations unit situated within the cardiac catheter suite which had out of date service stickers dated (November 2018). This was escalated to senior management at the time of the inspection. We were assured by senior management that this would be investigated and actioned.

Post inspection we were notified that the defibrillators in the cardiology catheter suite were due to be replaced. The new devices had been commissioned and were being installed by the resuscitation training team. The completion of the roll-out was due to conclude by mid-February 2019. We were assured that all defibrillators carried out an automated daily self-check, clinical staff also carried out a weekly shift check to verify full functionality of the device. The device itself incorporated a "Ready for Use" indicator which alerted clinical staff of any failures in the user checks.

There were some environmental challenges for staff in the endoscopy unit. The unit had Joint Advisory Group (JAG) accreditation (certificate JAGWEB/0137); however, the last accreditation review (December 2018) had highlighted non-compliance with regard mixed sex patient flow. A six-month action plan had been put in place to address this issue. Staff gave assurance on inspection that the trust were working to address this.

There was a room set aside on the endoscopy unit for post-procedure discussions with patients and their families. Staff in endoscopy and the cardiology unit received training for specialist equipment from the manufacturers who came into the hospital when necessary.

Emergency resuscitation equipment on each ward had daily and weekly checks completed in line with policy. 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 trolleys. Sharps bins were properly assembled, stored off the floor, not over full and signed and dated.

There was a seven-year planned programme of refurbishment for the tower block wards. Work was underway to refurbish ward 9, 10 and 12. The refurbishment was a planned 19-week project, we were assured on inspection by service managers that the project was underway. At the last inspection in 2016 it was noted that the nurse call system on wards 10 and 12 sounded the same as the cardiac arrest alert. Staff we spoke with told us that this continued to cause minor confusion and false alarms amongst staff. Ward 3 had been refurbished and the nurse and emergency call systems issue had been resolved as part of the programme.

Staff we spoke with reported they had enough equipment to provide safe care to patients e.g. moving and handling equipment and equipment for bariatric patients.

Assessing and responding to patient risk

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.

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. The service used a holistic approach to pressure ulcer prevention using a number of aid memoirs for individual patient assessment.

On admission all patients had an initial skin integrity body map assessment as part of the adult nursing care pathway. A Braden risk assessment, was used to record mobility, sensory perception, moisture, nutrition, friction and shear risks. The service had a pressure categorisation tool available to staff to identify high, medium and low risks. We met with the tissue viability nurse

lead to discuss her role within the service. We observed intentional rounding being completed by individual staff and observations recorded in individual patient care pathways.

We saw on inspection that patient falls risk assessments were completed on admission. Patients with a high risk of falling were placed in supervision bays close to the nurses' station so they could be easily monitored. Individual bay nursing was apparent on the wards that we visited, with each bay designated to a registered nurse and a healthcare worker. Patients requiring supervision to prevent falls were supported and we observed staff using appropriate distraction techniques with patients. Some wards had a number of beds which could be lowered to floor level if a patient was deemed at high risk of falls. We saw that walking aids and nurse call bells were within easy reach of patients. Anti-slip socks were used for patients at risk of falls who did not have appropriate foot wear. The trust had refreshed the falls prevention strategy reducing the rate of falls per 1000 bed days to 4.7 per 1000 bed days in 2018/19 (year to date) compared to 5.3/1000 bed days in 2017/18.

The trust participated in the 'End PJ Paralysis' campaign in April to June 2018 which provided the basis for a renewed focus on reducing deconditioning and supporting recovery particularly in the frail elderly; a group at high risk of falls. Display posters were evident on all wards that we visited. During inspection on ward 1, rapid access frailty assessment unit (RAFA) we observed a new delivery of electrical falls seat and bed monitor alarms. Staff explained that the devices would be an additional support assisting in reducing patients at risk of falls.

During our inspection we saw that deteriorating patients had evidence of appropriate escalation and intervention recorded via the national early warning score (NEWS 2) system. We observed that the service had a deteriorating patient policy which was in date, version controlled with a named author. Staff told us that doctors responded quickly when patients were escalated and there was a critical care outreach team out of hours to support the medical on-call team.

Post inspection we reviewed NEWS 2 audits for October, November and December 2018. Compliance scores evidenced good compliance with consistent scores of 100% across all medicine wards inspected.

Staff we spoke with described what they would do to treat and escalate sepsis. All patients with an elevated NEWS 2 score were considered for screening and escalation to senior medical staff. The trust used a nationally recognised sepsis-screening tool. Where applicable, we saw sepsis-screening tools in the notes we reviewed. The service had sepsis grab packs on individual wards and units. Further management, such as the use of the sepsis care bundle and antibiotics were implemented.

A network of sepsis champions had been introduced and there were currently 108 trained sepsis champions across the trust. The trust had a continuous awareness campaign for sepsis to ensure staff awareness and patient safety and continued to collaborate with regional colleagues to share and develop good practice in the assessment and management of the deteriorating patient.

The trust had a sepsis policy in place to provide best practice guidance to all staff involved in the care of patients presenting with sepsis. 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 NICE guidance (July 2016). We saw posters displayed on differing wards about the risk of sepsis.

The trust participated in the NHS England Commissioning for Quality and Innovation (CQUIN) for sepsis. This framework supports improvements in the quality of services and the creation of new, improved patterns of care. The trust audited compliance for timely identification of sepsis (screening), timely treatment of sepsis and assessment of clinical antibiotic review between 24

and 72 hours. The results were reported at trust level to monitor compliance and drive improvement where required. The levels of compliance for October (Q1), November (Q2) and December (Q3) can be seen below:

Sepsis CQUIN Overall compliance	Screening	Treatment	Review
Quarter 1	100%	84%	89%
Quarter 2	100%	95%	90%
Quarter 3	100%	81%	81%

We saw staff in the cardiac catheter lab and the endoscopy unit used a World Health Organisation (WHO) safer surgery checklist for patients undergoing procedures. Patients attending for procedures in these areas underwent pre-assessment screening to ensure they were fit to have the procedure and observations were taken during the procedures to monitor the patients' condition.

Patients stayed in recovery areas until they were fit to leave the department in both endoscopy and the cardiac catheter lab. There were two registered nurses on duty in this area as part of the staffing complement and all registered staff were trained in intermediate life support (ILS). All cardio-physiologists and consultants were trained in advanced life support (ALS). There was transfer and referral processes in place to ensure patients were transferred to tertiary centres for treatment when necessary.

Nurse staffing

The trust has reported their staffing numbers below as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
The James Cook University Hospital	413.3	450.7	109.1%
Trust level	618.2	637.7	103.2%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates
From October 2017 to September 2018, the trust reported a vacancy surplus rate of 1.0% in medicine. The James Cook University Hospital had a surplus of 11.3%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From October 2017 to September 2018, the trust reported a turnover rate of 8.0% in medicine, which was in line with the 10% trust target. The James Cook University Hospital was 7.1%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From October 2017 to September 2018, the trust reported a sickness rate of 4.9% in medicine this did not meet the trust target of 3.5%. The James Cook University Hospital was 5.0%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)
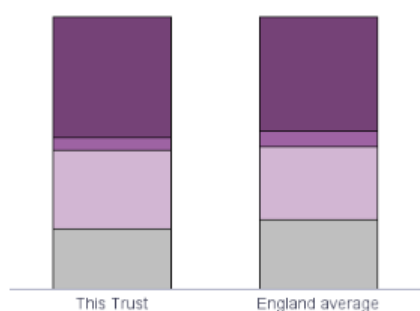
Bank and agency staff usage

From October 2017 to September 2018, the trust reported a bank usage rate of 364.5% an unfilled rate of 13.9% and no agency usage in medicine. The trust use bank staff for extra activities, for example to sit with patients at risk. This had led to a large bank staff usage rate.

All nursing staff

Site	Bank rate	Agency rate	Unfilled rate
The James Cook University Hospital	377.8%	N/A	10.5%

Qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
The James Cook University Hospital	231.1%	N/A	34.3%
Trust level	221.4%	N/A	34.5%

Non-qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
The James Cook University Hospital	580.5%	N/A	Surplus of 22.4%
Trust level	566.7%	N/A	Surplus of 15.1%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

During this inspection, we found improvement in planned and actual staffing levels and ratios of nurses to patients, with one nurse to six or eight patients during the day and one nurse to a maximum of 12 patients overnight (dependant on acuity on specialty wards), with good healthcare assistant support and escalation policies in place. Nurses assessed patient acuity levels and planned to staff wards according to demands.

The trust had taken a proactive approach to registered nurse (RN) recruitment to address the national supply challenges. There was a current vacancy rate of 3.5% in band 5 RN's. This was the lowest vacancy rate for the last three years and compared favourably with the national picture. At the last inspection we noted a 6% vacancy rate for nursing staff at the JCUH site, on this inspection there was an improved picture of a surplus 11% vacancy rate.

Senior management informed us that care hours per patient day (CHPPD) were consistent with peers, with the latest published data (July 2018) showing an overall CHPPD at South Tees of 8.6 CHPPD (Peer 8.9 and National Average 8.1).

Actual fill rate against planned had been over 90% for both registered nurses (RNs) and healthcare assistants (HCAs) since March 2018 with well-established processes for escalation should levels fall short of those planned.

A duty matron role was introduced in 2017 to ensure senior presence seven days per week, a key focus was to ensure safe staffing. We found that wards had supernumerary co-ordinators and ward managers had dedicated management time / days. Ward managers told us they were supported by senior matrons.

Each specialty assigned one individual to review and adjudicate on all exception reports rather than each educational or clinical supervisor. This gave assurance at senior level showing clear lines of accountability through clinical directors, guardian of safe working and the director for medical education for issues that were not resolved.

Nursing rosters were assessed monthly against key performance indicators (KPIs). Agency nursing had been eliminated with temporary staffing provided by National Health Service (NHS)

professionals with need assessed daily by the senior nursing team to ensure both safe and efficient staffing.

Medical staffing

The trust had reported their staffing numbers below as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
The James Cook University Hospital	83.5	76.5	91.6%
Trust level	294.2	270.8	92.1%

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy rate of 8.2% in medicine. For the James Cook University Hospital it was 7.2% which was lower than the trust vacancy rate.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 19.5% in medicine, this was not in line with the trust's 10% target. For the James Cook University Hospital it was 17.8%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 1.7% in medicine this did meet the trust target of 3.5%. For the James Cook University Hospital it was 1.5%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From October 2017 to September 2018, the trust reported a bank usage of 2.1% and locum usage rate of 1.0% in medicine. For the James Cook University Hospital it was bank 1.9%, locum 1.7%.
 (Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In July 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 297-whole time equivalent staff working in medicine at South Tees Hospitals NHS Foundation Trust

	This Trust	England Average
Consultant	44%	42%
Middle career^	5%	6%
Registrar group~	29%	27%
Junior*	22%	25%

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

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

Senior management explained that the trust was committed to ensuring that they had safe and sustainable medical staffing levels for consultants. We were assured that the trust identified these areas through directorate feedback but also through monitoring job plans, locum demand and the need for additional payments. Any areas where these factors demonstrated potential understaffing remedial plans had been put in place.

For junior medical grades, rota gaps were a nationally recognised challenge, particularly in certain specialities, and within the postgraduate. The education team worked closely with clinical directors, Health Education England North East (HEENE) and the rota team to identify these well in advance and put mitigating strategies in place.

Locally employed doctors (staff grade etc.) had support with career development through regular appraisal and targeted support for a certificate of eligibility for specialist registration (CESR) application and/or entry into formal training grades.

Medical Staffing for acute assessment of medical patients at the weekend only had one consultant rostered due to small numbers; however, they required three. The service was managing to fill this gap by all consultants undertaking additional shifts. Some of them had up to 13.5 programmed activities per week (typical week 10 programmed activities a week). Whilst this was not sustainable long-term we were assured that additional medical recruitment had been sourced. The service had two vacancies for thoracic medicine one of which had been filled. We were told that job plans had been annualised which assisted in smoothing peaks and troughs of workload. The trust continued to actively advertise for consultant posts.

The medical services had daily consultant ward rounds for both acute and speciality wards. Service had appointed junior doctor support for each consultant on duty to ensure that all consultants on medicine ward rounds had junior support which improved throughput, patient experience and continuous learning and support.

In Health Education England North East (HEENE) local general medical council (GMC) rankings by trust 2018, South Tees were the best performing educational large acute hospital trust. Reflecting delivery of training and pastoral care for trainee doctors.

Records

We reviewed 14 patient care records during our inspection. Nursing records were completed legibly and daily evaluations were evident but there were several gaps in documentation. For example, five of the thirteen records reviewed did not evidence patient and or family discussions or involvement in care planning. Three out of thirteen care plans were mostly standardised with little evidence of individual needs assessed and full completion. We escalated this at the time of inspection on the ward with the unit manager who agreed to review and action immediately.

We found medical notes were comprehensive and all patients had a documented history and plan of care. There was clear evidence of medical review within 14 hours of admission, ongoing medical reviews and multidisciplinary involvement where needed.

Staff had recorded outcomes following reviews and discussions with the multidisciplinary team,. We saw good examples of do not attempt cardio pulmonary resuscitation (DNACPR) which included discussions with patients and family.

However, we had concerns about the security of records on the wards. We found that patient records were not secure in ward areas. Records were stored in open, unlocked trolleys, the trolleys did have lids with locks; however, the trollies were not locked. Although the trolleys were next to nursing stations where there were staff present most of the time there was no assurance that these areas were never left unattended.

There was a mixture of electronic patient records and paper records. The trust had implemented and embedded the use of an electronic system for recording of patient physiological observations. Staff had a good understanding of the use of the equipment and how the system supported monitoring and recording changes in patient observations.

Data provided by the trust, showed that 83.1% of medical staff and 93.5% of nursing staff had completed information governance training, the trust target was 90%.

We reviewed the trust wide records audit for both medical staff records and nursing staff records. Audit compliance for both audits can be seen below:

Records Audit Overall compliance (average)	Medical Staff	Nursing Staff
October	97%	97%
November	97%	97%
December	96%	96%

Electronic patient status at a glance boards (e-PSAG) were visible on all units we visited. The boards displayed patient information. On admission the admitting nurse explained to the patient/relatives/carer the purpose of the e-PSAG board and the information displayed. Explicit consent to use a patient's data on a large electronic screen was sought and documented in the patient's notes. Where a patient lacked capacity to consent, the nurse would take a decision, in the best interests of the patient, around the use of this information. The trust had a standard operating procedure (SOP) for the e-PSAG. We reviewed the SOP post inspection which was in date, version controlled and had a named author.

The Information governance team had authorised the use of the patient's first name, surname, hospital number, consultant, specialty, admission date (& derived length of stay) as well as their expected date of discharge on the board. The information governance team had also approved the use of a standard set of status flags which did not carry wording, letters or icons that could give any concern to patients or indicate any information to visitors on a ward.

We reviewed specific records for patients who had mental health (MH) needs; they clearly showed involvement from the psychiatric liaison team (PLT). All records showed consideration of capacity where concerns had been identified and included an assessment of cognitive impairment (using the 4AT tool) and a deprivation of liberty safeguards (DoLS) application where applicable. Staff used a two-stage assessment of capacity in line with the mental capacity act code of practice. Examples of situations where capacity had been assessed included a patient who was removing their dressing and a patient who presented with aggressive behaviour and wanted to leave hospital.

Records contained evidence of specific care plans for delirium and generic confusion. One record contained a behaviour support plan, developed in conjunction with the PLT to support a patient who presented as agitated and aggressive with staff. Where a patient was on enhanced observations, the recording chart was present in their notes.

The PLT staff could print off certain mental health documents such as risk assessments and care plans and put a copy in the patient's paper file so that staff had access to them.
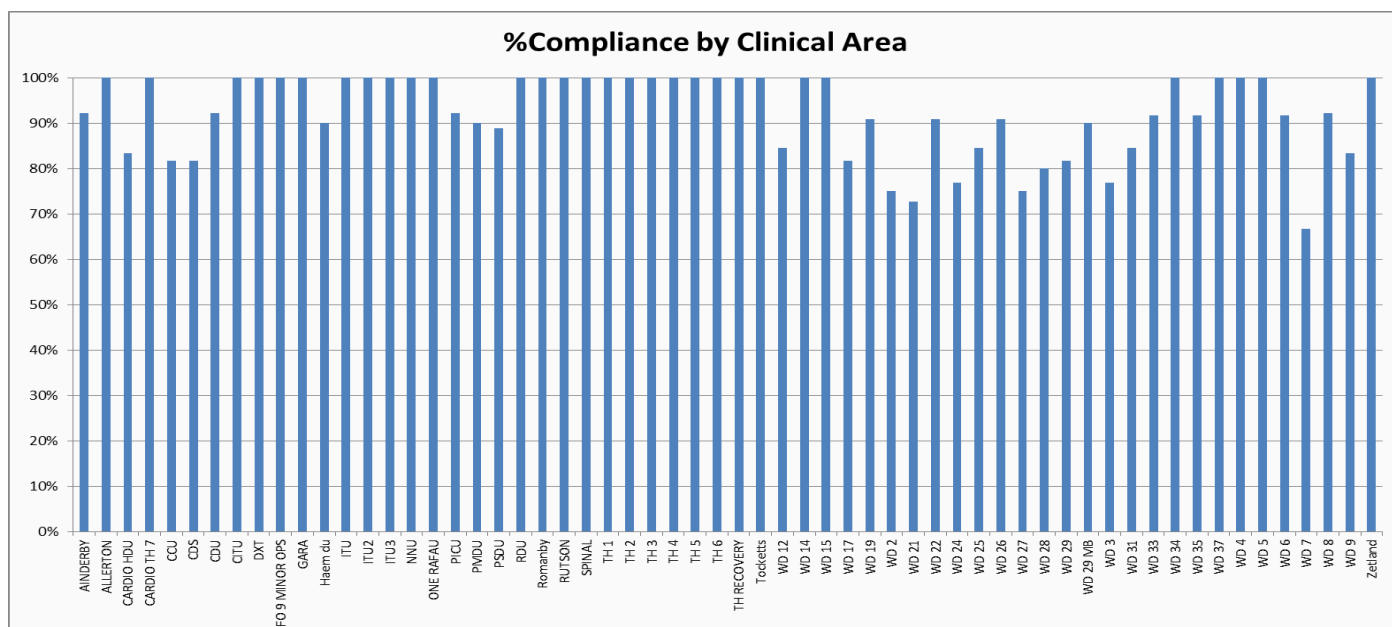
Medicines

The service followed best practice guidance when prescribing, giving, recording and storing medicines. We observed staff dispensing medication with the lead nurse wearing a red tabard to highlight 'do not disturb' during medication rounds. Staff assured us that medication processes were followed consistently and priority given to staff when dispensing medication to promote safety and culture. This was an improvement since the last inspection in 2016.

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 manufacturers'' recommended range of 2-8°.

We saw evidence on wards for medicine storage that room temperatures were checked and recorded daily. There were some inconsistencies for example on ward 3, where the room temperature had been recorded above 30 degrees centigrade for 16 days with no escalation to pharmacy staff. This was escalated at the time of inspection and we were assured that ward staff had been informed of the need for escalation and review as per trust policy. We found that allergies and weight were recorded on all medicine charts we looked at.

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. We reviewed the CD audit of ward controlled drugs meeting minutes (October 2018/19, Quarter 3). The audit measured compliance with CD cupboards, stock management, documentation and signature lists.

The audit results evidenced the compliance for clinical areas ranged from 67% to 100% compliance with the average of 92% across the trust both at Friarage Hospital and James Cook Hospital. The raw data for this audit was shared with the clinical pharmacy teams so they could assist in identifying areas of non-compliance within clinical areas as well as sharing areas of good compliance. This was confirmed on inspection by unit managers who gave assurance that lead pharmacists escalated poor compliance and worked with individual wards where further training and awareness was required.

%Compliance by Clinical Area

(Source, Controlled Drugs Audit data request DR19 & 30)

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 most wards. On the stroke ward (ward 28) we observed no opened date sticker system for bottled liquid medications. This was escalated to senior staff at the time of inspection.

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 reviewed 11 patient prescription records and spoke with four patients about medication management and found that pharmacists checked (reconciled) patients' medicines on admission to hospital. At our last inspection, we found compliance for medicines reconciliation for patients within 24 hours of admission was 90%. At this inspection we found the 24-hour medicines reconciliation compliance rate had deteriorated to 58.5% in (December 2018) against a trust target of 80%.

We reviewed the medicines reconciliation audit annual report 2018 which highlighted in the last 12 months the compliance with the standard had varied between 20% and 54.8%. Whilst there was a downward trend in compliance between October 2017 and March 2018, there had been a defined upward trend from April 2018 to September 2018. The report highlighted increasing pressures during the winter months, correlating to increased admissions, leading to an overall decrease in compliance. During October 2017 and March 2018 there was up to 20% of staff vacancies across the pharmacy department. However, in the last 4-6 months the department had started to successfully recruit to these vacancies within the clinical teams. Medicines reconciliation was listed as a key focus moving forward within the quality priorities for 2018/19.

Since April 2018, the medicines reconciliation figures, along with other metrics, had been shared monthly on the medicines management dashboards. Both hard and electronic copies of the 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 reconciliations when on the wards.

The trust had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of antimicrobial resistance. For example, the local antimicrobial formulary was available to all staff via the trust intranet. To strive for further improvement the trust was participating in a National Institute for Health Research (NIHR) sponsored research programme, the antibiotic review kit (ARK) trial which aimed to substantially reduce antibiotic overuse through better "review & revise" of antibiotic prescribing decisions. The in-patient medication administration record had been redesigned to incorporate a mandatory three and seven day antimicrobial review. The review targeted antimicrobial revision and de-escalation as appropriate.

We found that all patients we reviewed had been prescribed appropriate prophylaxis for Venous Thromboembolism (blood clots) where this was indicated.

During inspection pharmacy staff told us that omitted dose was one of the key metrics in the medication safety quality priority for 2018/19. The target was to maintain all omitted doses below 5% and omitted doses of critical medicines below 2%. The compliance results for omitted doses in December 2018 was 2.95% with critical medicines scoring 1.35%. The trust had achieved the target level since May 2018.

There was no trust policy for rapid tranquilisation (RT) for patients with mental health needs. The service followed the local mental health trusts policy for RT. Staff we spoke with were unclear regarding the management of RT and were not following national guidelines. NICE guidance clearly states: 'Rapid tranquilisation is a potentially high-risk intervention that can result in a range of side effects linked to the medication and dose. People given RT need to be monitored at least every hour until there are no further concerns about their physical status'. We looked at the records of two patients who had received RT and there was no evidence that staff had completed regular patient observations following the administration of RT medication. We also found the prescription records were written for post oral/intra muscular injection which was not in line with best practice.

Incidents

The service managed patient safety incidents well. Staff recognised incidents 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 we spoke with were aware of the reporting system and could tell us when 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. Staff told us they received quality and safety updates monthly and emails, which included information and learning from incidents. The trust issued safety bulletins from the most recent safety alerts which were displayed on quality performance boards. We saw evidence of this on the wards we visited.

Most staff could describe the process they used in relation to the duty of candour and gave examples of when they had used it such as after a fall with harm.

We reviewed minutes from the hospital's mortality and morbidity meetings, which showed discussion and learning points from the review of mortality cases and pathway audit. Themes were identified and cases were referred to the appropriate governance group or committee for further

consideration if thought appropriate. We saw that actions included where the learning points were to be shared and that this included nursing staff groups as well as medical staff.

During inspection we observed the flow chart for the process to support early identification and investigation for patient safety incidents. The chart had five steps of progression to support staff and assist in the decision-making process surrounding incidents.

Six senior staff had undertaken national health safety investigation (NHSI) training in 2018.

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 October 2017 to September 2018, the trust reported one incident classified as a never event for medicine at JCUH in the cardiology catheter laboratory in June 2018:

The patient attended for first stage leadless cardiac resynchronization therapy defibrillator (CRT-D) device, at the end of the procedure it was noted a swab was missing during the wound suturing. The incident was detected at the end of the procedure before the patient left the cardiac catheter laboratory (CCL). Investigation proved the swab had been retained in the wound. The wound was reopened and retrieved immediately.

(Source: Strategic Executive Information System (STEIS)

We reviewed the root cause analysis (RCA) and comprehensive investigation carried out on this never event. The RCA detailed the background and summary of the event, the involvement and support of the patient, relatives and carers as well as the involvement and support of staff. Contributory factors including root causes as well as lessons learnt; findings and conclusions were clearly identified. The RCA highlighted that detection of the incident could have been made prior to closure/suturing of the wound, thereby avoiding the need for re-opening.

During inspection we spoke to cardiology staff who informed us that never events were taken seriously and fully reviewed. Staff could explain lessons learnt and actions taken to prevent recurrence of the above incident. RCA findings were disseminated throughout the process at CCL team meetings and cardiology directorate meetings in August and September 2018. The incident was discussed at centre level, centre board and Trust wide (patient safety sub group).

On review of the RCA action plan (version 8, final 25th September 2018) during inspection it was evident that a number of actions remained open (six open, four amber and two red). We requested an updated action plan and additional audit data of the WHO safety checklist to seek assurance of safety check compliance within the CCL. The never event was not listed on the trust wide risk register to highlight concern regarding current risk surrounding ongoing actions.

We reviewed the preoperative site marking, correct site surgery and correct site regional anaesthesia policy (G25). The policy did not have a catheter laboratory specific safer surgery check list embedded within the document. The theatre safe surgery check list embedded within the document had an out of date review date (June 2014).

Post inspection we reviewed an amended and updated action plan (version 12, 24th January 2019) surrounding the never event in the catheter laboratory. We noted that a review of the action plan had been implemented at the trust directorate meeting in February 2019. One outstanding action

remained as amber; a local safety standard for invasive procedures (LocSIPP's) had been drafted and was awaiting sign off by the trust board.

Following a senior review there was a consensus for the WHO checklist to be clinician lead, this was added as an agenda item at the cardiology consultant meeting in February 2019. Individual consultants were notified of the need to adhere to this process. Audit practice of the swab and needle count check undertaken in October 2018 highlighted low compliance scores in two sections of the audit:

- Prior to local anaesthesia administration – 69%

- Before the patient leaves the catheter laboratory – 42%

We were advised that an additional WHO check list audit would be instigated and completed by the end of February 2019 to evidence awareness, consistent practice and compliance.

The service had requested staff to re-read and sign the trust policy relating to the swab needle and instrument count policy (G46) to give assurance of awareness and understanding. We reviewed the swab and needle check policy (G46) which was in date, had a named author and was version controlled.

We inspected the department post inspection and observed that white boards had been wall mounted in each catheter laboratory.

We reviewed nursing (September 2018) and cardiology directorate (September 2018) meeting minutes which evidenced discussion of the never event and subsequent learning and actions outstanding.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 43 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from October 2017 to September 2018.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with 17 (39.5% of total incidents).

- Pressure ulcer meeting SI criteria with 16 (37.2% of total incidents).

- Treatment delay meeting SI criteria with five (11.6% of total incidents).

- Sub-optimal care of the deteriorating patient meeting SI criteria with two (4.7% of total incidents).

- Information leak/ information governance breach incident meeting SI criteria with one (2.3% of total incidents).

- Medical equipment/ devices/disposables incident meeting SI criteria with one (2.3% of total incidents).

Site specific information can be found below:

- James Cook University Hospital: 38

(Source: Strategic Executive Information System (STEIS)

Safety Thermometer

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.
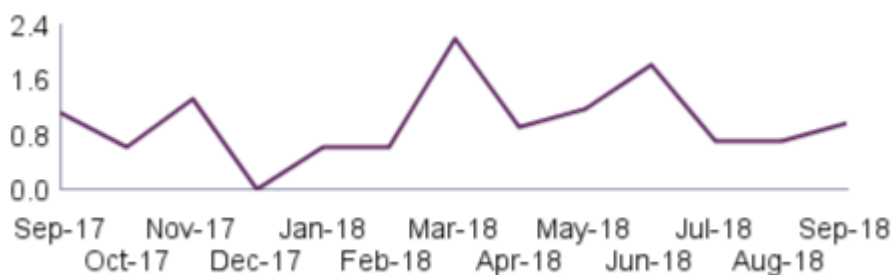
Data from the Patient Safety Thermometer showed that the trust reported 69 new pressure ulcers, 29 falls with harm and 58 new urinary tract infections in patients with a catheter from September 2017 to September 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at South Tees Hospitals NHS Foundation Trust

Total Pressure ulcers (69)

Total Falls (29)

Total CUTIs (58)

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 - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Care and treatment was based on relevant national guidance with systems and processes in place to benchmark and monitor outcomes. Trust policies and clinical pathways were based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE).

Staff had access to trust policies via the trust intranet hub. Patient records showed staff used a number of 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 medical wards. We found that these followed nationally recognised best practice and current evidence base. We were advised on inspection that the trust was to roll out a new nursing pathway and documentation in February 2019 that would further support frailty screening.

We reviewed specific pathways for patients receiving non-invasive ventilation (NIV) and found they were in accordance with best practice and British Thoracic Society (BTS) guidelines. We also noted care pathways for patients with stroke receiving thrombolysis and therapy treatment.

Nutrition and hydration

We reviewed care plan documentation; risk assessments were fully completed and fluid, food and rounding charts were completed appropriately. All patients using healthcare and care services were screened to identify those who were malnourished or at risk of becoming malnourished.

Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. The Malnutrition Universal Screening Tool (MUST) tool was used to identify adults who were malnourished or at risk of malnutrition. Patients were assessed regarding their general nutritional needs and these were recorded in care plans; patients were referred to the dietician for additional advice if required.

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 if assistance was required. Drinks were readily available and were in easy reach of patients.

On the stroke ward (ward 28) we found that health care support workers had been trained by the speech and language therapists to follow specialist feeding care plans. A range of textured meals and drinks was available.

Patients on the endoscopy unit were advised about fasting and bowel preparation at a pre-assessment clinic. They had seen an improvement in the numbers of patients attending for procedures who had been fasting for the correct length of time and not for several hours longer than necessary. Staff offered endoscopy patients a snack and drink following their procedure.

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 82.17% which was lower than the national average of 90.52%.

Individual multicultural patient needs were catered for including, vegetarian, vegan and halal choices. Drinks were readily available and in easy reach of patients. 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.

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

We reviewed care plans related to pain management. Pain assessment was carried out and recorded in patient notes. Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief was accessed through medical staff, if required.

Patients we spoke with had no concerns about how their pain was controlled and staff checked that pain relief administered had been effective. We were assured about the assessment of pain for those patients who may not be able to communicate when in pain.

Staff used a pain-scoring tool to assess patient's pain levels; staff recorded the assessment on paper records. We saw evidence of pain scores in patient documentation reviewed. Pain assessment was monitored as part of the monthly quality indicators and performance was monitored through Safety@SouthTees processes which reported into the quality assurance committee.

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 trust took part in several national and local audits. In 2017/18 the organisation participated in 97% of national clinical audits and 100% of National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies.

Safety@SouthTees was launched in May 2017, an umbrella term which encompassed a number of multi-disciplinary strategies and service developments in both the hospital and community settings to improve quality and safety. Multi professional collaborative meetings were held each month. Agenda items focused on emerging quality and safety issues. Harm and compliance data

was presented alongside educational updates and facilitated group discussions at each meeting. Learning bulletins were distributed to staff at these meetings. The bulletin in June 2018 was about mental health and the treat as one strategy.

There was a monthly programme of nursing audits for adult in-patient medicine wards which included physiological observations, national early warning scores (NEWS 2), infection prevention and control and other patient safety indicators. The service used nursing quality indicators and each ward participated in the audit programme. We reviewed the quality indicators for December 2018. The results for the wards that we inspected evidenced a compliance range from 93-99%. We saw the results of the indicators on the performance boards which were discussed at team briefs to raise awareness and drive improvement. Results were used to inform ward development plans which identified areas for improvement and actions to improve.

Implementation of electronic 'patient status at a glance' boards across in-patient areas linked to information software systems to support real time data collection and visibility of capacity across the trust were evident on all medicine wards that we visited.

Sepsis audit had demonstrated continued improvement in all areas.

Risk of readmission

From June 2017 to May 2018, patients at The James Cook University Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions

- Patients in medical oncology had a higher than expected risk of readmission for elective admissions

- Patients in clinical oncology had a higher than expected risk of readmission for elective admissions

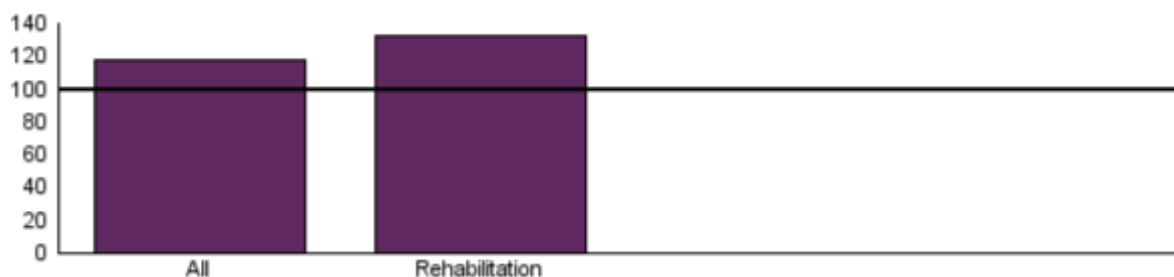**Elective Admissions -** *The James Cook University Hospital*
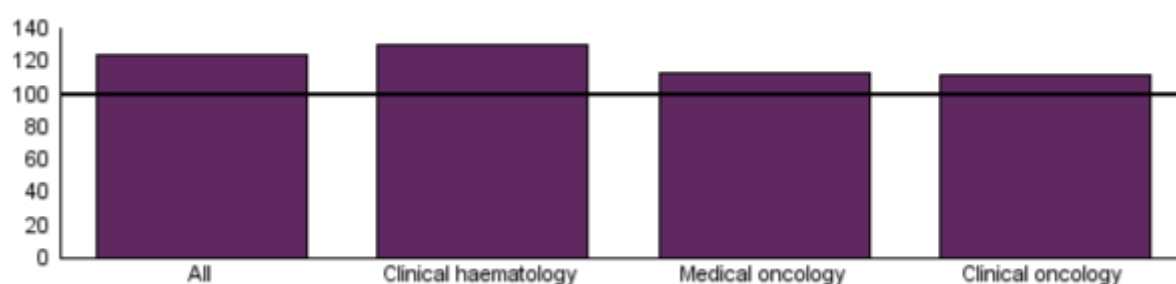
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of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

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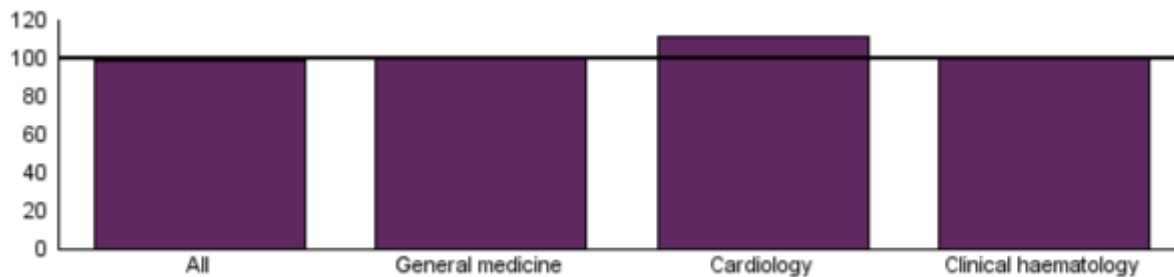
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of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

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- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions

- Patients in cardiology had a higher than expected risk of readmission for non-elective admissions

- Patients in clinical haematology had a slightly lower than expected risk of readmission for non-elective admissions

The trust was introducing services to help prevent readmission such as the introduction of an outpatient parental antibiotic therapy (OPAT) service for patients to attend and receive antibiotic therapy as an outpatient reducing length of stay and further reducing the risk of re admission. The service was led by advanced nurse practitioners with consultant support.

Sentinel Stroke National Audit Programme (SSNAP)

The James Cook University Hospital took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade A in latest audit, April to June 2018. From the January to March 2018 quarter the grades had stayed the same.

James Cook University Hospital

	Jan-Mar 18	Apr-Jun 18
Team-centred KI levels		
1) Scanning	A	A
2) Stroke unit[1]	B	B

	Jan-Mar 18	Apr-Jun 18
3) Thrombolysis	A	A
4) Specialist Assessments	B	B
5) Occupational therapy	A	A
6) Physiotherapy	B	B
7) Speech and Language therapy	C	C
8) MDT working	A	A
9) Standards by discharge	B	B
10) Discharge processes	B	B
Team-centred SSNAP level (after adjustments)	A	A
Team-centred Total KI level	A	A

Overall scores	Jan-Mar 18	Apr-Jun 18
SSNAP level	A	A
Case ascertainment band	A	A
Audit compliance band	A	A
Combined Total Key Indicator level	A	A

1 Included in IM reporting, indicator SSNAPD02

Best | A | B | C | D | E | Worst | N/A No assessment

(Source: Royal College of Physicians London, SSNAP audit)

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a cancer nurse specialist was 82.5%, which did not meet the audit minimum standard of 90%. The 2016 figure was 11.5%. Whilst the trust failed to meet the audit minimum standard for patients seen by a cancer nurse specialist there had been a positive increase since the 2016 inspection.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.9%. This is within the expected range. The 2016 figure was not significantly different to/significantly worse than the national level.

The proportion of fit patients with advanced NSCLC receiving Systemic Anti-Cancer Treatment was 74.7%. This was better than expected. The 2016 figure was significantly better than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 66.4%. This was within the expected range. The 2016 figure was not significantly different to the national level.

The one-year relative survival rate for the trust in 2016 was 35.5%. This was within the expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

Maintaining compliance against the 62-day cancer standard had been challenging and was an area of continued focus and one where the trust needed to deliver sustained improvement. The trust reviewed the weekly cancer performance wall, using data to drive improvement, attended by the multi-professional team.

In 2016 the trust recruited eight Macmillan cancer care coordinators in partnership with Macmillan cancer support and the local clinical commissioning group (CCG). Recruiting cancer care coordinators under this new model had significantly freed up nurse specialist time (which has been utilised more appropriately) whilst maintaining levels of face to face patient contact supporting improvements in both cancer patient experience and the 62-day target. Measuring impact of the role had been possible by the development of a bespoke intervention matrix within the trust. The model had been shortlisted in the workforce category of the Health Service Journal (HSJ) awards 2018.

The Trust had the most Macmillan quality environment mark awards in the UK.

National Audit of Inpatient Falls 2017

At the James Cook university hospital the crude proportion of patients who had a vision assessment (if applicable) was 89%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 50%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 30%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 64%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff

The service made sure nursing staff were competent for their roles. Managers appraised staffs' work performance and provided support and training to deliver safe and effective care.

There were clinical nurse specialists and clinical skills educators employed by the trust to provide advice support, education and training to staff in the medical clinical ward areas.

Staff told us they were supported with personal professional development and training to fulfil their role. Staff in cardiology told us they had received training from a clinical educator regarding electro cardio gram (ECG), telemetry, oxygen therapy, catheters and peripherally inserted central catheter (PICC) lines.

Staff on the stroke ward could attend an annual stroke update which included dysphasia assessment training. Nursing staff at band 5 and above on all wards also completed the mandated acutely ill management (AIMS) training course. Type 2 respiratory failure training was captured within NEWS 2 training which all staff had completed.

Endoscopy staff informed us they received training regarding decontamination, in the use of the equipment in the department and were given opportunity to attend the national annual conference. Some nursing staff had undergone specialist training to be able to undertake endoscopic procedures. There was clinical supervision in place for specialist nurse practitioners.

Staff on ward 9 (respiratory ward) had received additional training regarding non-invasive ventilation (NIV) and tracheostomy training, yearly competency assessments were instigated for nurses on the ward to care for these patients. Training was provided by the critical care outreach team (CCOT) who would initiate treatment and manage the patients at level 2 care. The care of patients would be handed over to ward staff when patients improved to level 1 or were transferred to critical care.

Newly recruited staff and student nurses told us they were supported by mentors. Newly qualified nurses said they had a preceptorship period and a supernumerary period when they first joined the trust. Staff told us they were competency assessed during their preceptorship period of 12months.

Some staff told us they had been supported with professional development and with undertaking additional training and courses outside of the trust.

Appraisal rates

From October 2017 to September 2018, 81.3% of staff within medical care at the trust received an appraisal compared to a trust target of 80.0%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
Qualified Allied Health Professionals (Qualified AHPs)	28	25	89.3%	Yes
NHS infrastructure support	42	37	88.1%	Yes
Medical & Dental staff - Hospital	310	271	87.4%	Yes
Support to ST&T staff	37	30	81.1%	Yes
Support to doctors and nursing staff	655	526	80.3%	Yes
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	5	4	80.0%	Yes
Qualified nursing & health visiting staff (Qualified nurses)	680	539	79.3%	No
Qualified Healthcare Scientists	39	29	74.4%	No

On wards we visited nursing appraisal meetings had been completed and compliance rates were above 80%.

Multidisciplinary working

Staff spoke positively about multidisciplinary team (MDT) working and said they had good working relationships between professions.

Referral pathways were in place for referral to the speech and language therapist, podiatrist and dietitian. Pharmacist and pharmacy technicians supported wards.

Staff reported they worked very closely with the local metal health trust to meet the needs of patients on the wards. The trust also had safeguarding link nurses and learning disability nurses who liaised with other agencies and community teams.

Specialist nurses were available to offer support, advice and training to staff in several specialist areas.

We saw that involvement from the MDT was documented in patients notes. This included input from the dietitian, physiotherapist, occupational therapist and the frailty team.

The trust had a clear healthcare professions strategy and in support of the recommendations in the allied health professionals (AHPs) into action paper was using allied health professionals to transform health, care and wellbeing. Intra professional working with occupational therapy was evident in the frailty and stroke units where professions worked together in a patient centred environment.

Advanced nurse practitioners (ANP's) were developing their role working front of house in ambulatory care and the assessment areas supporting the senior doctors to ensure patient flow was maximised.

Seven-day services

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

There was provision for ongoing therapy at weekends for patients undergoing rehabilitation, such as those who had suffered a stroke.

Health promotion

We saw health promotion information on the wards and displays around the hospital. For example, there was information on stopping smoking, local alcohol services, managing various conditions, stroke guidance, health screening, dementia, carers support and falls prevention.

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 frailty team could identify patients who were frail or elderly and who may need extra support to ensure a safe and effective discharge. This team worked closely with outside agencies to ensure that patients leaving the department were looked after so promoting better health amongst those vulnerable patients who had visited the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. It applies to individuals over the age of 16. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The MCA allows restraint and restrictions to be used but only if they are in a person's best interest. 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).

The trust reported that from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 73.2% of staff in medical care compared to the trust target of 90.0%.

The breakdown by site was as follows:

Site	Training complete (YTD)	Individuals required (YTD)	Completion rate	Target met
The James Cook University Hospital	829	1,153	71.9%	No

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

Additional mental capacity training sessions had been implemented at differing times for medical staff to increase compliance. We were assured by senior management that training remained high on the agenda and would be tracked by service managers in both clinical centres for acute and general medicine.

Staff we spoke with had attended mandatory training about mental capacity act and deprivation of liberty safeguards training and understood capacity was decision and time specific. The mental capacity assessment form contained a stage two assessment and a determination of best interests. It identified if an independent mental capacity advocate was required. Although the capacity form was fully completed in all the records reviewed, it did not always clearly summarise the reasoning behind the best interest decision or identify the names of other people that had been consulted in the making of that decision.

The trust used validated assessment tools such as the single question in delirium (SQID) and 4AT rapid clinical test for delirium detection to identify delirium in patients. If the results of the test were positive for delirium, staff would commence the 'Time2Care' bundle which was a range of social and non-pharmacological interventions to support patients.

Staff liaised with the psychiatric liaison team (PLT) from a local NHS provider for patients with mental health conditions and PLT would make decisions about required mental health treatment in conjunction with trust staff. PLT staff undertook mental health assessments to identify if a Mental Health Act Assessment was required.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. We saw staff respond quickly to call bells and requests for assistance. Staff introduced themselves to patients and explained care and treatment. Staff cared for patients with compassion 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 were assured on inspection by senior management that delivering high quality individualised, compassionate care every time was a fundamental principle that the trust was committed to and focussed on delivering.

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 Audit of the Care Environment (PLACE) score for privacy, dignity and wellbeing was 89.65%, which was above the trust average of 88.7% and the national average of 84.16%.

Friends and Family test performance
The Friends and Family Test response rate for medicine at the trust was 6% which was worse than the England average of 25% from October 2017 to September 2018.
The trust undertook a 1000 voices campaign undertaking face to face interviews with patients across the hospital each month to gain feedback on different areas of care. The 1000 voices programme had been in place since January 2017 and all wards participated in the programme. The 1000 voices campaign information was displayed on the entrance to each ward and the scores where consistently above nine (out of ten) for all ten domains. Each ward was visited every month and real time patient experience feedback was collected on at least eight patients via a structured questionnaire and detailed comments section. In addition to feedback in real time each ward received a monthly report of qualitative feedback used to drive local improvements, 'you said, we did'.

The '1000 voices' patient experience roll out had supported positive improvements, driven largely by providing feedback in real time to frontline clinical staff who were empowered to make rapid changes.

One of the areas identified for improvement from the 1000 voices feedback was communication with patients particularly focussing on reducing the amount of conflicting information patients received. The trust had stated that this was to be included as part of the quality priority for 2018/19 and was one of the drivers for a review of visiting times and the introduction of flexible patient centred visiting in October 2018.

The trust participated in the NHSI 'Always Event' collaborative to drive continuous improvement in patient experience.

The service offered a therapeutic care service which included over 400 volunteers (including supported volunteers) and support workers. Nationally recognised (Allocate Awards 2018) the contribution to the well-being of patients across all specialities on all sites was significant. Therapeutic care staff had been given relevant training to enhance their to de-escalate episodes of violence and aggression. A number of therapeutic volunteer carers (TVC's) had progressed to medical / nurse training.

The Dragonfly scheme was introduced in autumn 2016 in response to a relative's experience. Comfort bags are given to relatives of patients at the end of life. The packs included essential toiletries, vouchers for the coffee shop and free parking. The scheme was recently extended with the development of children's comfort packs for children who had a seriously ill relative in hospital. All are funded through charitable donations.

Friends and family Test – Response rate between 01/10/2017 to 30/09/2018 by site.

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	
WARD 26	727	81%	99%							97%	100%		96%		98%
WARD 9	313	14%	100%	100%	100%	92%	89%	100%	95%	100%	100%	92%	100%	95%	97%
PLANNED CARE ADMISSIONS UNIT	232	20%	96%	95%	95%	100%	100%	100%	93%	100%		100%	95%	100%	97%
WARD 25	219	37%	93%	100%	100%		100%	97%	97%	100%		100%	100%	100%	99%
JCEC	182	3%	100%	96%	100%	100%	100%	92%	96%	100%					98%
RAPID ACCESS FRAILTY ASSESSMENT UNIT	140	11%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%
WARD 8	108	9%		93%	93%	100%			100%		97%	100%	100%	100%	97%
AINDERBY WARD	104	31%		100%	100%	100%		100%					100%		89%
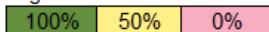
Key

Highest score to lowest score

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).

[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.

Note: sorted by total response

(Source: NHS England Friends and Family Test)

Emotional support

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.

The trust used the forget me not system to identify and support patients living with dementia. We observed this in use. Specialist nurses were available to provide guidance and training to staff on dementia. Some wards had therapeutic timetables displayed showing activities for patient to be involved with.

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, diabetes and respiratory nurse specialists provided a high level of emotional support and practical advice.

All wards had extended visiting times that allowed patients to be supported longer by friends and family.

In response to 1000 voices feedback a campaign was launched in December 2018. The Sleep Helps Healing (Ssh) campaign was aimed to protect and support rest in hospital at night. The sleep help healing campaign urged both staff and patients to dim lights and keep noise to a minimum between the hours of 11pm and 6am. The campaign focused on reducing noise overnight and for protected sleep time to help patients sleep to recover and support their emotional wellbeing. This was led by the matron group, evaluation of success was monitored via 1000 voices patient feedback.

Patients we spoke to 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. One patient who presented as challenging and had assaulted three staff members over the course of their admission. Staff were keen to ensure this patient received the support they needed and identified that placing security on a bed watch would be detrimental to this patient so were seeking alternative ways to ensure staff safety while meeting the patient's needs.

Staff from outside agencies reported that South Tees staff were caring and responsive to patients with mental health needs.

Staff on the medical ward had access to a hospital communications book. They also used the face, legs, activity, cry, consolability scale (FLACC). Staff were encouraged to use the 'forget me not' booklet for dementia patients. This identified 'things I'd like you to know about me' 'and 'Things you need to know to care for me'. We spoke with the parents and carer of one patient with a diagnosed learning disability. The patient had her own hospital passport and her carers fed back that staff took time to use it and get to know the patient. They followed the list of likes and dislikes and used them to form a trusting bond with the patient.

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

The staff had access to information through the psychiatric liaison therapist (PLT) and frailty team. There were a number of guidance documents that were on one sheet to enable staff to easily refer to and use them. Two of the booklets seen on a ward were 'Delirium – information for patients and relatives' and 'Dementia support and information'.

The patient experience team had been gathering data on the experience of mental health patients using the Healthcare Resource Group (HRG) code. This did not capture all patients but did give a general picture of those with the HRG code of mental health. Results had been positive and further work was being undertaken to analyse the narrative given in the feedback. The patient experience team were also working with TEWV to identify patient stories that they could publicise.

Schwartz Rounds had been established for six years as an invaluable opportunity for staff to reflect on the emotional aspects of their work.

Understanding and involvement of patients and those close to them

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.

The Trust supported 'John's Campaign', a national initiative to encourage carers to support and stay with people with dementia whilst in hospital.

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.

On ward 1 (acute frailty assessment unit) we found evidence of patients and family members being involved in their care. We saw a nurse assist a patient with a hearing aid device as the patient was having difficulty fitting new batteries which had been brought onto the ward by a family member.

In the records we looked at we saw that discussions and decisions made with patients and their relatives regarding their care, including planning for discharge and ongoing support were documented within care records. Staff recognised when patients and those close to them required additional support to help them understand and be involved in their care and treatment and enable them to access this. We saw staff refer a patient for a language interpreter to assist with translation for family members.

Is the service responsive?

Service planning and delivery to meet the needs of the local people

The service planned and provided services in a way that met the needs of local people. The service worked in partnership with local clinical commissioning groups (CCGs) and other providers across clinical networks to deliver them.

For example, during our inspection, staff on one ward told us how their service had introduced a multi-disciplinary diabetic foot team that undertook a weekly ward round. This was set up in response to the increased needs of patients in the area admitted to hospital with foot ulcers.

The acute medical unit (AMU) was open twenty-four seven and had medical and nursing cover throughout this time. The unit received direct referrals from general practitioners (GPs) and from the emergency department (ED). Patients were medically optimised and streamed to relevant wards for ongoing care if required.

The rapid access frailty unit (RAFA) was designed to meet the needs of the frail elderly population within the area and improve care. It enabled patients to be seen by quickly by specialist medical,

therapy and social care staff in one place aiming to discharging patients home with the support they required within the community. The unit was part of the acute frailty network. The trust had built frailty screening into the initial triage of patients. We were advised on inspection that the trust was to roll out a new nursing pathway and documentation that further supported frailty screening. The lead nurse for frailty was also a nurse advisor for the National Audit of Dementia which the trust had participated in for the last four years. In terms of assessment of patients for delirium and dementia, the trust had set a target to undertake this within 72 hours and refer to the patients GP if the patient scored less than eight on the initial assessment. The trust had not scored below target of achieving 90% of patients since the strategy launched in 2013.

Meeting people's individual needs

Staff identified patients who had additional care needs at point of admission, for example patients living with dementia, learning disabilities or mental health conditions. Staff we spoke with told us they were able to refer patients on to a variety of teams at the trust, for example the tissue viability team and the pain team. Staff referred patients to the adult psychiatry team if required and there was a mental health team available for support and advice.

There was a specialist lead nurse for dementia, frailty, falls and delirium and a dementia awareness team. Patients with dementia were flagged on patient systems and at board rounds. Staff were prompted to use the specialist dementia communication book, the 'forget me not' booklet at triage. The booklet included information about the patient under the headings 'things I'd like you to know about me' 'and 'things you need to know to care for me'. Dementia training was not included for staff as part of their mandatory core training; however, additional training sessions were undertaken by the dementia specialist nurses. The wards provided a care bundle for people living with dementia. The trust wide delirium team also attended wards to provide support to patients with delirium. The PLACE audit score for dementia scored 85.72% which was higher than the national average 78.9%. The trust had developed action plans from these assessments monitored by matrons.

The wards we visited had some dementia friendly adaptations in place including pictures on toilets and bathroom doors. Wards could access items to help dementia patients feel comforted, engaged and aid sensory stimulation such as twiddle muffs, memory boxes, arts and crafts and old newspapers. The trust had a local knitting group that would make the twiddle muffs allowing each patient to take one home.

We saw evidence of colour contrasting walls, additional grab rails, large clocks and different coloured crockery for patients diagnosed with dementia. We observed a painted bathroom with contrasting toilet seats optional lighting levels and dementia friendly signage on ward 12.

The trust had a learning disability (LD) lead nurse who would support patients by offering advice and support for ward staff. Patients with LD had hospital passports which detailed important information about them along with likes and dislikes. Staff we spoke with were aware of the learning disability specialist nurse.

The hospital frailty team supported staff across all wards to undertake assessments of patient's needs and had developed a number of guidance documents and tools to support this including a one-page guidance for staff on comfort and dignity interventions and an acute pathway for managing behaviours or psychological symptoms of delirium. The trust used validated delirium screening tools for patients. When patients were positively screened a 'time to care' bundle was initiated which included a range of social and non-pharmacological interventions to support

patients. Ward 12 had a dignity wardrobe available to all patients who required additional clothing. This initiative had been popular with patients who required day time clothing and was well supported by visitors, staff and the public.

To ensure patients with potential or pre-existing mental health disorders had their holistic health needs appropriately assessed and treated by appropriately skilled staff in the general setting a treat as one group had been established in 2017. Originally working with the trust's local mental health provider trust, the work now included the three acute trusts in the Durham Tees valley. A strategy had been developed with specific measurable objectives in relation to:

- Staff education and training screening and onward referral to 'Improving Access to Psychological Therapy Services' (IAPTS)

- Gathering patient experience reports from patients with mental illness to inform service developments

- Reduction of violent episodes by patients.

Patients with mental health needs were referred to the psychiatric liaison team (PLT) which was provided by a local mental health trust under a service level agreement and was available 24 hours 7 days a week. Staff reported good working relationships with the team and referral pathways were in place to ensure information sharing. The trust also worked closely with an external organisation who provided an onsite hospital intervention liaison team (HILT) to support patients with drug and alcohol issues. The trust employed their own alcohol liaison nurse specialist.

Medical wards had physiotherapy services, occupational therapists and speech and language therapists to assist and support patients on the wards. There was regular pharmacy attendance on the medicine wards.

Patients we spoke with said that staff respected their privacy and dignity by closing curtains and doors as necessary.

Patients' religious needs, dietary requirements, and hearing, sight or language difficulties were identified through structured assessments. The trust had produced a patient safety leaflet providing advice on minimising the risk of harms and deconditioning when in hospital. This leaflet was given to patients on admission and pre- assessment.

Wards and departments were accessible for patients with limited mobility and people who used a wheelchair.

Staff told us that translation services were available on the phone or face to face. New booking systems had been implemented recently and translation services could now be requested via an online booking service. Some staff did report that it could sometimes be difficult to access translators at certain times.

We saw evidence that the service had appropriate discharge arrangements in place for people with complex health and social needs. Discharge plans were discussed at multidisciplinary team meeting and daily 'board rounds'. Social care staff were involved in discussions to help facilitate safe discharges. We also saw evidence of staff liaising with other care services within the community. During our inspection we spoke with a member of the therapy team that had recently been on a home visit with a patient with a learning disability to assess if it was safe to discharge them with their current care package.

The therapeutic care team (THT) was established in 2013 and was a volunteer programme with over 500 volunteers across a variety of age ranges and abilities. Volunteers were recruited with

the primary role to support patients with dementia, delirium, mental health needs and brain injury. Some became staff members on an apprenticeship and undertook level III in care and support.

Access and flow

The hospital had three acute medical assessment units, the acute assessment unit (AAU), acute medical unit (AMU) and a rapid access frailty assessment unit (RAFA). All three units were open 24 hours, seven days a week and had access to medical cover. The assessments units allowed patients to be streamed quickly from emergency departments and helped reduce hospital admissions. The AAU also had direct access or next day appointments for GP referrals. During our inspection we saw the assessment units were well supported by therapists and specialist support teams. The units had access to a dispensing pharmacist as well as rapid access therapists who could see patients within two hours during the day and up to 8pm. Rapid response specialist nurses and support workers for discharge were also available. The quick response to meet patient needs helped to ensure access and flow throughout the hospital.

Patient flow for medicine was discussed at bed meetings which were held four times a day. The meeting was led by the hospital operations manager and was attended by matrons from each clinical area and clinical service managers. Access, flow, capacity, outliers and repatriation to North Yorkshire Friarage hospital was discussed. Flow through the emergency department and bed availability were discussed as well as staffing for each area. There was also a daily delayed transfer of care call that social care teams attended along with clinical staff that allowed complex discharges to be reviewed.

The stroke unit had direct access for patients Monday to Friday, 9am – 5pm and access to dedicated neuroimaging services during this time. Thrombolysis was carried out in the scanning room (not accident and emergency) and patients were transferred back to an enhanced care bay on the stroke ward for monitoring. The enhanced care bay provided three registered nurses (RGN) to six patients (1:2 ratio). Nurses completed initial swallow assessments at point of admission with appropriate referral to the speech and language therapists (SALT) if any concerns were highlighted.

Out of hours there was a stoke nurse practitioner (band 7) and a consultant on call if required. The service had a 'consultant of the day' for the stroke unit providing a service 24 hours a day, seven days a week; the service had good access to scanning for patients. They used neurology scanning facilities during the day Monday to Friday and general radiology out of hours including weekends.

When patients no longer required level 2 care they would be moved into another bay on the same stroke ward. There was an early supported discharge team made up of specialist therapists and social care staff which enabled patients to be discharged with appropriate support and rehabilitation provided at home.

Therapists (occupational health and physiotherapists) supported the service with seven day working apart from speech and language which was a six-day service. The service used a stroke pathway to document all care provided by the multidisciplinary team.

The coronary care unit provided direct access to patients suffering serious cardiac events. This service was open 24 hours a day, 7 days a week. Patients were triaged by advanced nurse practitioners and admitted directly to the unit if appropriate. When medically stable patients would be transferred to a base ward; however, staff told us that patients would often be discharged directly from the unit if deemed medically fit.

The endoscopy service informed us they had no six-week breaches. There was a 24-hour, seven-day a week emergency gastro-intestinal bleed rota in place.

The hospital had a discharge policy and processes in place. All patients were expected to have an expected discharge date (EDD) given by a clinician within the first 12 hours of admission and a discharge care plan completed. EDD and medically fit dates were recorded into the electronic patient monitoring system which allowed delayed transfers of care and 'stranded patients' to be flagged and easily identified by the flow team and social care. Discharges were discussed on daily ward and board rounds and wards had access to patient flow coordinators. The trust had rehabilitation and community beds across the region for patients requiring step down care.

The hospital had a clear escalation and winter plan to help them deal with extra demand over winter months. The plan included opening additional beds across several different wards rather than accommodating additional beds on one ward. We saw that many of the winter pressure beds were open on the wards we visited. Additional staffing was rostered to care for the increase in beds.

The trust had clear arrangements for ensuring medical outliers on surgical wards were seen daily by a relevant consultant or specialist registrar. Medical patients outlying on a non-medical ward were allocated to a designated consultant. We discussed the management of these patients and were assured that a robust process was in place. A designated respiratory physician was rostered seven days a week to see outlying patients. Medical outlying patients were classed as guests on non-medical wards.

We tracked an outlier report which listed 40 medical outliers on non-medical wards (16/01/2018). We checked 12 of these patients on the day of inspection. Each patient had been reviewed each day following relocation, medical and nursing notes had been recorded and updated with plan of care and next steps.

The trust had developed a performance dashboard to improve patient flow which gave a summary of performance for a range of measures, including elective metrics at centre level. The dashboard allowed performance to be reviewed at trust, centre level, specialty, site and individual consultant. The dashboard reported metrics, for example, cancer waits (seven days, sixty-two days), referral to treatment time and waiting list size.

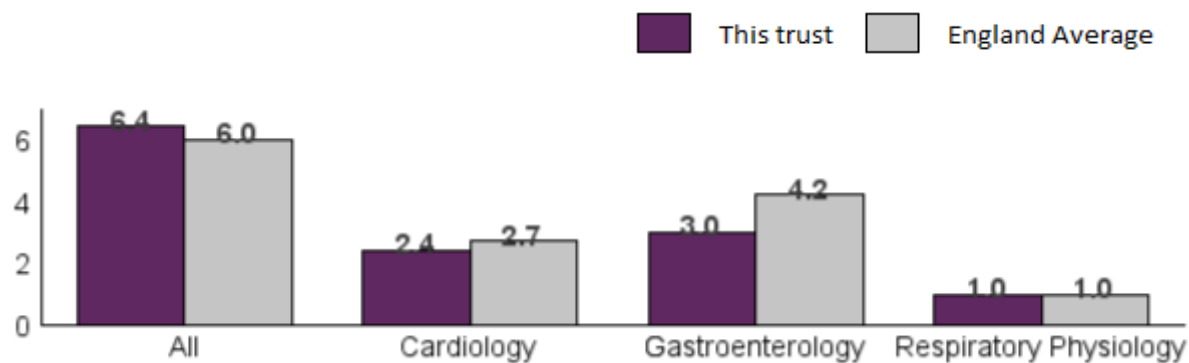**Average length of stay**

Trust Level

From July 2017 to June 2018 the average length of stay for medical elective patients at the trust was 6.4 days, which is higher than the England average of 6.0 days.

For medical non-elective patients, the average length of stay was 5.2 days, which is lower than the England average of 6.3 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology was similar to the England average.

- Average length of stay for elective patients in gastroenterology was lower than the England average.

- Average length of stay for elective patients in respiratory physiology was similar to the England average.
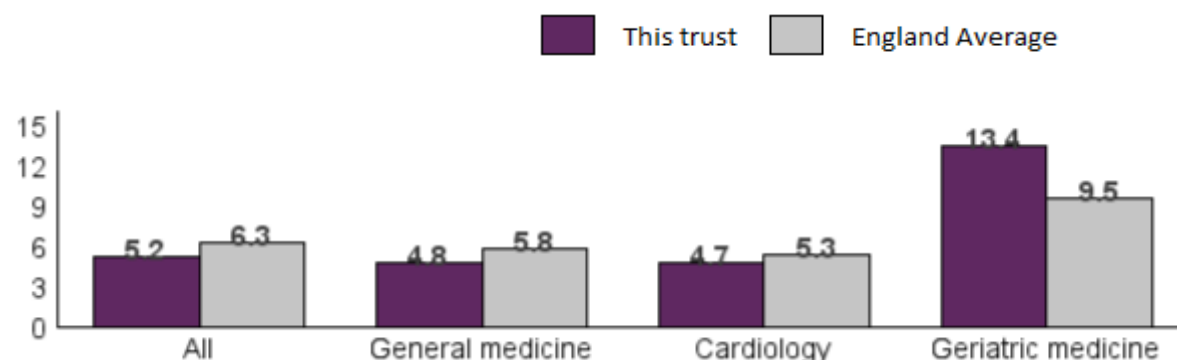
Elective Average Length of Stay – Trust Level

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

Average length of stay for non-elective specialties:

- Average length of stay for elective patients in general medicine was lower than the England average.

- Average length of stay for elective patients in cardiology was lower than the England average.

- Average length of stay for elective patients in geriatric medicine was higher than the England average.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.
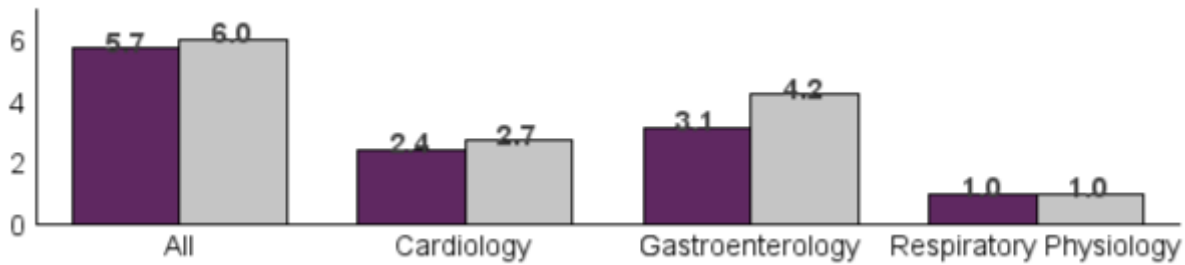
The James Cook University Hospital

From July 2017 to June 2018 the average length of stay for medical elective patients at the James Cook University Hospital was 5.7 days, which was lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 5.1 days, which was lower than England average of 6.3 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology was similar to the England average.

- Average length of stay for elective patients in gastroenterology was lower than the England average.

- Average length of stay for elective patients in respiratory physiology was similar to the England average.

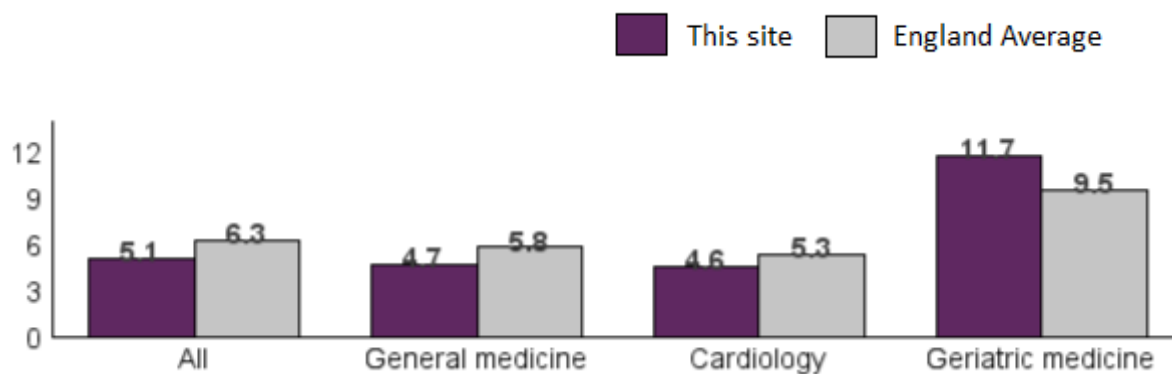## Elective Average Length of Stay - The James Cook University Hospital

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

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine was lower than the England average.

- Average length of stay for non-elective patients in cardiology was lower than the England average.

- Average length of stay for non-elective patients in geriatric medicine was higher than the England average. This figure was lower than the trust level figure of 13.4

The service had introduced board rounds attended by the multidisciplinary team to reduce delayed transfers of care. A key focus was to review discharge facilitation with the assistance of community networks and support.
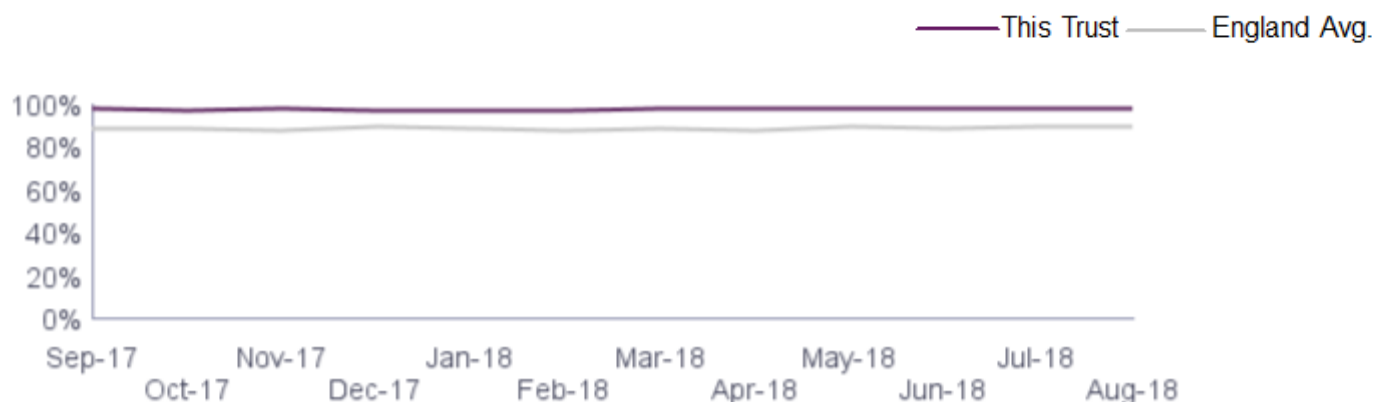
Non-Elective Average Length of Stay - The James Cook University Hospital

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

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

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for medicine was consistently better than as the England average.

(Source: NHS England)

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

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

Specialty grouping	Result	England average
General medicine	99.2%	96.6%
Rheumatology	98.9%	94.7%
Gastroenterology	98.3%	93.7%
Thoracic medicine	97.8%	93.4%
Neurology	96.0%	90.9%
Cardiology	95.9%	81.9%
Dermatology	94.7%	82.0%

Specialty grouping	Result	England average
Geriatric medicine	84.6%	96.9%

(Source: NHS England)

South Tees had seen a sustained rise in non-elective demand, with a 5% increase in emergency department (ED) attendances on the JCUH site since April 2018. Investment had been made to sustain performance as the trust entered the winter period with extended ambulatory care hours (to manage the increase in patients requiring medical treatment).

The 18-week Referral to Treatment (RTT) timescale had been an area of challenge for the trust with non-compliance since November 2017. Speciality specific recovery plans had been produced and were being closely monitored with an improvement trajectory to deliver compliance by March 2019.

Since the last inspection a Clinical Utilisation Review (CUR) was live on 640 acute beds and 100 community beds across the organisation with compliance consistently above 90%. A software system was in use to both support day to day operational management and inform service improvement and redesign to ensure patients were receiving the right care in the right environment at the right time

Patient moving wards per admission

The trust did not record or review data on ward transfers electronically. The trust monitored the numbers of patients on a ward where the specialty they were under was not supposed to use that ward; i.e. the number of ward stays on an incorrect ward. In practice the vast majority of these stays occurred as the first stay after admission (or transfer from an assessment ward) when a bed on the most appropriate ward was not available at the time of admission.

The trust assured us that they reviewed daily all patients who were being cared for in an alternative ward, with robust processes in place to ensure that the patients were seen by relevant clinicians and repatriated to the most appropriate clinical area.

The trust did not electronically record whether patients met the vulnerable criteria unless there were specific safeguarding concerns.

Details were recorded when patients reached end of life status; however, we were informed that the trust were unable to link this information to the ward stay data.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From October 2017 to September 2018, there were 3,612 patients moving wards at night within medicine. At James Cook University Hospital it was 3370 (per night in a hospital with 1,000 beds, 93.3%)

We were assured on inspection that less than 1% of patients (10 in total) in the medicine core service at James Cook moved beds at night on a daily basis. Staff confirmed that patient moves were accommodated during the day if possible.

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

Mixed sex accommodation breaches

National guidance indicates that it is acceptable to have level two patients in mixed sex accommodation; however, level 1 patients must not be mixed. There were zero mixed sex accommodation breaches in the medical service from October 2017 to September 2018. During our inspection we found no mixed sex accommodation breaches.

Delayed Discharges

Staff at the trust told us that reasons for delayed discharges included funding issues for some patients and sometimes nursing or care homes refused to take patients back when they felt they could not meet a patient's increased care needs. As the hospital worked across a large geographical area they told us they had to check where patients lived before discussing what support / level of funding was available on discharge.

The trust employed patient flow and discharge coordinators. We spoke with a patient flow coordinator who was part of the AAU team, who explained that part of their role was to assist in arranging the transfer of patients from the medical assessment unit to other wards. The discharge coordinators were based on the other wards and their role was to facilitate discharge for medically fit patients. Reducing delayed transfers of care (DToCs) to ensure patients were in the right place to receive care had been a key priority for the organisation.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. Information from complaints was shared at handovers and in communication books. Wards also undertook reflective training sessions led by a practice development nurse to address lessons learnt from complaints.

Wards had patient information leaflets available for the patient advice and liaison service (PALS).

Summary of complaints

From October 2017 to September 2018 there were 130 complaints about medical care. The trust took an average of 35 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be closed within 40 days. The rate of formal complaints compares favourably to the national acute average (20.2 per 10,000 finished consultant episodes compared to the national figure of 28.6). A breakdown of complaint subject with five or more complaints are below:

- Patient Care: 87

- Appointments: nine

- Communications: eight

- End of life care: five

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

Number of compliments made to the trust

From October 2017 to September 2018 there were 31 compliments within medicine.

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

Is the service well-led?

Leadership

The operational services were primarily led through four clinical centres which comprised of:

- Community Centre

- Urgent and Emergency Care Centre

- Specialist and Planned Centre

- Corporate and Clinical Services Centre

The clinical centres had a management structure in place with clear lines of responsibility and accountability. Centres were managed by a senior leadership team which included a clinical director, associate chief nurse, an allied health professionals lead and assistant director of operations. Each ward visited had a ward manager and a clinical matron with overall management responsibility.

Staffing levels were planned so that ward managers were given management time with other senior nurses in their teams. All ward managers and sisters said they were supported well by their clinical matron and their senior management team. During this inspection we saw matrons regularly on wards. However, we were told some matrons had undertaken clinical duties to cover staff shortages.

The Shelford Safer Nursing Care Tool (SNCT) was used to undertake establishment reviews in adult inpatient areas and was triangulated with care hours per patient day (CHPPD) data and professional judgement. A daily review of staffing was undertaken by centre assistant director of nursing (ADoN's) and clinical matrons seven days per week with staff redeployment actioned to match patient acuity and dependency.

In 2017 ward manager and clinical leads had participated in a development centre to assess core skills and capability, identify talent and create tailored development plans to enhance

performance. Over 20 ward managers had participated in a Level 5 management apprenticeship programme.

Vision and strategy

The trust's organisational strategy had been developed to meet the following priorities:

- Increase patient focus to ensure clinical effectiveness and excellence in both patient outcome and patient experience.

- Increase market focus building strategic partnerships in order to meet commissioning requirements and ensure long term financial sustainability.

- Increase operational focus to improve capacity and throughput, reduce waste and increase margin to invest in growth.

- Increase the capability of leadership and management teams and develop a high performance culture underpinned by ownership and accountability.

In order to achieve these priorities, the trust had developed a "Target Operating Model 2015 – 2020" which was launched in September 2015 which was delivered through the clinical centres.

Medical care services were delivered across these centres and each centre had its own statement of strategic intent. The main centre for medicine was specialist and planned care with the strategic intent of: "To defend specialist and planned care business by becoming the highest quality, lowest cost provider in the market place whilst at the same time remaining focussed on growth in areas and markets of choice".

This approach was based on the NHS five year forward view as the trust's drivers for change with the aspiration to re-direct appropriate patients away from acute services and into alternative care settings. This was demonstrated through the changes being made by moving specialties away from the traditional acute environment and into a community, specialist or planned environment as a new way of meeting specific patient needs. An example of such a move was the care of the elderly specialty which had previously been managed under the Acute Medicine team and was moved to the Community Care centre. We were told this was to help drive better outcomes and better management of patients by providing support in the community setting in order to restrict the amount of time a patient spent in the acute setting.

The trust had re-designed medical services across the trust over the past three years. This included: re-configuring inpatient bed bases, re-designing pathways and moving specialty teams in or out of hospital sites to drive this forward.

The trust had a dementia strategy 2013-2018. The strategy covered areas such as staff training, hospital environment and patient and carer experience.

Culture

We found staff to be highly motivated and focussed on patient care and development of the services. In addition, we saw that staff spoke with each other and patients in a respectful way.

Staff we spoke with during the inspection told us there was good teamwork, openness and morale was generally good.

Medical care services had strong leadership and senior managers were visible and engaged with staff. We interviewed a number of staff on an individual basis and held focus group discussions

before the inspection. Staff spoke positively about the service they provided for patients with high quality care being a priority. All staff interviewed were clear about their roles and responsibilities, were patient-focused, and worked well together.

Staff felt they received appropriate support from management to allow them to perform their roles effectively. Nursing staff reported a positive culture and good working relationships between staff groups. Centre unit managers informed us that they had appropriate access to senior staff members. This included being able to access support and leadership courses to help them in leading services.

Staff we spoke with were aware of the freedom to speak up guardian and told us they would raise concerns if they needed to but would be happy to do this with their line manager in the first instance. Medical staff at all levels felt that they could approach their medical director if they had any issues or concerns.

Governance

Governance structures were in place that provided oversight of performance against key performance targets and patient safety measures. However, it was unclear how senior management could evidence board to ward information and staff awareness as feedback methods varied on differing wards. There was no audit trail to evidence that staff had received weekly updates or feedback from incidents.

Each clinical centre held directorate meetings which fed into both the monthly centre governance meeting and the monthly centre board performance meeting. "Performance wall" meetings were held for; quality and patient safety, RTT waiting list, diagnostic, pay/non-pay, human resources (HR), cancer wall, patient flow, DToC and performance. Senior staff were encouraged to attend these meetings relevant to their individual centres; performance, activity and productivity were discussed, reviewed, challenged and planned.

Performance walls were in use as a quality improvement methodology. We saw that each ward had a quality performance dashboard which considered audit results, learning from incidents, safety alerts, medicine alerts (risky business), ward dashboard metrics and other performance measures. These were displayed in staff areas and ward managers told us they reflected areas for improvement and actions needed. We were told that the ward metrics and safety incidents were discussed at team meetings and were updated when improvements were made or other areas were highlighted for focus.

We saw minutes for a speciality clinical governance meeting. The minutes included, monthly key messages, review of key performance indicators (KPI's), patient experience; patient and public engagement, risk management including incidents, safeguarding, infection control, therapies and any other business.

The trust had focussed on plan, do, study, act (PDSA) cycles in areas with high numbers of falls helping to reduce the number of patient falls. The trust had refreshed the falls prevention strategy reducing the rate of falls per 1000 bed days to 4.7 in 2018/19 (year to date) compared to 5.3/1000 bed days in 2017/18. We reviewed the trust falls prevention strategy action plan (2018-2020) which listed falls prevention, assessment and risk reduction, governance, patient experience and education. The aim of the strategy was to improve patient experience and outcomes, reduce incidence of serious harm, achieve a 5% reduction in falls each clinical year and demonstrate improved compliance with interventions proven to reduce risk.

There was a lead consultant for mental health from a local NHS trust who worked with the trust. There were regular governance meetings which reviewed mental health breaches of waiting time targets, referral mechanisms and repeat attenders. The two trusts developed management plans for repeat attenders and worked closely to ensure a joined-up approach for these patients, along with GP's and the police/probation service.

The trust had developed a pathway that supported patients who were in mental health hospitals and required acute hospital admission for physical healthcare. The pathway supported an initial assessment of patients so that they were correctly placed without having to attend accident and emergency.

Management of risk, issues and performance

The services had systems to identify risks and plans to eliminate or mitigate them. The senior leaders we spoke with had an understanding of the current risks, challenges and pressures impacting on service delivery and patient care and could explain the actions they had taken to mitigate these. Management highlighted that risks at ward and unit level needed additional support to drive key challenges to enable managers to adopt a risk averse attitude.

The trust had contingency plans /policies which contained details about how the trust would respond to an incident or event, which could disrupt services and contained details of the key individuals to support staff. In addition, there was also a trust major incident plan. This was in date and contained appropriate guidance, contacts and level of escalation based on risk.

We reviewed the service risk register, which showed when each risk had been identified and when they were next to be reviewed. It was evident that risks were reviewed regularly and risk ratings were reflective of the mitigations taken. Nine risks were listed, two with a high-risk factor (limited specialist radiology cover for the lymphoma MDT and risk of the inability to sustain a stroke service across the regional stroke network).

We spoke with the senior managers for the medical service who told us about their main concerns surrounding risks. This included recruitment of additional medical workforce and therapists. Mitigating actions were explained, for example these included active recruitment and retention plans and a clear escalation process.

The trust produced monthly model ward and medication dashboards at ward, centre and trust level. These were discussed at ward meetings and centre wall monthly meetings. We reviewed ward quality dashboards during and following inspection to review ward data on acute and general wards. The quality dashboards were displayed on all wards and units inspected. The quality data was reviewed by individual ward managers and clinical matrons. Any outliers identified would be discussed and disseminated at ward level to increase awareness and compliance.

In addition to these dashboards a triangulation report was produced that included model ward metrics, patient experience and audit data.

Information management

The Accessible Information Standard (AIS) was introduced in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand.

We saw that all patient observations and information was recorded on paper and electronic formats. This gave immediate access to risk assessments, test results and treatment of all

patients. This ensured patients who had a disability, impairment or sensory loss were given information that they could access and understand.

The patient pathway records enabled staff to ask people if they had any information or communication needs. These were clearly recorded and highlighted in the record and covered disabilities, impairment or sensory loss. We saw contact methods, formats (audio, braille, easy read or large print) and support needed (e.g. interpreter, lip-read, hearing aid) were detailed.

The intranet was easy to navigate to find training information surrounding E learning. Ward managers had access to electronic staff records so they could view appraisal, sickness and training rates.

Information governance training rates for nursing staff were monitored at centre leadership level and was 93.5% within the medicine care group in September 2018.

Engagement

Staff and patient engagement was measured through national and local satisfaction surveys, patient experience information panels, patient stories and diaries. There was also feedback through comments, concerns, compliments and complaints from individual service users and members of the public. People using the service were encouraged to give their opinion on the quality of service they received. The wards participated in the trust's '1000 voices' surveys to gather feedback on services from patients.

Staff we spoke with told us they felt involved in development of services and this promoted good team working.

Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.

Leaflets about the friends and family test, and the patient advice and liaison service (PALS) were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes. We saw thank you cards and letters displayed at the entrances to wards.

Matrons and ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.

Learning, continuous improvement and innovation

Whist on inspection we saw examples of continuous improvement and innovation. For example, in the cardiac catheter lab we observed live streaming of a surgical cardiac catheter case to the British Cardiovascular Intervention Society (BCIS) conference in London with over 600 people observing shared learning. Staff involved explained that they were proud of the work that they had shared and that learning was a two-way process.

Surgery

Facts and data about this service

The James Cook University Hospital has 20 main theatres, four day theatres, five minor theatres and 10 local theatres.

The trust covers the following specialities across the two sites:

- Ear nose and throat (ENT)

- General surgery

- Ophthalmology (eyes)

- Oral and maxillofacial surgery

- Orthodontics

- Plastics and burns

- Urology

- Vascular surgery

(Source: Routine Provider Information Request (RPIR) – Sites tab/ https://www.southtees.nhs.uk/services/anaesthetics-and-theatre/theatres/*)*

The trust had 48,148 surgical admissions from July 2017 to June 2018. Emergency admissions accounted for 11,450 (23.8 %), 26,147 (54.3 %) were day case, and the remaining 10,551 (21.9%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 90.0% for completion of mandatory training.

Training compliance data was collected on a monthly rolling basis and for nursing staff we were assured that all surgery departments were on trajectory to meet trust training targets for compliance for the year ahead. Managers had overview of their team's training compliance and ensured staff were encouraged to attend their training. They explained staff took responsibility for booking their own training, for example, in theatres we saw dates for adult and paediatric basic life support training, which staff could book.

Mandatory training was delivered mostly as e-learning and there was some face to face training hosted on site, for practical skills, such as moving and handling.

Training information received from the trust did not include the percentage of staff that had completed sepsis training. However, staff we spoke with described the 'sepsis six' training they had completed.

Fire safety training was mandated to be completed three-yearly and the target for compliance was almost met. However, one staff member we spoke with who had been at the trust in over ten years, told us they did not know what the fire procedure was or what to do in the case of a fire.

We were advised that training was delivered on a rolling basis. It was unclear how the department knew that they were on track to achieve training completion rates with no overall target date.

Across the trust in surgery the 90.0% target was met for three of the five mandatory training modules for which qualified nursing staff were eligible. At the James Cook university hospital surgery departments, the 90.0% target was also 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 October 2017 to September 2018 for qualified nursing staff in the surgery department at The James Cook university hospital for year to date (YTD) below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust target	Met (Yes/No)
Health and safety (slips, trips and falls)	448	475	94.3%	90.0%	Yes
Equality and diversity	445	475	93.7%	90.0%	Yes
Information governance	433	475	91.2%	90.0%	Yes
Fire safety 3 years	410	475	86.3%	90.0%	No
Infection prevention (Level 1)	400	475	84.2%	90.0%	No

Trust-wide in surgery the 90.0% target was met for none of the five mandatory training modules for which medical staff were eligible. At the James Cook university hospital surgery department, the 90.0% target was met for none of the five mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for medical staff in the surgery department at the James Cook university hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust target	Met (Yes/No)
Health and safety (slips, trips and falls)	166	211	78.7%	90.0%	No
Equality and diversity	163	211	77.3%	90.0%	No
Fire safety 3 years	154	211	73.0%	90.0%	No
Information governance	151	211	71.6%	90.0%	No
Infection prevention (Level 1)	151	211	71.6%	90.0%	No

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

Safeguarding

We saw the trust had an up to date safeguarding policy accessible on the trust's intranet. The trust had systems and processes to protect patients from abuse and staff were trained in the safeguarding of vulnerable adults and children.

The trust had named lead nurses for adult and children safeguarding and staff said the trust safeguarding team was accessible and supportive when they needed advice about safeguarding concerns; they saw safeguarding was everyone's responsibility.

The James Cook hospital completion rate target for safeguarding adults and children level 2 and level 3 was met by registered nursing staff. This met the Safeguarding Intercollegiate Guidance 2016 requirements. However, the medical staff completion rates were slightly below the trust target.

Staff spoken with advised that they would escalate any concerns to their ward manager, who would inform matron prior to advising the local authority.

When we asked staff in theatre and wards about safeguarding procedures, they described specific circumstances when they had made safeguarding referrals with help from managers and matron. Staff ensured us that they checked with their matron if they were unsure or were concerned about a patient.

Safeguarding training completion rates
The trust set a target of 90.0% for completion of safeguarding training. At the James Cook university hospital surgery department, the 90.0% target was met for three of the four training modules, with one module almost met for safeguarding training modules that qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for qualified nursing staff in the surgery department at the James Cook university hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust target	Met (Yes/No)
Safeguarding children (Level 3 additional)	11	11	100.0%	90.0%	Yes
Safeguarding children (Level 3)	11	11	100.0%	90.0%	Yes
Safeguarding vulnerable adults	452	475	95.2%	90.0%	Yes
Safeguarding children (Level 2)	417	464	89.9%	90.0%	No

At the James Cook university hospital surgery department, the 90.0% target was met for two of the four safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for medical staff in the surgery department at the James Cook university hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust target	Met (Yes/No)
Safeguarding children (Level 3)	14	14	100.0%	90.0%	Yes

Safeguarding children (Level 3 additional)	14	14	100.0%	90.0%	Yes
Safeguarding children (Level 2)	159	197	80.7%	90.0%	No
Safeguarding vulnerable adults	170	211	80.6%	90.0%	No

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

Cleanliness, infection control and hygiene

The James Cook hospital followed the trust infection prevention and control (IPC) policies and procedures were available on the intranet for all staff. These were underpinned by national guidelines, to manage and monitor infection, essential for patient and staff safety.

An external company was contracted, to clean the wards. On the wards, we observed domestic staff actively cleaning the main areas. We spoke with domestic staff who were aware of policies and processes for cleaning individual ward environments. Flushing of taps to reduce the risk of Legionella was included in their cleaning schedule. Cleaning records were signed off by domestic supervisors.

Domestic staff we spoke with were aware of infection prevention and control procedures, for example, they used colour coded waste bags, mop heads and aprons. They had good awareness of how to manage control of substances hazardous to health; for example, cleaning products were stored safely in a dedicated cupboard which was kept locked.

All clinical, reception and waiting areas we inspected were visibly clean. Patient chairs on wards and theatre areas were upholstered with wipe-clean coverings.

We inspected reusable equipment, for example commodes, a bladder scanner, intravenous pumps, diathermy machines, anaesthetic equipment, electronic observation monitoring machines, drip stands, electrocardiograph machines and resuscitation equipment trolleys. All were clean and fit for use.

On the wards we observed 'I am clean' tags on some but not all equipment. The exceptions were ward 36, where we saw no stickers on ten intravenous pumps. Also, on the post-operative surgical day unit, there was a monitor and three intravenous pumps in the clean utility room with no stickers.

Alcohol hand gel was available in wall mounted dispensers at entrances and exits and at point of care on wards and in theatres. The clinical areas displayed clear instructions and signage to encourage staff and visitors to wash their hands and use alcohol hand gel when entering and leaving the department.

On the wards and departments, we visited, there were sufficient clinical wash hand basins with elbow taps and adequate supplies of liquid soap and paper towels.

We observed most staff carrying out hand washing prior to and after patient contact. The exception was on ward 36, where we observed five different staff wear gloves and aprons for patient contact, but they did not use gel on their hands. We observed one doctor enter a side room to cannulate a patient but did not see them washing their hands or using sanitising gel. Staff adhered to the "bare below the elbow" policy.

Staff told us that they had sufficient access to personal protective equipment (PPE), and in clinical areas, we saw dispensers for non-latex disposable gloves in a variety of sizes and plastic aprons. Staff used PPE appropriately on most occasions.

Rooms were available on all wards for nursing patients in isolation, in accordance with universal precautions. We observed signage in place to advise anyone before entering an isolation room. We saw one occasion where a member of staff entered an isolation room without donning the appropriate PPE.

All clean utility areas and treatment rooms were visibly clean and tidy. Dirty utility rooms contained products for cleaning reusable equipment. However, products that were subject to control of substances hazardous to health (COSHH) regulations were not locked away in the dirty utility room on ward 36. This meant there was a risk they could be accessible to children and vulnerable people.

Linen was stored appropriately on slatted shelving in linen rooms and decanted onto linen trolleys when required on the wards.

Theatres with laminar flow were used for trauma and orthopaedic cases. (Laminar airflow is used to separate volumes of air or prevent airborne contaminants from entering an area).

Disposable curtains in recovery were dated and were changed monthly, in accordance with local infection prevention policy.

We found clinical and domestic waste was managed appropriately in all areas. For example, waste bins contained colour coded sacks in accordance with waste streams and those we checked contained the correct type of waste.

Environment and equipment

Wards and departments, we visited were mostly quiet and calm, with a sense of order and control. The exception was ward 8, which was small and appeared overcrowded, chaotic and noisy. We noted lots of staff situated around the nurses' hub for long periods. Matron was new to post and had been initially concerned but felt the new model was embedding.

We visited the surgical admissions unit, which was usually operational from Monday morning to Saturday lunch time. At the time of inspection, it was operational over night as part of the winter-pressures management strategy.

All routes for fire escapes were clear and there was clear signage indicating escape routes.

Clean and dirty utility rooms in all areas we visited, were tidy.

Sterile stores and preparation areas in theatre were clearly labelled for staff to locate equipment they needed quickly. Most items were stored on shelves. However, we observed some boxes of theatre table covers stored on the floor.

Storage rooms were mostly organised and tidy. The exception was ward 8 where we found consumables such as bowls, aprons, cups, anti-embolism stockings, urostomy equipment and incontinence pads stored in filing cabinets and on trolleys in the corridors. A healthcare assistant mentioned this was due to lack of storage space. In addition, we observed some boxes of intravenous fluids stored on the clean utility room floor in ward 25.

We observed equipment stored in theatre corridors due to lack of storage space. For example, trolleys, limb positioning equipment, drip stands and a plaster trolley. However, the main corridor was clear to allow easy movement of patient trolleys.

There was a storage cupboard in theatre, which held seventy-three bottles of flammable liquids, including chlorhexidine and hydrex solution. The cupboard was not a metal flameproof cabinet.

We observed the dirty corridor at the rear of theatres was regularly cleared of waste bags and linen skips. There were foot-operated waste bins lined with colour-coded sacks and those we inspected contained appropriate waste.

Most sharps disposal bins in theatre were assembled and labelled correctly, not over-filled and stored off the floor. The exception was in ward 25 clean utility room, where we saw two sharps bins that contained waste, which were not dated or signed when assembled. We brought this to the attention of staff at the time.

We inspected a wide selection of consumable items in all the areas we visited and all packets were intact and within expiry dates.

Portable electronic equipment inspected had been safety tested within a reasonable timescale. For example, we looked at suction units, defibrillators, anaesthetic machines, monitors, tympanic thermometer chargers and capnography machines. All had a label stating when the next electrical portable appliance test was due. The trust had systems in place for recording the service and maintenance of other equipment, such as hoists and weigh scales, identified through compliance stickers.

We inspected anaesthetic machines in theatre and saw safety checks recorded in log books. They were mostly checked daily, in accordance with Association of Anaesthesiologists Great Britain and Ireland (AAGBI) safety guidelines. The exception was one machine in anaesthetic room six, which had not been signed as checked on Tuesday 15 January.

The recovery areas patient bays were clean and tidy and each bay was prepared with its own set of equipment, including patient warming machine, capnography monitor, tympanic thermometer and vital signs monitor. There were specialist equipment trolleys set up and ready for use, for example video laryngoscopy equipment and equipment for difficult cannulation.

We observed two adult recovery areas. The first area had ten spaces; one of which was kept for high acuity patients. The second area was for 'enhanced care' patients, who were expected to recover quickly and return to wards promptly. In addition to this, there was a dedicated paediatric recovery. This had a wall mounted projector to display pictures and calming images onto the ceiling, to help patients living with autism feel less anxious.

Staff we spoke with, including nurses, doctors, surgeons and anaesthetists confirmed there was adequate equipment to carry out their role and to meet the needs of patients, for example, moving and handling equipment and equipment for bariatric patients. However, staff we spoke with raised concerns to us that some anaesthetic machines were approaching 'end of life' and said there had been failure of laparoscopic stack equipment, for which replacement requests had not been approved. Staff explained there was a risk-based capital replacement programme and managers were permitted to sign off expenditure for single items under a specified value.

The anaesthetic rooms had signage available to put on the outside doors to alert staff not to enter, for a variety of safety reasons. In addition, there was signage to attach to patient trolleys to alert staff to patient latex allergy.

Patient bed-bays on the wards were single sex. All patients had designated bed space, which included a personal locker, bed-table and a call bell. All patients had access to gender-specific toileting and bathing facilities.

We checked the resuscitation equipment trolleys in all the areas we visited. These were clean and contained appropriate items, which were in accordance with Resuscitation Council (UK) guidelines.

We saw each resuscitation equipment trolley had a checking log attached to it for staff to complete when they had undertaken daily and weekly checks, in accordance with trust policy.

Most checks were completed consistently. The exceptions were for example, theatre corridor trolley, which had gaps in the record for 20 and 24 December 2018. In addition, ward 36 trolley had gaps in the checking log on 10 January, 10 and 31 December, and 9 November.

None of the trolleys were fitted with tamper-proof security. This meant there was a risk that equipment or emergency drugs could be removed between checks and would not be available when needed.

Assessing and responding to patient risk

Patients were pre-assessed for surgery in accordance with procedure-specific pre-assessment pathways. Most surgical patients were pre-assessed two to three weeks prior to admission, either face to face or by telephone, depending on individual risk assessment.

Patients were assessed for delirium and dementia in line with national guidance and where required, provision was made for enhanced supervision of patients. For example, on one ward, we observed therapeutic health care assistants assigned to patients that were vulnerable. Level three care was provided as one to one supervision and level two was decreased supervision, with checks made every fifteen minutes.

We observed that patients had access to a consultant anaesthetist review for general anaesthetic cases, to determine ASA grade. ASA is the American Society of Anaesthesiologists physical status classification system, for assessing the fitness of patients before surgery.

Staff used a national early warning score (NEWS 2) to assess the health and wellbeing of patients. These assessment tools enabled staff to identify if the clinical condition of a patient was deteriorating and required early intervention and or escalation to keep the patient safe.

Nursing staff we spoke with could describe signs and symptoms of a deteriorating patient and gave examples of when and how they would escalate a concern.

We checked care plans and risk assessments in detail. These included NEWS 2 charts, venous thromboembolism (VTE) risk assessments, pressure ulcer risk assessments, pain scores, nutrition, fluid balance and hydration charts.

The quality of record keeping was variable. For example, four VTE risk assessments had ticks indicating risk factors but the final box indicating when the patient was at risk and whether pharmacological and mechanical prophylaxis should be prescribed, was not ticked. However, these had been prescribed. Pressure ulcer risk assessments on the reverse of intentional rounding charts, were mostly assessed daily but there were no assessments completed on admission, in three records.

We saw inconsistency in the way pain assessments were recorded. For example, pain scores for three patients were recorded on electronic vital pack units and on their paper NEWS 2 charts but only electronically for seven of the ten we looked at.

NEWS 2 scores were generally completed well. One exception was a patient found to have very high systolic blood pressure. This was not recorded again for four hours and there was no record

of raised blood pressure, in the nursing evaluation. When checked again, blood pressure remained high and staff noted they called a doctor to review. However, when the medical notes were checked for this same patient, there was no record of doctor review. We saw in the records that antihypertensive medication had been prescribed two days previously.

In another record, we could not find evidence in nursing notes that a low blood pressure reflected in NEWS 2 score had been escalated to doctors. A doctor had been informed according to medical notes but the blood pressure was not rechecked. We made a nurse aware and were told that it had been rechecked but was 'not yet put on the system'.

A health care assistant we spoke with said they were unclear when observations should be rechecked; they said they were done routinely at 10am 2pm, 6pm, 10pm, 2am and 6am and that the vital pack machine indicated when further assessment was required. This meant there was a risk some staff depended on prompts by the machine rather than using it in combination with clinical judgement.

Seven out of nine records we looked at had fluid balance charts, but none of them were fully completed or added up.

The quality of record keeping seen on inspection meant we were not assured that staff always maintained accurate and contemporaneous records for all patients.

There was a comprehensive protocol in place in theatre for massive blood-loss and cell saver equipment was available, so patients who declined blood transfusion due to personal or religious beliefs could receive autologous transfusion if needed.

The major incident command centre for the trust was in theatres. Staff we spoke with in theatres, described major incident 'collapsed building scenario' training they had participated in recently. Staff found the training useful and there were few improvements required following debrief.

We observed two surgical cases in theatre and saw good compliance with completion of World Health Organisation (WHO) safer surgery checks and associated documentation.

Patient safety briefings were carried out pre-operatively. The team brief check was robust and included sign in, time out and sign out. Patient name, date of birth, surgical site, allergies and skin marking were all checked pre- operatively.

The trust sepsis and early warning score policy and pathway was in date and version controlled. Management of sepsis after admission to hospital usually involved three treatments and three tests, known as the 'sepsis six'. Staff we spoke with on the wards and in theatres said they had received 'sepsis six' training on a cascading basis. When asked, they could articulate the signs of sepsis and were aware of actions required for escalation and treatment. We saw sepsis boxes in all theatre recovery areas.

We saw a clear poster flow-chart in recovery describing action to take when emergency anaesthetist help was required.

In theatre recovery, there was a dedicated 'ITU' bay for very high acuity patients. Managers we spoke with explained theatre recovery staff were not high- dependency trained, so these patients were looked after by an anaesthetist and recovery staff assisted. Patients with lower acuity that still required close observation were placed nearest to the nurses' station.

There was a named resuscitation officer and staff we spoke with told us they had participated in two emergency scenarios in the previous two months. The most up to date resuscitation algorithms were attached to the emergency resuscitation equipment trolleys.

Nurse staffing

The trust reported their qualified nursing staff numbers in surgery in terms of whole time equivalents (WTEs), as below, as of September 2018. The WTE for each person was based on their hours worked as a proportion of the contracted hours normally worked by a full-time employee in the post.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage hospital	101.2	95.5	94.3%
The James Cook university hospital	486.5	428.6	88.1%
Trust level	600.7	535.9	89.2%

(Source: Routine Provider Information Request (RPIR) –Total staff tab)

Nursing establishment reviews were completed following National Institute of Clinical Excellence (NICE) guidance, National Quality Board (NQB) guidelines, the use of safe care data and professional judgement.

Managers used a recognised, safer-care acuity tool to identify staffing needs. Matron monitored staffing levels three times each day (10am,1pm and 3pm) and we observed a 10am bed management meeting, attended by service managers, to see how this information was fed back centrally.

Managers and most staff we spoke with said they felt staffing levels were safe, although there were times when actual staffing was lower than planned, due to staff sickness absence. The exception was on ward 36, where two staff we spoke with said they felt the ward was often short staffed. One patient on ward 36 told us 'on occasions there are not enough staff available'. Another said they felt there were sometimes delays in answering call bells because staff were busy with patients. However, two other patients said they perceived staffing levels to be good. On the day of inspection, the actual and planned staffing numbers on wards 36 and ward 8 matched.

Temporary staffing was used in areas where staffing levels fell short. The daily staffing huddle reviewed the use of temporary staffing to ensure the ratio of substantive staffing level to temporary staff was balanced and safe. Patient acuity was also considered when redeploying staffing. Matrons also backfilled and helped on the wards when required.

We found staff were suitably skilled. For example, on the trauma and orthopaedic ward, there were a trauma specialist nurse and a peri-operative practitioner in post.

Planned and actual staffing levels were displayed prominently in all clinical areas.

There were formal handovers between nursing staff at each shift.

Vacancy rates
From October 2017 to September 2018, the trust reported a vacancy rate of 9.8% in surgery. At the James Cook university hospital it was 10.9%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From October 2017 to September 2018, the trust reported a turnover rate of 8.0% in surgery, this was better than the trust's 10% target. At the James Cook university hospital it was 8.8%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From October 2017 to September 2018, the trust reported a sickness rate of 5.6% in surgery, this was worse than the trust target of 3.5%. At the James Cook University Hospital it was 5.8%.

Bank and agency staff usage

From October 2017 to September 2018, the trust reported a bank usage rate of 554.2% an unfilled rate of 17.8% and no agency usage in surgery. The trust use bank staff for extra activities, for example to sit with patients at risk. This is has led to a large bank staff usage rate.

All nursing staff

Site	Bank rate	Agency rate	Unfilled rate
The James Cook university hospital	577.7%	N/A	16.1%
Friarage hospital	192.9%	N/A	44.5%

Qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
The James Cook university hospital	301.5%	N/A	29.2%
Friarage hospital	57.6%	N/A	23.4%
Trust level	284.9%	N/A	28.8%

Non-qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
The James Cook university hospital	946.4%	N/A	surplus of 1.4%
Friarage Hospital	438.7%	N/A	82.8%
Trust level	920.4%	N/A	2.9%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

On the orthopaedic wards, doctors were ward-based during the day and at night, there was a junior doctor who covered three surgical wards, supported by an on-call registrar.

Doctors we spoke with said their shifts were busy but they could finish on time. They said there was appropriate cover on day and night shifts. They told us there was good support from the outreach team if patients required escalation to critical care.

Doctors we spoke with reported they were happy with the amount of supervision they received from senior colleagues.

There was an on-call system in place for consultant cover; for general surgery there was a consultant on site from 8am to 6pm and then on call. For orthopaedics and trauma, there was a consultant on site 8am to 8pm and then on call.

Theatre rotas identified surgeons and anaesthetists on duty and on-call.

An anaesthetist we spoke with said they were happy with equipment provided and teams 'worked together fluidly'.

Some staff and doctors we spoke with told us there was a lack of anaesthetists, which meant they felt 'stretched but not unsafe'. They explained this was because of a national shortage of anaesthetists.

Nursing staff we spoke with on the wards said they had good working relationships with their medical colleagues and that doctors responded promptly when they were called.

The trust has reported their staffing numbers below as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	40.57	37.08	91.4%
The James Cook university hospital	187.8	183.5	97.7%
Trust level	228.3	220.6	96.6%

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates
From October 2017 to September 2018, the trust reported a vacancy rate of 5.7% in surgery. At the James Cook university hospital it was 6.3%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From October 2017 to September 2018, the trust reported a turnover rate of 19.3% in surgery, which was worse than the trust's 10% target. At the James Cook university hospital it was 19.7%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From October 2017 to September 2018, the trust reported a sickness rate of 0.7% in surgery, this is in line with the trusts 3.5% target. At the James Cook university hospital it was 0.8%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)
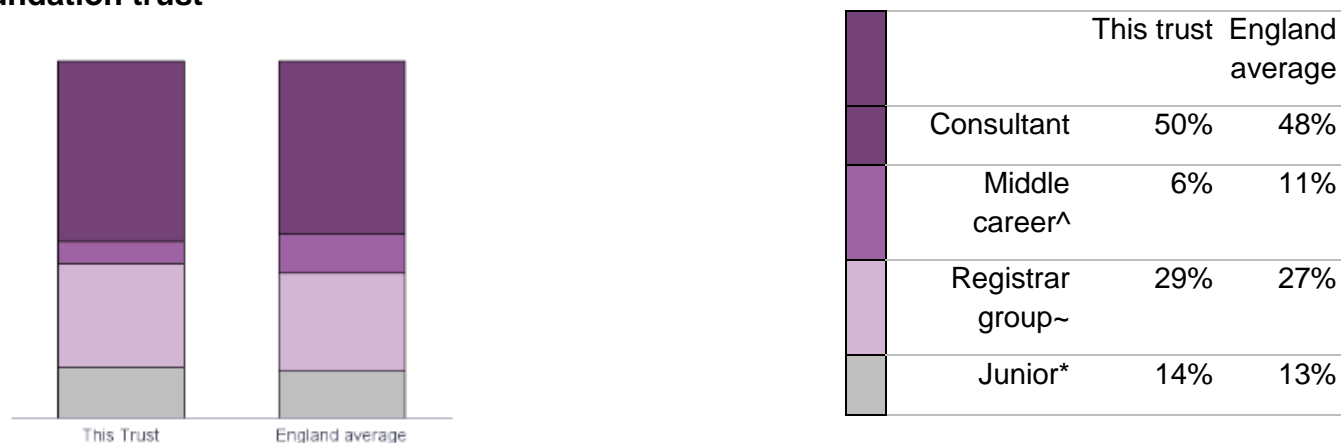
Bank and locum staff usage
From October 2017 to September 2018, the trust reported a bank usage of 2.5% and locum usage rate of 1.1% in surgery. At James Cook university hospital it was: bank 2.2%, locum 1.0%.
(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

From July 2018 to July 2018, the proportion of consultant staff reported to be working at the trust was slightly higher than the England average and the proportion of junior (foundation year 1-2) staff was slightly higher.

Staffing skill mix for the whole time equivalent staff working at South Tees hospitals NHS foundation trust

		This trust	England average
	Consultant	50%	48%
	Middle career^	6%	11%
	Registrar group~	29%	27%
	Junior*	14%	13%

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

(Source: NHS Digital Workforce Statistics)

Records

Nursing and medical records were primarily on paper. Paper records were available for each patient that attended the wards, surgical admissions unit and theatres. Nursing staff used hand-held electronic 'vital pack' devices to record patient observations.

Electronic Patient Status at a Glance Board (e-PSAG) boards were used on the wards we visited. These provided up to date bed occupancy data and key information about patient risks and treatment. The information included flags to identify those living with dementia, patient acuity and discharge plans. The boards ensured that staff also had easy access to clinical information, such as reviews by other members of the multi-disciplinary team and clinical observations.

We saw an up to date standard operating procedure for e-PSAG board use. The procedure stated 'explicit consent to use a patient's data on a large electronic screen is to be sought and documented in the patient's notes. Where a patient lacks capacity to consent, the nurse must take a decision, in the best interests of the patient, around the use of this information. This must also be documented within the patient's notes'.

We reviewed ten sets of patient records during the inspection and did not see documented evidence that patient consent had been obtained to display their information on the board.

Nursing, allied healthcare professionals and medical staff used black ink, had legible handwriting and documentation occurred at the time of review or administration of treatment. The designation of the doctor in two records was not recorded following admission and it was unclear whether these were consultants.

We observed non-compliance with General Data Protection Regulation legislation, which was introduced in 2018. For example, we saw a record file left unattended on top of a confidential waste paper disposal unit (ward 8) and records on ward 8 and surgical day wards were kept in open trolleys which were not lockable. In addition, on ward 36, we observed notes in an unlockable trolley, that was unattended at the unmanned nurses' station. This meant there was a risk records could be accessed by unauthorised persons when unattended

However, records on the surgical admissions unit were stored in lockable cabinets.

Medicines

There was an up to date medicines management policy on the intranet, which all staff could access. We observed good management of medicines in all the areas we inspected.

There was a dedicated pharmacist and a pharmacy technician for the trauma and orthopaedic ward. Staff we spoke with explained the pharmacist engaged staff in 'drug of the week' training and conducted monthly medicines management audits.

Controlled drugs were stored securely in wall mounted metal cabinets. Fields in the controlled drug (CD) registers were completed well; all drugs administered were signed for and wastage was recorded. Compliance with completion of the CD registers and weekly balance checks was audited monthly by a pharmacist.

There were colour coded burn-bins available to disposal of waste medicines.

Medication trolleys were locked and stored securely when not in use. We observed staff that were conducting medicines rounds wore tabards to reduce the risk of distraction by other staff.

We found that patients had been prescribed appropriate prophylaxis (treatment given or action taken to prevent blood clots) for venous thromboembolism (blood clots) where this was indicated.

In theatres, medicines cupboards were closed but unlocked, as staff were working nearby. Emergency drugs stored in a box and tray, were ready for use if required. Anaesthetic drugs were prepared for the current case only and all syringes were labelled.
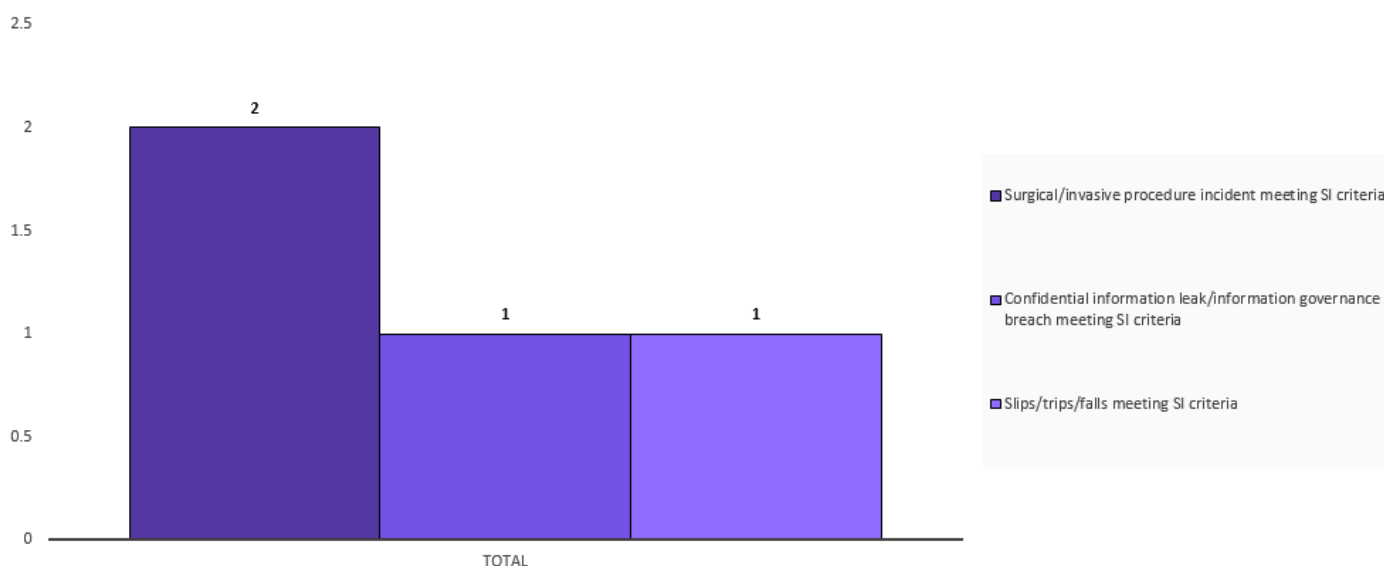
Incidents

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 October 2017 to September 2018, the trust reported two incidents classified as never events for surgery, both of which were due to a surgical/ invasive procedure.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) two of which were due to a Surgical/ invasive procedure, one due to an information leak/ information governance breach, one due to slips/ trips/ falls, in surgery which met the reporting criteria set by NHS England from October 2017 to September 2018.

Site specific information can be found below:

- The James Cook university hospital: Three
- Friarage hospital: one

(Source: Strategic Executive Information System (STEIS))

Nursing staff and doctors, we spoke with, said they felt there was a good incident reporting culture. They were clear about how to report incidents on the electronic incident reporting system and said matrons reviewed all reported incidents and provided feedback.

They told us they received feedback about outcomes of incident investigations at team meetings, team huddles and via bulletins. For example, on one ward the focus for the month was on pressure ulcers.

We saw a recently published bulletin displayed on the model-ward boards in all the areas we visited. (Model-ward boards were where quality and safety information was displayed for staff). This described a surgery never event and lessons learned and all staff we spoke with were aware of the incident.

Managers confirmed that although incidents were discussed in staff huddles, these were not documented.

There was a system in place to cascade safety alerts and these were displayed on the model-ward boards for staff to access. For example, in theatre we saw alerts about double-bagging of clinical waste and single-use medication vials.

Regulation 20, duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients and other 'relevant persons' of certain 'notifiable safety incidents' and provide reasonable support, truthful information and a written apology.

Staff we spoke with were aware of the duty of candour and provided us with examples of when they would use this. We were assured this was well embedded. Staff explained it would usually be sister or matron who would speak with patients.

Safety Thermometer

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 40 new pressure ulcers, five falls with harm and 10 new catheter urinary tract infections from September 2017 to September 2018 for surgery.

The graphs below refer to the reporting period September 2017 to September 2018.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at South Tees hospitals NHS foundation trust

[1]

Total Pressure ulcers (40)

2

Total Falls (5)

3

Total CUTIs (10)

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)

All areas we visited displayed their monthly safety thermometer audit data on the model-ward boards, including pressure ulcer rates and number of days elapsed since last reported pressure ulcers, falls, venous thromboembolisms and catheter urinary tract infections.

Is the service effective?

Evidence-based care and treatment

Staff referred to several National Institute for Health and Care Excellence (NICE) guidelines and quality standards, and Royal College best practice guidelines in support of their provision of care and treatment.

Local policies, which were accessible on the ward and on the trust intranet site, reflected up-to-date clinical guidelines. For example, we saw protocols for VTE prophylaxis, pre-operative anti-coagulation and use of antimicrobial medications, which were all referenced to national guidance.

The surgery service was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment. There were monthly audit meetings, which managers attended.

We saw an annual clinical audit report of activity that specified a range of completed, planned, and ongoing evidence-based reviews.

We saw the service had implemented guidance for sepsis screening and management.

Nutrition and hydration

Trust policies were in place regarding fasting times and intravenous fluids, in accordance with best practice. We saw written information available detailing pre-operative fasting instructions for patients admitted on the day of surgery; no food for six hours before admission time and patients could drink clear fluids up to two hours prior to admission.

Staff we spoke with explained patients on elective morning theatre lists were nil by mouth from midnight but could sip clear fluids until 6am. Those on afternoon lists had early breakfast before 7am and could sip clear fluids. Patients were also kept hydrated with intravenous fluids if required.

We found the surgery services had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients and visitors.

The ward kitchen was clean and tidy and we saw temperature monitoring records completed for the food fridge. There was a sign on the fridge which stated, 'do not leave anything on the top of the fridge'. However, the top was used to store plastic cups, utensils, a bag, two box files of documents and a ring binder.

Staff identified patients at risk of nutritional and dehydration risk or requiring extra assistance at

pre-assessment stage. Staff used the Malnutrition Universal Screening Tool (MUST) tool to

identify adults who were malnourished or at risk of malnutrition. Guidance to use the tool was displayed on a notice board on ward 8, with instructions to weigh patients on Wednesdays and weekends; 'every patient every time'.

We observed patients being offered food and drinks post-procedure and saw patients supported by nursing staff, to eat and drink if assistance was required.

We reviewed care plan documentation and risk assessments of seven patients. These included fluid charts; none of those we looked at were completed fully or added up.

A snack trolley service was available between meal times which provided patients the option to purchase additional snacks such as chocolate. We saw regular afternoon hot drinks rounds and drinking water jugs being replenished.

Staff explained how they could access advice from a dietitian and the diabetes specialist nurse.

Special dietary needs were catered for. For example, there were diabetic diets, renal diets, gluten free choices, diets for patients with food allergies, vegan and vegetarian options.

Patients we spoke with felt the quality of food was variable; one patient said, 'the food is lovely' and 'I can have cups of tea when I want one'. However, another patient said, 'the food isn't great'. On one ward, we also saw negative comments about the quality of food, from friends and family written feedback.

Patients did not have protected meal times; meal times were 8am, 12 noon and 5pm. Staff allowed family members to attend and help their relative during meal times. Staff ensured they assisted, when family members required help or support, when helping patients with eating or drinking.

Post-operative patients and those experiencing nausea and vomiting were routinely prescribed antiemetic medication.

Pain relief

Staff had access to a dedicated pain management team and a palliative care team, to support patients with complex pain needs. The pain team attended the wards weekly and as required. The palliative care team was available as required via an on-call system. Nursing staff explained that doctors reviewed patients' analgesia if required out of hours and at weekends.

All patients we spoke with who identified they had experienced pain, said that this had been managed well during their stay and nursing staff had responded promptly when pain relief had been requested.

On the wards we visited we saw pain scores were monitored as part of the NEWS 2 records, using a 0-3 assessment.
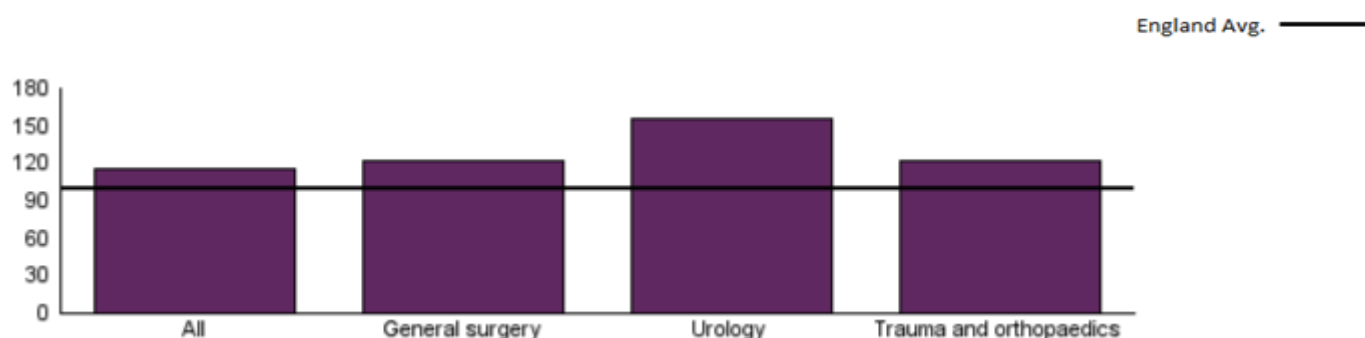
Patient outcomes

Relative risk of readmission - trust level

From June 2017 to May 2018,

- All patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

- Trauma and orthopaedics patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
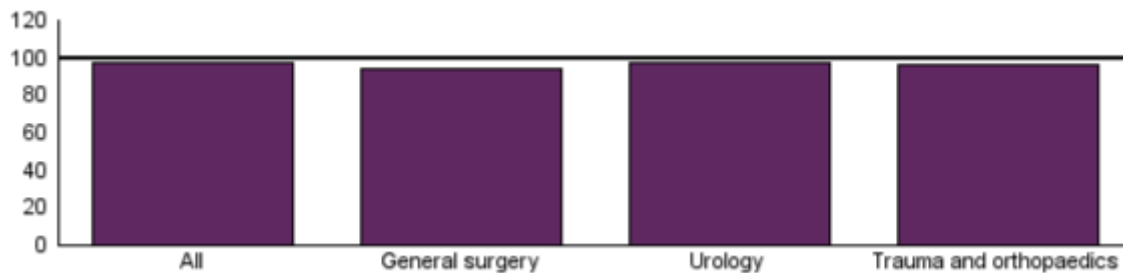
Elective Admissions – Trust Level

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 trust based on count of activity

- All patients at the trust had a slightly lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- Urology patients at the trust had a slightly lower expected risk of readmission for non-elective admissions when compared to the England average.

- Trauma and orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

England Avg. ——

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 trust based on count of activity
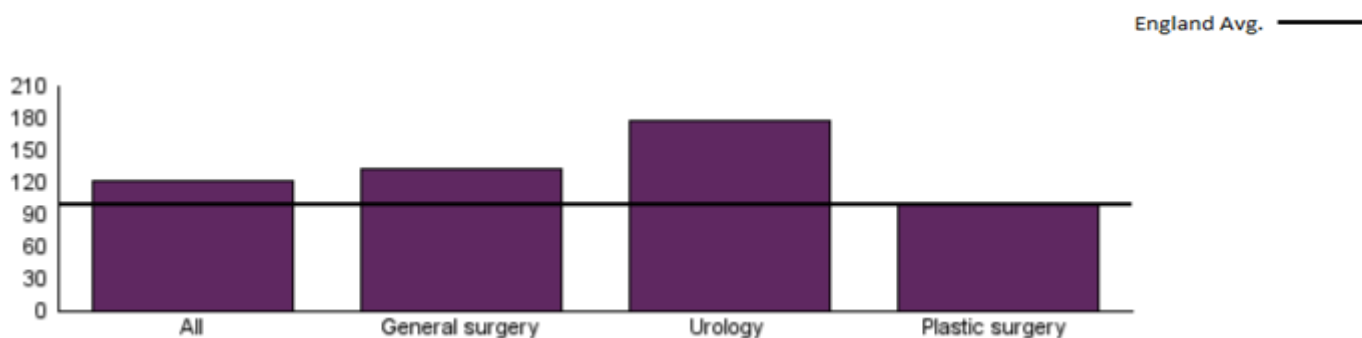
(Source: Hospital Episode Statistics - HES - Readmissions (01/06/2017 - 31/05/2018))

The James Cook University Hospital

From June 2017 to May 2018,

- All patients at James Cook university hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at James Cook university hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at James Cook university hospital had a much higher expected risk of readmission for elective admissions when compared to the England average.

- Plastic surgery patients at James Cook university hospital had a slightly lower expected risk of readmission for elective admissions when compared to the England average.
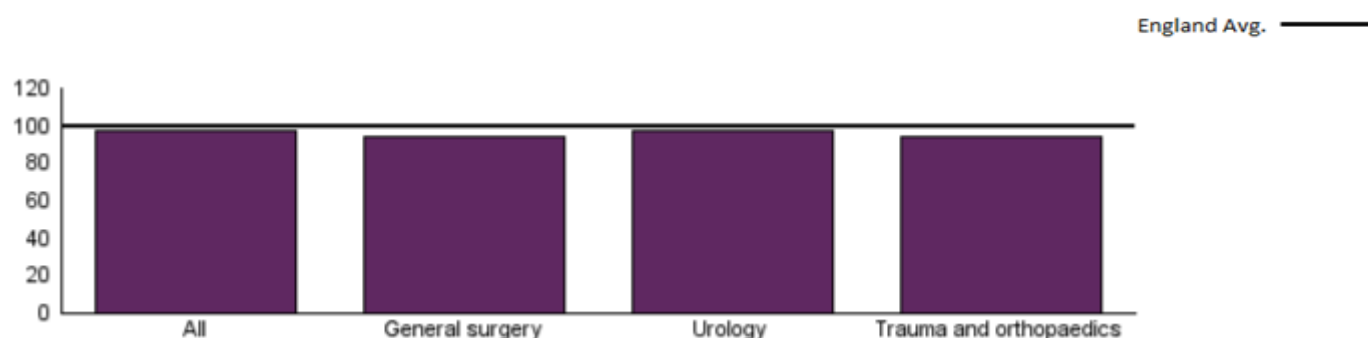
Elective Admissions - *The James Cook University Hospital*

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 James Cook university hospital had a slightly lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at James Cook university hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- Urology patients at James Cook university hospital had a slightly lower expected risk of readmission for non-elective admissions when compared to the England average.

- Trauma and orthopaedics patients at James Cook university hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - *The James Cook University Hospital*

England Avg. ────

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

In accordance with NICE quality standards, the surgery service was involved in data collection activity for numerous national audits such national hip fracture database, bowel cancer audit, national vascular registry, oesophago-gastric cancer national audit and national emergency laparotomy audit.

National Hip Fracture Database

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 6.6% which was within the expected range. The 2016 figure was 7.5%.

The proportion of patients having surgery on the day of or day after admission was 57.8%, which failed to meet the national standard of 85%. This was within the bottom 25% of trusts. The 2016 figure was 70.7%.

The perioperative medical assessment rate was 91.2%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 92.7%.

In 2018 the percentage of patients developing pressure ulcers as recorded on the national database was 98.2% against a national average of 95.5% (putting the trust in the upper middle quartile).

The length of stay was 22.7 days, which falls within the middle 50% of trusts. The 2016 figure was 21.6 days.

(Source: National Hip Fracture Database 2017)

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 59.5% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than expected. The 2016 figure was 56.4%.

The risk-adjusted 90-day post-operative mortality rate was 3.3% which was within the expected range. The 2016 figure was 3.9%.

The risk-adjusted 2-year post-operative mortality rate was 13.2% which was better than expected. The 2016 figure was 18.2%.

The risk-adjusted 30-day unplanned readmission rate was 11.5% which was within the expected range. The 2016 figure was10.9%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 53.6% which was within the expected. The 2016 figure was 50.9%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.6% for Abdominal Aortic Aneurysms. The 2016 figure was 1.4%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 18 days, this was worse than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 1.1%, this was a within the expected range.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), poor quality data were provided for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing.

The 90-day post-operative mortality rate was 2.3%. This was a positive outlier within the expected range. The 2015 rate was 0.9%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.2%. This was worse than the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

The James Cook University Hospital

In the 2016 National Emergency Laparotomy Audit (NELA), the James Cook university hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 131 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 109 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 80 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 48 cases.

The risk-adjusted 30-day mortality for the site was within the expected range. This was based on 131 cases.
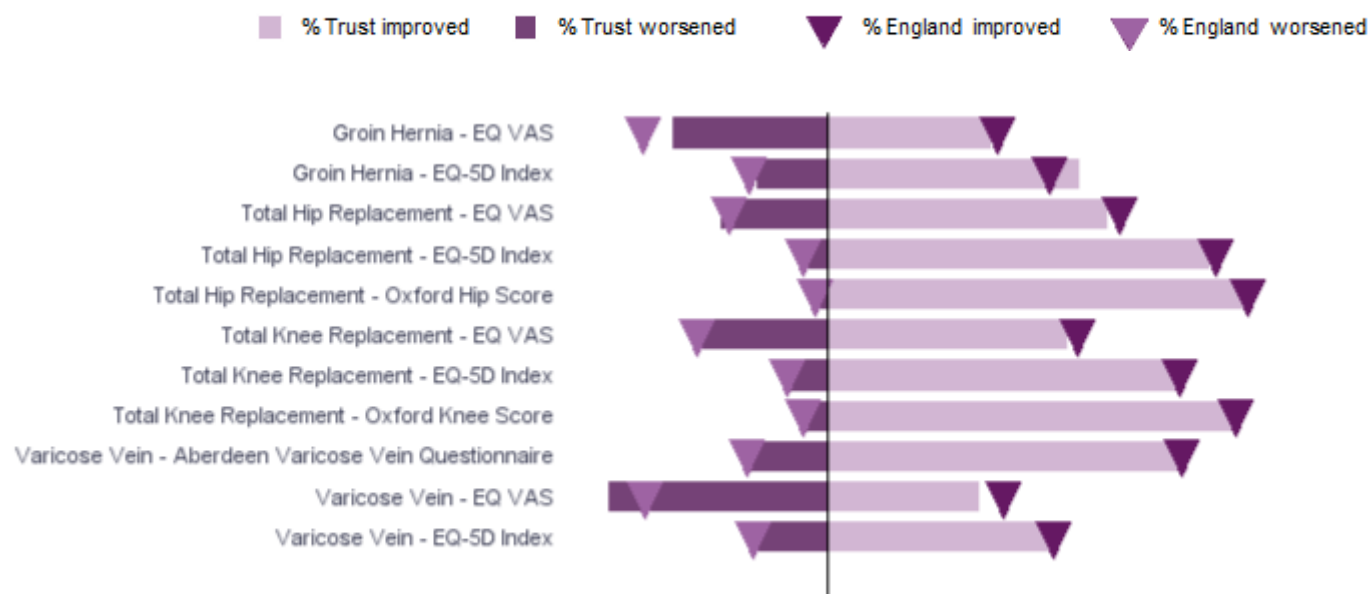
(Source: National Emergency Laparotomy Audit)

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.

In 2016/17 performance on groin hernias was better as the England average. There were less patients reporting they felt worse compared the England average. There were a similar number of patients for EQ-VAS and more patients for EQ-5 index that reported an improvement compared the England average.

For Varicose Veins, performance was about the same as the England average. The results of the Varicose Veins questionnaire and the EQ-5 index were similar to the England average. The EQ-VAS showed that more patient reported they worsened and more patients reported they improved than the England average.

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

For Knee replacements was about the same as the England average.

(Source: NHS Digital)

The trust had a programme of scheduled local audits throughout the year.

We saw patients were assessed for risk of venous thromboembolism (VTE) prior to surgery and the service participated in VTE audits to monitor compliance against policy and best practice.

We saw evidence that the service conducted hand hygiene audits and these were conducted by named hand hygiene champions. For example, all staff including allied healthcare professionals and doctors, participated in random checks using a light box to assess effectiveness of handwashing. Infection prevention control audit compliance figures for individual wards was displayed on most 'model ward' boards. However, there were no results displayed on the board on ward 8.

We looked at audit data provided by the trust, for the period July to December 2018, to monitor compliance with NEWS 2 completion and appropriate escalation. We noted consistently high compliance across the wards.

Audit data provided by the trust, to monitor compliance with MUST assessment within 24 hours and appropriate follow-up action, was reviewed. Results from July to December 2018 showed varying compliance across the wards ranging from 58% to 100%. In general, it was an improving picture.

Pain scores and evaluation post analgesia audit data, provided by the trust was reviewed for the period June to December 2018. This showed variable compliance. For example, consistently poor compliance for wards 8 and 36 and improved compliance for ward 25. The trust told us they were reviewing the audit criteria because it was believed the low compliance scores were due to inconsistent interpretation of the audit question.

The trust had an up to date policy for pre-operative site marking, correct site surgery and correct site regional anaesthesia. The trust provided a copy of the main theatres check list but this was dated for review 2014. Compliance against policy, with completion of WHO safer surgery checks was audited routinely each month. We looked at audit data for the previous nine months and found consistently good compliance across all specialities. This concurred with what we observed in theatre.

Competent staff

Nursing staff we spoke with said managers supported them with training needs and revalidation. For example, in theatre we saw a dedicated 'NMC and revalidation' information board, displaying up to date guidance and a step by step process.

Managers we spoke with said they were on track to complete staff performance appraisals and this concurred with schedules we saw in the clinical areas we visited. All staff we spoke with said they had received an annual performance appraisal in the last twelve months.
A new staff member we spoke with told us they had not had a formal induction and were not supernumerary on commencing post but had completed a competency package relevant to their role.

Appraisal rates

From October 2017 to September 2018, 77.2% of staff within surgery at the trust received an

appraisal compared to a trust target of 80.0%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
Qualified Healthcare Scientists	31	29	93.5%	Yes
Qualified Allied Health Professionals (Qualified AHPs)	25	22	88.0%	Yes
Support to ST&T staff	35	30	85.7%	Yes
Medical & Dental staff - Hospital	244	196	80.3%	Yes
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	157	125	79.6%	No
Qualified nursing & health visiting staff (Qualified nurses)	577	443	76.8%	No
Support to doctors and nursing staff	581	431	74.2%	No
NHS infrastructure support	65	48	73.8%	No

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

Multidisciplinary working

We also observed informal discussions between professional colleagues at safety huddles.

Formal documented input from the multidisciplinary team collective was recorded in the medical records. The entries highlighted involvement in care and treatment planning, discharge processes, and social considerations.

We observed physical therapies being provided by the multidisciplinary team.

There were clear internal referral pathways to therapy and psychiatric services. All wards had developed strong links with community colleagues when implementing discharge plans and care packages.

Staff we spoke with on the surgical admissions unit and post-operative surgical day unit (POSDU) explained that discharge from the service was nurse-led. They told us surgeons often visited their patients post operatively as a courtesy and visited routinely if their patient had stayed overnight. We saw clear post-operative instructions recorded in notes and we were assured nurses could contact consultants directly, to advise on discharge if required.

Medicines to take home were prescribed and dispensed the day prior to discharge as far as possible. On the surgical assessment unit medicines were prescribed by the on-call surgeon and fit-for-work notes were prepared in theatre in advance of discharge.

Staff we spoke with explained discharge information was sent to general practitioners (GPs) promptly via the e-discharge system. However, some consultants chose not to use the system and some GPs were unable to access e-discharge. In these cases, a discharge summary was printed and sent by post, resulting in some delays.

In theatre, we observed a difficult intubation procedure and saw how the team kept very calm and systematically went through correct options until the airway was secured.

Seven-day services

Nurses and junior medical staff were available seven days a week, twenty-four hours a day with support from senior (middle grade) doctors and consultants, available on-call. There was a matron available, seven days a week but not overnight as this was provided by the clinical site management team who were senior nurses.

Staff had access to a dedicated pain management team available Monday to Friday. Staff explained doctors reviewed pain management and analgesia out of hours.

Occupational therapy and physiotherapy staff were ward based on orthopaedic wards, Monday to Friday. Physiotherapists also routinely visited elective surgery patients at the weekends and staff could refer patients directly for chest physiotherapy if acutely unwell.

There was no access to occupational therapy at weekends.

Dietitian services were available Monday to Friday when needed and planned patient care in advance of the weekends. For example, they ensured weekend feed regimes were written up for patients having total parenteral nutrition feeds and percutaneous gastrostomy tube feeds. Staff explained they could make a referral to a dietitian over the weekend and the dietitian would always visit weekend referrals on the Monday.

Speech and language therapy services were available Monday to Friday; staff could refer over the weekend for patients to be seen on Monday.

The trust safeguarding team was available Monday to Friday. Out of hours, staff contacted the duty matron for advice and support as required.

There was access to interpreters in the hospital (often doctors) and interpreter services via switchboard.

Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Patients also had seven- day a week access to diagnostic services and emergency therapies provided through on-call services.

Health Promotion

We saw a wide variety of information leaflets available for patients, carers and visitors in public areas, including for example, MRSA screening information, infection prevention information, signposts to support services. smoking cessation, and advice about flu vaccination.

Health promotion was also incorporated into the surgery pre-assessment process.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 64.6% of staff in surgery compared to the trust target of 90.0%.

The breakdown by site was as follows:

Site	Training complete (YTD)	Individuals required (YTD)	Completion rate	Target met
Friarage hospital	111	136	81.6%	No
The James Cook university hospital	612	983	62.3%	No

The trust did not report Deprivation of Liberty Safeguards training during the same period.

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

Staff could access an up to date consent to examination and treatment policy on the intranet, which was referenced to current mental capacity legislation and described how consent was obtained when people lacked the capacity to make decisions.

There were no young persons on the wards at the time of this inspection but the policy referred to Gillick competency.

The policy did not describe a best-practice two-stage consent procedure and managers we spoke with on the surgical admissions unit confirmed patients were consented on the day of surgery. We noted the process of obtaining informed consent initiated in surgery pre-assessment, through provision of information however, this was not always documented on the consent forms we saw in patient records.

We looked at ten sets of patient records and consent forms were completed comprehensively; risks and benefits of surgery were documented and all forms were saw were signed and dated.

Staff at band 5 and above had been trained to undertake mental capacity assessments. Managers explained they had experience of applying for deprivation of liberties orders and training was undertaken as part of safeguarding. We found that most of nursing staff had a clear understanding of the Mental Capacity Act or the Mental Health Act.

We inspected the record of a patient who had post- operative delirium. The patient was nursed with level three enhanced observation and deprivation of liberties documentation was completed.

Is the service caring?

Compassionate care

We observed patients being treated with dignity and respect in all areas we visited. In theatres and wards, staff were seen to observe patient's dignity by ensuring that curtains were closed around them and patients on trolleys were covered with blankets.

There were windows in the theatre transfer bay with obscured glass and blinds. Patients waiting wore gowns, dressing gowns and slippers. This area was shared by male and female patients and a screen was available to allow segregation.

We observed staff speaking with a patient in an anaesthetic room. They were introduced to the theatre team and staff explained what would happen during administration of anaesthetic. We observed the patient being reassured as monitoring equipment was attached, having given their verbal permission.

All patients we spoke with reported that their privacy was maintained throughout their stay. Patients we spoke with on ward 36 told us; 'they are happy, friendly staff' and 'I feel well cared for'.

Another on ward 8 told us, 'my treatment has been marvellous; it's very clean and the staff are friendly'.

On ward 36, we had concerns that call bells were not always answered promptly. For example, one bell was not answered for approximately ten minutes although there were staff walking past. Another rang for approximately five minutes until a manager asked a nurse to answer it. Another rang for approximately five minutes prior to being answered. We brought this to the attention of managers who informed us there was a fault with the call bell system, which engineers were addressing.

On ward 8, we observed one occasion when a call bell was not answered for over five minutes, until we alerted a member of staff. Otherwise, call bells were answered promptly, within two minutes and this was confirmed by patients we spoke with.

Staff were seen to help patients at meal times to ensure food and drinks were within reach and appropriately prepared for them.

Friends and Family test performance

The friends and family test response rate for surgery at South Tees Hospitals NHS Foundation Trust was 10% which was worse than the England average of from October 2018 to September 2018. A breakdown of response rate by site can be viewed below:

Friends and family test response rate at South Tees Hospitals NHS Foundation Trust, by site.

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]											Annual perf[1]
			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	
WARD 36	423	21%	88%			95%		100%	100%	100%		89%	100%	97%	98%
WARD 7	355	43%	96%	94%	94%	93%	100%	98%	100%	100%	100%	97%	100%	95%	97%
POSDU	327	20%		100%	100%		100%		100%			100%	100%		100%
GARA WARD	319	44%	98%				100%	96%	100%		100%	100%	100%	100%	91%
Surgical Admissions Unit	249	7%		96%	97%	100%			100%	97%		100%			98%
WARD 5	179	18%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	99%
WARD 6	168	29%	100%	93%	93%	100%	100%	100%	100%	100%	100%	88%	100%	100%	97%
WARD 37	152	13%		97%	97%	100%	100%	91%	100%	100%	94%	87%			96%
SPINAL INJURIES REHABILITATION UNIT	131	96%	100%					100%	100%	100%	100%				100%

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).

[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.

Note: sorted by total response

(Source: NHS England Friends and Family Test)

Emotional support

We saw senior nursing staff and doctors were visible on wards and patients and relatives could speak with them when they wanted to.

Spiritual support was available to patients and their families at all times, for example a multi-faith chaplaincy service.

Clinical nurse specialists were available within surgery and attended wards to provide additional support and advice to patients for example, breast and stoma care.

Understanding and involvement of patients and those close to them

We spoke with several patients on different wards during our inspection, about how they were involved in their plan of care. We did not speak to any relatives at the time of inspection.

One patient raised concerns with us about how their medication interactions were managed. They reported this was being investigated by a pharmacist and consultant, but perceived staff to be 'slightly colder' since they made a complaint.

Another patient said, 'I was moved here from Friarage hospital without being involved in the decision, but I know it was in my best interests. Now I'm fifty miles from home and my relatives can't visit very often'.

A patient we spoke with said, 'my surgery was postponed three times, but I have been kept well informed by staff'. This patient told us they were aware of discharge plans but anticipated difficulties with travel to attend out-patient follow up.

One patient said they had witnessed relatives 'snapping at staff'. However, staff did not respond and remained very professional. They said they had remarked to staff about how well they handled the situation.

Another patient told us they 'felt in the dark' about their care and that 'communication could be better'. They raised their concerns with nursing staff and this resulted in doctors telephoning a relative to clarify the situation. They reported that since then, the doctors and nursing staff had explained everything and provided written information as well.

A range of information and advice leaflets were available in the areas we visited; these included discharge information, specialist services and support groups that were available.

Wards had extended visiting times that allowed greater time for friends and relatives to be part of a patient's care.

Is the service responsive?

Service delivery to meet the needs of the local people

The facilities and premises were accessible to all patients. The service worked in partnership with clinical commissioning groups (CCGs) and other providers across clinical networks to deliver both elective and non-elective surgical treatments, in a way that met the needs of local people. For example, in the surgical admissions unit, patients could use 'choose and book' for planned minor procedures.

Patients were seen at pre-assessment appointments where they were assessed whether they were suitable for surgery. This also gave patients an opportunity to ask questions about their surgery.

Meeting people's individual needs

We saw that staff cared for patients as individuals and strived to meet their individual needs. We saw patients being treated with dignity and respect by addressing them as they wished to be addressed and closing curtains and doors as necessary.

The ward managers confirmed that the needs of all patients, irrespective of age, disability, gender, race, religion, or belief were considered.

We asked staff how they ensured people's individual needs were met. An example given, was a patient who had been on the ward for a prolonged period due to post-operative complications. Staff were mindful of how this impacted on the patient's mental health and involved the therapeutic care team, who spent time with the patient and helped implement activities to ensure they were kept occupied.

During the inspection we observed initiatives in place, to improve care of those living with dementia. For example, the wards had adopted the butterfly scheme, which enabled family carers to teach staff how to help people who needed memory support whilst in hospital, and the forget-me-not scheme, which discreetly identified patients living with dementia. The wards had dementia friendly signage on bathroom and toilet doors.

The trust employed an advisor for learning disability and autism for thirty hours per week, to cover the whole of South Tees. Nine hours were dedicated to staff training and twenty-one hours were 'assurance rounds'.

Staff knew how to contact them for advice when required. They visited the wards routinely in response to the electronic patient admission flagging system. They were available for patient appointments and admissions and supported the staff to make reasonable adjustments on the wards, such as ensuring availability of single rooms and additional beds / recliner chairs to accommodate carers overnight.

There was also a dedicated room in the surgical admissions unit, which could accommodate patients wishing to bring their carer, community dental patients and to provide more privacy for admission of patients undergoing transgender procedures.

Initiatives to enhance the care of those with a learning disability were in place. For example, most patients had a 'this is me' hospital passport, which detailed personal preferences, likes/dislikes, anxiety triggers, and interventions, which were helpful in supporting them during difficult periods.

Staff informed us that they had ease of access/referral into psychiatric services for those patients requiring this care, when needing mental capacity act and deprivation of liberties.

All wards and the surgical admissions unit displayed up to date information leaflets for patients and carers about specific health topics and signposting to other services. For example, how to access home from hospital services, Macmillan cancer care, advocacy support, patient advice and liaison services (PALS), and complaints process.

However, all information leaflets we saw were in English language only and staff we spoke with were unclear where to obtain other language versions.

Staff explained that interpreter services were available via language line and face to face.

The trust had chaplains who provided access to multi-faith facilities within their communities. Staff accommodated faith preferences, and this was facilitated by the chaplaincy service or at the bedside.

Staff we spoke with explained that they could access bariatric equipment from central equipment storage and other wards when this was required. This included access to special beds, commodes, wheelchairs, bariatric hoist and chairs. High-low beds were available for patients at high risk of falls.

Staff we spoke with explained they now observed protected sleep times for patients from 11pm to 6am. This was due to feedback from the trust's 1,000 Voices patient survey which identified noise

at night as the main area that could be improved to help make a patient's hospital stay more comfortable.

Actions taken included reducing general noise levels and speaking volume, closing doors quietly, purchasing bins with soft-close lids, reducing light levels, conducting clinical interventions only when necessary (vital signs monitoring) and ensuring phones and televisions were switched off at 11pm.

Visiting was permitted 8am to 8pm but visitors were asked to leave if patient care interventions were required.

Access and flow

Theatre teams were actively monitoring allocations and turnover for all recovery areas to maximise utilisation and were working toward mirroring the Friarage empty-recovery model.

Bed management meetings occurred at 8am, 1pm, 3pm and 5pm every day. These were attended by representatives from all departments including theatre, to ensure access to beds for elective surgery patients.

Managers looked at reasons for theatre delays daily and discussed trends and areas for improvement with the patient flow team, at quarterly meetings.

Staff we spoke with in theatre raised concerns to us about access to radiological services; demand had increased but they felt that seven machines and six radiographers to operate them was insufficient resource. They explained there was a daily 4pm management meeting to try to improve planning.

Managers we spoke with told us instances of delayed transfers of care (DTOC) were improving due to social services providing care packages more quickly.

'Discharge to assess' processes were in place to ensure people that did not require an acute hospital bed, but that required care services were provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting.

The surgical admissions unit was usually operational from Monday morning to Saturday lunchtime, however at time of inspection, the unit remained open at night to accommodate increased activity during winter.
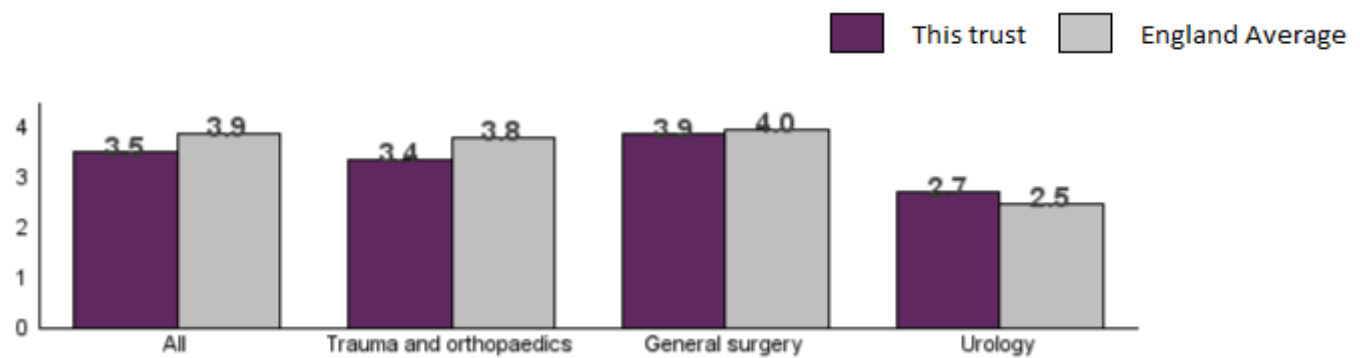
Average length of stay

Trust Level – elective patients

From July 2017 to June 2018, the average length of stay for all elective patients at the trust was 3.5 days, which is lower compared to the England average of 3.9 days.

- For trauma and orthopaedics elective patients at the trust was 3.4 days, which is lower compared to the England average of 3.8 days.

- For general surgery elective patients at the trust was 3.9 days, which is as expected compared to the England average of 4.0 days.

- For urology elective patients at the trust was 2.7 days, which is as expected compared to the England average of 2.5 days.

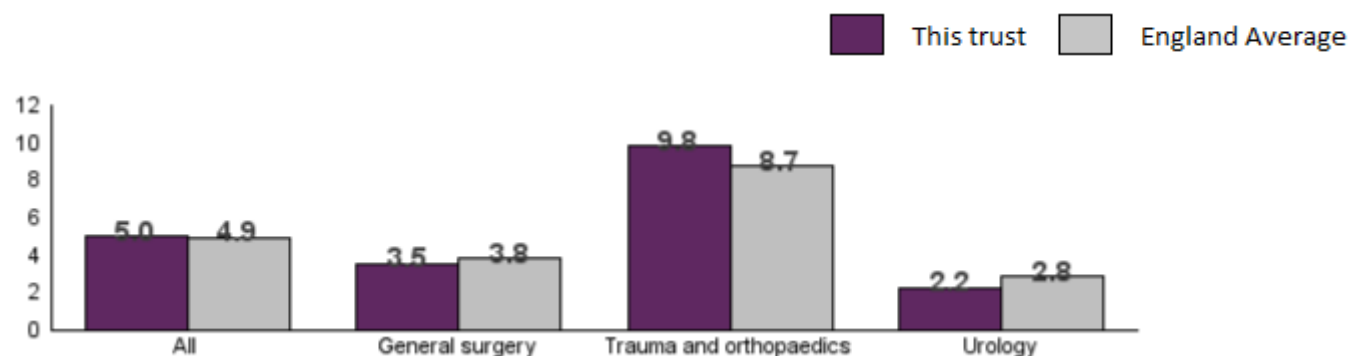**Elective Average Length of Stay – Trust Level**

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

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 5.0 days, which is as expected compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at the trust was 3.5 days, which is lower compared to the England average of 3.8 days.

- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 9.8 days, which is higher compared to the England average of 8.7 days.

- The average length of stay for urology non-elective patients at the trust was 2.2 days, which is lower compared to the England average of 2.8 days.
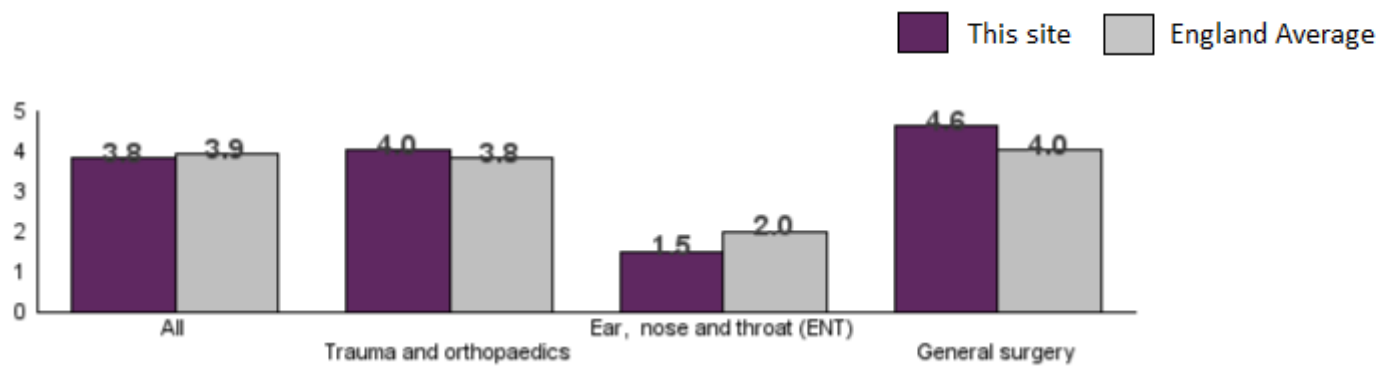
Non-Elective Average Length of Stay – Trust Level

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

The James Cook University Hospital - elective patients

From July 2017 to June 2018, the average length of stay for all elective patients at the James Cook university hospital was 3.8 days, which is as expected compared to the England average of 3.9 days.

- The average length of stay for trauma and orthopaedics elective patients at the James Cook university hospital was 4.0 days, which is as expected compared to the England average of 3.8 days.

- The average length of stay for ear, nose and throat (ENT) elective patients at the James Cook university hospital was 1.5 days, which is lower compared to the England average of 2.0 days.

- The average length of stay for general surgery elective patients at the James Cook university hospital was 4.6 days, which is higher compared to the England average of 4.0 days.

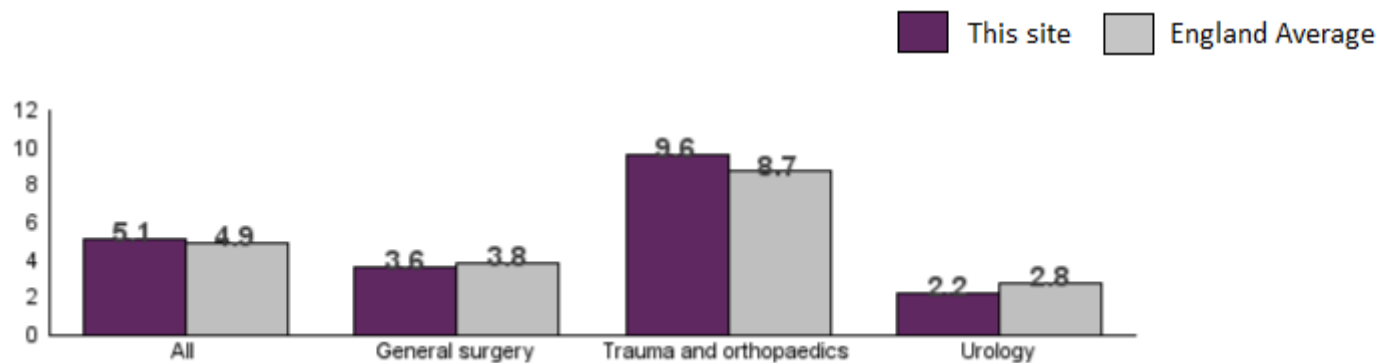## Elective Average Length of Stay - The James Cook University Hospital

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

The James Cook university hospital - non-elective patients
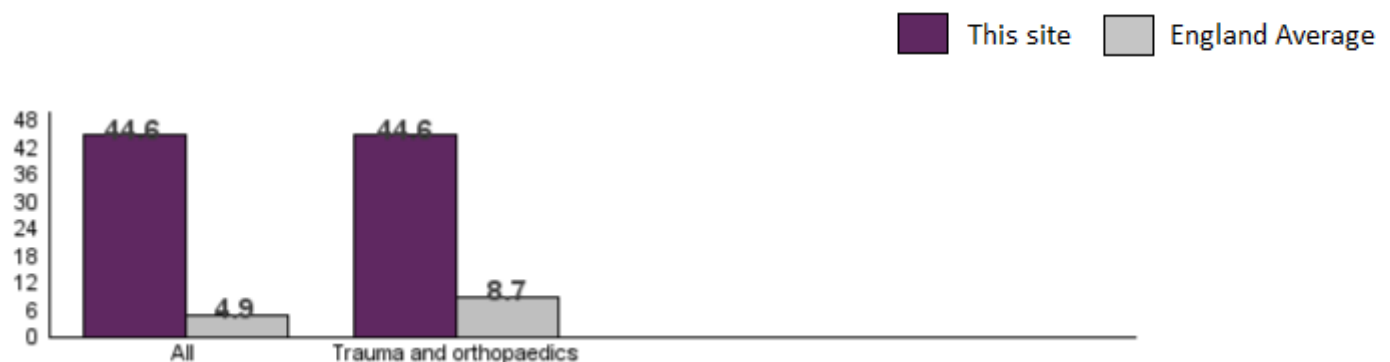
The average length of stay for all non-elective patients at the James Cook university hospital was 5.1 days, which is as expected compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at the James Cook university hospital was 3.6 days, which is as expected compared to the England average of 3.8 days.

- The average length of stay for trauma and orthopaedics non-elective patients at the James Cook university hospital was 9.6 days, which is higher compared to the England average of 8.7 days.

- The average length of stay for urology non-elective patients at the James Cook university hospital was 2.2 days, which is lower compared to the England average of 2.8 days.

Non-Elective Average Length of Stay - The James Cook University Hospital
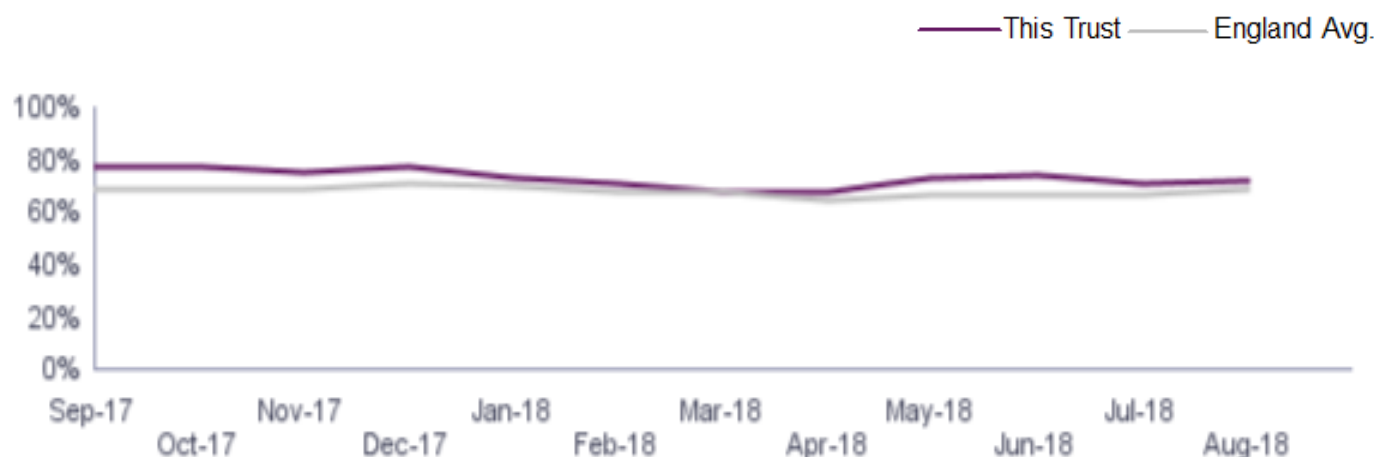

Note: Top three specialties for specific site based on count of activity.

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

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

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was consistently better than the England average. The trusts RTT within 18 weeks dipped in March and April 2018 to similar to the England average. The trust latest month RTT within 18 weeks, in August 2018 was 72.0%.

(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	95.3%	79.6%
ENT	91.2%	63.1%
Plastic surgery	84.8%	81.1%
Neurosurgery	82.5%	69.9%
General surgery	77.6%	72.6%
Ophthalmology	68.3%	68.2%
Oral surgery	63.9%	59.4%

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

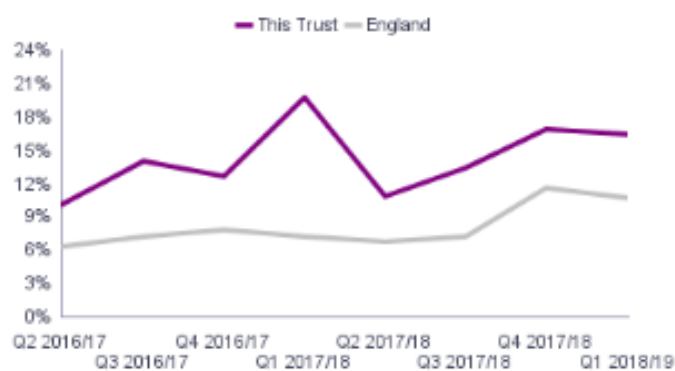| Specialty grouping	Result	England average
Urology	73.5%	76.7%
Trauma and orthopaedics	59.3%	60.0%

Cancelled operations

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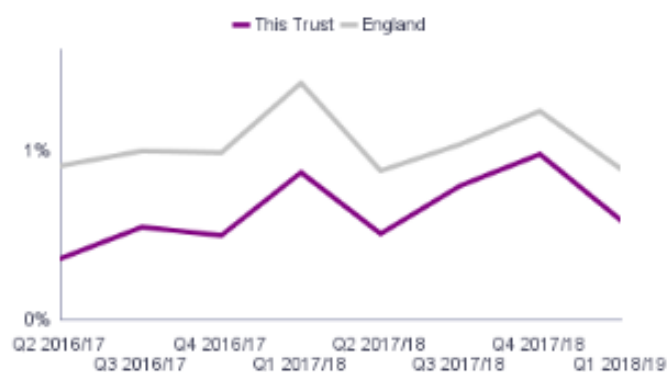
due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

Over the two years, the percentage of cancelled operations at the trust showed a consistently worse than the England average. With the most cancellations in Q1 2017/18, the trust cancelled 121 surgeries. Of the 121 cancellations 20% weren't treated within 28 days. The trust then improved in Q2 2017/18, with 110 cancelled surgeries 11% of which weren't treated within 28 days. Performance then showed a trend of decline up to Q4 2017/18, the trust cancelled 202 surgeries. Of the 202 cancellations 17% weren't treated within 28 days. The latest quarter Q1 2018/19, the trust cancelled 122 surgeries. Of the 122 cancellations 16% weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - South Tees Hospitals NHS Foundation Trust

Cancelled Operations as a percentage of elective admissions - South Tees hospitals NHS foundation trust

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

(Source: NHS England)

Learning from complaints and concerns

The trust had a version controlled complaints policy detailing principles of handling comments, concerns and complaints. Staff were aware of the policy and could source this electronically on

the intranet.

The trust had a system in place to encourage complaints and compliments, with a view to improving services for patients.

Summary of complaints

From October 2017 to September 2018 there were 142 complaints about surgical care. The trust took an average of 36 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be closed within 40 days.

The James Cook university hospital: There were 129 complaints, a breakdown is given below:

- Patient Care: 95
- Appointments: 14
- Communications: six
- Privacy, dignity & wellbeing: three
- Admin/policies/procedures (including patient record): three
- Access to treatment or drugs: three
- Admissions and discharges (excluding delayed discharge due to absence of care package): Two
- Other (specify in comments): one
- Values & behaviours (staff): one
- Staff numbers: one

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

Staff we spoke with said they would seek to resolve a concern informally in the first instance but complaints were dealt with formally if necessary. The governance arrangements in place ensured that lessons learned from complaints were shared amongst staff. Staff we spoke with could not provide examples of lessons learned from complaints and confirmed complaints were a theme discussed at ward huddle meetings.

Patients, and carers could provide feedback to the trust in several ways, for example by completing feedback cards and on-line. The trust complaints and feedback process was open and accessible to all who were eligible to use it.

We saw notices displayed within the services showing how to complain which signposted patients or their carers or relatives to the trust's patient advice liaison service (PALS) for support in making a complaint. Leaflets were available to patient and their families advising how to submit a compliment, comment, concern or complaint.

We discussed complaints with staff. Staff told us response times for complaints were met with support from the trust's PALS team. All written compliments/complaints received by the complaints team were logged in the PALS department.

Staff stated that face to face complaints were met with sensitivity and resolved on the day if possible to prevent ongoing concern.

Number of compliments made to the trust

From October 2017 to September 2018 there were 39 compliments within surgery of which 33 were for the James Cook university hospital.

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

We saw 'thank you' cards displayed in the wards we visited.

We observed patient satisfaction and friends and family feedback data displayed on model-ward boards. Satisfaction scores were high; for example, one ward had received an overall satisfaction rating of 9.34 out of 10. Metrics scored included dignity and respect, involvement, good doctors, good nurses, kindness and compassion, pain control, cleanliness and hand hygiene.

Is the service well-led?

Leadership

The trust was led by a chief executive, medical director for urgent and emergency care, medical director for medical care, medical director for community care, medical director for corporate clinical services, education and research, director of nursing and director of finance. We met and spoke with them during and after inspection.

Staff perception of senior management visibility was variable. For example, some staff and doctors we spoke with felt senior managers above matron level were not very visible or approachable.

There was a senior matron for surgery who covered Friarage and James Cook hospitals and they were contactable by telephone when not on site. Staff said they were comfortable to approach matron for support or if they wished to raise a concern.

Staff raised concerns to us there were too many different surgical specialties located on ward 8 and this made it a stressful environment to work in. They told us they never felt 'on top of the work'.

Vision and strategy

The trust vision was to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement. The values included putting patients at the centre of everything they do, continuously improving quality and using resources to the benefit of the wider community.

The trust clinical services strategy was to be the specialised cancer, cardiovascular, trauma, children's and neurosciences provider for the north of North Yorkshire and the south of the North East, and to provide integrated healthcare for local communities.

Four strategic objectives defined their clinical services strategy:

- To be the major provider of specialised services in the south of the North East and northern North Yorkshire

- To be the predominant provider of integrated secondary and community services in Middlesbrough, Redcar and Cleveland, Hambleton and Richmondshire

- To realise significant quality and efficiency improvements through the integration and transformation of secondary and community services

- To realise significant quality and efficiency improvements through major service innovation every year.

Staff we spoke with below manager level were not aware of the trust strategy going forward. Managers we spoke with said the CEO briefing was posted on the intranet which all staff could access.

Culture

Staff at all levels spoke passionately about their work, and about the quality of care delivered. Staff spoke openly about some of the staffing difficulties faced on the wards but described their commitment to deliver the best possible care at all times.

We observed staff working together on the wards and felt a sense of 'pulling together' to get the job done. We saw staff from a variety of specialisms and grades of staff working together effectively.

Staff we spoke with in theatres said there was a 'good team feel'. Some staff we spoke with said 'it's very stressful on the ward at times' and they expressed concerns about being moved to backfill other wards. They told us matrons supported them and helped on wards when required. However, they said they felt proud of how they had worked together to overcome these difficulties and managers said they were proud of staff resilience and retention.

All staff we spoke with told us their immediate line managers and clinical leaders were professional, supportive and helpful. Nursing and junior medical staff described their senior peers as 'supportive and approachable'. Staff we spoke with at all levels felt there were no issues with bullying and all staff we asked were aware of the whistleblowing policy.

Staff we spoke with said they recognised the need for changes to be implemented but considered the amount of changes and speed of change in the organisation added to existing pressures.

Student nurses said they were satisfied with the support received from their mentors and were never left unsupervised. The trust received a 'placement of the year' nomination from a local university.

Governance

All staff we spoke with knew how to access policies and procedures on the trust intranet.

There was a clear governance structure in place which ensured quality and safety information was cascaded from 'ward to board' and back down.

Service managers attended daily 'wall' meetings, where information about key performance indicators was presented and discussed. This included safety reports, patient satisfaction feedback, complaints, lessons learned from serious incidents, infection prevention and control, venous thromboembolism, falls and pressure ulcers.

Governance metrics were presented as dashboards each month and displayed on model-ward boards, for all staff to see. Managers explained it was their responsibility to ensure all staff were aware and did this through staff huddles around the model-ward board, staff meetings and written bulletins.

Staff we spoke with in theatres said they no longer held department team meetings as these had been stopped by trust managers. They said they had found the meetings useful but now kept a communication book to hand over any news, issues and information cascaded down from band 6 / matron's meetings.

Management of risk, issues and performance

We saw the trust had a risk management policy which described the trust risk management strategy and roles and responsibilities. All staff could access it on the intranet.

Business continuity plans had been developed and implemented for critical services. Staff we spoke with described scenario training they had undertaken for management of major incidents.

We saw a departmental risk register held in a manager's office on a ward and staff we spoke with could provide examples of risks which had been addressed. For instance, panic buttons were required due to high levels of patient aggression. These were subsequently provided and the ward implemented 'behaviour agreements' for patients.

Managers explained that areas of the estate required refurbishment and this was on the risk register.

Was saw that the surgical centre had an active risk register in place which identified risk, controls, gaps in control and action plans. All risks had review dates in place with evidence of updates.

Information management

Policies and procedures were held electronically on the trust intranet and all staff we spoke with could access the system.

Important governance information was cascaded to teams via huddle meetings although the content of these meetings was not documented.

Patient records were predominantly on paper. The exception was the use of hand held electronic vital pack machines for recording vital signs. Senior managers we spoke with after inspection told us they were aware the trust was 'paper heavy and IT light'.

Managers we spoke with explained how statistical data held electronically was analysed to provide patient focused care. For example, they could see via Electronic Patient Status at a Glance (e-PSAG) boards, which patients were on which wards at any one time, see previous admissions information and pick up any trends or alerts, which might be a trigger for further actions such as safeguarding.

Computer screens in theatre were locked when unattended in accordance with information governance policy.

Engagement

Leaflets about the friends and family test, and PALS were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes.

Ward sisters and matrons were visible on the ward, which provided patients and visitors with opportunity to express their views and opinions.

Discussions with patients and families regarding decision making was recorded in patient notes. We saw thank you cards and letters displayed at the entrances to wards.

We were told by staff that their line managers engaged with them well, for example, through bulletins, team briefs and safety huddles. Staff we spoke with told us they could voice their

opinions and speak with the ward sister and matron, receive feedback and discuss any concerns. However, some staff felt senior managers above matron level were not very visible.

Learning, continuous improvement and innovation

We spoke with staff who were supported to develop their careers through college and university-based learning and in-house leadership development programmes.

Staff we spoke with provided examples of how they had changed practice to improve patient experience and efficiency. For example, on one ward, waiting time taken to collect patients from theatre was reduced on average from 90 minutes to 20 minutes.

One of the operating theatres utilised robotic equipment for multi-specialty surgical cases. Staff commenced modular training in 2014 and the equipment had associated standard operating procedures and manuals, for safe use.

In the surgical assessment unit, there were plans from April 2019, for health care assistants to be upskilled to assist doctors with stent removal. Competency based training was in place to do this. This initiative was led by a consultant urologist and a nurse manager.

Managers we spoke with explained how they were working differently to improve patient care. For example, they developed a care pathway for patients with abscesses. These patients previously had to wait all day until the end of theatre lists for their procedure. The new pathway meant they were admitted to the surgical admissions, operated on promptly and discharged home the same day.

Additionally, a 'hand block' service was introduced, which meant patients could have hand surgery under regional anaesthesia instead of general anaesthesia and could go home more quickly. These patients also received a follow up phone call at home to ensure they were comfortable when the block wore off.

Diagnostic imaging

Facts and data about this service

The main radiology departments are in The James Cook University Hospital, Middlesbrough and Friarage Hospital, Northallerton. The two main departments provide services 24 hours a day, seven days a week.

General radiography is also provided to the community hospitals of Redcar, Guisborough, East Cleveland (Brotton) and the Friary Hospital, Richmond.

Advanced practice radiographers are also based at both James Cook and the Friarage radiology departments, who perform and provide imaging procedures and reports in general radiography, CT, MRI, breast imaging, ultrasound scanning and fluoroscopy.

The trust provides a range of services in diagnostic imagine including:

- Radiology

- Mammography

- Neuroradiology

- Ultrasound

The inspection was unannounced (staff did not know we were coming). *We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings.* At this inspection we inspected and rated all key questions except for effective. During the inspection of diagnostics at James Cook University Hospital we spoke with 17 staff, 12 patients, two relatives and reviewed five patient records.

(Source: Routine Provider Information Request ACUTE – Context)

Is the service safe?

Mandatory Training

The department required all staff to complete mandatory training in topics such as infection prevention and information governance. The trust target for completion of mandatory training was 90%.

During the inspection, we asked leadership for compliance rates for training, we were told the department did not have access to this data. Following the inspection, the trust was unable to provide retrospective data therefore we were not assured how the department monitors mandatory training compliance. The department reported the data for mandatory training to be out of date and therefore appearing less compliant. We saw evidence of mandatory training compliance being discussed at governance meetings.

Manual handling and basic life support however both topics was mandatory for all clinical staff in the department however was not included in the mandatory training data. The department had a manual handling champion who was responsible for training staff in manual handling. Following our inspection, the trust submitted the current compliance for manual handling in Radiology which was 82.5% this was below the trust target of 90%. The current compliance for basic life support in Radiology was 69.6%.

We spoke with five staff regarding mandatory training compliance. All told us they could access

training and their manager received alerts when training was due. All staff reported to have sufficient allocated time to complete mandatory training. During the inspection, five members of staff reported to be up to date with training. However, staff told us they felt some training was not adequate for example some training was provided as e-learning rather than face to face.

The department made sure all diagnostics and radiology staff had undergone specific training in handling radioactive and hazardous substances in line with their roles and responsibilities.

Trust level

Below is the breakdown of compliance for mandatory training courses from October 2017 to September 2018 at trust level for medical and dental staff in diagnostics:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Equality and Diversity	18	18	100.0%	90.0%	Yes
Health and Safety (Slips, Trips and Falls)	18	18	100.0%	90.0%	Yes
Information Governance	17	18	94.4%	90.0%	Yes
Infection Prevention (Level 1)	17	18	94.4%	90.0%	Yes
Fire Safety 3 years	16	18	88.9%	90.0%	No

In diagnostics the 90.0% target was met for four of the five mandatory training modules for which medical and dental staff were eligible. Medical staff worked across James Cook University Hospital and Friarage Hospital.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 at trust level for qualified AHPs in diagnostics is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health and Safety (Slips, Trips and Falls)	117	128	91.4%	90.0%	Yes
Information Governance	116	128	90.6%	90.0%	Yes
Equality and Diversity	115	128	89.8%	90.0%	No
Fire Safety 3 years	110	128	85.9%	90.0%	No
Infection Prevention (Level 1)	107	128	83.6%	90.0%	No

In diagnostics the 90.0% target was met for two of the five mandatory training modules for which qualified AHPs were eligible.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 at trust level for scientific, therapeutic and technical support staff in diagnostics is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Information Governance	66	72	91.7%	90.0%	Yes
Equality and Diversity	62	72	86.1%	90.0%	No
Health and Safety (Slips, Trips and Falls)	60	72	83.3%	90.0%	No
Fire Safety 3 years	54	72	75.0%	90.0%	No
Infection Prevention (Level 1)	48	72	66.7%	90.0%	No

In diagnostics the 90.0% target was met for one of the five mandatory training modules for which scientific, therapeutic and technical support staff were eligible.

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

Safeguarding

Safeguarding processes were embedded and established within the Trust. During our inspection we saw that the trust had 'adults at risk' and 'safeguarding children' policies in place that staff could access on the trust's intranet. Staff told us they knew about female genital mutilation, how to access the policy on the intranet and what action to take should they have any concerns about patients attending the department. There was information on the hospital intranet about how to report safeguarding concerns about patients. Staff also told us if they were unsure what action to take, they would speak with their line manager or the safeguarding team within the trust for advice. Staff we spoke with knew about the trust safeguarding team. Any previous safeguarding information would be shown on the patient record for staff to see.

The trust set a target of 90.0% for completion of safeguarding training. NHS England guidance states clinical staff working with children and young people should complete Safeguarding level 3 however the trust reported one eligible staff member for safeguarding level 3. Staff reported to be up to date with safeguarding training. The training was provided via e-learning but staff interviewed stated they would prefer face to face training which they thought would be better for engagement and focus.

One staff member told us they had attended non- accidental injury training as part of their continuous professional development. Staff reported prevent radicalisation was part of the safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 at trust level for medical and dental staff in diagnostics is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 3 Additional)	1	1	100.0%	90.0%	Yes

Safeguarding Children (Level 1)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 3)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 2)	16	16	100.0%	90.0%	Yes
Safeguarding vulnerable adults	17	18	94.4%	90.0%	Yes

In diagnostics the 90.0% target was met for five of the five safeguarding training modules for which medical and dental staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 at trust level for qualified AHPs in diagnostics is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding vulnerable adults	119	128	93.0%	90.0%	Yes
Safeguarding Children (Level 2)	117	128	91.4%	90.0%	Yes

In diagnostics the 90.0% target was met for two of the two safeguarding training modules for which qualified AHPs were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 at trust level for scientific, therapeutic and technical support staff in diagnostics is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 2)	49	54	90.7%	90.0%	Yes
Safeguarding vulnerable adults	64	72	88.9%	90.0%	No
Safeguarding Children (Level 1)	5	18	27.8%	90.0%	No

In diagnostics the 90.0% target was met for one of the three safeguarding training modules for which scientific, therapeutic and technical support staff were eligible.

Cleanliness, infection control and hygiene

Staff could access the trust infection prevention and control policies on the Trust intranet. These were underpinned by national guidelines, to manage and monitor infection for patient and staff safety. We looked at COSHH (Control of substances hazardous to health) policies and found them to be in date. Any substances hazardous to health such as cleaning products were safely stored.

During our inspection we looked at the cleanliness of the department. All areas including clinical rooms, corridors and waiting area were clean and uncluttered. We saw evidence of bimonthly infection, prevention and control meetings for the radiology department and the trust's health care acquired infection monthly update included actions for the radiology department. There were cleaning schedules in place and these showed regular cleaning of the department and the

equipment being used. Staff wiped down equipment between patients and used a disposable paper covers on beds, this was changed after every patient. Sharp bins were signed, dated and not over ¾ full as according to policy. There were processes in place to manage clinical waste within the department.

There was sufficient personal protection equipment such as gloves and aprons available to staff and we observed staff adhered to 'bare below the elbow' guidance. Staff ensured any infectious patients received treatment at the end of the list and domestic staff carried out a thorough cleaning of the treatment room to prevent the potential spread of infection after treatment.

There was hand gel and an adequate number of sinks around the department and posters around to promote hand washing infection control. During our inspection, we observed staff washing their hands. The trust provided the hand hygiene audit for the radiology department at the hospital. The information showed between July 2018 to December 2018 x-ray and ultrasound achieved 100% compliance with hand hygiene apart from in November 2018 the X-ray department achieved 70% this is significantly below the trust target of 90%.

Environment and equipment

The department provided x-rays, ultrasound scans, CT, MRI and fluoroscopy. The x-ray department had clear signage for controlled area x-rays and 'do not enter' areas to warn staff and patients of the risks of radiation. X-ray rooms had illuminated signage to inform patients when it was safe to enter and there were clear warnings for patients about MRI and CT scanner safety such as metal objects close to the MRI scanner. Non-magnetic equipment had 'MR safe' stickers for use in the MRI room. The MRI unit was accessible to staff only with secure access. We saw rooms displaying the diagnostic reference levels. Staff had individual keys that could show who had accessed the rooms. The department had adequate storage.

During the inspection, we saw the department did not have sufficient seating in the various waiting rooms and this resulted in patients standing for prolonged periods of time. The waiting area had toilets and there was a children's play area with toys.

All equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and safety checked. There were maintenance and repair contracts in place. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. The department had business continuity plans in place to manage mechanical breakdown or IT system failures including using equipment at James Cook University hospital and rearranging appointments. Staff reported the orthopantomogram to be well used, during our inspection it stopped working. Staff followed the correct procedure by reporting the fault and taking the equipment out of action. During our inspection, we checked the service log and found pumps in two rooms were out of date for servicing. We requested the department's maintenance log, all equipment at James Cook University radiology department was up to date for servicing. All equipment should have portable appliance testing (PAT), during our inspection all equipment we checked had up to date PAT stickers.

The resuscitation trolley was checked regularly in line with trust policy to make sure all emergency equipment was in place and in date. During our inspection, we checked the resuscitation trolley which was sealed, in date and within trust guidelines. We saw the resuscitation checklist completed appropriately.

The department had a satisfactory amount of lead aprons to protect staff from over exposure to harmful rays. All staff were allocated a dosimeter to wear. These were sent away regularly for monitoring and assessment. Any concerns with abnormally high doses were highlighted to the member of staff responsible. We spoke with a member of staff who described to us the action they would take if a dosimeter showed an abnormal reading. This was in line with the trust process. Staff reported they received the appropriate equipment training for their role.

There were also protective aprons available for patients who needed, for example, pregnant women. We saw evidence that the protective equipment was checked however we saw one apron which was an infection control risk due to appearing worn and the material coating was frayed, this did not correlate to the description on the visual checklist infection control.

The trust provided a radiation physics report to the radiation protection committee (RPC). This report highlighted staff doses information. The report also highlighted three risk assessments in the service required review. Results were not available at the time of inspection.

Assessing and responding to patient risk

Policies, procedures and local rules were in place for radiology. Local rules were displayed around the department and in date. Staff could demonstrate good awareness of the local rules. There was an ionising radiation medical exposure regulations (IRMER) policy for the use of diagnostic x-rays. This had a review date of December 2021. Ionising Radiation (Medical Exposure) Regulations (IRMER) sets out the responsibilities of duty holders (the employer, referrer, IR(ME)R practitioner and operator) for radiation protection.

The trust had arrangements in place to seek advice from an external Radiology Protection Advisor (RPA) in accordance with relevant legislation. The hospital had a service level agreement (SLA) in place with the RPA at a neighbouring trust. The RPA was easily accessible through regular meetings or telephone contact. The department participated in the national audit radiation survey however results were not available.

The service had access to a medical physics expert and staff told us they were accessible. Following the inspection, the trust submitted the medical physics expert report for South tees hospital November 2018.

The department had appointed and trained three Radiation Protection Supervisors (RPS) with plans to train an additional staff member. Their role was to ensure equipment safety and quality checks and ionising radiation procedures were performed in accordance with national guidance and local procedures. We saw evidence of this happening. Staff were aware.

All staff were observed to be wearing body dosimeters (dose meters) on the front of their torso. A radiation dosimeter is a device that measures exposure to ionizing radiation. Staff told us they changed their dosimeters monthly. We saw the dosimeters were in date and had their expiry date on the back.

We observed diagnostic reference levels (DRLs) were on display in the X-ray rooms. Risk assessments, including COSHH risk assessments, were all up to date.

Staff described how they would ensure pregnancy tests were performed for patients aged between 12 and 55 who were unsure of their pregnancy status.

We observed staff completing the 'paused and checked' checklist used in radiology departments for procedures. The pause part of the checklist indicates patient, anatomy, user checks, systems

and settings checks, exposure and draw to a close. Staff we spoke with could describe the pause and check during the inspection.

The trust had a safety alert system on the patient record. If there were any associated risks staff needed to know about a red, amber or green alert flagged up, all clinical staff we spoke with knew about this system.

The department had a major incident policy in place including a major incident list to call staff in. During the inspection we found staff members have changed and the major incident list was not updated with the new staff. Staff we spoke with were aware of major incident policy and procedure.

Staffing

There was a standard operating procedure for reduced staffing levels, including cancelling mandatory training when staffing levels were poor. During our inspection we spoke with management regarding staffing, the table below shows the overall sickness for the department between September 2018 to December 2018 for all staff including medical, nursing and administration. The trust target for sickness rates is 3.5%:

Month	Sickness
September 2018	3.03%
October 2018	4.15%
November 2018	4.66%
December 2018	3.99%

The overall rate of sickness is above the trust target for every month apart from September 2018. The average rate of sickness is 3.95%, which is above the trust target.

Medical and dental

The trust had significant problems recruiting radiologists despite actively trying to recruit. The trust continued to try to recruit as a continuous process. There were links with the local university to recruit radiography students on qualifying. Management reported, to manage staff shortages, they were looking at developing current staff. The department had four associate practitioners due to start. There was a long-term plan to develop the associate practitioner by offering staff the opportunity to become a radiographer after two years. The department told us they are planning for the future with the student liaison role working across both sites and the local university to increase recruited radiography students on qualifying.

The trust has reported their staffing numbers for diagnostics below as at September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	4.7	2.0	42.2%
The James Cook University Hospital	26.3	17.6	66.8%
Trust level	31.1	19.6	63.1%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Staff reported medical emergency cover was prioritised however this impacted on elective work. At the time of the inspection, the department was outsourcing some of its routine and straightforward reporting such as MRI and CT to external companies. If urgent advice or reporting

was required out of hours, staff accessed one of the outsourced companies. Staff reported issues with outsourcing, for example outsourced reporting do not have full clinical picture. Radiologist were not always present in the department but could be contacted at James Cook University Hospital.

There were out of hours radiologists on call, overtime was offered to staff to cover the rota. We saw in the trauma reporting radiographers meeting; bank holidays and weekend cover was discussed. The out of hours rota was available up to June 2019, there were lists of weekends without cover for staff to complete where able.

During the inspection we spoke with management who reported the current budget for medical staffing was 30.8WTE however to cover the service safely 36WTE radiologists were required, at the time of the inspection the service was running on 17.4WTE. This could be split into the various subspecialties within the department as shown below:

	Actual WTE December 2018	Predicted WTE April 2019	Required WTE	Met
Diagnostic Neurology	1.5	1	4	No
Ears, nose and throat	1.2	1.2	2	No
Chest and cardiac	1.5	1.5	3	No
Gastrointestinal	2	2	3	No
GU	0.6	0	2	No
Gynaecology	2	1	2	Yes
Paediatric	0.8	0.8	2	No
Musculoskeletal	0.6	0.6	4	No
Nuclear medicine	1	1	2	No
Lymphoma	0	0	2	No
Interventional	3.5	2.5	6	No
The Friarage Hospital	2.6	2.6	4	No

The service did not meet the required staffing for any subspecialty apart from gynaecology, however based on predicted staffing none of the subspecialties would achieve the required staffing.

Vacancy rates
From October 2017 to September 2018, the trust reported a vacancy rate of 38.8% for medical staff in diagnostics.
- The James Cook University Hospital: 35.4%
- Friarage Hospital: 57.8%

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

Turnover rates
During our inspection, we spoke with clinical and management staff in plain film x-ray, we were told medical staff turnover was a challenge because people came straight from university or overseas, stayed for a few years, gained experience, and then moved on to other modalities or organisations where they were paid at a higher grade.
From October 2017 to September 2018, the trust reported a turnover rate of 14.9% for medical staff in diagnostics.

- Friarage Hospital: 0.0%
- The James Cook University Hospital: 16.6%

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

Sickness rates
From October 2017 to September 2018, the trust reported a sickness rate of 5.7% for medical staff in diagnostics. This is significantly higher than the Trust target of 3.5%.

- Friarage Hospital: 0.0%
- The James Cook University Hospital: 6.4%

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

Bank and locum staff usage
We spoke with the manager of the general radiology department. They told us they used regular locums and offered overtime to all staff from all sites to cover vacant shifts.
Staff told us if the department was at risk of being short of medical staff, radiographers would come from other sites to cover. Staff moved between the Friarage Hospital and James Cook University Hospital as needed to cover gaps in the rota.
From October 2017 to September 2018, the trust reported a bank usage rate of 0.4% and locum usage rate of 8.5% in diagnostics.

(Source: Routine Provider Information Request (RPIR) – Bank Agency Locum)

Allied Health Professionals (AHPs)
*This staff group includes diagnostic radiographers who use a range of techniques to produce high quality images to diagnose an injury or disease.
The trust has reported the AHP staffing numbers for diagnostics below as at September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	24.2	23.3	96.2%
The James Cook University Hospital	78.7	56.6	71.9%
Trust level	147.9	122.2	82.6%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates
At the time of the inspection there were 2.53 band 2 vacancies waiting to recruit,
three whole time band 3 vacancies. One band 5 and 1.6 band 7.
From October 2017 to September 2018, the trust reported a vacancy rate of 19.0% for AHP staff in diagnostics.
- The James Cook University Hospital: 25.6%
- Friarage Hospital: 6.3%

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

Turnover rates
From October 2017 to September 2018, the trust reported a turnover rate of 7.0% for AHP in diagnostics.

- Friarage Hospital: 17.4%
- The James Cook University Hospital: 5.1%

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

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 2.9% for AHP in diagnostics. In December 2018 sickness was 4% this was above the trust target for sickness at 3.5%. For December 2018 short term sickness was 0.78% and long-term sickness was 3.20%.

- Friarage Hospital: 2.3%
- The James Cook University Hospital: 3.1%

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

Support to scientific, therapeutic and technical staff

*includes support staff such as assistant practitioners and radiography helpers.

The trust has reported their scientific, therapeutic and technical staffing numbers for diagnostics below as at period September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	8.9	8.9	100.0%
The James Cook University Hospital	41.7	42.4	101.7%
Trust level	62.3	62.8	100.9%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy surplus rate of 4.6% for scientific, therapeutic and technical staff in diagnostics.

- The James Cook University Hospital: surplus of 3.5%
- Friarage Hospital: surplus of 5.6%
- South Tees Hospital: 12.0%
- Redcar Primary Care Hospital: surplus of 10.5%
- East Cleveland Primary Care Hospital: 0.0%
- Guisborough Primary Care Hospital   0.0%

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

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 4.0% for scientific, therapeutic and technical staff in diagnostics.

- East Cleveland Primary Care Hospital: 0.0%
- Friarage Hospital: 0.0%
- Linthorpe Halls: 0.0%
- Redcar Primary Care Hospital: 0.0%
- The James Cook University Hospital: 5.0%

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

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 5.1% for scientific, therapeutic and technical staff in diagnostics. This is significantly higher than the trust target of 3.5%

- Friarage Hospital: 3.4%

- The James Cook University Hospital: 5.9%

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

Records

The department ensured individual care records was managed in a way to keep patients safe. We looked at the record keeping system used in the department. It was linked to the patient's main record. The system made sure all relevant fields of information were completed and results were easily accessible to relevant personnel. When patients attend from wards, ward staff would bring the patient notes.

The department used electronic records and digital images accessible to all appropriate staff for viewing. Reports were available digitally and were part of the electronic patient record.

Staff could check the emergency department system to make sure any anomalies on x-rays or scans had been picked up by the medical staff in the emergency department who would look at the image before a reporting radiographer or radiologist would.

X-ray results were emailed or posted to GPs; the timeliness of this was dependent upon how quickly the x-ray or scan was reported. Staff informed us reporting time for CT scans was 2 weeks. Reporting times was discussed in the Radiology senior staff team meeting, at the meeting on 26th November 2018 it was stated the GP plain film reporting was taking approximately 6-7 weeks to report. Due to the ongoing issues with reporting time, the department had complaints from local GP practices.

Medicines

The department ensured the proper and safe use of medicines. The department had an administration of medicines policy and staff could tell us about the policy and where to access it. We observed medication including contrast being administered safely and according to the trust policy. We observed staff checking allergies on consent forms prior to injecting patients. Staff we spoke with were aware of the side effects and contra indications and carried out checks with patients to ensure their safety.

We checked the storage of medicines across the diagnostic and radiology departments at James Cook University Hospital. We found medication was stored safely and securely and was rotated to make sure no medicines were out of date. Medicines were stored above floor level in locked rooms with restricted access. We checked medicines and found these were all in date. The department did not store or use controlled drugs. The department used specific radiology related contrast media on this site. This was stored safely and securely in a locked room in a warmer.

Fridge temperatures were recorded and monitored daily. Medicines should be stored at the correct temperature to ensure they do not become ineffective or harmful. We checked the fridges and found medicines to be in date and stored in an organised manner. The fridge was in a locked and secure room.

We saw many patient group directives (PGD) were used across the department. A patient group directive allows registered health professionals (such as nurses) to give specified medicines to a predefined group of patients without them having to see a doctor. During our inspection we saw PGD's used for administering contrast injections and saline. All the PGD's were signed for and in date.

Incidents

The department did not manage incidents as according to Trust policy. During our inspection, we were not assured staff were able to recognise incidents and report incidents appropriately. We were told shared lessons learned did not happen consistently.

Staff received incident training in their induction however there were staff who had been working in the department for long periods without any update training. The department had access to an electronic incident reporting system and staff we spoke with were aware of how to report incidents. We were told there was a 10-day incident reporting time for incidents. Staff reported they did not receive feedback from reporting or see shared learning from incidents. The reporting system alerted the complaints lead, patient liaison lead and the appropriate manager. Some staff told us they should report more however, they didn't because of time pressures, lack of understanding of what an incident is and feeling "nothing will be done".

In July 2018 the department at James Cook University Hospital had a serious incident regarding cross contamination and involved numerous patients. All staff we spoke to regarding this incident showed good insight and could explain how practice had improved including changes to procedure to reduce the risk of future patient harm. We followed the process of this incident and saw evidence of a root cause analysis report. Apart from this incident staff could not give any other examples of incidents in the department.

During the inspection, we reviewed an extravasation (leakage of intravenous fluid which can cause damage to patient skin) reported as an incident and noted on the radiology information system as per the policy. However, we followed six incidents and found two did not follow the correct policy of reporting as IRMER incidents. Recent reported incidents were discussed at safety huddle meetings and the departments governance meetings. Trends or themes of incidents were not monitored according to the departments management.

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 October 2017 to September 2018, the trust reported no never events for diagnostic imaging.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) one due to HCAI/ infection control incident in diagnostics and one SI due to treatment delay,

which met the reporting criteria set by NHS England from October 2017 to September 2018.

(Source: Strategic Executive Information System (STEIS))

During the inspection, staff demonstrated they understood the principles of duty of candour, being open and honest and told us if they made a mistake, such as an incorrect x-ray, they would inform the patient and then report it as an incident. We observed staff following duty of candour when the orthopantomogram stopped working and the patient was sent away without an image.

Is the service effective?

Evidence-based care and treatment

The department followed national and local guidance in the treatment of patients. Staff could describe working to the National Institute of Care and Excellence (NICE) guidelines, the Society of Radiographer guidance and the Royal College of Radiologists guidance.

Guidance was available on the intranet for all staff to refer to if they were unsure. Staff told us they followed best practice, guidelines, policies and procedures. During the inspection, we checked policies and found them to be in date and appropriate.

Patients were given advice about action to take if their condition deteriorated. Staff informed us information leaflets for patients about specific conditions and procedures was posted out prior to any procedures.

The service had access to a radiation protection advisor (RPA). The RPA was responsible for completing the annual radiation protection advisor report. The trust submitted the report for November 2018, which included management of safe radiation, facilities and equipment, personal monitoring and radon.

We asked staff about the three-point checklist which ensured the correct patient received the correct procedure. Staff we spoke with were aware of the three-point check list and reported it to be embedded in practice.

Nutrition and hydration

Patients attending appointments were not always in the department for a long period of time and therefore did not require food or fluid. In the radiology day unit, patients were offered sandwiches at meal times and hot food could be requested. There was always hot drinks and snacks available. Staff would inform the hospital catering of any dietary requirements. Staff stated they asked in pre-assessment if any support was needed and would help patients as required. During the inspection we checked three records, all patients had been offered regular food and fluids.

The departments had water fountains available for patients to access cold water and there were café facilities and shops selling food and drinks within the hospital which patients and relatives could access.

There was a nutritional policy that staff were aware of and followed. During our inspection, staff showed us the policy. The policy was in date and appropriate to the clinical environment.

Pain relief

The department generally did not administer pain relief for patients, there was limited pain relief

kept in a locked medicine cupboard, as according to the Trust policy. Patients brought to the department from wards or from the emergency department had usually received pain relief before being brought to the department. If a patient was in pain, the staff contacted the referring ward to let them know.

When pain relief was required it was prescribed and administered by qualified staff in line with departmental policies and procedures. We observed staff asking patients about their pain levels and ensuring any procedure was carried out in the least painful way.

In the radiology day unit, staff followed the pain pathway and used patient group directives to administer pain relief. During our inspection, we checked three pain assessment tools. All had been asked if they were in pain, of the two patients who reported to be in pain, both were given pain relief as appropriate.

Patient outcomes

The department monitored the effectiveness of care and treatment however we were not assured the department was using the findings to improve them.

We asked the trust for evidence of ongoing audits within diagnostic services. The evidence sent to us showed the radiology audit plan for 2019. The audit plan consisted of 45 audits including marker audit, CT contrast checklist compliance and patient identification audit. The plan included frequency of review, audit lead and monitoring. The trust provided a selection of these audits, listed as follows:

- The radiology marker audit for January 2018 to January 2019.
- MRI on call audit for November 2017 to November 2018.
- Neuroradiology audit 8 April 2016.
- Neonatal x-ray quality for June 2016 to August 2016, due to be reviewed after six months.

The neuroradiology and neonatal x-ray quality audits were not current. All the audit data the trust submitted did not include review dates or action plans therefore we could not be assured how effective the audits were.

There was a monthly outsourcing audit. We saw evidence of error audit meetings and Marker and ID audit, this was planned for February 2019.

No audit information was on display. When we spoke with staff, they reported to be unaware of any audits.

The department used a dashboard for collecting and monitoring data. There was dashboard data available for both cancer target performance and general departmental performance. There are plans to display performance data on staff notice boards but there was no data displayed at the time of the inspection. Staff told us dashboard data is not discussed at team meetings.

The department reported no ongoing clinical trials

We discussed discrepancy meetings with staff and the manager. They told us discrepancies were discussed with staff and meetings held at weekly in line with the Royal College of Radiologists guidance. If concerns about the performance of individual staff members were noted at the discrepancy meeting this would be addressed by the manager with the individual.

There was a radiology senior staff team meeting for radiologists which was held monthly and reporting radiographers had also attend this meeting. The trust submitted evidence of the monthly trauma reporting radiographers meeting.

Staff received ongoing image quality feedback, there was a paper template to support this. Staff we spoke with reported it had been beneficial and had helped improve image quality. The feedback also monitored any patterns of issues. Staff reported this had led to a reduction in issues.

The Surgical Safety checklist was introduced by the World Health Organisation (WHO) in 2008, the aim was to reduce the number of surgical deaths world-wide. The checklist was designed to underpin safe practice and foster more effective communication between clinical teams (WHO, 2009). The Royal College of Radiologists (RCR) in collaboration with NPSA developed a checklist specific to interventional radiology, adapted from the WHO Surgical Safety checklist (RCR, 2009) along with a set of standards for their implementation, (NPSA, RCR, 2010). This checklist had been further modified by the Radiology department at South Tees Hospitals NHS Foundation Trust to fit best current practice within the division. The Trust submitted the radiology WHO safer surgery checklist audit for James Cook University Hospital and informed us plans were in place for the Friarage radiology department to be audited from February 2019. The trust plans to continue monthly audits and the target is to achieve 100% compliance by July 2019. During our inspection, staff reported there was ongoing work to embed the WHO checklist process, the trust provided evidence of the WHO checklist action plan this included identified issues, solutions and target dates. The WHO checklist action plan was in date.

During our inspection we saw patient safety checklist for allergies and administering contrast used prior to contrast injection.

Reporting

The radiology backlog monitoring report provided by the trust updated 4 February 2019 showed total reporting backlog and reporting backlog by modality. The department had a backlog of reporting due to the shortage of radiologists. The total number of exams waiting eight days or more was 962, the trust did not provide the backlog for each modality.

The change from 12 September 2018 to 4 February for the number of exams waiting for reporting from eight days to eight weeks by modality was as follows:

- CT, 92% decrease.
- Fluoroscopy, 77% decrease.
- MRI, 72% decrease.
- Plain, 98% decrease.
- Ultrasound, 82% decrease.
- Other, 98% decrease.

The change from 12 September 2018 to 4 February for the number of exams waiting for reporting over eight weeks by modality was as follows:
- CT, 46% decrease.
- Fluoroscopy, 49% decrease.
- MRI, 66% decrease.
- Plain, 99% decrease.
- Ultrasound, 36% decrease.
- Other, 76% decrease.

The change from 12 September 2018 to 4 February for the number of exams waiting for reporting eight days to eight weeks by priority was as follows:

- Two weeks wait, 97% decrease.
- Urgent, 92% decrease.
- Routine, 95% decrease.
- All, 95% decrease.

The above data shows the department has improved its report backlog for every modality. The trust stated reporting backlog has been addressed and will focus on monitoring reporting time against key performance indicators.

The Core business integration of sustainability (CBIS) monitored the departments performance, at time of inspection 82.2% reported within 8 days of order for department over both sites.

Competent staff

The service made sure nursing staff were competent for their roles however we were not assured managers appraised all staff's work performance.

Staff reported they were encouraged to develop professionally, there was additional course availability, and were supported by managers to do so. Staff told us there was "lunch time learning"; advanced nurse practitioners educated others on various topics for example x-ray of an elbow. Staff could eat their lunch through the sessions to encourage attendance. However not all staff we spoke with were aware of the "lunch time learning" sessions.

Staff told us the support for revalidation was good. Radiologist's revalidation every five years and qualified nurse's revalidation every three years. The process included sign off on competencies, evidence of continuous professional development, evidence of feedback, feedback, any involvements in complaints or incidents.

Staff reported the department had a good induction process, profession specific competencies were included as part of the induction. Newly qualified nurses had a period of preceptorship as part of their induction, staff we spoke with reported they had a supernumerary period of preceptorship.

Staff we spoke with reported to follow the Trusts lone worker policy. The trust submitted the policy, the policy was appropriate but was last reviewed November 2017, there was no review date provided.

Staff reported they found the appraisal process purposeful and worthwhile. Staff we spoke with reported they received supervision and peer support regularly, this was not recorded, therefore we did not see any evidence. However, we saw evidence of reporting radiographers having regular peer reviews, as it was discussed in the trauma reporting radiographers meeting.

Appraisal rates

From October 2017 to September 2018, 75.7% of staff within diagnostic imaging department at the trust received an appraisal compared to a trust target of 80.0%. Medical and dental staff fell significantly below the trust target as only 60% were up to date with their appraisal. Staff we met during inspection told us they had received an appraisal during the past year. During the inspection, we asked management for up to date appraisal data for the department, they reported to be unable to provide this.

A split by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
Qualified nursing & health visiting staff (Qualified nurses)	14	14	100.0%	Yes
Support to doctors and nursing staff	15	13	86.7%	Yes
Qualified Healthcare Scientists	36	30	83.3%	Yes
NHS infrastructure support	16	13	81.3%	Yes
Support to scientific, therapeutic and technical support staff	73	54	74.0%	No
Qualified Allied Health Professionals (Qualified AHPs)	126	91	72.2%	No
Medical & Dental staff - Hospital	20	12	60.0%	No

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

Multidisciplinary working

The department staff included various professionals such as radiologists, radiographers, sonographers, receptionists and registered nurses who worked together to deliver effective care however we were not assured the department always engaged with the wider organisation.

Radiologists attended gynaecology, neurology, urology and cancer pathway meetings as regularly as possible. Reporting radiographers attended the chest multidisciplinary meetings twice a month. These meetings discussed patient diagnoses and treatment options with specialists such as surgeons and oncologists. During our inspection, staff reported issues with radiologists not always attending meetings. Staff would travel between sites meaning there was a lot of travel time and prioritising meetings was challenging with radiologist staffing issues. Staff reported not achieving key performance indicators, delaying the patient pathway and increased clinical risk is impacted if staff cannot attend multidisciplinary meetings However, the department had started to use videoconferencing to improve attendance of meetings.

We observed good examples of teamwork within the department; healthcare professionals working well together to support each other and to provide effective patient care.

The departments at James Cook University Hospital worked with the outpatient's department and specialties to provide x-rays and scanning services for inpatients, the emergency department and outpatients. Radiologists worked on site at the James Cook University Hospital, however they could report on films from any location that had a reporting station.
Radiologists on site at James Cook University Hospital also carried out clinical interventions with patients using radiological guidance such as biopsies, injections and placement of stents. These interventions involved working with specialties and staff from other disciplines.

During the inspection, staff reported good communication links with GPs. The department had recently received complaints from GPs regarding reporting times. Staff stated they communicated

with GPs by telephone, emails, meetings and reports. Radiographers in the MRI modality told us they collaborated with the electrophysiologist to scan patients with pace makers. We observed good communication between the x-ray department and the emergency department, for example, a verbal patient hand over. Staff in the department told us the inpatient wards did not always follow fasting times due to poor communication, this impacted on the patients waiting time. We spoke with five members of staff who worked in the emergency department and had professional relationship with the diagnostic department. All reported good relationships and good communication between the departments.

During inspection we noticed staff of different professions wearing different uniforms, this made it clear for patients to see what role they were. There was information around the department to explain the uniforms.

Seven-day services

The James Cook University Hospital diagnostic department was open 8am to 8pm weekdays and 9am to 5pm on weekends. There was 24-hour CT cover for inpatients and the emergency department. The department was open on bank holidays including two hours on Christmas day for ultrasound scans. Neuroradiology was available 24 hours a day, seven days a week. Images could be reported 24 hours a day and there was outsourced reporting cover in place backed up by an on-call radiologist employed by the trust.

Health Promotion

The department had limited posters and leaflets to promote patient health, we saw cancer support posters in the patient waiting area. We asked staff if they spoke with patients about promoting good health, they told us aftercare leaflets were available and given regularly to patients.

We were told in December 2018, the department held an open access chest clinic. This meant patients could attend without a referral for a check-up, all patients were given smoking cessation information.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

During our inspection we found consent to care and treatment was always sought in

line with legislation and guidance.

Staff demonstrated how to access the up to date policies and procedures on the intranet, including mental capacity legislation and gaining consent when people lacked the capacity to make decisions.

During the inspection we asked staff about the mental capacity act and best interest. A best interest decision is a decision made on behalf of a patient by clinicians when the patient is unable to make decision themselves. All staff we spoke with showed good understanding.

We spoke with staff about obtaining consent form patients who had learning difficulties or were living with dementia. They told us if the patient was unable to identify themselves they would not perform the examination. We were unable to corroborate this as there were no such instances during our inspection.

Staff knew their responsibilities to explain procedures, possible side effects and complications during, or because of, a procedure and to make sure the patient could understand and retain the information before taking consent. We observed five staff members asking for consent

appropriately including explaining the procedure and getting the patient to sign documents. During the inspection we saw the MRI safety checklist had a prompt to document consent.

For plain film x-rays, verbal consent was obtained from patients. The process included staff informing patients of the risks of having an x-ray and the contraindication of x-raying when patients had some conditions or were pregnant. Staff told us when a patient was pregnant or suspected they were, staff would discuss the risk of an x-ray on the unborn child and supported patients to make a decision.

At the time of the inspection, the compliance for mental health awareness training was 100% for all staff members.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 65.3% of staff in the diagnostics department at The James Cook University hospital, compared to the trust target of 90.0% as shown in the table below:

Site	Training complete (YTD)	Individuals required (YTD)	Completion rate	Target met
The James Cook University Hospital	115	176	65.3%	No

We were told at the time of the inspection, the Mental health capacity (MCA training) compliance was 88% for all staff across both sites in the diagnostic department. This was a significant improvement; however, it was still below the trust target. The trust did not report Deprivation of Liberty Safeguards training during the same period.

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

Is the service caring?

Compassionate care

Staff provided compassionate care. We spoke with 12 patients during our inspection of the James Cook University Hospital diagnostics departments. Patient feedback during the inspection was positive. Staff introduced themselves to patients and patients were provided with the opportunity to ask questions. All the patients we spoke with told us they had been treated with courtesy and respect. Patients told us they had their dignity preserved as they were treated and staff made sure they were covered and not left exposed. Staff told us chaperones were offered when appropriate and same sex chaperones were available. Patients reported plenty of time for them to ask questions and be listened to, even though the department was very busy.

We observed two interactions between patients and the medical staff. The medical staff were kind, patient and caring with patients as they supported transferring on to beds, out of wheelchairs and on to scanning and x-ray apparatus. All patients told us reception staff were courteous and professional. Although we observed one man asking to accompany his wife into the X-ray room and was simply told he could not without an explanation about why this would not be appropriate. We observed three patients receiving intentional rounding, all patients had their fundamental care needs met.

The department did not participate in the friends and family test therefore there was no results on display. There were no inpatient survey results. However, we saw multiple examples of positive feedback in form of thank you cards on display within the department.

Emotional support

Staff provided patients with emotional support during their attendance at the departments if it was needed in the form or reassurance and explanations. Staff interacted and communicated with patients during scans.

Anxious patients were not rushed and were given time to get used to the environment. For example, patients worried about having a CT or MRI scan could visit the department prior to their appointment to look at the scanner and have staff explain exactly what would happen during the scan. Staff also supported patients with further advice and support and spent time with patients discussing procedures and diagnosis with patients.

Interpreter services are available and, if required, would be booked prior to appointment, however no interpreter services were available without planning.

We spoke with four members of staff who could give examples of how they would adapt practice to ensure a patient's cultural needs were met, such as ensuring appointments fit in around prayer times.

Understanding and involvement of patients and those close to them

Patients and relatives felt they were involved in care. The patients and relatives we spoke with said staff explained information about procedures in a way that was easy to understand. Patients and relatives said they were given time to absorb information and then ask questions about their treatment. This also ensured patients fully understood what they were consenting to and any associated risks.

Patients we spoke with told us they had enough information to understand what was going to happen on the day. Staff told us information leaflets were sent to the patient before their appointment which explained the procedure. All patients and staff interactions we observed demonstrated empathy. During our inspection we observed an interaction where a patient reported to doctor they had a phobia of needles, the doctor spent time talking through procedure, allaying anxieties and offering alternatives to the patient.

Is the service responsive?

Service delivery to meet the needs of local people

The department planned and provided services to reflect the needs of local population. The service worked in partnership with the local clinical commissioning groups (CCGs).

The various diagnostic and imaging departments on site were all located on the ground floor of the hospital with wide doors and corridors, therefore it was easy for patients and relatives to access. The department was well signposted from all hospital entrances and patients told us it was easy to find. All signage in the department was in English only. Car parking on site was limited as there was a lot of demand for parking spaces.

The general radiology department standard opening hours were 9am-5pm, with access open 24 hours a day. However, overnight, service was limited to emergency services only and ran with limited staffing.

The waiting areas did not always accommodate the number of patients of visiting the departments. We observed many patients attending radiology where there was insufficient seating for all patients in the waiting area. There was a children's play area with toys but no children's waiting area.

We asked staff about long waits in the departments. They told us patients did sometimes have long waits, especially if another patient was an emergency. Although waiting lists were designed to allow some capacity for urgent and emergency appointments throughout the day, because of the unpredictability of emergency demand, there were times when routine patients experienced delays.

Staff told us they tried to keep patients informed of delays both when they checked in and throughout their wait if the situation changed. There were no delays seen at the times we carried out our inspection.

Meeting people's individual needs

During our inspection, we saw staff caring for patients as individuals however there was little evidence of how the department accommodated individuals with additional needs.

When we asked staff what support there was for patients with additional needs their response was limited; some said they would provide one-to-one support. Staff told us there was a learning difficulties lead nurse for the trust, however there was no additional support for patients with learning difficulties in the departments.

The department did not use the butterfly scheme to identify patients with dementia and the environment had limited adaptations to become dementia friendly. We saw dementia friendly signs on the toilets. The department did not have a dementia champion.

There were no specific quiet areas for patients with sensory needs or who did not like to be in busy areas due to health conditions in the general x-ray department. Staff told us patients would be supported to be seen as quickly as possible. There were no such patients in the department at the time of the inspection and therefore we were unable to see this in practice.

Staff told us they could access interpreters for patients as required for spoken languages and for British Sign Language for planned appointments only. Staff collected patients from the waiting areas and took them to the scan room. This was helpful for patients who were deaf, but we were not clear if staff used any other method than calling someone's name out as there was no display system for people waiting for appointments in the waiting areas. Staff could add an alert to the record if someone needed additional support related to a disability e.g. a hoist.

Staff told us information was sent out to patients about treatments offered by the radiology departments prior to any treatment. There were no leaflets or posters displayed in the department. Additionally, there was no information about how to access the leaflets in other formats such as large print, Braille, easy read or other languages.

The department had a bookings team responsible for booking appointments for the service. The booking team offered alternative appointments and a choice of appointments if required. Patients told us they found the booking service flexible in appointment times.

Hoists were available if needed and shared with other departments in the hospital. The department could accommodate bariatric patients and bariatric equipment was available when required. Staff had received training in the use of bariatric equipment. The department was accessible for wheelchair users and wheelchairs were available within the department. The department had pressure relieving equipment available as required.

Access and flow

The department did not always meet waiting times standards. The trust submitted the radiology cancer performance weekly meeting matrix between August 2018 to December 2018. Overall, data from the trust showed the department was not meeting most target key performance indicators. The target key performance indicator for appointments within 48 hours was 80%, for all specialisms, the department did not achieve this between August 2018 - December 2019. The target key performance indicator for patients examined within five days was 80%, for all specialist areas, the department did not achieve this between August 2018 -December 2019. The target key performance indicator for reporting within eight days was 80%, the department did not achieve this between August 2018 to December 2019. On average the department achieved the trust internal key performance indicator of reporting results within eight days for 58.5% of all radiology cancer cases between August 2018-December 2018.

Diagnostic waiting times (percent waiting 6+ weeks)

Between September 2017 and March 2018, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average. From March 2018 the trust dropped lower than the England average and has remained lower until the latest month of August 2018. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows six plus weeks percentages over time.
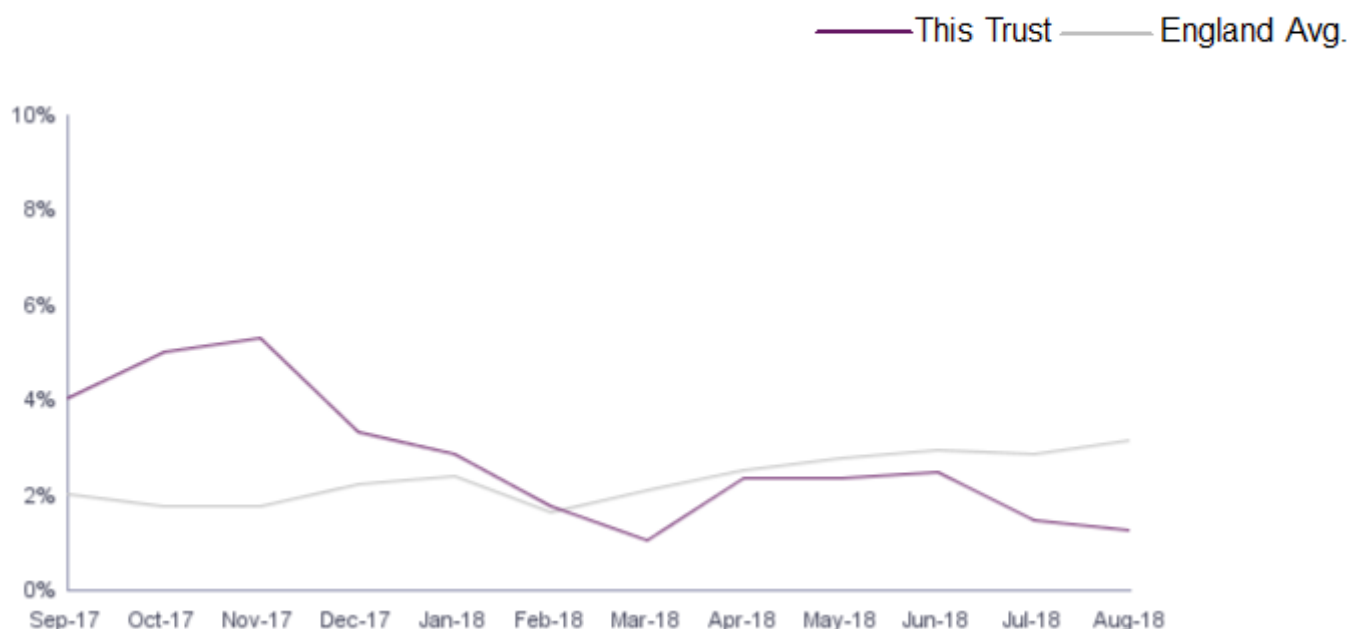
(Source: NHS England – Diagnostic Waits)

Managers we spoke with told us they are currently achieving the six-week waiting time, however they had not achieved it consistently in the previous twelve months. Managers told us the current action plan was to ensure targets continued to be met. Managers told us most referrals were within the six-week waiting list indicator and the service held monthly meetings to check where the department was with breaches in waiting times for the service.

The department bookings team could identify which appointments were urgent using a numbered system. Staff we spoke with told us this was how prioritisation of appointment bookings were done. Patients could contact the service bookings teams and arrange alternative appointments if required.

We discussed inpatient demand with managers in the trust. They told us inpatient referrals were given priority, particularly from the emergency department followed by the wards. Priority was then given to two-week urgent referrals, urgent referrals and then routine referrals. Patient flow within the department could be affected by emergency referrals taking precedence. Staff reported waiting times could be more than one hour with no information available to patients regarding anticipated waiting times. There was a standard operational procedure for CT and MRI referrals from the emergency department, referrals could be made without prior discussion, staff reported this was to help with the flow of patients and stated there were no issues with inappropriate referrals.

The department managed winter pressures by holding regular planning meetings through the year, these were attended by the operational manager.

Learning from complaints and concerns

The department had access to the complaints policy on the intranet. Staff were aware of the policy and how to access the policy.

During the inspection, management showed us how complaints, incidents and risks were stored and reported on the incident reporting system. All complaints made were routed through the Patient Experience Team (PET), the PET team directed complaints to the appropriate team or individual, for example to the chief executive, patient liaison service (PALS) or to the diagnostic department. Complaints were logged on to the incident reporting system by the PET team and given a reference number.

The department had a complaints and PALS lead who received all complaints for the diagnostic department. The complaints were then allocated to the appropriate person to lead the investigation. Any formal complaints or those that involved moderate harm or above would be looked at immediately. Even if it was judged the harm category was not appropriate, they would leave the harm level as logged until the end of the investigation.

Management reported lessons were learned from complaints. We saw evidence of complaints discussed in the governance meetings. Staff reported concerns and complaints were a fixed agenda point on monthly team meetings. Staff within smaller staff teams used complaints and concerns as part of daily safety huddles.

We were not assured complaints regarding patient harm were, if required, declared as serious incidents and we were not assured learning was always implemented. We examined five complaints in detail on the incident reporting system. These were selected at random. Out of the five complaints we checked, all audit trails were good, and responses were made/in process within 25 days. We saw outcomes were explained clearly in the letters. Three of these complaints related to late results for patients. Staff reported the major complaint theme was lateness of results. Two complaints described patient harm because of late results, both complaints were considered for the serious incident process but dismissed.

During the inspection, none of the patients or relatives spoken with knew how to make a complaint, nor was there any information about the process. There was no information about the PALS team. The department displayed no data or information regarding learning from previous complaints or associated data.

From October 2017 to September 2018 there were four complaints about diagnostic imaging. The trust took an average of 37 days to investigate and close complaints, this was in line with their complaints policy, which stated complaints should be closed within 40 days. The department reported they were meeting the complaint response timeframe set out by the policy. This could be extended to 60 working days by agreement with the complainant. A breakdown of these complaints is given below:

- Patient care: two

- Communications: one

- Access to treatment or drugs: one

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

During our inspection, we were told there were nine formal complaints, 19 PALS concerns and five PALS enquiries for 2019 so far.

Number of compliments made to the trust

We saw evidence of compliments being discussed in the governance meetings. From October 2017 to September 2018 there were 17 compliments within diagnostic imaging.

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

Is the service well-led?

Leadership

The Leadership team and front-line staff told us there had been several changes to the management team from December 2018. A new governance structure had been implemented and there had been changes to the leadership structure. The business intelligence unit was in the process of reviewing each directorate's performance. We were told that if a service was deemed to be "failing" it was temporarily managed to turn it round, we were told the trust had identified radiology as "failing" and plans had been put in place for radiology to be under temporary management.

The department had an overall lead for diagnostics and four managers who reported to the diagnostics lead. The department had 18 lead professionals, for example radiology medicines lead, IR(ME)R lead and communication lead, these leads were supported by the four modality managers/senior nursing sisters depending on the speciality. There were also various champions, for example MRI champion and incident reporting champion. Management told us they were looking at giving the champions protected time away from clinical work.

Each manager was responsible for a different specialist area such as CT, MRI, Ultrasound, medication and communication. The communication manager was on maternity leave with no cover at the time of the inspection.

Overall, staff were positive about senior staff and leaders in the department. Staff told us the department leadership team was approachable and supportive, and there was a visible leadership presence in the department.

The nursing team in the department was led by the senior nursing sister who provided clinical and professional supervision.

The majority of staff we spoke with told us they knew who the chief executive was and felt the trust had changed in a positive way.

Vision and Strategy

The department had a vision and strategy however this was not embedded. The Leadership team told us the vision was to be a service which patients were happy to attend, work closely with the wider organisation, have a happy workforce with good continued professional development for staff and to be an employer of choice. We saw evidence of the vision documented however this was not dated. We spoke with staff during the inspection who were unaware of the departments vision, we could not see any evidence of staff involvement in the departments vision.

The department's vision was in line with the trusts vision, to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement.

The leadership team told us the strategy for diagnostic and radiology services was to fully integrate with the trust and region, to improve job planning and to explore home reporting however, progress with the strategy was ongoing and not fully embedded with frontline staff. Staff we spoke with were not aware of the department's strategy.

Culture

During our inspection, we found there was good collaborative working between the staff at the Friarage Hospital and James Cook University Hospital. Some staff we spoke with at James Cook University Hospital worked across both sites.

Staff we spoke with told us there was a "positive culture" with good teamwork between the different modalities on site. Staff reported the department had an open and honest culture. Junior staff told us they felt supported by more experienced colleagues.

The departments were patient focussed and staff worked together to make sure patients had a good experience. Staff spoke positively about the service they provided for patients and were aware of the importance of providing a quality service with a positive patient experience.

Governance

The department had recently implemented a new governance structure and the service had a full-time radiology governance lead and governance coordinator.

The department held monthly clinical governance meetings, these were chaired by the governance lead and attended by the department's various lead professionals. These meetings discussed finances, incidents, backlog, standard operating procedures and preparations up-coming inspections. Incidents discussed in the clinical governance meeting were allocated to the involved team to investigate.

The department also held a bimonthly clinical diagnostic and support services centre radiology governance meeting. These meetings discussed incidents, sickness, mandatory training, vacancies, non-medical referrers and standard operational procedures. We saw evidence of these meetings and issues discussed being actioned, however there were no deadlines for actions to be completed by.

Staff told us the radiologists gave feedback to the radiographers about the quality of the images. Quality assurance systems and feedback was made via the departmental computer system. We saw examples of this during the inspection; some radiographers showed us their feedback, which was mostly positive with some constructive advice. Following the inspection, we saw the log of feedback for radiographers, however this was not dated.

The service outsourced parts of the MRI and CT reporting to manage the backlog of reporting. Managers told us the service escalated issues to the outsourcing provider and the outsourced provider would send the trust a report on the outcome. There were key performance indicators with the outsourcing provider. There were governance processes in place to ensure externally reported images were scrutinised and managers told us they had sought assurance from each outsourcing support provider of their governance processes to ensure they were at least as robust as those of the trust.

Meetings were held with the Radiation Protection Advisor (RPA) and Radiation Protection Supervisor (RPS), which were recorded. The department had regular radiation safety committee meetings where the radiation protection supervisors and diagnostics manager attended, we saw the minutes of the meetings which discussed incidents, personal monitoring review, reporting from medical exposure and MRI safety.

We saw evidence of monthly mortality and morbidity meetings and error and audit meetings. The department held weekly discrepancy meetings for radiologists and reporting radiographers. Staff also told us senior radiographers meet regularly. Feedback from medical staff was speciality meetings were well established, but unfortunately not always well attended due to staffing.

Information management

Staff had access to the required information systems. For example, staff had access to documents, policies, procedures and protocols electronically. Staff had access to the required radiology systems and password protection was used for the various systems. The radiology systems used in diagnostic imaging provided electronic access to scans. Some information such as scan and x-ray reports were shared with GPs however this was done with the agreement of patients.

The trust had information governance policies and procedures in place to ensure information was stored securely and protected patients' privacy and security. Information governance training was part of mandatory training, at the time of the inspection the compliance for all staff was 95.4% which was above the trust target of 90%.

The department collected information used to monitor and manage performance. There were measures in place to monitor and manage the performance of the department against local and national indicators.

Management of risk, issues and performance

Managers were aware of the challenges facing their departments in relation to performance, demand, and staffing levels. Managers could not accurately describe staff performance, as they reported data regarding mandatory training was out of date or incorrect.

We found that not all incidents were being reported or when incidents were reported the correct process was not always followed. We saw a lack of evidence of the service monitoring trends and themes from incidents. We saw incidents that had not followed the correct procedure of reporting

to external organisations. Staff we spoke with shared limited learning from incidents except for one particular in incident in July 2018. This was a serious incident regarding cross contamination which involved numerous patients. All staff we spoke to regarding this incident showed good insight and could explain how practice had improved including changes to procedure to reduce the risk of future patient harm. We followed the process of this incident and saw evidence of a root cause analysis report.

We requested the trust submitted an up to date copy of the radiology risk register. The three risks identified were: risk of not meeting waiting times due to radiologist capacity, risk of delay in radiology reporting and, risk of misdiagnosis from radiology and pathology results. Each identified risk was assigned a current and target risk level, control in place and gaps in control were acknowledged and an action plan was documented with a review date. All risks identified were within the review date and had a clear owner.

During our inspection, we had concerns that the risks which managers told us about were not documented on the risk register. Managers told us the three main risks to the service were workforce, introduction of electronic systems and finances. To mitigate the staffing risk, managers told us there was a working group, ongoing recruitment, speaking with staff in training; and there was also engagement with the wider network. To mitigate risks associated with the introduction of picture achieve and communication system (PACS) and electronic patient record (EPR) there were ongoing working groups and managers told us they were investing in upskilling staff to manage finances.

In terms of the increased demand, managers told us they were considering what they could do to meet this. The service had moved to seven days working with extended hours to address this. Managers told us they were having discussions currently about how to plan for future demand.

All pregnant staff had completed risk assessments and were on amended duties.

Engagement

The trust did not supply us with any evidence to demonstrate engagement with patients who used the diagnostic and radiology services at the James Cook University Hospital. The trust did not have a patient group for diagnostics however staff stated they would encourage patients to join other patient groups.

There were no comment cards or patient liaison leaflets. The department did not participate in the friends and family tests. Staff were in the process of developing a patient questionnaire for feedback on patient experience.

There was engagement with staff through team meetings across the department. The trust had provided evidence of staff meetings. Staff reported to be involved in the development of policies and improving practice. Three staff members said they felt empowered and involved in changes within the department.

The trust confirmed the Radiology department did take part in the national staff survey however due to the small sample size the results were not able to be distributed at department level.

Learning, continuous improvement and innovation

Staff were unable to provide us with any examples of innovation in the department.
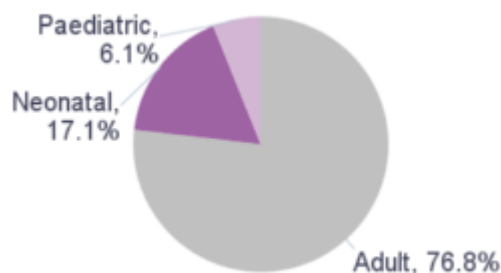
Critical care

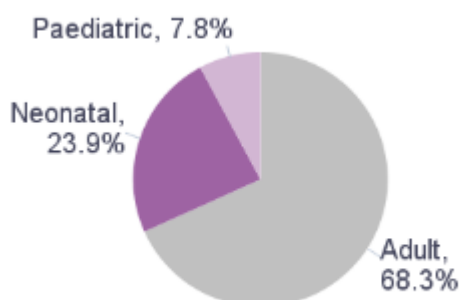## Facts and data about this service

The trust has 82 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, South Tees Hospitals NHS Foundation Trust and England.

This trust

Paediatric, 6.1%
Neonatal, 17.1%
Adult, 76.8%

England

Paediatric, 7.8%
Neonatal, 23.9%
Adult, 68.3%

(Source: NHS England)

South Tees hospitals trust has seven critical care wards at The James Cook University Hospital:

- Cardiothoracic HDU
- Cardiothoracic ITU
- Generic HDU
- Intensive care unit 2
- Intensive care unit 3
- Neurology HDU
- Spinal HDU

(Source: Trust Routine Provider Request)

South Tees Hospital NHS Foundation Trust has 66 adult critical care beds across seven wards at The James Cook University Hospital in Middlesbrough. The hospital is a designated major trauma centre and the critical care facilities admit critically ill patients from Middlesbrough and surrounding areas as well as providing specialist care and taking regional referrals via the Critical Care Network.

The critical care service has speciality specific and general intensive care units (ICU) and high dependency units (HDU). These provide level two (patients who require pre-operative optimisation, extended post - operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care to adult patients.

Critical care services have been consolidated so that they are delivered through one clinical centre - Urgent and Emergency care.

National Audit and Research Centre (ICNARC) data was collected from the ICU and the generic HDU at The James Cook University Hospital and the unit at the Friarage hospital. The data showed that between 1 April 2017 and 31 March 2018 on the ICU there were 763 admissions with an average age of 55 years. Of these:

- 32% were unplanned admissions from the emergency department or outside of the hospital
- 24% were admitted following emergency surgery
- 16% were from ward areas
- 16% were planned or unplanned transfers from other critical care units
- 7% were planned admissions from theatre following elective surgery
- 3% were planned admissions from the emergency department or outside of the hospital
- 1% were from another critical care unit (repatriation)
- 1% were unplanned admissions from theatre following elective surgery

The average (mean) length of stay on the unit was 2.9 days.

Data from 1 April 2017 and 31 March 2018 on the generic HDU showed that there were 1,315 admissions with an average age of 61 years. Of these:

- 30% were planned admissions from theatre following elective surgery
- 25% were planned or unplanned transfers from another critical care unit
- 20% were from ward areas
- 12% were unplanned admissions from the emergency department or outside of the hospital
- 11% were admitted following emergency surgery
- 1% were unplanned admissions from theatre following elective surgery
- 1% were planned admissions from the emergency department or outside of the hospital

The average (mean) length of stay on the unit was 1.8 days.

The units did not accept paediatric admissions. The anaesthetist or consultants may provide support in an emergency and stabilise the patient until a bed was available on the neonatal ICU or the dedicated intensive care transport service for children arrived.

The critical care outreach team (CCOT) provide a supportive role to medical and nursing staff on the wards when they are caring for deteriorating patients or supporting patients discharged from critical care. The outreach team offer a 12-hour service, seven days a week. The critical care service is part of the North of England Critical Care Network.

Is the service safe?

Mandatory Training

Mandatory training completion rates
The trust set a target of 90% for completion of mandatory training. The mandatory training data provided showed a significant variance in the number of staff eligible for different training modules. It was unclear why there was such a variance, particularly in areas such as falls

prevention and basic life support which is usually completed by all staff.

We reviewed some mandatory training information for nursing staff on site which was reflective of the figures shown below. For example, overall compliance on ICU 2 and 3 and generic HDU was 85.5% and for cardiothoracic ICU and HDU it was 70%.

Training comprised of face to face and e-learning modules. Staff reported they sometimes struggled to attend face to face training because of staffing shortages, and that some e-learning was completed in their own time.

We were concerned about the compliance with training related to life support for both nursing and medical staff. We were not aware of any specific action plans to address this. It is noted in the critical care services directorate meeting minutes from 10 December 2018 that there was to be no training until after Christmas.

There were systems in place which enabled individual staff to be alerted when training was due for renewal. We were concerned that some ward managers were not aware of their units training compliance as they told us it was held centrally. They were therefore not aware of any areas where training compliance needed to improve.

Sepsis training was provided by the trust however it was not included as part of the mandatory training data provided. Staff told us they had undertaken sepsis training and we were shown Adult Acute Registered Nurses Sepsis Competencies' during the inspection. As part of these competencies, staff had to discuss with an assessor which patients would require a sepsis screen and be able to identify and discuss the elements of the Sepsis Six care bundle.

Some areas had a sepsis lead identified from within their existing staff, for example, on the neuro HDU. This person had six hours of protected time each month to give to this role.

James Cook University critical care department
A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for qualified nursing staff in the critical care department at the James Cook University is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Triennial Review	30	30	100.0%	90%	Yes
Mentor Update	30	30	100.0%	90%	Yes
Equality and Diversity	262	288	91.0%	90%	Yes
Health and Safety (Slips, Trips and Falls)	261	288	90.6%	90%	Yes
Falls prevention inpatient training	67	74	90.5%	90%	Yes
Information Governance	254	288	88.2%	90%	No
Fire Safety 3 years	236	288	81.9%	90%	No
Dementia Awareness (inc Privacy & Dignity standards)	154	188	81.9%	90%	No

Infection Prevention (Level 1)	234	288	81.3%	90%	No
Anaphylaxis awareness	37	47	78.7%	90%	No
Immediate life support - ILS	104	139	74.8%	90%	No
Manual Handling – People	209	284	73.6%	90%	No
NEWS 2	4	6	66.7%	90%	No
Adult Basic Life Support	92	150	61.3%	90%	No
Advanced life support - ALS	35	60	58.3%	90%	No
Blood Transfusion	163	282	57.8%	90%	No
Prevent -WRAP	143	290	49.3%	90%	No
Conflict Resolution	27	62	43.5%	90%	No
Learning Disability Awareness Training	0	1	0.0%	90%	No
Basic Life Support	0	1	0.0%	90%	No

At the James Cook University critical care department, the 90% target was met for five of the 20 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for medical staff in the critical care department at both sites is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Falls prevention inpatient training	5	6	83.3%	90%	No
Information Governance	29	36	80.6%	90%	No
Anaphylaxis awareness	3	4	75.0%	90%	No
Equality and Diversity	27	36	75.0%	90%	No
Health and Safety (Slips, Trips and Falls)	27	36	75.0%	90%	No
Fire Safety 3 years	26	36	72.2%	90%	No
Advanced life support – ALS	5	7	71.4%	90%	No
Infection Prevention (Level 1)	24	36	66.7%	90%	No
Adult Basic Life Support	11	17	64.7%	90%	No
Blood Transfusion	16	29	55.2%	90%	No
Dementia Awareness (inc Privacy & Dignity standards)	7	14	50.0%	90%	No
Advanced paediatric life support – APLS	1	2	50.0%	90%	No
Basic Life Support	6	13	46.2%	90%	No
Prevent -WRAP	13	36	36.1%	90%	No
Manual Handling – People	9	26	34.6%	90%	No
Conflict Resolution	3	11	27.3%	90%	No
Learning Disability Awareness Training	0	2	0.0%	90%	No
Immediate life support - ILS	0	4	0.0%	90%	No

At the James Cook University critical care department, the 90% target was met for none of the 18 mandatory training modules for which medical staff were eligible.

Safeguarding

Safeguarding training completion rates
The trust set a target of 90% for completion of safeguarding training.

There was a trust safeguarding policy which could be accessed via the intranet. We were told there was a policy for rapid tranquilisation, however, when asked, staff were unable to locate this.

Staff we spoke with could describe what may be seen as a safeguarding concern and how they would escalate this. However, we found very limited understanding around female genital mutilation (FGM) and the mandatory reporting required for this. Several staff had to have FGM explained to them by the inspection team as they were unaware of what it was.

There were named lead nurses for adult and children's safeguarding at the trust as well as a safeguarding team who were available for advice.

The James Cook University Hospital critical care department
A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for qualified nursing staff in the critical care department at the James Cook University Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding vulnerable adults	268	288	93.1%	90%	Yes
Safeguarding Children (Level 2)	261	288	90.6%	90%	Yes

At the James Cook University Hospital critical care department, the 90% target was met both for the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for medical staff in the critical care department at the James Cook University Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 2)	29	36	80.6%	90%	No
Safeguarding vulnerable adults	27	36	75.0%	90%	No

At the James Cook University Hospital critical care department, the 90% target was not met for two of the two safeguarding training modules for which medical staff were eligible.

Cleanliness, infection control and hygiene

The units were visibly clean, tidy and dust free. Hand hygiene points were visible at the entrances of each unit. Empty bed spaces had checklists completed to indicate they were clean and ready for the next patient.

We spoke with domestic and housekeeping staff who were aware of policy and processes for cleaning the ICU environment. Cleaning checklists were in place and the service manager audited the standard of cleaning within the different areas.

We found appropriate waste segregation and disposal systems in place. Sharps bins were also seen throughout the different areas and had completed labels.

We observed staff interactions with patients were compliant with key trust infection control trust guidelines, for example hand hygiene and the use of personal protective equipment (PPE).

The CCOT had a daily record of each central line that was inserted. As part of their follow up of patients who had been transferred to ward areas, they ensured they were removed as soon as they were no longer required.

Eighty one percent of nursing staff and 67% of medical staff had completed mandatory training in infection control and prevention. This was below the trust target of 90%. There were identified link workers within the nursing teams for IPC.

Alcohol hand gel and hand wash facilities were available at each bed space.

ICNARC data for the ICU showed there had been 1.1 unit acquired infections in blood per 1000 patient bed days between 1 April 2017 and 31 March 2018. This was better than similar units who had a rate of 2.4. The ICNARC report for 1 April 2018 to 30 September 2018 showed this had been sustained as the rate was 1.6 compared to similar units who had 2.8.

ICNARC data for the generic HDU showed there had been 0.2 unit acquired infections in blood per 1000 patient bed days between 1 April 2017 and 31 March 2018. This was better than similar units who had a rate of 1.0. The ICNARC report for 1 April 2018 to 30 September 2018 showed this had further improved and there had been no cases of unit acquired infections in blood.

There was a lack of effective processes to ensure data submissions to ICNARC were correct and when anomolies were identified they were acted upon, for example infection rates.

Care bundles were in place to prevent ventilator associated pneumonia (VAP). Monthly audits were undertaken looking at areas of compliance on ICU and HDU. However, cardiothoracic ICU was not included in the audit data.

Data was provided from August 2018 to January 2019 on compliance with the VAP care bundle. 100% was consistently achieved for regular observations and ongoing care in ICU. The data showed for the generic HDU compliance ranged from 80% to 100%.

ICNARC data below shows the percentage of unit acquired cases of methicillin resistant staphylococcus aureus (MRSA), unit acquired clostridium difficile and unit acquired vancomycin-resistant enterococci (VRE) cases at this site.

	ICNARC April 2017-March 2018	ICNARC April 2017-March 2018	ICNARC April 2017-March 2018	ICNARC April 2017-March 2018	ICNARC April 2018-September 2018	ICNARC April 2018-September 2018	ICNARC April 2018-September 2018	ICNARC April 2018-September 2018

	ICU	Similar unit %	Generic HDU	Similar unit %	ICU	r Similar unit %	Generic HDU	Similar unit %
MRSA	0.5	0.2	0.5	0.2	0.3	0.1	0.0	0.1
C. difficile	0.6	0.3	1.3	0.2	0.1	0.0	0.1	0.0
VRE	0.2	0.3	0.8	0.2	0.2	0.2	0.8	0.2

We were provided with a copy of the trusts, getting it right first time (GIRFT), Intensive and critical care review report from September 2018, which was commissioned by the Department of Health. The data was from 2014-2017. There was information about the reported number of unit-acquired infections per 1000 patient days for patients staying in critical care at least 48 hours.

Data for the cardiothoracic ICU showed the number of blood steam infections was higher (worse) when compared with the England average; 2.7 compared to 1.6. The figures for MRSA were also higher (worse); 0.8 compared to 0.3. The figures for clostridium difficile and VRE were lower (better) than the England average.

The report showed for generic HDU the infection rates were lower (better) when compared to the England average. The only exception was clostridium difficile which was slightly higher (worse), 0.4 compared to an average of 0.3. For ICU, the number of blood stream infection was higher (worse) than the England average; 2.2 compared to an average of 1.6. For other infections the numbers were lower (better).

Data on infection rates was also collected monthly for each unit as part of the directorates summary documents and displayed in the areas we visited. This included information on MRSA, clostridium difficile and methicillin-susceptible Staphylococcus aureus (MSSA). The data showed the number of cases for the previous six months.

Data from September 2018 to February 2019 showed that the neurology HDU, ICU 2, cardiothoracic HDU and cardio ITU had no unit acquired infections. For the same time period, generic HDU had one case of clostridium difficile and one case of MSSA; ICU 3 had one case of MSSA.

The incident data for critical care from February 2017 to February 2018 showed there were 168 incidents related to infection control across both sites. The majority of these (156) related to the category 'unsafe/inappropriate clinical environment. From our observations and discussions with staff, issues were highlighted with the unit's ability to isolate patients with an infection. This was due to a lack of isolation rooms and at times staffing problems, which meant isolation rooms could not safely be used to provide patient care.

We spoke with the IPC team during the inspection. They were aware of any patients within critical care who had an infection and had a tracking sheet to monitor them. On the day we spoke with them, there were a total of 15 patients with 'alert organisms' at this site. Ideally each of these patients would be cared for in an isolation room; three of them were, the remainder had isolation precautions in place within a bay.

The IPC team also told us that the generic HDU had trialled using different coloured pillows to try and prevent any cross contamination. These were coloured coded so blue pillows were only used for under patients' heads. They could not say if this had had any impact at the time of inspection.

Whilst there was a process for identifying and managing the risk of patients with an infection when isolation rooms were not available, we were concerned that the number of infections could be related to the service being unable to isolate patients.

The lack of isolation rooms and infection rates did not feature on the service's risk register. Quality of care and patient's safety were a standing agenda item on the critical care services directorate meeting. We reviewed three sets of minutes from these meetings, the number of infections was noted but there was no detail or evidence of discussion. We saw from the matron's report from January 2019, the only action related to IPC was to deep clean an area on the generic HDU.

The trust produced an action plan following receipt of the GIRFT report in January 2019. There was one action related to IPC which was specific to the cardiothoracic ICU infection status. The actions were to undertake an independent baseline review of practice including; failure to isolate, hand hygiene compliance, IPC audits, antibiotic compliance, cleaning compliance and mandatory training compliance. This was due to be completed by May 2019.

It was also noted during our inspection that not all side rooms met the Department of Health, Health Building Note (HBN) 04-02 best practice guidance for critical care units as they did not have lobbies or the appropriate ventilation in place.

We raised concerns with the chief nurse and the chief executive during the inspection about infection rates and the issues around being unable to isolate patients. In response, we were provided with an action plan which detailed on going audits and oversight to address the concerns raised.

We also wrote formally to the trust raising our concerns following the inspection. We requested weekly assurance information be sent about any infection control issues. Data from the 14 March 2019 to the 21 March 2019 showed there had been six incidents related to an inability to isolate patients. Five patients had also developed infections which were under investigation.

Environment and equipment

Access to the different units was via intercom with a security camera. Mixed sex accommodation for critically ill patients was provided in accordance with the Department of Health guidance and managed in line with agreement with commissioners. In the main bays, bed spaces were separated by curtains to maintain patients' privacy and dignity. The exception to this was cardiothoracic ICU where screens were used. These did not provide 100% visual privacy as outlined in HBN 04-02.

Each of the units had windows allowing natural light in, however the space limitations and a lack of ceiling-mounted twin-armed pendants in the neuro and cardiac HDU's meant they were not fully compliant with HBN 04-02.

Theatres were closely located to the units providing easy access and there was central monitoring in place to allow oversight of patients.

There were a limited number of side rooms and some areas did not have any, for example, the spinal and neuro HDU and cardiothoracic ICU. HBN 04 02 best practice guidance states no units should have less than 20% of their beds as isolation rooms. The generic HDU was the only area compliant with this.

Storage areas were organised, there were digital locks in place and signs indicating door should be kept locked, however in each area we found the doors unlocked or propped open. These areas contained various supplies including intravenous fluids.

The replacement of equipment was part of the trust wide capital replacement programme. There was adequate equipment in the unit to meet the needs of patients. We saw that specialist equipment was available for patients with a high body mass index (BMI) when required.

We checked 35 pieces of equipment across the units and found evidence of up to date electrical safety testing. We inspected a wide selection of consumable items in resuscitation trollies and store rooms in the different units we visited. We found all packets were intact and within expiry dates.

Appropriate emergency equipment was available at each bed space, for example, tracheostomy safety boxes. There were resuscitation trollies centrally located on each unit. Some areas also had difficult intubation trollies. We found evidence of daily checks being completed and contents in line with Resuscitation Council (UK) guidelines. We did note that tamper proof seals were not used, this meant staff could not be fully assured that items had not been removed between checks.

Transfer bags were well organised with laminated contents sheets for each section.

Training for new equipment introduced to the unit was provided by the manufacturer and training and competency checks were carried out by clinical educators. There were also key trainers identified for specific pieces of equipment.

Equipment training compliance was recorded on a spreadsheet maintained by the two clinical educators. We requested training compliance figures and current compliance for critical care. We were only provided with information for the staff working on general ICU and generic HDU.

The information showed each staff members training for the 34 pieces of equipment. The equipment and staff compliance were red, amber and green (RAG) rated. Red pieces of equipment included ventilators, infusion pumps and blood gas machines. Attached to the spreadsheet was guidance on training percentage targets for high risk (red rated) equipment. These ranged from 70-85% for registered nursing staff, however the spreadsheet did not provide overall compliance figures, so we were unclear if these were achieved.

Assessing and responding to patient risk

The critical care outreach team (CCOT) provided cover seven days a week for 12 hours during the day. Overnight cover was provided by a nurse practitioner as part of the hospital out of hours team.

The CCOT played a vital role in supporting staff on the wards when patients become unwell. They had several other roles including, providing support for patients with tracheostomies or requiring non-invasive ventilation. They also reviewed patients who were discharged from ICU to ward areas. A list of patients who were discharged was provided to the CCOT each day who ensured patients were reviewed by them on the ward within 24 hours.

The trust used the national early warning score system, version two (NEWS) as a tool for identifying deteriorating patients. The wards had an electronic system for recording patient observations. This allowed the CCOT to remotely view any patients with elevated NEWS scores.

There was a clear escalation policy in place for when patients had an elevated NEWS score; despite this, we were concerned by some information in the serious incidents reported by the trust.

There were two serious incidents where trust and national guidance was not followed in relation to raised NEWS scores which led to adverse outcomes for the patients involved. Following the inspection the trust told us that these were linked to cancellation of elective surgery due to lack of critical care capacity in January 2018. Non elective demand was high with high levels of seasonal flu and a national objective to reduce elective activity at that time to manage the seasonal pressures.

The CCOT used a 'ward watcher' system to provide information and oversight of any unwell patients or patients who have moved from critical care to ward areas. The system included data from the electronic observation system to identify any patients of concern, as well as any patients identified by the medical and surgical teams.

The system was used for handover between the CCOT and the hospital at night team handover.

If there were no critical care beds available patients may at times be cared for in theatre recovery. If this occurred the patient would be cared for by an anaesthetist who had access to support from the critical care consultant. Support could also be provided by the CCOT.

Patients with an acute bleed in the brain would be transferred to a regional centre.

From reviewing incident data prior to the inspection and from discussions during the inspections, we were concerned that elective patients requiring a critical care bed postoperatively were being taken to theatre when it was not known if a bed was going to be available.

Following the inspection, we were provided with a standard operating procedure (SOP) related to elective patients requiring general critical care. This document had been due for review in January 2019. This document stated that *'Given the emergency demand upon critical care it is rare to have capacity to admit more than 4 elective cases on any day'.*

During our inspection we attended a number of bed meetings and observed that the number of elective patients requiring a critical care bed following surgery had exceeded four. We observed during the 10am bed meeting on the 6 February 2019 that a patient was taken to theatre who required a critical care bed following surgery and at the time one was not available.

We had concerns that the bed meetings appeared reactive and did not include contingency planning for any patients who may deteriorate and require admission to critical care. As a major trauma centre, critical care is required to have a level three and level two bed available. We also noted that when planning for beds on critical care there was no discussion over whether there was the nursing capacity to provide the number of beds and level of care needed.

This was seen in the 5pm bed meeting we observed on the 6 February 2019. It was identified critical care was over capacity by one bed. Two deteriorating patients had been identified, one was on a ward the other in theatre recovery. There was no plan made for overnight should these patients or any other emergency admissions require admission to critical care.

We raised our concerns with the medical director who was unaware of the issue. They did however attend the patients in the evening and bring in additional nursing staff to care for the patients in the critical care areas.

The GIRFT report from 2018 identified *"a lot less people than the national average are admitted needing pre-existing support for increased dependency"*. The report suggested this was reviewed in more detail to ensure patients were not being denied critical care inappropriately.

Most of the staff we spoke with highlighted concerns over the busyness of the unit, capacity and nurse staffing. There was a clear message that patient safety was always a priority and experience and team work supported this. Staff described, and we observed situations where risks were present to patient care because of these issues.

We wrote to the trust about this following inspection and asked for assurance that the trust were following their SOP in the management of the elective programme on a weekly basis.

From reviewing incident data, we saw there had been several pressure ulcers reported. Data from February 2018 to February 2019, across all areas of critical care showed there had been 118 incidents related to pressure ulcers. Forty-seven of these were related to devices, the remainder were because of skin damage due to pressure; one of these was reported as a serious incident due to its severity.

We raised concerns with the chief nurse and the chief executive during the inspection about pressure ulcers and were told the majority were device related and unavoidable. From reviewing the data, it is evident this was not the case, for example, some related to oxygen tubing and anti-embolism stockings. From reviewing the data, most of the device related incidents resulted from the use of nasogastric bridles. This is a piece of equipment used to secure a feeding tube in place.

Following these concerns, we were provided with an action plan which detailed on going audits and teaching to address the concerns raised. This involved the presence of the tissue viability team on the critical care units and ensuring link nurses had protected time to support training and share learning and updates with staff.

The action plan references device related pressure damage but is not specific about nasogastric tube bridles. The action plan stated monitoring would be via the ward dashboards and they had demonstrated a sustained downward trend in acquired pressure damage.

We requested data on these dashboards. Information from September 2018 to February 2019 did not support a sustained downward trend in all areas. The only areas which did show this were cardiothoracic and neurosurgical HDU. The other areas showed mixed or deteriorating performance. The data also showed there had been two further category three or four pressure ulcers, one in January 2019 at the Friarage and one on the general ICU in February 2019.

As we still lacked assurance on patient safety related to pressure damage we wrote formally to the trust raising our concerns following the inspection. We requested weekly assurance information be sent. Data from the 14 March 2019 to the 21 March 2019 showed there had been three device related pressure damage incidents on the generic HDU.

We were told there were plans to look at reviewing capacity on generic HDU and flex between level two and level three beds. During the inspection we observed a level three patient on generic HDU. We were told when this occurred a bed would be closed to ensure appropriate staffing was in place. The GIRFT report from September 2018 stated, '*there are 16 HDU beds, which are specified as HDU and not allowed to spec higher*'.

We had concerns of the skills and competence of the staff caring for level three patients in HDU as we could not be provided with assurance over equipment training for staff. The VAP data provided

by the trust showed a deteriorating picture on generic HDU for ventilated patients ongoing care. From November 2018 to January 2019 this had declined from 100% (green) to 80% (red).

Sepsis screening tools and pathways were in use, staff were aware of these and we saw evidence of them in the patient records we reviewed.

We observed completed daily bedside safety checks. Within patient records risk assessments and care bundles were completed, for example, for falls and moving and handling.

Staff we spoke with knew how to access the mental health support. There was access to specialist nurses and crisis teams.

Nurse staffing

Nurse staffing guidance and standards from D16 NHS standard contract for adult critical care and GPICS describe minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients' ratio for level two patients. The guidance also recommends a supernumerary coordinator in place twenty-four hours a day in units with more than six beds and in units with more than ten beds an additional supernumerary coordinator.

The service had a network peer review in June 2016. Three of the recommendations following this were; maintaining sufficient and safe nurse staffing levels, the nurse coordinator should not be rostered to deliver direct patient care and that there should be a review of clerical and reception staff establishment to ensure sufficient support is available. Following the review an action plan was put in place to address these areas, however, we found these areas were still a concern.

During our inspection we observed that cardiothoracic HDU and ICU and generic HDU had a supernumerary coordinator in place. These areas had ten, 12 and 16 beds respectively. On neurosurgical HDU and the ICU units, there was no supernumerary coordinator on two of the three days we visited. On one of the shifts the coordinator on ICU was not supernumerary and was also caring for a level three and a level two patient. We observed the impact of this; examples included, a level three patient being left unattended for 25 minutes whilst the coordinator attended the ward round. We also observed a coordinator who was caring for two level two patients having to constantly break off from what they were doing to deal with staffing shortages for the night shift. From reviewing incident data from February 2018 to February 2019 we found ten incidents where staff had cared for more than one level three patient.

The challenges with staffing were also compounded by a lack of administrative support. Not all areas had full time ward clerk cover. This meant that nurses had to answer telephones, give access to people wishing to visit the unit and undertake administrative tasks.

We visited the spinal HDU, on this unit two of the four beds were occupied. The unit was staffed with one registered nurse and a health care support worker. We observed staff from the ward coming to check on their colleagues, the ward also provided cover for breaks.

All the staff we spoke with raised concerns over nurse staffing. We were told caring for more than one level three patient was a common occurrence. Staff also told us they often did not incident report staffing issues. The staffing shortages we observed had not been incident reported. One

coordinator had looked back at incident data for their unit, there had been 36 staffing incidents since April 2018. They stated this was not reflective of the staffing issues as they were a daily concern.

We reviewed incident data from February 2018 to February 2019 and saw here were 44 incidents related to a lack of suitably trained staff in critical care. Following the inspection, we were provided with information on staffing incidents by the trust. This showed that between August 2018 and January 2019, 12 incident reports had been submitted under the category headings 'staff shortage' or 'inappropriate skill mix'. However, one of these related to being unable to complete an audit and nine related to the Friarage hospital.

It was noted from the infection control incidents, of which there were 168. A significant number of these related to an inability to isolate patients in side rooms due to staffing shortages.

We reviewed staffing rotas on site. On ICU and HDU a daily sheet was completed with staffing numbers on each of the units compared the number and care level of patient. The planned level of registered nurses for these three areas including a supernumerary coordinator was 27. From the 7 January 2019 to 20 February 2019 this number was not achieved on any shift.

For this time period there were very few shifts where staffing allowed for a supernumerary coordinator on the ICU's. Except for three shifts, staffing ratios were in line with GPICS recommendations of 1:1 and 1:2 ratios, however, if a further admission arrived this would not have been the case. The site is a major trauma centre and emergency admissions can arrive at any time. The units would struggle to respond to this with the staffing level being below the planned level on every shift. On some days the number of actual registered nurses was as low as 19.

We were very concerned about the nurse staffing levels during our inspection and the lack of supernumerary coordinators who play a vital role in terms of safety and oversight of risk on the units. We were also concerned that the information the senior management team saw regarding nurse staffing was not representative of the challenges the staff were experiencing on a day to day basis.

We attended bed meetings and further meetings specifically about critical care capacity. When considering what beds were available there did not seem to be consideration over what nurse staffing was available when planning admissions in to unoccupied beds.

Planned and actual staffing numbers were displayed on each unit. Electronic rostering was in place which incorporated the safe care staffing tool. The senior management team told us staffing shortages would be reported via 'red flags' on this system. Three of the senior nurses on the units we spoke with were not aware of what red flags were or how this was reported. We requested data on the number of red flags reported in critical care at this site. The data provided by the trust from July 2018 to February 2019 showed only one. This supported our concerns that nurse staffing was not recognised as an issue by the senior team.

Nurse staffing also did not feature on the critical care risk register.

We raised our concerns about nurse staffing to the chief nurse and the chief executive during the inspection and we formally wrote to the trust raising our concerns following the inspection. We

were provided with little assurance initially as the staffing data provided for the same period that we reviewed on site did not correlate. Whilst it is accepted the numbers of patients could be different as data may have been collected at different times of the day, some of the figures related to the numbers of registered nurses were very different. For example, during the day on the 12 February 2019 the data we saw showed there were 24 nurses across generic HDU and ICU. The data provided after the inspection from the trust stated there were 27.

Further information was requested from the trust with regards safe staffing levels, this information was requested formally and to be submitted weekly. This is ongoing until we feel assured that staffing is being provided to safe levels.

We also observed that there were only a small number of health care support workers utilised on the units. Most had a planned number of one health care support worker. We were provided with the safe care staffing report from December 2018. This showed that except for the neurosurgical HDU, fill rates for registered nurses during the day were amber rated. Fill rates were between 87% and 94%. For nights shifts the fill rates were between 86% and 94%.

Gaps in staffing were covered by moving staff between areas and staff working additional shifts; there was some use of bank staff. Agency staff were use very rarely. Support with staffing was also provided by senior nurses who may have been planned to work non-clinically.

We observed nurse handovers in four of the units. A team handover was given and then one to one handover took place at the bedside. A more detailed handover also took place between the shift co-ordinators.

There was a specialist critical care pharmacist who visited ICU four days a week. The other areas had limited pharmacy input, and this was not always by a specialist. This was not in line with GPICS recommendations.

From speaking with physiotherapy staff and reviewing patient records, we saw that patients received therapy each day. However, it was a challenge to deliver the respiratory and rehabilitation elements of patient care. An increase in specialist pharmacy and physiotherapy provision were further recommendations from the 2016 peer review of the service.

The trust reported their staffing numbers below as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
The James Cook University Hospital	132.9	126.1	94.9%

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates
From October 2017 to September 2018, the trust reported a vacancy rate of 5.4% at the James Cook University Hospital. Information seen on site supported these figures.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
As at October 2017 to September 2018, the trust reported an overall turnover rate of 10.8% in critical care this in not in line with the trust 10% target;

- The James Cook University Hospital: 10.1%

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

Sickness rates
As at October 2017 to September 2018, the trust reported an overall sickness rate of 5.9% in critical care, this was worse than the trusts 3.5% target. At James Cook University Hospital it was 5.5%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Information seen on site showed sickness had increased to 6.72%.

Bank and agency staff usage
From October 2017 to September 2018, the trust reported a bank usage as shown below, there was no agency usage in critical care;

All nursing staff

Site	Bank rate	Agency rate	Unfilled rate
The James Cook University Hospital	73.1%	N/A	47.0%

Qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
The James Cook University Hospital	7.9%	N/A	30.7%

Non-qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
The James Cook University Hospital	394.2%	N/A	127.2%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The critical care services had a clinical director. There were 20 consultants providing the medical cover across ICU and HDU at the James Cook University hospital, with daily cover provided by three consultants. They also covered the outreach team from Monday to Friday and the critical care unit at the Friarage hospital.

Overnight cover was provided by an on-call consultant who could attend within 30 minutes. The on-call consultant would often remain on site until 10pm, there was a room available for them to stay on site if required.

Patients on the other units (neurosurgery, cardiothoracic and spinal) were under the specialty consultant care, however critical care consultants would also review them if required. Consultant cover was from 8am until 5pm with on call cover out of hours.

On the neurosurgical HDU a consultant attended from another trust each Monday to review patients. The unit was co-located with the neurology ward, middle grade doctors were always available.

The cardiothoracic unit also had support from two critical care practitioners during the day and one at night. Part of their role was to have oversight and monitor patients moved from ICU to HDU. There had been approval for a further four critical care practitioners, three of these posts had been recruited to, however the applicants needed to undergo training.

At the time of inspection, the standards of care; a consultant in intensive care medicine must be immediately available twenty-four hours a day, seven days a week; and, consultants must be freed from all other clinical commitments when covering intensive care, were being met. The consultant to patient ratio was also in line with the recommended range of 1:8 to 1:15.

The recommendation regarding block working to provide continuity of care was not fully met. GPICS recommend as five days working block, the consultants worked a two to four-day block. However, we observed handovers which were very thorough and staff did not raise concerns about continuity of care for patients.

There were recognised challenges with filling the middle grade staffing rota. Support with any gaps was provided by associate specialists and the consultants. There were concerns over how sustainable this was. There was an identified risk on the risk register that the critical care medical rota could become unsustainable. Following our inspection, a decision was made to reconfigure services and the critical care unit at the Friarage was closed in March 2019.

We observed consultant wards rounds, and in the 16 patient records we reviewed we saw that twice daily consultant led ward rounds took place and that all patients had been reviewed by a consultant within 12 hours of admission.

The trust has reported their staffing numbers below as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
The James Cook University Hospital	34.8	40.3	115.9%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates
From October 2017 to September 2018, the James Cook University Hospital reported a vacancy surplus rate of 3.6% in critical care.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From October 2017 to September 2018, the James Cook University Hospital reported a turnover rate of 19.9% in critical care, this is not in line with the trust target of 10%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From October 2017 and September 2018, the James Cook University Hospital reported a sickness rate of 2.2% in critical care, this is in line with the 3.5% trust target.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage
From October 2017 to September 2018, the trust reported a locum usage rate of 0.5% in critical

care.
(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Records

Paper records were in use in all the areas we visited. Nursing and medical records were stored in a trolley at the end of each bed space or outside the room of those patients requiring isolation. Information provided by the trust showed 88% of nursing staff and 81% of medical staff at the James Cook University hospital had completed information governance training, which was just below the trust target of 90%. There were plans to implement electronic patient records, which would include a critical care module. This was not expected to be in place until 2022.

We reviewed 16 sets of nursing and medical records in detail looking at care plans and risk assessments, across all sites and areas in critical care. Nursing records were accurate, fully completed and in line with trust and professional standards. Specific critical care proformas were used.

Care bundles and pathways were in use for specific conditions or procedures. There was evidence in the notes we reviewed of assessments which focused on details other than physical health needs, for example, mental health conditions and emotional needs.

The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital. A daily critical care assessment form was completed and on discharge from the unit a summary document was completed. CCOT staff confirmed that discharge information was thorough with clear escalation plans for individual patients.

We saw staff complete the, safe patient transfer bundle for discharges to the ward document. This detailed, pre-transfer checks to be completed, a detailed handover and post transfer checks once the patient had arrived on the ward.

The physiotherapy team completed records that met the National Institute for Health and Care Excellence (NICE) CG83 (rehabilitation after critical illness) requirements during a patient's stay in critical care.

Following the inspection, we were provided with a copy of the trusts SOP for referral and admission to critical care. It was noted this was due for review in January 2019. This detailed the timeframes and pathways for admission to critical care referencing some of the standards within Guidelines for the Provision of Intensive Care Services 2015 (GPICS).

Medicines

We reviewed 16 medicine charts across the different areas and sites and found these to be completed in line with trust and national guidance. Six of the medicine charts had not been reviewed by the pharmacist, this was reflective of the gaps in pharmacy cover.

The allergy status had been completed on each of the charts. Eight of the charts we reviewed had antibiotics prescribed. There was a separate section of the chart for prescribing antibiotics with

clear review timescales in place, this was in line with national guidance. Oxygen and preventative treatment for venous thromboembolism (VTE) was also prescribed.

Information on medicines management was collated on a dashboard. We were provided with data from November 2018 to January 2019 for each area. This showed variable compliance. Medicines reconciliation within 24 hours of admission was marked as 'not applicable'. Figures for omitted doses ranged from 0% to 3.6%. Controlled drugs compliance ranged from 79% to 100%.

During our inspection we found medicines were handled safely and stored securely. The exception to this was cardiothoracic ICU where we observed a large number of drugs stored on top of a cupboard near the entrance to the unit. These included, epinephrine and amiodarone injections for emergency use, vials of propofol and intravenous paracetamol. We alerted the nurse in charge to this, but the items were still present the following day. We informed the nurse in charge again and they were moved to a locked cupboard.

Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed controlled drug records in five areas and saw that accurate records and checks were completed. It was noted that in ICU, neurosurgical HDU and cardiothoracic ICU daily stock balances were recorded differently. In one area they were recorded on the page of each individual drug. In another they were recorded at the back of the controlled drug record book, and in the other there were using a separate theatres controlled drugs book to record balance checks. We reviewed the trust policy which stated, *'Each stock item balance check must be recorded on the relevant page of the Ward CDs Record Book'*. As staff rotated between areas this could cause confusion when stock levels needed to be checked.

We observed in each area fridge temperatures were monitored and recorded in line with trust policy. Staff could explain the process of escalation if fridge temperatures were outside of the safe temperature ranges and we saw evidence of this.

In main area of cardiothoracic ITU there were two fridges containing medication located in a corner. They were difficult to access and we observed staff kneeling and sitting on the floor when looking for items in them. The fridges were very full and untidy. Neither fridges were locked. We found a syringe containing an antibiotic that had been made up for a patient on the 14 February. We also found 30 vials of Ventavis (a nebuliser solution) some were in a box and several were loose in the fridge, they had expired in November 2018. Staff were alerted to this and they were disposed of.

Pharmacy staff would provide advice and support to support patients withdrawing from drugs or alcohol. There was on line guidance available for staff regarding intravenous drug infusions.

Medicines updates were included as part of the services learning bulletin, for example the most recent ones included information on the antimicrobial's guidelines having been updated.

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 October 2017 to September 2018, the trust reported no incidents classified as never events for critical care.
(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) related to pressure ulcer(s) in critical care which met the reporting criteria set by NHS England from October 2017 to September 2018.
(Source: Strategic Executive Information System (STEIS))

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and gave examples of what they would report. With the exception of staff at the Friarage site, staff told us there were incidents relating to staffing levels and potential safety incidents because of this, that they did not report. We were told because they occurred so frequently it was seen as "the norm" and that staff did not have time to complete incident forms. We observed staffing and potential patient safety incidents which when asked, staff said they had not completed an incident form.

We observed a learning from events bulletin from February 2019. This explained a review of serious incidents had shown a delay in recognising and reporting patient safety incidents. Actions following this included reminding staff it is their responsibility to report, and departments should be reviewing incidents daily and discussing actions to prevent a reoccurrence.

Critical incidents were a standing agenda item on the critical care services senior staff meeting. This meeting had recently been reintroduced to the service. There was some evidence of discussion about incidents, but it was limited. Brief details of the incident were recorded but no actions or learning.

Senior nurses recognised that safety huddles needed to be better established. We were told they took place as part of the nursing handover. We did not see this during the three of the four handovers we observed in different areas.

From reviewing incident data, we saw there had been three serious incidents between April 2017 and January 2018 resulting in patient harm, as a consequence of critical care beds not being available. From attending bed meetings and speaking with staff we were aware this was still a concern. Occupancy levels on the units were high and during the eight bed meetings that were observed throughout the core service and well led inspection, we saw that managing critical care capacity was a challenge.

Decisions had to be made on individual planned and emergency theatre cases almost on an hour by hour basis to decide if critical care beds would be available and if operations could go ahead. Staff on the unit we spoke with reported feeling under pressure to 'step patients' down to create more capacity.

We did find some evidence of the impact of this from the incident data we reviewed. For example, there was an incident in March 2018 where a patient was moved from HDU to ward area at 15.25 hours, they experienced an acute episode and required readmission at 23.30 hours the same

day. There was another incident in November 2018 where a patient had been planned to go the critical care but there was no bed, they became unwell on the ward and required transfer to critical care.

The CCOT also collected data on the number of early readmissions to critical care. Data provided showed that from April 2018 to February 2019 there were 11 occasions when this happened.

The matron for the service had sight of all incidents and all incident rated moderate and above were reviewed by the patient safety team. Incident forms were also reviewed by a designated consultant and any learning shared. Senior staff told us themes of incidents related to staffing, a lack of isolation rooms and pressure ulcers.

There were various systems in place to feedback learning from incidents. Information was sent via email, shared at team meetings or via closed social media groups and via safety bulletins. On the neurosurgical HDU we saw information on risk alerts in a folder. This was the area where we observed incidents discussed as part of the handover.

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 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 was displayed for individual areas in critical care as part of the urgent and emergency care summary. This included information on infection rates, falls and category two and category three and four pressure ulcers.

We reviewed data from September 2018 to February 2019. During this time there had been no falls in any area. There had been between zero and six category two pressure ulcers.

We saw information on the current focus of the month. This related to pressure ulcers. Actions for staff included ensuring risk assessment tools were completed, repositioning patients, and the appropriate use of equipment and dressings.

Is the service effective

Evidence-based care and treatment

Polices and guidance were accessed on the trust intranet. We were told there was a protocol for each procedure and these were updated by consultants. We experienced difficulties in locating specific polices and guidance. For example, we looked for policies on the use of sedation and restraint, staffing escalation and the admission and discharge policy. We asked three senior nurses to help with this and there were also unable to locate them.

Following the inspection, we requested the policy for sedation and restraint. We found these were in date with author and version control. These were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).

Care pathways in place for specific conditions, for example, on cardiothoracic ICU for the management of acute coronary syndrome.

The trust was part of the North of England Critical Care Network. The last peer review of the service had been in 2016. There had been a GIRFT Intensive and critical care review in September 2018, this looked at each of the critical care areas. The report covered 14 metrics, for example, length of stay and admission and discharge outcomes, as well as looking at staffing and multidisciplinary team input.

We were provided with a copy of the services action plan in response to the GIRFT report. Many of the areas of concern were resolved by the unit closure at the Friarage hospital.

The service collected data for ICNARC, however this was not for all areas within the service. Cardiothoracic, neurosurgery and spinal service did not contribute to this data set. ICNARC data enables a service to benchmark itself with similar units and monitor performance.

We were provided with the audit plan for critical care. Between April 2018 and March 2019 eight audits had been completed. These covered a wide range of areas from sepsis and airway assistance to documentation and communication with families. For the same time period there were five audits that were ongoing. These included topics such as managing alcohol withdrawal and post-operative instructions in the HDU.

The service had a guideline for delirium screening and diagnosis. The trust policy identified non-pharmacological treatments and approaches to use prior to looking at pharmacological interventions. We saw evidence of screening for delirium in each of patient records we reviewed in line with NICE guidance.

We saw evidence of sepsis screening in the patient records we reviewed and saw a sepsis assessment and management document from the sepsis action group.

We saw admission and discharge documentation was in line with the NICE CG50 acutely ill patients in hospital. We saw evidence of outreach team activity data collection. This included information on the number of patients followed up on discharge from critical care and the number of visits they had. The data showed that each patient had a minimum of two visits. The data also showed the number of referrals to the service and that each of these were seen by the CCOT.

In addition to this data set the CCOT also conducted audits looking at the management of deteriorating patients. These included sepsis and fluid balance recording. We were provided with a gap analysis of the CCOT requirements as outlined in GPICS, the service was fully compliant.

The service leads were aware that further work needed to be done to provide care that was in line with NICE CG83 rehabilitation after critical illness. The service was challenged as funding had not been approved which would support full compliance, this particularly related to psychological input for patients.

The service had developed a comprehensive patient information leaflet, the critical care rehabilitation manual. This contained information about the patient journey from intensive care to discharge home. It included pictures and descriptions of the various pieces of equipment and information on resources and support once patients were at home.

We were not told during the inspection, but information provided after the inspection explained there was a multidisciplinary rehabilitation after critical illness working group. This was led by one of the CCOT. All patients discharged from critical care were screened and those at greatest risk were followed up. We also saw from departmental minutes that progress against this guideline was discussed.

Nutrition and hydration

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We saw this had been completed in each of the patient records we reviewed.

The unit had an emergency feeding protocol in place. This provided guidance for staff on feeding patients who were unable to eat and needed to be fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.

Staff were aware of the risks associated with enteral feeding and described how they would assess for and manage symptoms of re-feeding syndrome.

There was access to a dietitian and they would visit the units and attend the weekly multidisciplinary team meetings. They were also available out of hours on an on-call basis. The provision was in line with GPICS recommendations.

During our inspection we saw that water was available for those patients able to drink and assistance was provided as required for those patients. We found fluid balance charts were fully completed in each of the records we reviewed.

Pain relief

There was access to an acute pain team to provide advice; they worked with the multidisciplinary team. Pain relief was discussed on ward rounds and reviewed by the pharmacy team.

In the 16 records we reviewed we found evidence of pain scores being completed and appropriate action taken in response to any indication a patient was experiencing pain. The trust used a pain scale which was recorded on the patient observation tool at the patient bedside. We saw staff using an appropriate pain scoring tool for patients unable to communicate.

We were provided with audit data relating to pain charts being present and pain assessment being undertaken following the administration of analgesia. The data from October 2018 to January 2019 related to the ICU and HDU areas. One hundred percent complaint was consistently achieved.

The patients and relatives we could speak with reported pain control being effective and that it was provided in a timely way.

Patient outcomes

ICNARC Participation
The trusts ICU and HDU areas contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide. There were plans to combine this in to one data set. ICNARC data was collected by a data clerk who worked closely with the clinical team to collate information.

We used data from the 2016/2017 annual report and the 1 April 2017 and 31 March 2018 and 1 April 2018 to 30 September 2018 reports.
(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (all patients)
Critical care specific mortality and morbidity meetings took place weekly, which was in line with GPICS recommendations. Feedback from consultants we spoke with was this process was embedded within the service. All staff were invited to attend. Case reviews took place as well as learning from care that had gone well to share good practice. Learning and any changes in protocols were shared via email. The service also had mortality and morbidity meetings with other specialities, for example, neurosurgery and colleagues in the emergency department.

For the James Cook University Hospital, cardiac intensive care Unit, the risk adjusted hospital mortality ratio was 0.7 in 2016/17. This was positive outlier. The figure in the 2015/16 annual report was 0.9.

Number of cases	Metric	2015/16	2016/17	National aggregate	Asp Standard	Comparison
1,140 admissions	Risk-adjusted hospital mortality ratio (all patients)	0.9	0.7	1.0	None	Positive outlier

For the James Cook University Hospital, generic high dependency unit, the risk adjusted hospital mortality ratio was 0.98 in 2017/18. This was within expected range. The figure in the 2016/17 annual report was 0.9.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
1,305 admissions	Risk-adjusted hospital mortality ratio (all patients)	0.9	0.98	1.0	None	Within expected range

Data from the 1 April 2018 to 30 September 2018 report showed this had reduced to 0.84.

For the James Cook University Hospital, intensive care unit, the risk adjusted hospital mortality ratio was 0.98 in 2017/18. This was within expected range. The figure in the 2016/17 annual

report was 1.0.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
751 admissions	Risk-adjusted hospital mortality ratio (all patients)	1.0	0.97	1.0	None	Within expected range

Data from the 1 April 2018 to 30 September 2018 report showed this had increased slightly to 1.01 but was still within the expected range.
(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (for low risk patients)
For the James Cook University Hospital, cardiac intensive care unit, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.6. This was within expected limits. The figure in the 2015/16 annual report was 0.7.

Number of cases	Metric	2015/16	2016/17	National aggregate	Asp Standard	Comparison
1,073 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	0.7	0.6	1.0	None	Within expected limits

For the James Cook University Hospital, generic high dependency, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.99. This was within expected limits. The figure in the 2016/17 annual report was 0.8.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
1,060 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	0.8	0.99	1.0	None	Within expected limits

Data from the 1 April 2018 to 30 September 2018 report showed this had reduced to 0.56.

For the James Cook University Hospital, intensive care unit, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.87. This was within expected limits. The figure in the 2016/17 annual report was 0.7.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
416	Risk-adjusted	0.7	0.87	1.0	None	Within

admissions	hospital mortality ratio for patients with predicted risk of death <20% (lower risk)					expected limits

Data from the 1 April 2018 to 30 September 2018 report showed this was 0.83.
(Source: Intensive Care National Audit Research Centre (ICNARC))

The generic HDU had an unplanned readmission rate within 48 hours of 1.5% for the period of 1 April 2017 to 31 March 2018. This was higher (worse) than the rate for similar units which was 0.85%, however was within the expected range when compared to the England average.

Data from the 1 April 2018 to 30 September 2018 report showed this had improved and reduced to 0.5%. This was lower (better) when compared to similar units who had a rate of 0.7%.

The ICU had an unplanned readmission rate within 48 hours of 1.8%. This was higher (worse) when compared with similar units who had a rate of 1.3%, however, was within the expected range when compared to the England average.

Data from the 1 April 2018 to 30 September 2018 report showed this had significantly improved to 0% which was better when compared to similar units where the percentage had increased to 1.5.

Sepsis formed part of the services annual audit plan. This included an audit of compliance against the sepsis bundle, training and the use of sepsis champions. It was unclear where audit results were discussed as we saw no evidence in the meeting minutes we reviewed.

The physiotherapy team completed a national rehabilitation outcome measure called the 'Chelsea Critical Care Physical Assessment Tool', a scoring system to measure physical morbidity in critical care patients.

Competent staff

Appraisal rates
From October 2017 to September 2018, 76.3% of staff within critical care at the trust received an appraisal compared to a trust target of 80%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
Medical & Dental staff - Hospital	40	38	95.0%	Yes
Qualified nursing & health visiting staff (Qualified nurses)	313	239	76.4%	No
Support to doctors and nursing staff	73	49	67.1%	No
Qualified Allied Health Professionals (Qualified AHPs)	1	0	0.0%	No

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

Data we were shown on site for staff working in ICU and HDU at the James Cook University Hospital which showed 57% had undergone a recent appraisal. The matron described the plans that had been put in place to complete those which were outstanding.

All new staff both medical and nursing attended a corporate induction when starting at the trust. A local induction was completed by all new staff. Registered nursing staff had an induction week for then a six-week supernumerary period. During this time support was provide by the clinical educator and a mentor. Training was provided covering a range of topics from body systems to stoma care and human factors.

We spoke with advanced critical care practitioners who confirmed that initial training and education was very good with support from a consultant mentor who personally assessed them to sign off competencies. Ongoing supervision was provided by the clinical director.

Information provided by the trust showed that 33% of nurses in ICU had a post registration award in critical care nursing. This was a consequence staff vacancy and turnover rates and was not in line with the GPICS minimum recommendation of 50%. The trust had a trajectory of 48% by the end of the academic year as there were 16 staff currently undergoing this training. It was noted the data provided only applied to nurses working in ICU and HDU we were not provided with data for the other areas.

Following the inspection, the trust told us they had planned to move from a standard 16 bedded HDU to a flexible 16 bedded HDU/ITU. However, this was not communicated to staff or inspectors and we could not be provided with evidence of this at the time of inspection.

We spoke with the two clinical educators, they were in dedicated roles in line with GPICS recommendations. They provided a variety of education and maintained central records for equipment training, steps and post-registration training on the units.

There was a clinical educator for ICU and HDU who oversaw 198 staff. The clinical educator for cardiothoracic HDU and ICU had 78 staff. GPICS recommendations are that there should be one whole time equivalent educator per 75 staff.

We were told approval had been given for two further whole time equivalent educators in December 2018. At the time of inspection these had not been appointed to.

All registered nurses in critical care are required to complete step one of the National Competency Framework for Adult Critical Care Nurses within 12 months of commencing employment on the units. Step one competencies have been designed to provide core generic skills required to safely and professionally care for the critically ill patient in a general critical care unit under the supervision and support of a mentor, lead assessor and /or practice educator.

We were provided with training data only for staff working on the general ICU and generic HDU. From this data overall percentages with step competencies was not evident. However, it was seen that steps training for levels one to five was undertaken.

The GPICS guidelines are currently under review. The new guidelines will include major trauma step competencies. The clinical educators had a plan in place for delivery of this and some

training already commenced with the staff in ICU.

Cardiac surgery advanced life support (CALS) training was provided for staff. We did not see training compliance figures for this.

Staff rotated between units as required to support staffing shortages. Staff on the generic HDU told us they were all trained to care for level three patients. However, from the information we were provided with, we lacked assurance that staff had the necessary skills and training to be able to provide care to patients on critical care as full training compliance data was not provided. We also lacked assurance over how the skills and competencies of staff fed in to the rota to ensure an appropriate skill mix at all times in each unit.

Additional study days were provided by staff in areas such as surgery, hemofiltration and ventilation. There were identified link workers in each area, for areas such as blood transfusion and tissue viability. The IPC team did ten-minute training sessions with staff to deliver key messages and used the train the trainer methodology for cascading information.

Doctors reported there were good teaching opportunities for medical staff on a range of conditions. There was a weekly consultant led teaching programme on a Wednesday and a middle grade teaching programme was in development. There was also access to a simulation centre to support training.

Multidisciplinary working

During our inspection we observed good multidisciplinary team (MDT) working. This was supported by the various staff we spoke with and in the patient records we reviewed. Good working relationships with other specialities were evident and we observed a number of conversations between ICU consultants and speciality consultants over plans of care as well as agreements to keep each other up dated with any changes. We also observed theatre staff coming to critical care to see a patient pre-operatively. There was a detailed discussion between them and consultant over the patient's condition and any potential issues that may occur during surgery.

The James Cook hospital site is a major trauma centre, the consultant explained this meant there were lots of different speciality consultants to call on for advice.

It was recognised by the staff in the units and the inspection team that the effective MDT working played a significant role in providing effective care and treatment for patients. Particularly with the staffing pressures we observed. We observed a number of situations where staff supported each other to deliver care when there were staffing shortages.

There was a lead pharmacist, physiotherapist and dietitian for critical care. Access to speech and language therapy and nurse specialists was available when required, such as acute pain management and infection prevention and control.

MDT staff did not all accompany medical staff on the ward round, however there was a weekly MDT meeting which was attended by all members of the team. The discussions from this inputted into care planning and decision making. We saw evidence of this from speaking with staff and reviewing patient records. There were also weekly meetings with radiology staff.

Multidisciplinary staffing was generally in line with GPICS recommendations; however, it did not meet the full recommendations. We spoke with physiotherapy staff who confirmed that in line with GPICS recommendations they could provide the respiratory management and rehabilitation components of care. They reported this was a challenge as many covered other areas as well as critical care. Physiotherapy input had been highlighted as an area which needed further input in the 2016 Network peer review, to support a more robust service.

As previously discussed there was a shortage of critical care pharmacy provision which meant GPICS standards were not met.

Microbiology ward rounds took place three times a week with an on-call service available. We observed the team coming to discuss a patient with the on-call ICU consultant.

The CCOT liaised with allied health professional as required as part of their role. They also ensured ward managers were aware of any unwell patients there may be on their wards and the plan of care.

Seven-day services

We saw from patient records consultant led ward rounds took place twice daily. Consultant cover was available twenty-four hours a day, seven days per week, in line with GPICS standards.

Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Physiotherapists provided treatment seven days a week with an on-call service available overnight.

Speech and language therapy were offered Monday to Friday.

X-ray, computerised tomography (CT) scanning, interventional radiography and endoscopy was accessible 24 hours a day, seven days a week.

Health promotion

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. Staff told us the pharmacist and consultants would provide advice and support in such situations. Nicotine patches could also be prescribed and provided to patients if required

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

A range of patient information leaflets were available for patients and families. This included information such as preventing blood clots and smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 59% of staff in critical care compared to the trust target of 90.0%.

The breakdown by site was as follows:

Site	Training complete (YTD)	Individuals required (YTD)	Completion rate	Target met
The James Cook University Hospital	208	357	58.3%	No

The trust did not deport report Deprivation of Liberty Safeguards training during the same period.

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

MCA training was done face to face, consultant staff were aware they needed updating with this training.

Despite training compliance being below the trust target, the staff we spoke with demonstrated good understanding of the mental capacity act and deprivation of liberty safeguards. We saw evidence of capacity being assessed and recorded in patient records.

Staff were unable to find the policy on restraint whilst we were on site, however this was provided after the inspection when requested. Staff were aware of the process if a patient required any form of restraint. Staff told us where possible this would be avoided, and we observed staff comforting patients to stop them pulling at tubes rather than using mitts.

Where mitts were in use we found evidence of capacity assessments being completed, care plans were in place and there was evidence of ongoing assessment.

In the records we reviewed there were daily prompts to undertake Richmond Agitation-Sedation Scale (RASS) scores and screening using the Confusion Assessment Method (CAM) for ICU. These are used to measure the agitation, sedation or delirium levels of a patient. We saw that where appropriate these had been completed and appropriate actions taken.

We spoke with a specialist pharmacist who was undertaking a review looking at the use of sedation and if the use of drugs such as propofol could be reduced.

The falls assessment chart included a screening tool for dementia. This was completed as appropriate in the records we reviewed.

Staff we spoke with demonstrated a good understanding of consent, and where possible, would always seek consent from patients. On HDU we observed verbal consent being taken before procedures were undertaken.

Is the service caring?

Compassionate care

The patients and relatives we could speak with were consistently positive about the care given. Feedback was that staff were caring and compassionate to both patients and their relatives.

Despite the staffing challenges, we observed all members of staff providing care for patients' in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious or unconscious.

During the inspection all the units were very busy, despite this staff calmly provided care and attended to the needs of their patients. Some staff did comment that the staffing pressures meant they could not always do the 'extra things' they would like to do for their patients, such as providing regular mouthcare or washing their hair.

The lack of curtains on the cardiac ICU meant providing privacy and dignity for patients was more of a challenge. We observed staff using additional screens, whilst you couldn't see the patients when stood outside they did not provide 100% privacy for patients when care was being delivered.

In the other areas the privacy and dignity of patients was maintained when care and treatment was being delivered by pulling curtains round.

Areas had link nurses for privacy and dignity whose responsibilities were to encourage staff to become dignity champions, support environmental changes to enhance privacy and dignity and feedback findings dedicated meetings.

Patients and relatives we were able to speak to described how they were very happy with the care being given. Relatives reported flexible visiting and high standards of care delivery. One relative explained, "the staff are excellent, so caring and hardworking".

Staff respected religious, cultural and social needs of patients and their families. For example, staff respected an Asian families' choice to carry out personal care for their relative and supported this to happen.

The focus of the month within critical care was on protected sleep time, to try and distinguish between day and night and provide rest time for patients.

The service won the team winner for outstanding contribution to patient care in 2018, as part of the trust's annual awards.

Emotional support

We observed the emotional support provided by staff during our inspection. We observed staff holding patient's hands and providing assurance. During a ward round the consultant was aware of a patient's anxiety and changed their use of language, they also reduced number of people round the bed during the ward round.

The use of patient diaries was established on the intensive care units and we saw these being completed during our inspection. Patient diaries can help patients to understand what has been happening whilst they have been critically ill. Patients who have been in a critical care environment often report memory loss and some may suffer from psychological problems. Research has found patient diaries help to fill in some missing gaps and have also given the patient understanding as to how poorly they have been. Information explaining their purpose was

provided to relatives.

The CCOT looked at both physical and emotional needs of patients when they reviewed them on the wards following discharge from critical care. They used both of these factors to determine the number of visits required by individual patients.

Non-physical risks were included in the critical care rehabilitation pathway document. This included prompts for patients in areas such as reoccurring nightmares and anxiety.

The service had developed a support group as part of the ICU steps charity. This group was for patients who had been on ICU and their families. It was run by former patients, relatives and health professionals, to provide ongoing support after discharge from hospital. The group also aimed to promote the recognition of the physical and psychological consequences of being on ICU.

There was also a comprehensive leaflet to support patients and relatives, with information on getting back to a 'normal' routine and providing practical advice and places to seek further support.

A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients. There was access to the palliative care team including an out of hours advice line.

Understanding and involvement of patients and those close to them

We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment. The relatives we spoke with said they felt informed and involved with the care of their relative.

We saw a document 'getting to know your loved one, can you help?' in some of the records we reviewed. This document was for relatives to complete and asked questions about, likes and dislikes, family and hobbies.

With support from the palliative care team and donations from families, the Dragonfly scheme had been developed to provide essential items to relatives who were staying in hospital with their loved ones. The items were in a bag with the Dragonfly logo and this also gave relatives discounted meals.

We observed medical and nursing staff taking time to explain what was happening to relatives, so they understood the care and treatment.

Staff could describe using communication tools such as ABC boards, picture boards and we observed these being used during ward rounds and other interactions with patients.

We observed a physiotherapist delivering treatment to a patient, they provided reassurance and praise explaining what each exercise was for. They ensured understanding throughout the treatment and explained they would continue to deliver therapy once they were discharged from the unit.

The trust was committed to drive awareness and culture surrounding organ donation. Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life. The units had a lead organ donation specialist nurse, who was

available at all times. There were high number of donors, the James Cook hospital ICU was an exemplar for donation practice.

Is the service responsive?

Service delivery to meet the needs of the local people

The department worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.

The service recognised the need to change services offered by critical care, particularly around the sustainability of service at the Friarage hospital. Following the inspection, a decision was made to close the unit at this site.

The service was involved in the regional critical care operational delivery network.

The service had follow up clinics in place, however these were unfunded, and we were told they ran on 'goodwill'. Predominantly patients from the ICU were referred to the clinic. The GIRFT report identified the clinics were only available to about 6% of the patient population and prioritised by risk. There was no psychology input in to the clinics. If patient needs were identified referrals were made via their general practitioner.

The neurosurgical and cardiothoracic units at the James Cook University hospital had some challenges with the facilities and environments. There was limited space on some units and a lack of isolation rooms.

Arrangements were in place to manage patients with complex long-term weaning problems and the service had access to a home ventilation team.

The Butterfly scheme and unit champions were used to support those patients living with dementia.

There was some provision for relatives to stay overnight. The facilities were limited in some of the units and did not have access to shower and changing facilities.

Tea and coffee making faculties were provided in some of the relative's room. Staff said they could provide hot drinks and biscuits. There were cafes and vending machines in the hospital for relatives to have meals and snacks.

Meeting people's individual needs

Staff we spoke with knew how to access interpreting services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were also available.

Staff we spoke with told us they could access bariatric equipment to care for patients as required.

Initiatives to enhance the care of those with a learning disability were in place. Hospital passports were in use. These detailed personal preferences, triggers, and any interventions which were helpful in supporting individual during difficult periods.

Staff recognised the importance of involving relatives and carers for any patient with additional needs. We saw evidence in patient records that care plans included assessment and interventions for any patients with additional needs. This information would be communicated to all staff during handovers.

The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this. Named nurses were identified for each patient in the units we visited.

The critical care outreach team reviewed all patients who were discharged from intensive care to ward areas.

There was a clear message from all staff about the importance of patient centred care. There were a number of projects that were focused on improving care for patients in intensive care. These included, the enlightens study which was looking at circadian rhythms and how these are affected by light. Light globes were in rooms for long stay patients. These slowly light up as the sun rose and could also include bird song.

We were also told about voice activated television and radio systems for patients to provide them with some control over their environment.

The service was also involved with patient orientated research to reduce noise in the critical care environment.

Access and flow

Access and flow remained a challenge for the service as it provided specialist critical care provision for a large geographical area. The James Cook University hospital was also a designated major trauma centre.

We had concerns over the management of booked beds following elective surgery. Regular bed meetings took place each day which were attended by a critical care consultant. The matron for critical care was also available to support the escalation process in terms of access and flow.

We attended several bed meetings and observed the SOP in relation to the numbers of booked beds was not adhered to. We observed as many as six elective critical care beds being booked on one day. The SOP identified four was an appropriate number with the capacity challenges. From what we observed we did not see the service was planning effectively to work towards their SOP.

Data was requested on the number of cancelled elective operations because of no critical care capacity. Monthly information from January 2018 to February 2019 showed the number of cancellations raged from zero to 20.

The GIRFT report from 2018 identified there had been 33 cancellations during a 3-month period of which 27 were due to a lack of critical care beds. However, the data was not necessarily accurate as it came from differing sources.

We also attended an afternoon handover and planning meeting to plan for critical care capacity overnight. However, we were told any plans can change with emergency admissions that may

arrive. We were given an example from the previous day where at 4.30pm there had been three level three beds and three level two beds, but by 2am these had all been filled.

The hospital did not have a post anaesthetic care unit (PACU) at the time of inspection. This was a much-needed service which would take some of the pressure off the critical care units. Some elective cases required an extended period of recovery, but this did not necessarily need to be in critical care. A PACU could provide this. This service was identified in trust action plans we were provided with from 2016.

The network peer review of the service in 2016 strongly supported the case for a PACU. It was also identified as a partial solution to capacity issues in the GIRFT report in 2018. The clinical lead agreed this would be of benefit. It was unclear why this had not progressed prior to our inspection.

Action plans from the 2016 peer review planned for this to be in place in the winter of 2016. Financial constraints had prevented this from happening. The PACU also was part of the action plan following the GIRFT report being received by the trust in January 2019. A review of capacity and demand had taken place, with a date of April 2019 for the unit to be fully operational.
There had been a recommendation in place for a number of years to increase and flex capacity in the generic HDU and establish a PACU. We lacked assurance around the pace of delivery for this and how it was being monitored by the trust; a PACU had been identified as a means of mitigating some of the issues around access and flow in 2016. Whilst plans had been approved for PACU at the time of writing the report the PACU was not yet operational. CQC had requested weekly updates following the inspection regarding the safety of critical care and it was noted that the opening of PACU had been deferred until July 2019 because of staffing levels.

From the 16 patient records we reviewed we could not find evidence that patients were admitted to critical care within four hours of a decision being made as this was not clearly recorded. Information from the GIRFT report stated, *"over a quarter of admissions are delayed, some are from theatre and buffered in recovery and some from emergencies affecting ED patient flow"*.

The GIRFT report from 2018 also highlighted that fewer patients were being admitted directly from theatre to critical care following emergency laparotomy surgery compared to the national average. The led to high numbers of unplanned admissions to critical care from ward areas. The figures in the report were 5.3% compared to the national average of 3.2%, the report stated this represented a capacity and quality of care issue.

Bed occupancy
From September 2017 to October 2018, South Tees Hospitals NHS Foundation Trust has seen adult bed occupancy remained higher than the England average. The largest rate of bed occupancy was seen in August 2018. A slight improvement was seen from November 2018.

Adult critical care Bed occupancy rates, South Tees Hospitals NHS Foundation Trust.

——— This Trust   ——— England Avg.

R 3
Critical care bed occupancy - Adult
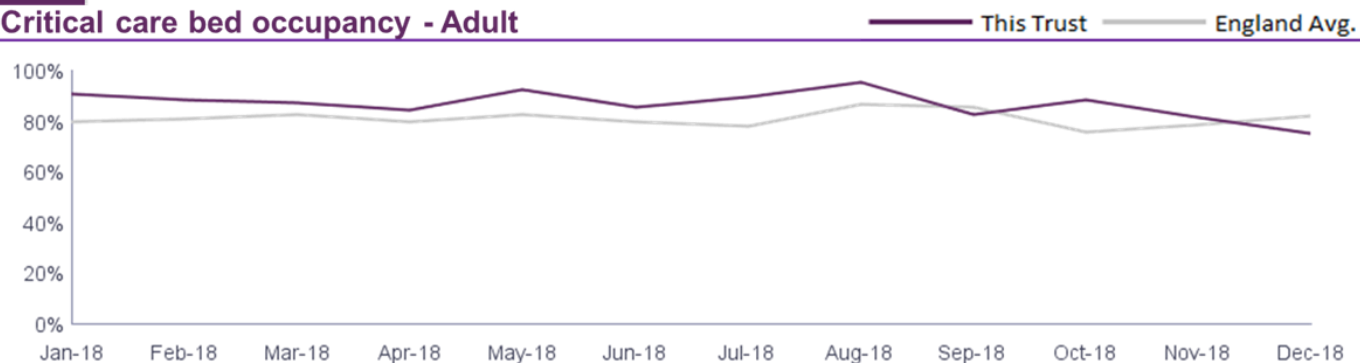
Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.
(Source: NHS England)

Delayed discharges

The James Cook University Hospital
For the James Cook University Hospital, cardiac intensive care unit, there were 4,380 available bed days. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 0.1%. This compares to the national aggregate of 4.9%. This meant that the unit was Not in the worst 5% of units. The figure in the 2015/16 annual report was 0.1%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Asp Standard	Comparison
4,380 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	0.1%	0.1%	4.9%	0%	Not in the worst 5% of units

For the James Cook University Hospital, generic high dependency unit, there were 5,840 available bed days. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 2.3%. This compares to the national aggregate of 4.9% and was much better when compared to similar units who had a rate of 8.0%. The figure in the 2016/17 annual report was 5.9%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
5,840 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	5.9%	2.3%	4.9%	0%	Not in the worst 5% of units

Data from the 1 April 2018 to 30 September 2018 report showed this had increased slightly to

2.7% but remained lower when compared to similar units which had a rate of 6.1%.

For the James Cook University Hospital, intensive care unit, there were 5,840 available bed days. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 0.5%. This compares to the national aggregate of 4.9% and was better when compared to similar units who had a rate of 3.6%. The figure in the 2016/17 annual report was 1.3%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
5,840 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	1.3%	0.5%	4.9%	0%	Not in the worst 5% of units

Data from the 1 April 2018 to 30 September 2018 report showed this had increased slightly to 0.7%.
(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-clinical transfers - The James Cook University Hospital
For the James Cook University Hospital, Cardiac Intensive Care there were 1,183 admissions, of which 0.1% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 0.0%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Asp Standard	Comparison
1,183 admissions	Crude non-clinical transfers	0.0%	0.1%	0.4%	0%	Within expected range

For the James Cook University Hospital, Generic High Dependency Unit there were 1,471 admissions, of which 0.2% had a non-clinical transfer out of the unit. This was within the expected range. The figure in the 2016/17 annual report was 0.1%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
1,471 admissions	Crude non-clinical transfers	0.1%	0.2%	0.4%	0%	Within expected range

Data from the 1 April 2018 to 30 September 2018 report showed this had reduced further to 0.1%.

For the James Cook University Hospital, intensive care unit there were 820 admissions, of which 1.3% had a non-clinical transfer out of the unit. This was higher (worse) when compared to similar units who had a rate of 0.5%, however it remained within the expected range. The figure in the 2016/17 annual report was 0.4%.

Number of	Metric	2016/17	2017/18	National	Asp	Comparison

cases				aggregate	Standard	
820 admissions	Crude non-clinical transfers	0.4%	1.3%	0.4%	0%	Within expected range

Data from the 1 April 2018 to 30 September 2018 report showed this had improved to 0% and was better when compared to similar units.
(Source: Intensive Care National Audit Research Centre (ICNARC))

Following the inspection further information was supplied by the trust to December 2018 indicated that the non-clinical transfers remained better when compared to similar units following.

Information from the GIRFT report in 2018 stated non-clinical transfers from the James Cook university hospital ICU were generally to a nearby trust because of capacity issues. The ICNARC data did not include non-clinical transfers from the trust's emergency department, theatre recovery or the Friarage hospital. The report stated non-clinical transfers reflect stress in the system and they should be urgently reviewed.

This was in the action plan following receipt of the report. The plan stated non-clinical transfers would continue to be monitored and reported monthly.

Non-delayed out of hours discharges to the ward - The James Cook University Hospital
For the James Cook University Hospital, Cardiac Intensive Care Unit 0.0% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within expected range. The figure in the 2015/16 annual report was 0.4%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Asp Standard	Comparison
256 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	0.4%	0.0%	1.9%	0%	Within expected range

For the James Cook University Hospital, generic high dependency unit, 6% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within expected range, however was significantly higher (worse) when compared to similar units who had a rate of 2.5%. The figure in the 2016/17 annual report was 3.4%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
1,172 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	3.4%	6%	2.1%	0%	Within expected range

Data from the 1 April 2018 to 30 September 2018 report showed this had improved to 2.9%, this was still slightly higher when compared to similar units and the national aggregate. However, it remained within the expected range.

For the James Cook University Hospital, intensive care unit 8.6% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was significantly higher when compared to similar units, who had a rate of 2%, but was within the expected range. The figure in the 2016/17 annual report was 5.9%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Asp Standard	Comparison
222 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	5.9%	8.6%	1.9%	0%	Within expected range

Data from the 1 April 2018 to 30 September 2018 report showed this remained high at 7.9%, however the rate remained within the expected range.
(Source: Intensive Care National Audit Research Centre (ICNARC))

The GIRFT report highlighted there were a high number of admissions to the generic HDU occurred overnight, some were elective admissions which were delayed, some were emergency admissions. The report also stated ICU night time admissions were very high, with four in ten admissions taking place overnight.

Delayed admissions were also high at around 10%. A high number were discharged at night and the unit was an outlier.

The data provided from the trust showed that from August 2018 to January 2019, a total of 24 patients had been nurse in theatre recovery when critical care beds were not available. The length of time in recovery ranged from two to eight hours.

Trust incident data from February 2018 to February 2019, showed there were seven incidents reported of patients being held in recovery due to a lack of a critical care bed.

The action plan following receipt of the GIRFT report stated the service would continue to monitor delays in admission to critical care. An audit of patients with delay of more than four hours was to be undertaken by July 2019.

Learning from complaints and concerns

Summary of complaints
From October 2017 to September 2018 there were two complaints about critical care, both regarding patient care. The trust took an average of 70 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 40 days.
(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust
From October 2017 to September 2018 there were two compliments within critical care.

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. There was also information encouraging relatives to speak to the nurse in charge if they had any concerns to try and resolve any issues before they escalated.

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.

Is the service well-led?

Leadership

Since the previous inspection there had been changes with cardiothoracic and neuro areas being brought under the same management structure as other critical care areas. The GIRFT report from 2018 identified that whilst this was viewed as a positive step, further closer working was still required. This was evident from our observations and discussions with staff. Also, from information requested following the inspection. The focus was felt to be on the general ICU and HDU areas with other areas not included in discussions and information not provided for them.

The lack of information and inclusion of all areas meant we could not be assured that the corporate team understood all the challenges to quality and sustainability within critical care as a whole.

From discussions with the clinical leadership team it was clear they had an understanding of the current challenges and pressures impacting on service delivery and patient care. Consultants had direct access to the chief executive as they chaired the critical care strategy group meetings, however feedback to the inspection team from focus groups was that they did not feel they had a strong clinical voice.

There was a lead consultant and a lead nurse for critical care and the CCOT. Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. The exception to this was the role of supernumerary coordinators. The generic HDU was the only area which regularly had a coordinator in place, however even here due to the number of beds GPICS recommendations would be to consider two coordinators.

The coordinator plays a significant role in oversight of safety and risk and importantly supporting staff on the units. During the inspection we observed coordinators providing direct care and not being in a supernumerary role.

We could not be assured that training and development of staff for succession planning was in place to enable sustainable leadership, as training information was not provided for all areas. Appraisal rates were also below the trust target. Appraisals are used to identify learning and development needs of staff.

There was strong medical leadership on the units. From our observations and from speaking with staff, it was clear that staff had confidence in the nursing leadership in the different units. The clinical leadership team were highly visible and approachable. The matron visited the units regularly.

Vision and strategy

The vision for the unit was ultimately dependent on the reconfiguration of critical care services across the two hospital sites, in particular what would happen with the unit at the Friarage.

At the time of inspection there was uncertainty over the future of Friarage. There were plans to make the generic HDU more flexible in terms of level three capacity and there had been ongoing discussions about opening an additional bed.

There were also plans to open a PACU to support with access and flow for those patients who required an extended recovery period and whose needs could be met outside of the critical care units.

Each of these areas had been under discussion for a number of years and financial constraints within the trust had prevented them being achieved. They were identified in the peer review of the service in 2016 and in the GIRFT report in 2018.

We were provided with the critical care strategy from 2017. The vision of the changes mentioned above fed into the overall strategy which had four aims. These were

- Maintain high standards of patient care, manage capacity and demand

- Development of the critical care service

- To attract, develop and retain a highly skilled sustainable workforce

- To achieve financial viability

Each of the aims had strategic objective which sat below them with actions to meet them and metrics which could be used as a measure of success. No time scales were attached to these.

The strategy did not detail where responsibility lay or where monitoring of progress against the strategic aims would take place. It was also unclear how staff and the public fed in to this. Staff we spoke with spoke about uncertainty with the future of critical care.

Following the inspection, a decision was made to close the critical care unit at the Friarage hospital. We were provided with an action plan that stated PACU would be operational by April 2019.

Culture

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.

There was a clear focus of patient centred care and teamwork, support between colleagues was strongly evident throughout the different areas we visited for both nursing and medical staff.

We observed examples of this including, a consultant taking time to do some teaching with a medical student during the ward round and after seeing each patient, the ICU consultant checked with the nurse if they had any other concerns.

We were told following a college visit the service was identified as the most popular critical care training unit in the region.

Staff morale within the CCOT team was good. The team felt they worked well and supported each other. They had monthly meetings which included a teleconference link with the Friarage site.

Staff morale in other areas was mixed. This was due to staffing challenges, a lack of a coordinator to provide support and staff being moved between units. We observed staff not able to take lunch breaks until 15:30 hours and the difficulties experienced by coordinators when they were caring for patients as well as trying to fulfil the coordinator role. However, staff reported there were good opportunities for promotion within the service.

Medical staff reported good support between colleagues and nursing staff, however, some medical staff felt their concerns weren't always listened to by the corporate leadership team.

Governance

Critical care was part of the urgent and emergency care centre. This included the directorates of emergency and acute medicine. Recently all areas of critical care had been brought in to this structure.

Operational critical care meetings had been re-established, monthly governance and weekly mortality and morbidity review meetings were in place.

Meeting minutes included little details of lessons learned and actions taken in response to incidents and audits. It was unclear how this information was then shared with staff at unit level. From our observations and discussions with staff, Safety huddles were not well established.

We lacked some assurance about individual staff's awareness of their roles and responsibilities. This was because incidents were not always reported, we were concerned that issues had also not been appropriately identified and escalated. In particular, those of nurse staffing and associated patient harms.

We were provided with a gap analysis against the GPICS recommendations in relation to nurse staffing. This was not reflective of what we saw on inspection. For example, they had recorded themselves compliant for 1:1 care, this is not what we observed during our inspection.

Management of risk, issues and performance

There was a critical care risk register which contained five risks. We were concerned that the risks identified during our inspection did not all feature on the risk register. Namely, nurse staffing, concerns with infection rates and the number of pressure ulcers.

Senior nurses were aware of the impact of not having a coordinator in terms of support for junior, oversight and staff morale. When staffing challenges occurred this was the first role to be pulled in to the clinical numbers. Times of peak activity are when coordinators are needed more to support safety and the staff on the units.

The concerns over medical staffing and the sustainability of this at the Friarage site was contained within the risk register, as well as the risk of patients being ventilated outside of ICU due to capacity and demand, and cardiac HDU not meeting national guidelines.

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.

The risk register gave a current and target risk level for each risk. However, it did not contain any detail on mitigating actions, so it was unclear how the level of risk would reduce.

There was no evidence of regular review of the risks. For example, the risk related to capacity and demand and ventilated patients outside of ICU had been on the risk register since September 2014, the next review date was April 2019.

It was unclear from our discussions with staff and reviewing meeting minutes how information related to performance was used to monitor quality and identify when action should be taken. For example, issues related to infection rates were identified in the services ICNARC data and the GIRFT report however little action had been taken in response to these. There were also large number of incident forms related to IPC issues.

The dashboards for individual units identified when infections or pressure ulcers had occurred. This showed there was varying performance. The corporate team had identified this was showing a sustained downward trend in acquired pressure damage. This what not the case. We were concerned that information being viewed at this level was providing false assurance over patient safety issues.

We were not provided with training compliance and overall percentages for all staff. This meant we could not be assured that staff in all areas had the relevant experience and training for the patients they were caring for.

Information management

The admission, discharge and transfer documentation was in line with best practice and NICE guidance.

Staff received training on information governance and were aware of the importance of managing confidential patient information. We found that records were stored securely within the unit.

Blood results, x-rays and scan results could be accessed electronically, mobile workstations allowed these to be reviewed at the patients' bedside.

The service contributed to the ICNARC data collection, however this was for the general areas only. Information on performance was collected, however it was unclear due to a lack of detail how much of this was discussed at meeting and how this information was then shared with staff to address any issues.

Engagement

We saw notice boards that were used to share patient safety information, however from reviewing meeting minutes we found limited discussions around incidents and performance data and actions in response to these. It was also unclear how managers assured themselves that information had been passed on, and how this information was then shared with staff on the units.

We were told there would sometimes be team debriefs after difficult situations. This was a good opportunity for proving support to colleagues and sharing good practice and areas for improvement.

We received mixed views in terms of staff feeling involved and informed about what was happening in the trust in relation to critical care services.

There was staff engagement by recognition and reward of their work. This was done via an annual awards event where staff and teams were nominated and received awards,

There were systems in place to obtain feedback from patients. Feedback was obtained using a

system called 1000 voices. This was used in the HDU areas and feedback scores were seen displayed. We were provided with data from January from the three HDU areas. One hundred percent of respondents would recommend the service. The questionnaire asked about several different areas related to care and treatment from cleanliness to communication. It was noted the number of responses was only between seven and eight for each unit.

The ICU steps sessions were an opportunity for patient and relative engagement. They were also able to contribute to the development of the service and research studies being undertaken.

Informal feedback was also obtained from the CCOT when they reviewed patients after discharge from critical care and from follow up clinics.

Learning, continuous improvement and innovation

The service was involved in the regional critical care operational delivery network.

The service had employed advanced critical care practitioners (ACCP's) and others were training. They would support the medical workforce in HDU areas.

Information provided showed the service was a desirable location for trainees with high rates of success.

There was a well-established mortality and morbidity review process, this also involved other services within the trust and looked at complex cases which had been managed well to share good practice, as well as patient deaths.

Other quality improvement that were being looked at included, introducing ultrasound meetings and formalisation with radiologists for storing images and delivering mentoring for the trainees and upskilling nurses looking at airway skills and safety of intubation.

Neuro HDU was involved in a clinical trial to investigate catheter use and different medication treatments for patients who have experienced a subdural bleed. The unit was also looked at changing practices for patient's prior to undergoing a craniotomy including the use of mediation and changing the environment. We were told some positive patient outcomes had come from this.

The service was involved in seven research studies and recognition had been given due the high numbers recruited. Examples included, adaptive sepsis looking at using inflammatory markers to guide antibiotic usage.

The Friarage Hospital

Urgent and emergency care

Facts and data about this service

At the time of the inspection, the Friarage Hospital was one of two emergency departments for South Tees hospitals NHS Foundation trust.

- The James Cook University Hospital - emergency department
- Friarage Hospital - emergency department.

Minor injury units were available at Redcar Primary Care Hospital and a children's minor injury unit model is delivered at the Friarage Hospital.The Friarage A&E was open seven days a week, 24 hours a day. Patients were cared for in four main areas; paediatrics, minors, majors and resuscitation. Children who were unwell or had major injuries are treated at JCUH.
*(Source: Routine Provider Information Request (RPIR) – Sites tab)*

At the time of the inspection, the department was categorised as a type one emergency department for adults and a type three emergency department for paediatric patients. The department was able to see paediatric patients presenting with injury and had pathways in place to stream paediatric patients presenting with minor illness.

Following this inspection, the service closed on 27 March 2019, and opened as an Urgent Treatment Centre. The plan was for the department to be able to see and treat more paediatric patients as they planned to see both paediatric minor illness and injury.

Activity and patient throughput
Total number of urgent and emergency care attendances at South Tees Hospitals NHS Foundation Trust compared to all acute trusts in England, July 2017 to June 2018
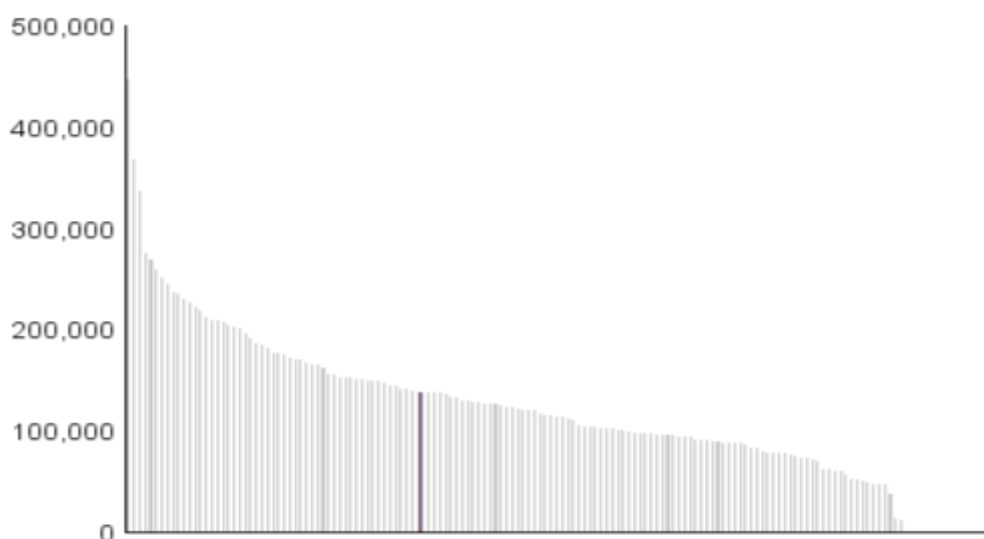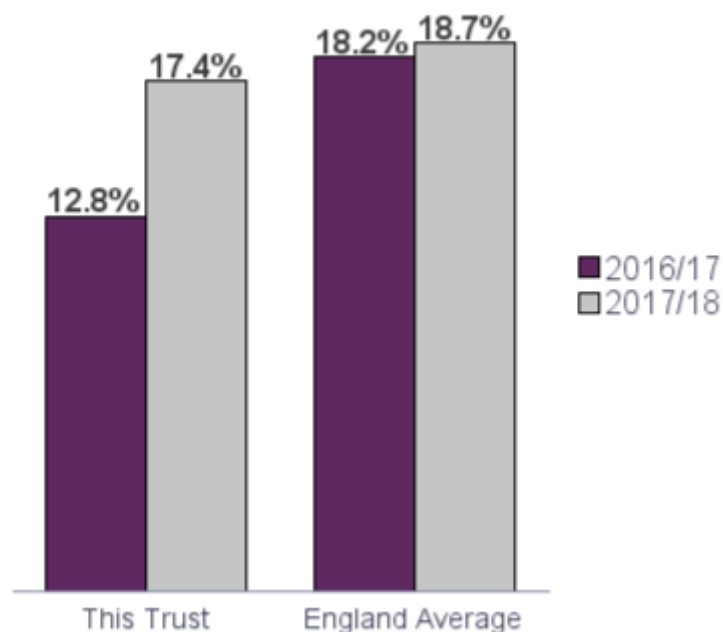

From July 2017 to June 2018 there were 137,614 attendances at the trust's urgent and emergency care services as indicated in the chart above.
(Source: Hospital Episode Statistics)

Information provided by the trust showed that between July to December 2018 there were 9958 attendances at Friarage urgent and emergency care department of these 1,523 were paediatric attendances.
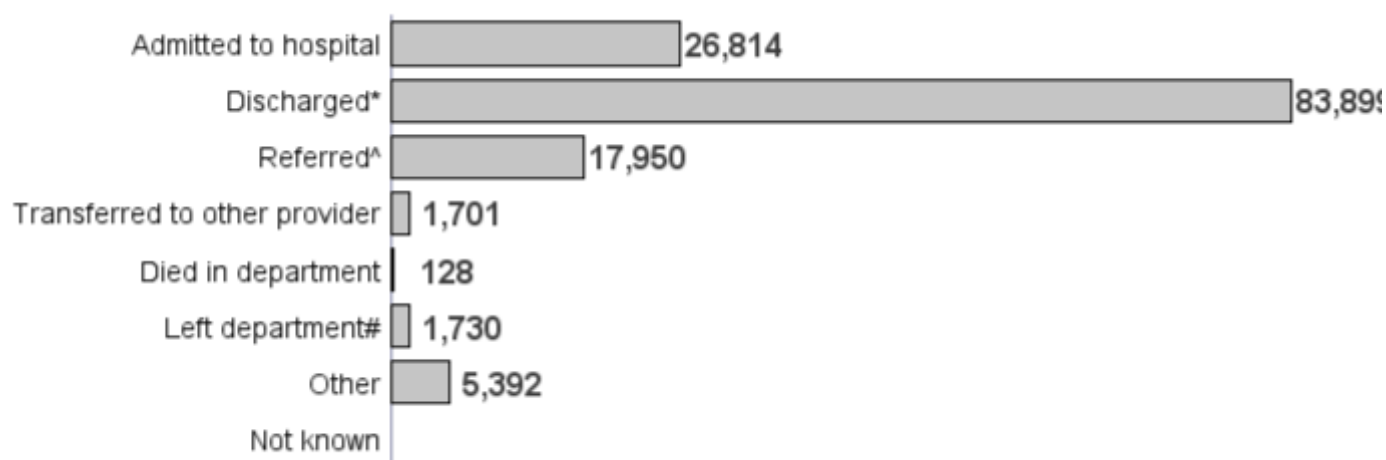
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission increased in 2017/18 compared to 2016/17. In both years, the proportions were lower than the England averages.
(Source: NHS England)

Urgent and emergency care attendances by disposal method, from July 2017 to June 2018

* 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?

Mandatory Training

The service had systems in place to ensure all staff received mandatory training. They set a target of 90% for completion of all mandatory training modules. Data for the department up to September 2018 indicated that the 90.0% target was met for 13 out of the 18 mandatory training modules for which qualified nursing staff were eligible and met for two of the 11 mandatory

training modules for which medical staff were eligible. More recent data from the trust indicated an improvement in some areas however, figures for paediatric and adult life support training remained low.

Friarage Hospital urgent and emergency care department

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for qualified nursing staff in the urgent and emergency care department at Friarage Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Anaphylaxis awareness	4	4	100.0%	90.0%	Yes
Clinical Risk Assessment	1	1	100.0%	90.0%	Yes
Dementia Awareness (inc Privacy & Dignity standards)	3	3	100.0%	90.0%	Yes
Falls prevention inpatient training	1	1	100.0%	90.0%	Yes
Equality and Diversity	20	20	100.0%	90.0%	Yes
Mentor Update	6	6	100.0%	90.0%	Yes
Triennial Review	6	6	100.0%	90.0%	Yes
Fire Safety 3 years	19	20	95.0%	90.0%	Yes
Information Governance	19	20	95.0%	90.0%	Yes
Immediate life support - ILS	19	21	90.5%	90.0%	Yes
Health and Safety (Slips, Trips and Falls)	18	20	90.0%	90.0%	Yes
Infection Prevention (Level 1)	18	20	90.0%	90.0%	Yes
Advanced life support - ALS	1	1	100.0%	90.0%	Yes
Paediatric Immediate Life Support - PILS	18	21	85.7%	90.0%	No
Manual Handling - People	17	20	85.0%	90.0%	No
Conflict Resolution	5	6	83.3%	90.0%	No
Prevent -WRAP	17	21	81.0%	90.0%	No
Blood Transfusion	15	21	71.4%	90.0%	No

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for medical staff in the urgent and emergency care department at Friarage Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Manual Handling - People	2	2	100.0%	90.0%	Yes
Advanced life support - ALS	1	1	100.0%	90.0%	Yes
Basic Life Support	3	5	60.0%	90.0%	No
Adult Basic Life Support	3	6	50.0%	90.0%	No
Health and Safety (Slips, Trips and Falls)	5	6	83.3%	90.0%	No
Equality and Diversity	5	6	83.3%	90.0%	No
Blood Transfusion	3	4	75.0%	90.0%	No
Infection Prevention (Level 1)	4	6	66.7%	90.0%	No
Fire Safety 3 years	4	6	66.7%	90.0%	No

Information Governance	4	6	66.7%	90.0%	No
Prevent -WRAP	3	6	50.0%	90.0%	No

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

Mandatory training was undertaken via e-learning and face-to-face settings. The service had recently appointed a training lead for the department. Post the inspection, the training faciliator had been given protected time to support staff with training and development requirements.

We spoke with seven staff, who all said they had completed their mandatory training, or were booked onto outstanding courses. Staff also said that they supported to complete their mandatory training.

Post the inspection, the trust provided information which showed overall training compliance for November 2018 was we were unsure from the data provided whether this included medical and nursing staff:

Name of course	Completion rate	Trust Target	Met (Yes/No)
Health and Safety (Slips, Trips and Falls)	89.1%	90.0%	No
Equality and Diversity	88%	90.0%	No
Information Governance	83.6%	90.0%	No
Fire Safety 3 years	75.5%	90.0%	No
Infection Prevention (Level 1)	74.9%	90.0%	No

We requested to review training compliance rates for resuscitation training, these showed 85.7% of qualified nursing staff were qualified in paediatric immediate life support. Data we reviewed showed that the majority of staff eligible for advanced paediatric immediate life support had completed it. Data for medical staff was not supplied showing how many were qualified in paediatric immediate life support or advanced paediatric immediate life support this did not provide assurance that staff were qualified to provide paediatric resuscitation.

Training compliance rates for paediatric resusitation training was not supplied in a consistent way to provide assurance that the current resuscitation provision in the department met the required standards.

We were unable to gain assurance that there was one member of staff with APLS (or equivalent) training on duty at all times. Or that all qualified staff were trained in infant and child basic life support.

Following the inspection, the trust provided information, which showed that:

- 12 Consultants and 1 Associate Specialist with Advanced Paediatric Life Support (APLS)
- 2 Trust Grade Doctors with Paediatric Intermediate Life Support (PILS)
- 2 GP's with Paediatric Basic Life Support (PBLS)
- Any locum doctors meet the standard for a middle grade in Emergency Medicine which would include paediatric life support.

Staff we spoke with said that they had recently undertaken a paediatric resuscitation scenario.

Data for qualified nursing staff was not supplied showing how many were qualified in basic life support, data we reviewed also showed that only one member of staff was qualified in advance

life support (100% compliance), when other training modules equated to 21 qualified nursing staff. Staff we spoke with confirmed that they had received immediate life support training. This did not provide assurance that staff were qualified to provide adult resuscitation.

Training compliance rates for resuscitation training was not supplied in a consistent way to provide assurance that the current resuscitation provision in the department met the required standards. For medical staff the trust's data showed 60% of medical staff were qualified in basic life support, this was worse than the training compliance rate of 90%. Data also showed that 100% of staff eligible for advanced life support had completed it, however; this only equated to one medical staff member when other training modules equated to six medical staff.

Following the inspection the trust told us that there was a funded establishment for seven WTE doctors at the Friarage hospital. At the time of the inspection there were three doctors in substantive posts and they were compliant with the Advanced Life Support training.

Safeguarding

At this inspection, the service had systems in place for the identification and management of adults and children at risk of abuse. Staff we spoke with said that they completed adult and children's safeguarding as part of their mandatory training. They also said that the trust safeguarding team was accessible and supportive when staff needed advice about safeguarding concerns.

The service had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse, and issues which staff should report. Staff we spoke with were aware of what concerns could potentially be a safeguarding concern and knew how to raise them.

Staff we spoke with were knowledgeable with the safeguarding referral process for both adults and children. They could provide examples of safeguarding referrals they had made to ensure patients were safe. Staff were also able to confirm they received level three safeguarding training if appropriate.

The safeguarding lead for the department was the clinical director. The safeguarding lead provided support to the nursing and medical team. The safeguarding duty nurse from the trust safeguarding team, visited the emergency department daily. The triage system included the use of a screening tool, staff used this tool to establish parental responsibility, who attended with the child and whether the child has a social worker.

We reviewed five paediatric care records and found that, the safeguarding assessment was complete in all records reviewed.

The trust had a safeguarding duty nurse reviewed the records of children who had been through the department daily. The purpose was to ensure that any relevant organisations such as GPs, school nurses or health visitors had been informed of the visit and to make sure that no vulnerable children, or incidents had been missed.

The service had systems in place to ensure all staff received safeguarding training. They set a target of 90% for completion of all mandatory training modules as indicated in the tables below.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for qualified nursing staff in the urgent and emergency care department at Friarage Hospital is shown below:

Name of course	Staff trained	Eligible staff	Completion	Trust	Met

Name of course	(YTD)	(YTD)	rate	Target	(Yes/No)
Safeguarding Children (Level 2)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 3)	19	19	100.0%	90.0%	Yes
Safeguarding vulnerable adults	20	20	100.0%	90.0%	Yes
Safeguarding Children (Level 3 Additional)	14	19	73.7%	90.0%	No

At Friarage Hospital urgent and emergency care department the 90.0% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for medical staff in the urgent and emergency care department at Friarage Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 2)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 3)	5	5	100.0%	90.0%	Yes
Safeguarding vulnerable adults	4	6	66.7%	90.0%	No
Safeguarding Children (Level 3 Additional)	1	5	20.0%	90.0%	No

At Friarage Hospital urgent and emergency care department the 90.0% target was met for two of the four safeguarding training modules for which medical staff were eligible.

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

Post the inspection, the trust provided information which showed overall training compliance for November 2018 was:

Name of course	Completion rate	Trust Target	Met (Yes/No)
Safeguarding -vulnerable adults	90.7%	90.0%	Yes
Safeguarding children	93.3%	90.0%	Yes

Female genital mutilation (FGM) was included in the hospitals safeguarding training programme. Staff were aware of FGM and understood their responsibilities to report cases.

Prevent training for the service October 2018, showed 81% qualified nursing staff and 50% medical staff both sets of data were worse than the training compliance rate of 90%. Post the inspection, the trust shared information which showed they now had 79% compliance with PREVENT training (trust wide data).

Sexual exploitation training was included as part of safeguarding training staff were aware of how to recognise this and actions that were required.

Cleanliness, infection control and hygiene

The service had systems in place to prevent and control infections. These included staff training, audits and policies and guidance documents.

The trust had an infection, prevention and control policy, this directed staff to other policies and protocols for guidance containing information on hand hygiene, personal protective clothing and patient isolation precautions.

At this inspection, we found the department was visibly clean and tidy.

We reviewed patient led assessments of the care environment (PLACE) reports for the hospital and noted 99.6% compliance for cleanliness which was better than the England average of 98.5%.

Records we reviewed showed that that 18 out of 20 qualified nursing staff and four out of six medical staff had completed infection prevention and control training (level one).

Infection prevention and control assurance visits were carried out by the infection prevention and control team, these included specific actions for completion.

During the inspection, we observed that staff were compliant with hand hygiene policies, including 'bare below the elbows' and personal protective clothing policies. However, we did not see that staff were compliant with control of substances hazardous to health policies, as we saw that staff had left cleaning solutions unlocked in an unlocked sluice.

Handwashing advice was clearly displayed and facilities for hand hygiene were available. We observed staff decontaminating their hands appropriately. Staff had access to at the point of use alcohol gel. During the inspection, we did not see hand hygiene compliance data on display.

We observed staff cleaning and disinfecting equipment between patients, which followed the trust policy. We reviewed five pieces of reusable equipment stored on the department, and all items appeared to be visibly clean and ready for use. We saw that staff used a specific label to identify that commodes were clean and ready for use. Toys we reviewed in the department were clean and in good condition.

Staff we spoke with were knowledge about infection prevention and control procedures within the department. Staff we spoke with confirmed that they had access to appropriate personal protective clothing (PPE). Patient we spoke with confirmed and we observed staff using gloves and aprons appropriately.

We saw processes for segregation of waste including clinical waste. Staff could segregate waste at the point of use. Sharps bins were used by staff to dispose of sharp instruments or equipment. Sharps bins in the areas visited were secure, dated signed and stored of the floor. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.

Cubicles were available for patients requiring isolation during the inspection, all patients requiring isolation were isolated appropriately and staff caring for them, did this using the appropriate precautions.

The trust carried out audits of antimicrobial prescribing in the department, this also included actions taken and required to achieve the antimicrobial commissioning for quality and innovation

CQUIN target. The trust had begun to work with partner organisations to improve antimicrobial prescribing across the healthcare community.

Records we reviewed from November 2018, showed there had been 31 trust attributed cases of clostridium difficile, five Methicillin Resistant Staphylococcus Aureus blood stream infections and 21 Methicillin Sensitive Staphylococcus Aureus bloodstream infections attributed to the trust. However, none of these infections were attributed to the department.

Environment and equipment

Resuscitation equipment including paediatric and neonatal were available in the department. We checked these and found that the emergency medicines required for patients, usually stored on the resuscitation trolley were stored in locked cupboards, we were concerned that this could lead to delays in the administration of vital medicines. Post the inspection, the trust confirmed that medicines were stored on all resuscitation trolleys.

We discussed this with the trust at the time of the inspection, and they reviewed the procedure and provided assurance that these were stored at the bottom of the resuscitation trolley.

There was a specific paediatric entrance to the department, which led onto a specific paediatric waiting area. The children's waiting area had toys available to provide distraction.

Triage facilities were available. Ambulance patients arrived via a separate area and were admitted in to cubicles for assessment.

The department was separated into different areas for patients to be reviewed for example: paediatric, minors, majors and resuscitation.

At this inspection, we found that the paediatric environment was not secure to ensure paediatric patients were separated from adults, the door remained unlocked during the inspection, and we observed an adult patient being treated in this area. We did not receive assurance that the current paediatric provision in the department meet the standards for children in emergency departments. During the inspection, we discussed this with the senior management team, who acknowledged improvements could be made in both the pathways. They shared with us their visions for future services. The senior management team were in the process of completing a compliance audit in relation to current Facing the future: Standards for children in emergency settings June 2018 was due to be report on in March 2019.

The department had access to a designated mental health room, we inspected the room and found that it did not meet the quality standards for liaison psychiatry services, it contained fixings and fittings which posed ligature and harm risks to patients, visitors and staff. Patients under a section 136 (of the Mental Health Act) and medically fit, but requiring a place of safety were transferred to a dedicated 136 suite at a neighbouring mental health trust.

We reviewed patient led assessments of the care environment (PLACE) reports for the hospital and noted 87.4% compliance for condition, appearance and maintenance which was worse than the England average of 94.3%.

The departments waiting room had available seating for 129.3 patients per 100,000 admissions this was better than the mean average of 66.4 patients when benchmarking with other emergency departments (NHS benchmarking network emergency care project November 2018). This report also showed that the number of major's cubicles was better 22 to the mean of 18.7 per 100,000 attendances. The department had more minor's cubicles 22 to the mean of 12 per 100,000 attendances. Overall the department had 59 available treatment spaces for patients which was better than the mean average of 44.4 per 100,000 attendances.

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 evidence of stock rotation. We checked emergency transfer bags, and saw equipment that was out of date stored in this bag, we found that a suction catheter, breathing bag and intravenous packs were out of date, some since 2017. We discussed this at the time of the inspection, and staff tool immediate action to replace the out of date items.

It is good practice to record and change breathing circuits on anaesthetic machines daily (Association of anaesthetists). Records we reviewed provided assurance this had been completed.

Staff also had access to a difficult airway trolley, records we reviewed, provided limited assurance that this was checked as per the departments procedure, we noticed five gaps in checking over the previous month (December 2018).

A computerised asset management system was in place within the trust. We looked at five pieces of equipment and found the majority to have been safety tested within the review date.

Relatives rooms were available for relatives who were in distress or whose relative was being cared for in the resuscitation room.

Assessing and responding to patient risk

The trust scored better than other trusts for two of the five Emergency Department Survey questions relevant to safety and "about the same" as other trusts for the remaining three questions.

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?	9.4	Better than other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.9	About the same 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?	7.2	Better than other trusts
Q33. In your opinion, how clean was the emergency department?	8.8	About the same as other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.6	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

The median time from arrival to initial assessment was better than the overall England median in

each month from October 2017 to September 2018. Performance was consistently 4 minutes. During the inspection, only one patient arrived by ambulance and was seen immediately.

Ambulance – Time to initial assessment from October 2017 to September 2018 at South Tees Hospitals NHS Foundation Trust
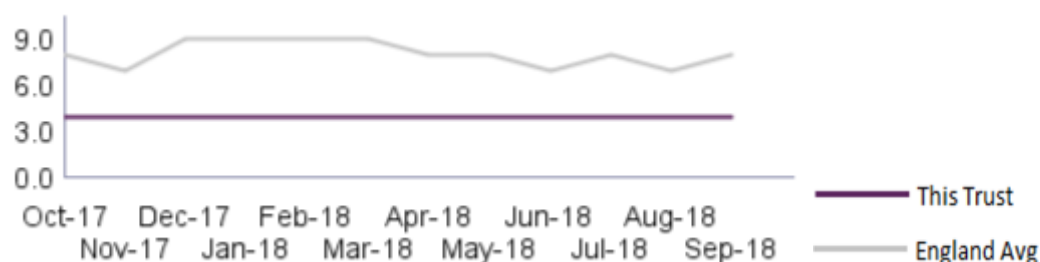
(Source: NHS Digital - A&E quality indicators)

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department had less 16% than the mean average of 30% when comparing the percentage of attendances that arrive via ambulances.

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department had better 14 than the mean average of 20 when comparing the average number of minutes ambulance handover time.

Following a change in clinical pathways, the emergency departments have protocols in place, in agreement with Yorkshire Ambulance Service (YAS), regarding the patients who can be admitted by ambulance.

Acutely unwell patients were admitted to the Friarage site following discusion with the acute medical team; if they were not able to accept the patient the patient was admitted to JCUH. This meant the department received low numbers of patients via ambulance. After 9pm no patients were admitted by ambulance to the emergency department. Staff we spoke with working in the department were aware of this protocol, we asked to review the protocol, this contained the information regarding eligibility criteria.

The service had access to an on-site resuscitation team, this included an on-site anaesthetist.

It is recognised best practice in emergency departments to carry out clinical streaming, prior to and post triage. Streaming is the allocation of patients to different physical areas/services to meet the needs of the patients. This should be undertaken by a trained clinician as soon as possible following admission.
At the time of the inspection, self-presenting paediatric patients were streamed by reception staff and signposted to a paediatric unit or a co-located GP service if presenting with minor illness. Streaming of patients by reception staff did not met best practice guidance.

Adult patients who self-presented were triaged and streamed by a registered nurse.

As the department did not employ any qualified registered sick children's nurses, or staff that possessed a recognisable post-registration paediatric qualification, we did not receive assurance that the current paediatric provision in the department meet the standards for children in emergency departments for having access to staff with appropriate paediatric competence to provide immediate assessment of children.

We were concerned that the short stay paediatric assessment unit was only available Monday to Friday 9am till 6pm. Data we reviewed showed that between July to December 2018, 191 (87%) of the 220 paediatric attendances (under 16) with a presenting complaint of illness attended outside of the short stay paediatric assessment units working hours. Another 630 attended out of hours with injury. Of the 191 OOH paediatric attendances with illness, 93 (47%) were triaged and discharged, 30 (16%) were triaged and discharged back to their own GP, 30 (16%) were triaged and admitted to JCUH, 25 (13% were triaged and streamed to OOH GP and 13 (7%) were triaged and asked to return in the morning. Of the 191 OOH paediatric attendances with illness, the average time spent in the department was 1 hour 8 minutes, ranging from 1 minute to 3 hours 56 minutes.

We were also concerned that there was a gap in provision between 08.00 when the GP OOH service ends and 09.00 when the short stay paediatric assessment unit opens. During this time the pathway for ill children was that they were triaged, asked to wait in the department until the unit opened, or leave and consult their own GP. Any children with life-threatening conditions were transferred to James Cook

It is recognised best practice in emergency department to carryout triage, to enable the prioritisation of patients. Triage should be delivered within 15 minutes of the arrival in the department, by staff qualified staff. We reviewed ten sets of admission records and triage records and saw that on all occasions people waited less than the 15 minutes, from the records we reviewed we saw than on average patients waited 4.7 minutes for triage with the wait time ranging from 0 to 15 minutes.

Patients where there was a concern of abnormal physiology were assessed using the national early warning system (adults-NEWS2) and for paediatrics (PEWS) this provided a baseline for staff and provided staff with an early warning of deteriorating patients, to enable them to take the appropriate action and escalate any patient, of concern to medical staff. Records we reviewed showed that, on all occasions NEWS and PEWS calculations were recorded accurately, and appropriate actions were taken if scores were escalated.

Crowding in emergency departments is recognised as a risk to patients receiving good quality care, escalation policies are required to reduce overcrowding and increase the flow through the department. Within the department we saw robust escalation systems in place and governance procedures to avoid overcrowding.

The department had implemented the "fit to sit" initiative, for patients who were well enough to sit in chairs whilst awaiting treatment, rather than waiting on trolleys.

During the inspection, we reviewed risk assessment documents on falls and skin integrity in the majority of occasions these were not documented as completed. Intentional rounding was used in the department to check on patients at set times to manage their fundamental care needs, from

the records we reviewed we saw that staff recorded intentional rounding on the patient administration system.

There was a mental health liaison team, this was provided through a service level agreement from a neighbouring mental health trust. This service was available 24 hours per day, seven days a week. The response time for access to the liaison team was within one hour, staff working in the department confirmed that this was a very responsive service. Staff working in the emergency department also had access to child and adolescent mental health teams and community crisis teams. Staff did not use specific formal risk assessments for suicide or self-harm.

Staff we spoke with, were knowledgeable and able to talk with us about how they would manage patients in the department with mental health needs. Staff confirmed that if patients presented a risk to themselves or others they were supervised. Patients who arrived under a section 136, were observed by the police. During the inspection, we did not see any patients presenting with mental health issues in the emergency department.

During the inspection, we were concerned that the mental health safe room and the toilet facilities contained ligature points. The senior management team were aware of these and shared with us risk assessments for the safe room, no risk assessments were available for the toilet. Knowledge amongst staff of what constituted a ligature risk varied for example; some staff viewed ligature points as something high up that would hold the weight of a person, whilst others were aware that ligature points could take many different forms.

All staff we spoke with confirmed that no recent incidents had occurred where patients attempting to harm themselves in the emergency department.

Security staff were used in the department if patients displayed aggressive or challenging behaviour to themselves, staff or other patients.

It is recognised best practice to have systems in place to identify children and young people who attend frequently. Due to different computer systems in place in the computer system used at the local minor injury unit was not integrated with the computer system within the emergency department so the service was not able to have accurate picture two of the three units providing emergency care the systems were not able to identify of all attendances at all units. The senior management team shared with us the plans to capture this information from April 2019.

Receptionist cover was only available 9am till 9pm, out of hours patients were booked in via the nursing staff, this meant that the waiting room was not directly observed out of hours.
We were unable to attend a safety huddle; however, we did review the safety huddle file information included in the file which covered performance, guideline changes and service updates. We were unsure as too how often this information was updated.

Nurse staffing

The department had determined what number of nursing staff was required on each shift to maintain safety of patients.

Planned staffing for the dayshift was three registered nurses, and one health care assistants. Planned staffing for the night shift was two registered nurses and one health care assistants.

We reviewed duty rotas over the last three months and examined 42 shifts. Data we reviewed showed that on the majority of occasions areas were staffed at planned levels.

The standards for children in emergency departments 2018 state that there should be two nurses per shift possessed a recognisable post-registration paediatric qualification, During the inspection, staff we spoke with confirmed that no qualified children's nurses were available within the department, we did not receive assurance that children who attended the department were assessed to meet the standards for children in emergency.

The trust used the safer nursing care tool to monitor patients' acuity and plan staffing levels, establishment reviews had been carried out and had been recently approved at the trust management board. Staff escalated staffing issues through the site management meetings twice a day, these meetings were used to review activity, manage staffing issues and monitor capacity and demand on each site.

The trust reported the following qualified nursing staff numbers as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	18.3	18.7	102.0%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From October 2017 to September 2018, the trust reported an overall vacancy rate of 0.5% for qualified nursing staff in urgent and emergency care. However, at Friarage hospital there was a surplus of 3.3%.

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

From October 2017 to September 2018, the trust reported a turnover rate of 12.2% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 10%. However, at Friarage Hospital it was better than the target at 7.8%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From October 2017 to September 2018, the trust reported a sickness rate of 5.0% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 3.5%. However, at Friarage hospital it was 4.8%.

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

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department was similar to 78.9% the national mean average of 78% when comparing the percentage of nursing staff that are qualified per 100,000 emergency department attendances for November 2018. Information also showed better (12.7%) than the mean average of 10.8% when comparing the percentage of advanced nurse and emergency nurse practitioners per 100,000 emergency department attendances for November 2018.

Staff we spoke with highlighted concerns, about staffing levels at night and the difficulties staff

had in monitoring patients with mental health conditions if they presented at night.

Medical staffing

The department had determined what number of medical staff was required on each shift to maintain safety of patients.

Medical staff worked shifts to meet the demands for the service for example:
- The medical team comprise staff grade doctors and an associate specialist who are available 24/7.
- Consultant medical staff were available 8am -6pm Monday to Friday
- Advanced nurse practitioners were available between 10am till 10 pm daily.
- Planned staffing for the dayshift was 2 junior doctors, supported with two advanced nurse practitioners (ANPs). Planned staffing for the night shift was one junior doctor's and no ANP.

- Planned staffing for the dayshift was delivered Monday to Friday by a consultant in emergency Medicine covering 8am to 6pm, supported by a middle grade or associate specialist. Overnight one staff grade or associate specialist was available.

- There was one emergency nurse practitioner (ENP) planned on the roster each day, however at the time of the inspection there was no ENP on duty..

The trust reported the following medical staffing numbers as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	7.94	3.525	44.4%

 (Source: Routine Provider Information Request (RPIR) – Total staffing tab)

During the inspection, information we reviewed showed that 42% of all middle grade shifts were covered by locum staff and that the "no doctor policy" had been implemented at the emergency department four times in 2018.

From October 2017 to September 2018, the trust reported a vacancy rate of 27.6% for medical staff in urgent and emergency care. For the Friarage Hospital this was much worse at 57.7%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From October 2017 to September 2018, the trust reported a turnover rate of 20.4% for medical staff in urgent and emergency care. This was higher than the trust target of 10%. For the Friarage Hospital it was 0.0%.

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

From October 2017 to September 2018, the trust reported a sickness rate of 0.7% for medical staff in urgent and emergency care. This was lower than the trust target of 3.5%. At Friarage Hospital it was 0.0%

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

From October 2017 to September 2018, the trust reported that 2.1% of medical shifts in urgent and emergency care were filled by locum staff and 0.6% of shifts were filled by agency staff.

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department was worse than (50) the mean average of 100 when comparing the number of hours per week a consultant was present in the ED per 100,000 emergency department attendances for November 2018. Information also showed that the department was worse than (10) the mean average of 15 when comparing the number of hours, a day a consultant is presented in the ED on a weekday and worse than (0) the mean average of 12.4 when comparing the number of hours, a day a consultant is presented in the ED on a weekend.

In July 2018, the proportion of consultant staff reported to be working at the trust were higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 35-whole time equivalent staff working in urgent and emergency care at South Tees Hospitals NHS Foundation Trust.

	This Trust	England average
Consultant	52%	29%
Middle career^	9%	15%
Registrar group~	27%	32%
Junior*	12%	24%
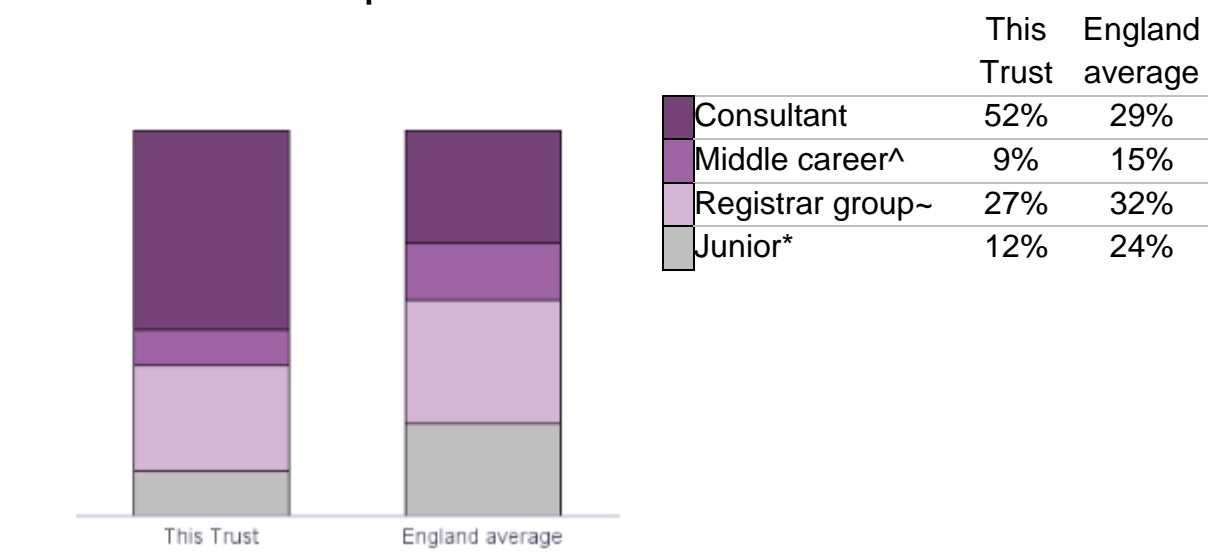
^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

Medical staff we spoke with said that they rotated to work in both the trust emergency departments.

Records

The service used electronic records, any written records were scanned into the electronic record system at the time of the admission.

Ambulance records were paper and staff received these at the time of the handover; these were scanned in to the electronic system at the time of the admission.

We reviewed 10 sets of patients' records and found completion of documentation to be in line with professional standards, for example all writing was legible and all entries were dated and timed.

Records were stored securely when not in use and were only accessible to appropriate people.

Individual care records were written and managed in a way that kept patients safe. The care records we reviewed showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Staff working in the trust did not have access to the mental health trust records system, but the liaison team had access to both systems and would print off any vital information such as risk assessments and care plans and attach these to the trust records to enable effective sharing of vital information.

All staff were required to complete information governance training every year. Training records showed 95% qualified nursing staff, and 66.7% of medical staff in the department had completed information governance training, Medical staff did not meet the trust overall training compliance rate of 90%.

Medicines

Medicines including controlled drugs were stored correctly with access restricted to authorised staff, they were checked in line with the policy and there were no discrepancies in controlled drug registers. Controlled drugs were audited by the nurse in charge of the unit on a twice daily base.

We saw that staff recorded medicines refrigerator temperatures daily, we also saw action recorded if the temperatures were not within expected ranges. Staff we spoke with could describe the process for reporting if the fridge temperature went out of range. We did not see that staff recorded the temperature of the room medicines were stored in.

We did not see then when multi-use bottles of medicines were opened a robust process was used to record the date opened and disposal date of the medicine.

Pharmacy services were available seven days a week, with an on-call service available out of hours and on weekends.

We reviewed medicines administration records for ten patients. We saw that arrangements were in place for recording the administration of medicines and allergies were clearly documented.

Incidents

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 October 2017 to September 2018, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Serious incidents (SI) are incidents that require further investigation and reporting. In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October

2017 to September 2018. The breakdown of the types of incident reported were:
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) – two (67% of total incidents)
- Treatment delay meeting SI criteria – one (33% of total incidents)

(Source: Strategic Executive Information System (STEIS))

The service had systems in place for reporting, monitoring and learning from incidents. The service had an incidents policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents. The emergency department recorded incidents in an electronic system. We spoke with staff who were knowledgeable of the incident reporting system, had confidence that incidents were being reporting and investigated correctly and confirmed that they received feedback on incidents they reported.

Lessons were learned following the investigation of incidents and learning was shared with staff via staff meetings, information displays (staff room), huddles and emails.

Duty of candour is a regulatory duty that relates to openness and transparency, it requires providers of health and social care services to notify patients (or other relevant persons) of certain examples of when they would use this.

Staff we spoke with were aware of the duty of candour regulations, they could provide us with examples of when they would use this such as missed fractures.

For the trust we saw that the summary hospital level mortality indicator (SHIMI) and the hospital standardised mortality ratio (HSMR) were "as expected" and "higher than expected", SHIMI 111 April 2017 March and HSMR 110 February, 113 March 2018. Mortality data was discussed at the directorate meetings to share learning and improve performance.

Medical safety dashboards were used to gather information on mortality and share learning from deaths, data we reviewed showed this information was discussed at the monthly governance meetings. The trust also had medical examiner roles in place to review all deaths.

Safety Thermometer

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, three falls with harm and no new urinary tract infections in patients with a catheter from September 2017 to September 2018 within urgent and emergency care.
(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

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. Guidelines and policies, we reviewed were in date and based on current best practice.

Quality improving projects were being undertaken in the department these included improved nurse led pathways, admission avoidance pathways and innovative models of care, improving the access to patients to consultants.

The trust was using the commissioning for quality and innovation framework- improving services for people with mental health needs who present to A&E.

Nutrition and hydration

People's nutrition and hydration needs were not always met. During the inspection, we did not see any staff offer patients any food or drink. Drinking water was not easily available, and patients only had to access a water machine outside of the main department.

In the CQC Emergency Department Survey, the trust scored 7 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was about the same as other trusts.
(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

We reviewed patient led assessments of the care environment (PLACE) reports for the hospital and noted 95.7% compliance for food and hydration which was better than the England average of 90.2 %.

The department did not have patient / carer access to a vending machine providing drinks and snacks to patients.

Pain relief

During the inspection, we reviewed ten patient records, staff had assessed and documented patients pain five occasions and provided pain relief. One patient we spoke with said that they had been offered pain relief and that staff checked that pain relief administered had been effective.

In the CQC Emergency Department Survey, the trust scored 6.7 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 7.9 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 to March 2017; published October 2017)

The service did not audit pain relief.

Patient outcomes

The emergency department failed to meet any of the national standards, however when compared nationally with other emergency care settings the department was in the upper quartile for some of these standards.

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Friarage's emergency department failed to meet any of the national standards, however when compared nationally with other emergency care settings the department was in the upper quartile for three standards

- Standard 1a (fundamental): O_2 should be given on arrival to maintain sats 94-98%. This department: 89.2%; UK: 19.0%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised $\beta 2$ agonist bronchodilator therapy. This department: 90.9%; UK: 77%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as according to guidelines. This department: 76.9%; UK: 52%

The department was in the lower UK quartile for three standards:
- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: X%; UK: X%.
- 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: 19.0%.
  - Standard 5b (fundamental): within 4 hours (moderate). This department: 6.9%; UK: 28.0%.

The department's results for the remaining standard was within the middle 50% of results.
(Source: Royal College of Emergency Medicine)

Action plans we reviewed captured issues of concern within the audits and actions were in place to improve performance.

In the 2016/17 Severe sepsis and septic shock audit, Friarage's emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for five standards:
- Standard 3: O_2 was initiated to maintain SaO_2 >94% (unless there is a documented reason not to) within one hour of arrival. This department: 80.0%; UK: 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. This department: 90.0%; UK: 60.0%.
- Standard 5: Blood cultures obtained within one hour of arrival. This department: 83.3%; UK: 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 56.7%; UK: 43.2%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 73.3%; UK: 18.4%.

The department's results for the remaining three standards were all within the middle 50% of
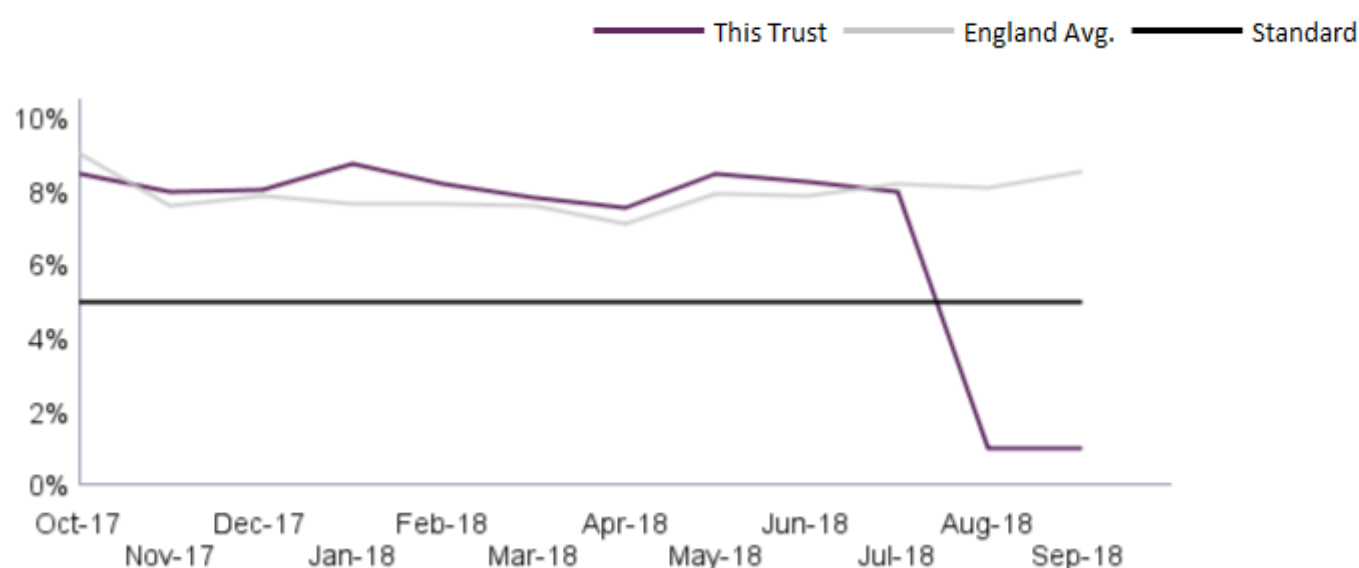
results.
(Source: Royal College of Emergency Medicine)

Action plans we reviewed were not completed, they did not have actions identified or re-audit dates included to improve performance.

From October 2017 and July 2018, the trust's unplanned re-attendance rate to A&E (both sites) within seven days was worse than the national standard of 5.0% and about the same as the England average, however for the last two months reported, performance has improved and was now better than the national standard and the England average.

Unplanned re-attendance rate within seven days - South Tees Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Competent staff

From October 2017 to September 2018, 74.6% of staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 80.0%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
NHS infrastructure support	4	4	100.0%	Yes
Qualified ambulance service staff	2	2	100.0%	Yes
Qualified Allied Health Professionals (Qualified AHPs)	4	4	100.0%	Yes
Medical & Dental staff - Hospital	43	37	86.0%	Yes
Support to doctors and nursing staff	76	55	72.4%	No
Qualified nursing & health visiting staff (Qualified nurses)	131	92	70.2%	No

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

Staff described the appraisal process as a valuable experience and felt their learning needs were addressed. They were also given opportunities to attend courses to further their development.

Nursing staff we spoke with said that they did not rotated to work in both the trust emergency departments. We had concerns about the competence and skills of nursing staff and abilities to respond to different situations if they did not rotate as the pathways at this department only exposed staff to certain situations.

Staff we spoke with said that the service offered a comprehensive induction programme to newly qualified or newly appointed staff, however some staff expressed concerns to us that the induction into the department for bank staff was variable.

The department had recently appointed a training lead. Post the inspection, the training faciliator had been given protected time to support staff with training and development requirements.

Staff working in the department said they had good access to training, however they also said that they were not offered additional training to develop role specific competences and qualifications, such as triage and navigation competences. In the safety huddle file, we also saw that staff signed to state their competence with equipment, such as manual blood pressure machines, blood gas machines and pressure breathing equipment (Bilevel positive airway pressure machines) however we did not see what the criteria for declaring competence was.

Registered staff we spoke with that they had been supported through revalidation by the hospital.

Multidisciplinary working

We saw evidence of an effective multi-disciplinary team (MDT) approach to patient care and treatment, including seeking advice and joint decision making about patients across the emergency departments and with other medical disciplines.

Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships. Staff from outside agencies confirmed that the trust staff treated patients with mental health needs in caring, responsive and non-judgmental ways.

A commissioning agreement was in place with a neighbouring mental health trust to provide support for patients experiencing mental health conditions. Staff had access to 24-hour, seven days a week access to mental health liaison staff. Staff from the department held regular meetings with the staff from the mental health trust to support joint working arrangements. Staff we spoke with from both trust described good working relationships.

Staff working in the department, worked closely with the trust frailty, physiotherapy and occupational therapy teams, to undertake assessments of patients' needs and prevent inappropriate admissions to hospital.

Staff working in the department worked effectively with members of the ambulance service, during the inspection we saw medical and nursing staff meet and greet ambulance staff with in a professional manner.

Reception staff ensured that letters for attendances were sent to the GP's daily.

Seven-day services

The adult emergency department and the children's minor injury unit was open 24 hours a day, seven days a week.

Consultant staff were on duty in the department five days a week. The mental health liaison team provided cover within the department 24 hours a day, seven days a week.

Access to emergency GP appointments in and out of hours were available via the navigation nurse.

Radiology services and diagnostic services were available within the department 24 hours a day, seven days a week.

Health Promotion

Health promotion information was not available within the department.

The department identified patients that required additional support during initial assessment. Staff worked with external agencies to provide referrals to external services when this was required for example; drug and substance misuse services and young people's service when exhibiting risky behaviour.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards
Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures and best practice and professional standards. We observed nursing and medical staff obtaining consent, prior to carrying out treatment on patients.

We did not see any records where consent was documented, even when sedation was being used patients.

Staff we spoke with were aware of Gillick competency guidelines relating to decisions made by children and young people. The Mental Capacity Act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, where someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests. Staff we spoke with could give a clear explanation of capacity assessment and the importance of recognising how ill health could impact on patients' capacity. However, we did not see any capacity assessments being carried out or documented.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are Deprivation of Liberty Safeguards (DoLs). DoLs can only be used if the person will be deprived of their liberty in a care home or a hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards.

The trust reported that from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 73.2% of staff in urgent and emergency care compared to the trust target of 90.0%. The breakdown by site was as follows:

Site	Training	Individuals	Completion	Target

	complete (YTD)	required (YTD)	rate	met
Friarage Hospital	24	28	85.7%	No
Redcar Primary Care Hospital	11	17	64.7%	No
The James Cook University Hospital	62	143	43.4%	No
East Cleveland Primary Care Hospital	0	2	0.0%	No

The trust did not deport report Deprivation of Liberty Safeguards training during the same period.
(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Staff working in the department confirmed that they were expected to complete mandatory mental health awareness training as an e-learning package, they also confirmed that they were expected to complete a combined course on mental capacity act and the deprivation of Liberty Safeguards. All staff had access to living with dementia training tier one.

We spoke with three members of staff across the department, staff could confirm that they had received MCA and DoLs training, including capacity assessments.

Staff we spoke with said they access to mental health referral pathways and they would use these with any patients they had concerns about.

During the inspection, no patients had We did not see any records that had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place so we were unable to review any.

Is the service caring?

Compassionate care

We spoke with two patients and one relative in the department, at this hospital. Patients and relatives, we spoke with were happy with their care.

We observed staff caring for patients and found that they were compassionate and reassuring.

We heard and patients confirmed that staff introduced themselves by name and explained the care and treatment they were delivering.

Patients we spoke with said that that staff were "lovely". Patients described their care as "efficient".

Patients we spoke with said that staff attended to them quickly if they required assistance, and staff had provided patients with buzzers.
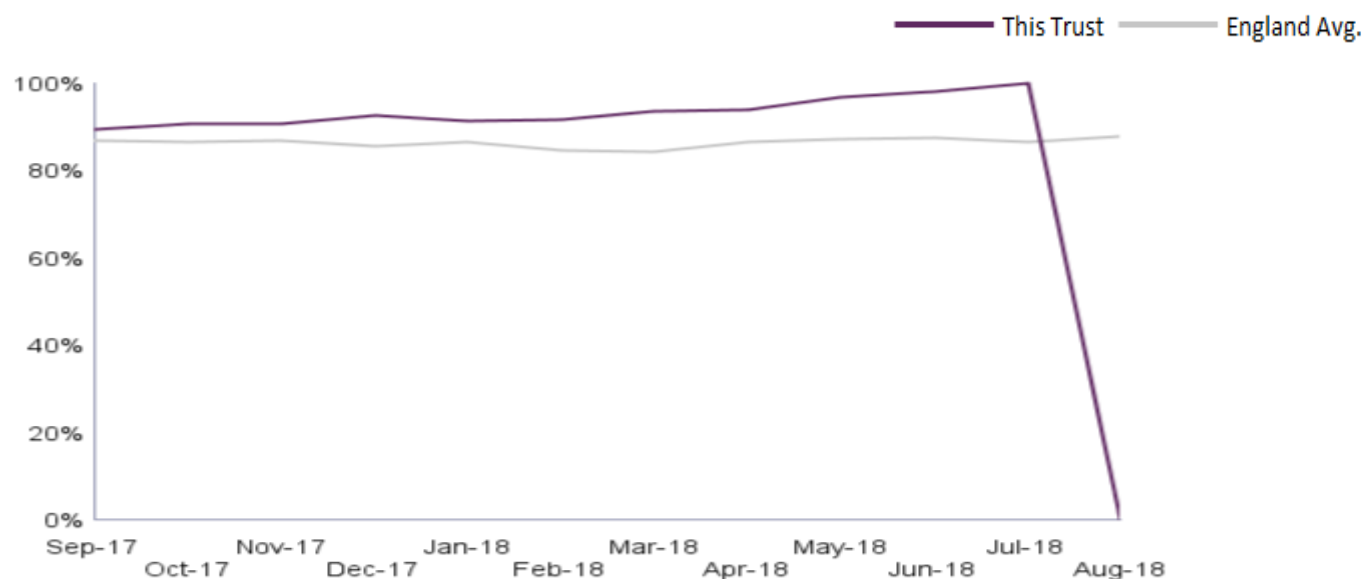
During the inspection, all patients we observed were comfortable, looked well cared for and had their privacy and dignity maintained.

We reviewed patient led assessments of the care environment (PLACE) reports for the hospital and noted 87.4% compliance for privacy and dignity which was better than the England average of 84.2%.

The trust's urgent and emergency care Friends and Family Test performance (% recommended)

was better than the England average from September 2017 to July 2018. In August 2018 there were only four responses and in any month, were there are fewer than five responses the trusts scores zero.

A&E Friends and Family Test performance - South Tees Hospitals NHS Foundation Trust

(Source: NHS England Friends and Family Test)

Emotional support

We saw that the department manager and matron were visible, and patients and relatives could speak with them.

During the inspection, when patients were distressed we saw staff provide them with support and reassurance.

Patients we spoke with said that staff had been reassuring and kind.

Staff we spoke with said that they supported patients with mental health conditions, in a non-judgmental way and provided support according to the patient need and risks that they presented with.

Relatives rooms were available for relatives who were in distress or whose relative was being cared for in the resuscitation room.

Understanding and involvement of patients and those close to them

We observed staff in the department as they explained to patients, what they needed to do and why. Staff involved the patients in their decision making and we saw medical staff clearly explaining the next steps and providing appropriate information prior to making decisions. We also heard staff gain the patients permission to proceed for treatment.

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 that they were aware of their plans of care and they had been given the time for questions and felt listened too.

Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions.

Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.

The trust scored better than other trusts for three of the 24 Emergency Department Survey questions relevant to the caring domain and about the same as other trusts for the remaining 21 questions.

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	4.7	Better than other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.6	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?	8.3	About the same as other trusts
Q14. Did the doctors and nurses listen to what you had to say?	8.8	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.5	About the same as other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	9.0	About the same as 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?	7.8	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?	8.8	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?	8.6	Better than 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?	9.0	About the same as other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.9	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?	9.2	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?	7.4	About the same as other trusts

Question	Trust 2016	2016 RAG
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	7.1	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?	8.8	About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests?	9.2	Better than other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	8.7	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?	9.4	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	6.1	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?	6.0	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	5.7	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?	6.9	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?	7.6	About the same as other trusts
Q45. Overall... (please circle a number)	8.5	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Is the service responsive?

Service delivery to meet the needs of local people

The department worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.

The service recognised the need for improvements in the emergency pathways and the need to change services offered by urgent and emergency care and had recently submitted a preferred clinical model, at the time of the inspection, the senior management team anticipated agreement and formal consultation later in the year. Following the inspection at the trusts board meeting on the 5 February it was agreed that this would be urgently implemented to maintain patient safety.

Meeting people's individual needs

The department provided services and made them available to patients with different needs, including patients with protected characteristics under the Equality Act and those in vulnerable circumstances. Reasonable adjustments were made so that patients with a disability could access services on an equal basis to others. For example, the department, was accessible for patients with limited mobility and people who used a wheelchair.

We reviewed patient led assessments of the care environment (PLACE) reports for the trust and noted 78.5% compliance for disability which was worse than the England average of 84.2 %.

The department provided information and facilitates to meet the needs of patients with sensory loss. Staff could access services from the British sign language service.

On the electronic patient administration system bespoke patient flagging occurred for those with additional communication needs. Patients were provided with information leaflets on topics such as head injury, treatment for sprains and strains and minor illness. The leaflets were in English and staff informed us that patient advice leaflets could be requested in large print, other languages and formats, including a 'read aloud' version. Staff we spoke with confirmed that they had access to a communication book on the nurse's station, which contained information on how to support patients with hearing loss, useful basic sign language and photo and picture cards. The trust employed four specialist nurses for vision impairments.

Translation services were available for patients whose first language was not English. Staff we spoke with knew how to access these services. Staff we spoke with said this service was responsive.

A mental health liaison team was on call for the department 24 hours a day, seven days a week. The emergency department had a dedicated consultant lead for mental health. The trust and the mental health trust had worked together on joint management plans for frequent attenders.

Patients who attended the department who were known to be living with dementia or learning disabilities were flagged on the computer system. The system identified patients with learning disabilities; this was a system used to ensure staff were aware of important patient information and requirements. Patients living with dementia were identified by a 'forget-me-not' icon was added to their notes to alert staff that extra support may be needed. The trust employed a lead nurse for frailty, they were also the lead for dementia. We saw specific 'dementia friendly' cubicles in the department, we did not see that any distraction aids were available for use by patients to help minimise agitation and anxiety. Following the inspection the trust told us that the department had single patient use twiddle blankets kept in the office until needed. Two high visibility cubicles have been decorated to support the care of patients with dementia.

The trust employed lead nurse for learning disabilities, and staff could refer to them for advice or additional support for patients. The trust had an overall "treat as one strategy" which they had shared with staff through bulletins.

Staff we spoke with, said that patient's living in care homes, had care home passports and those living with dementia or learning disabilities had "this is me" documents which shared vital pieces of information with care staff. During the inspection, we did not see any passports or "this is me" documents in use.

The trust had specific patient pathways to support patients with mental health needs to access the right care, for example; direct access to surgical wards rather than attending the emergency department.

Patients we spoke with said that staff respected their privacy and dignity by closing curtains and doors as necessary.

We reviewed patient led assessments of the care environment (PLACE) reports for the hospitals and noted 95.9% compliance for dementia which was better than the England average of 78.9%.

Whilst waiting in the unit patients had access to WIFI.

The trust scored better than other trusts for one of the three Emergency Department Survey questions relevant to the responsive domain and about the same as other trusts for the remaining two questions.

Question – Responsive	Score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	7.4	About the same as other trusts
Q11. Overall, how long did your visit to the emergency department last?	8.2	Better than other trusts
Q20. Were you given enough privacy when being examined or treated?	9.4	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

A range of information leaflets and advice posters were available on wards we visited. These included discharge information, specialist services and general advice about their care and treatment.
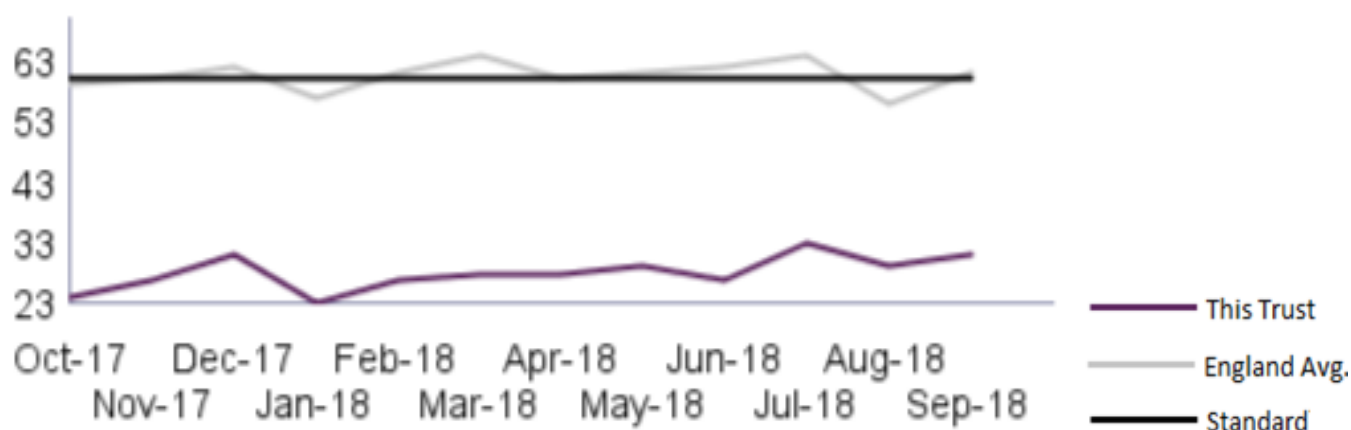
Access and flow

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. The trust met the standard for each month over the 12-month period from October 2017 to September 2018.

From October 2017 to September 2018 performance against this standard was consistently better than both the standard, and England average.

In the most recent month reported, September 2018 the median time to treatment was 31 minutes compared to the England average of 61 minutes.

Median time from arrival to treatment from October 2017 to September 2018 at South Tees Hospitals NHS Foundation Trust
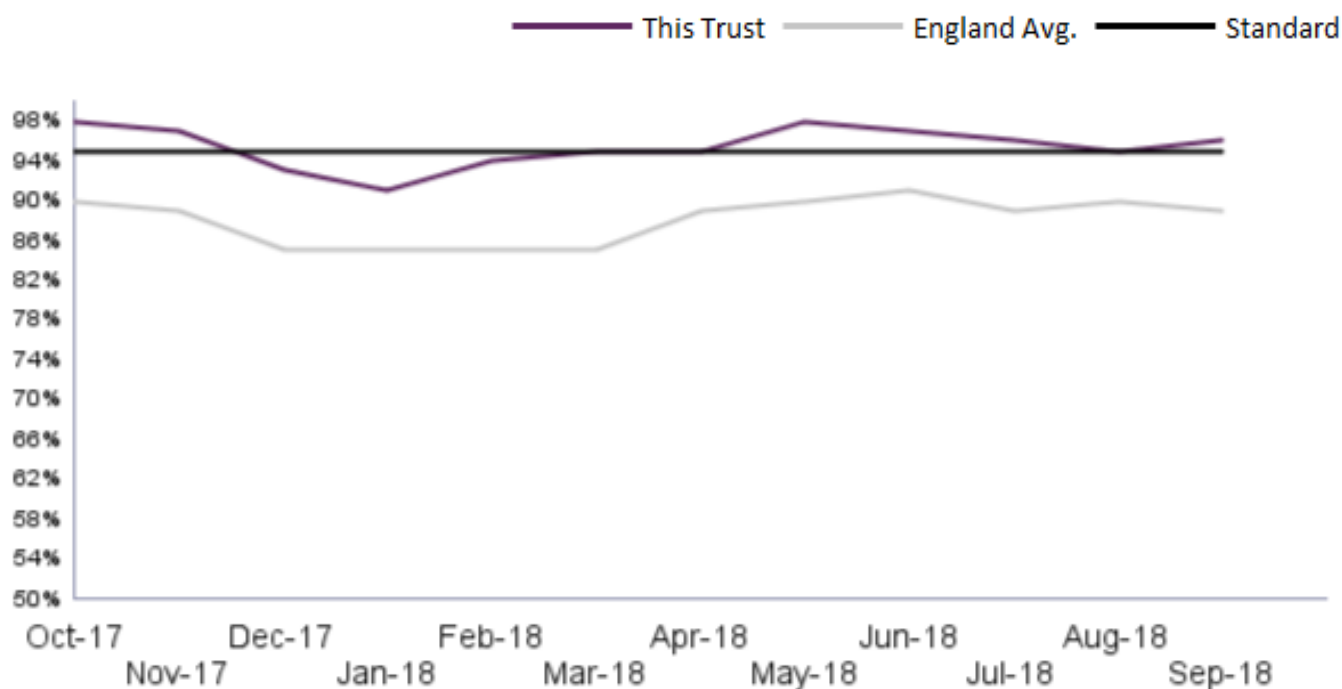

(Source: NHS Digital - A&E quality indicators)

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 October 2017 to September 2018 the trust met the standard for nine of the 12 months reported and performed worse than the England average.

From October 2017 to September 2018 performance against this metric showed performance decrease over the winter period however recovered from February onwards.

Four-hour target performance - South Tees Hospitals NHS Foundation Trust

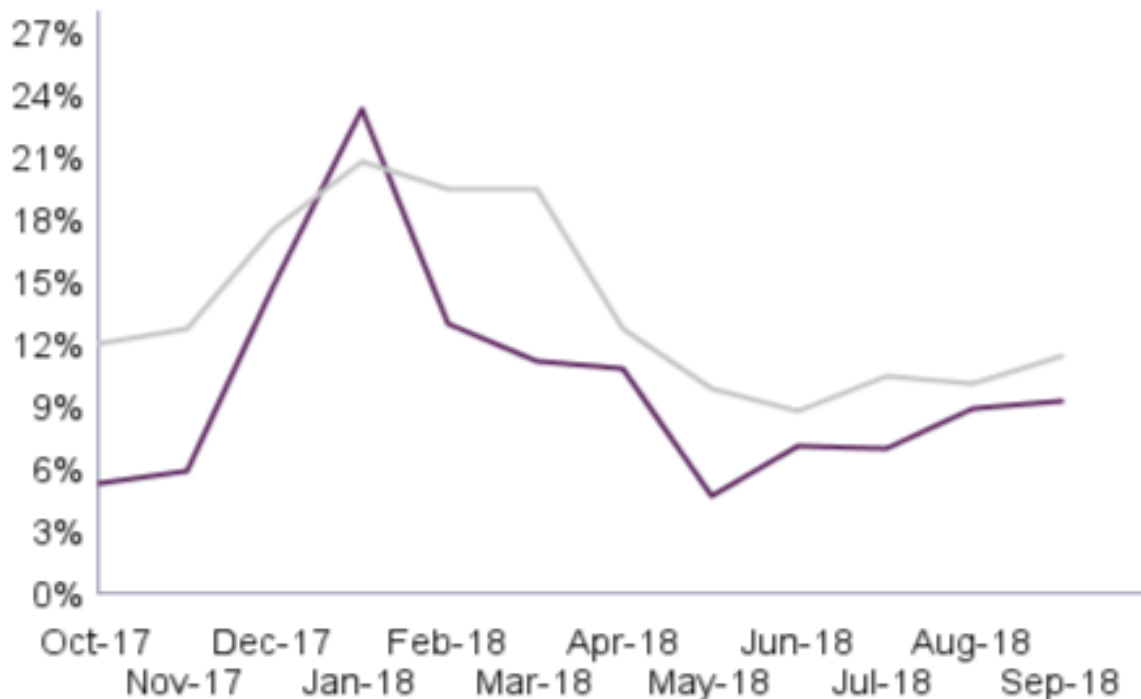*(Source: NHS England - A&E Waiting times)*

From October 2017 to September 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average.

From October 2017 to September 2018 performance against this metric showed expected worsening during the winter months however recovered and has been lower than the England average since January 2018.

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department was 97% than the mean average of 83% when comparing the percentage of patients seen within four hours.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - South Tees Hospitals NHS Foundation Trust
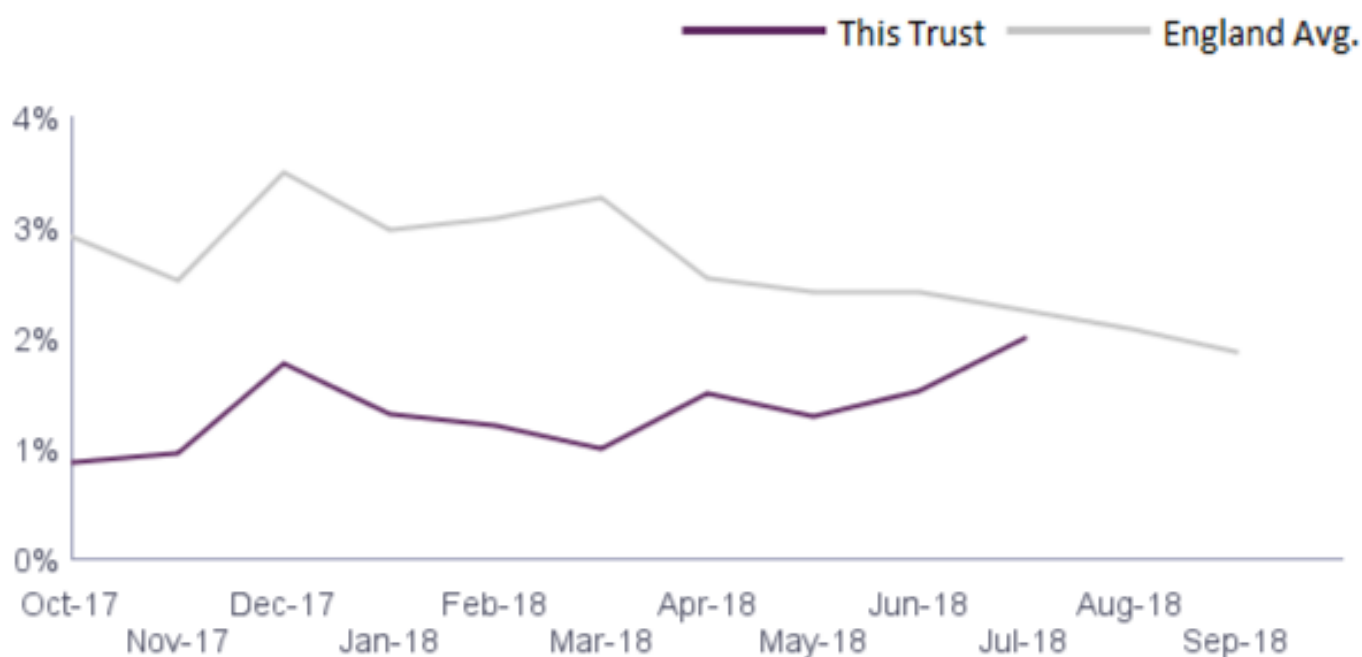
(Source: NHS England - A&E SitReps).

Over the 12 months from October 2017 to September 2018, eight patients waited more than 12 hours from the decision to admit until being admitted. They were all in January 2018 which is when performance was at its worst.
(Source: NHS England - A&E Waiting times)

From October 2017 to September 2018 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. For the last two months reported, the numbers leaving before being seen are classed as "small numbers" so are not reported which is why the chart has no value.

Percentage of patient that left the trust's urgent and emergency care services without being seen - South Tees Hospitals NHS Foundation Trust

From October 2017 to September 2018 the trust's monthly median total time in A&E for all patients was lower than the England average.

In the most recent month, September 2018, the trust's monthly median total time in A&E for all patients was 116 minutes compared to the England average of 154 minutes.

Median total time in A&E per patient - South Tees Hospitals NHS Foundation Trust
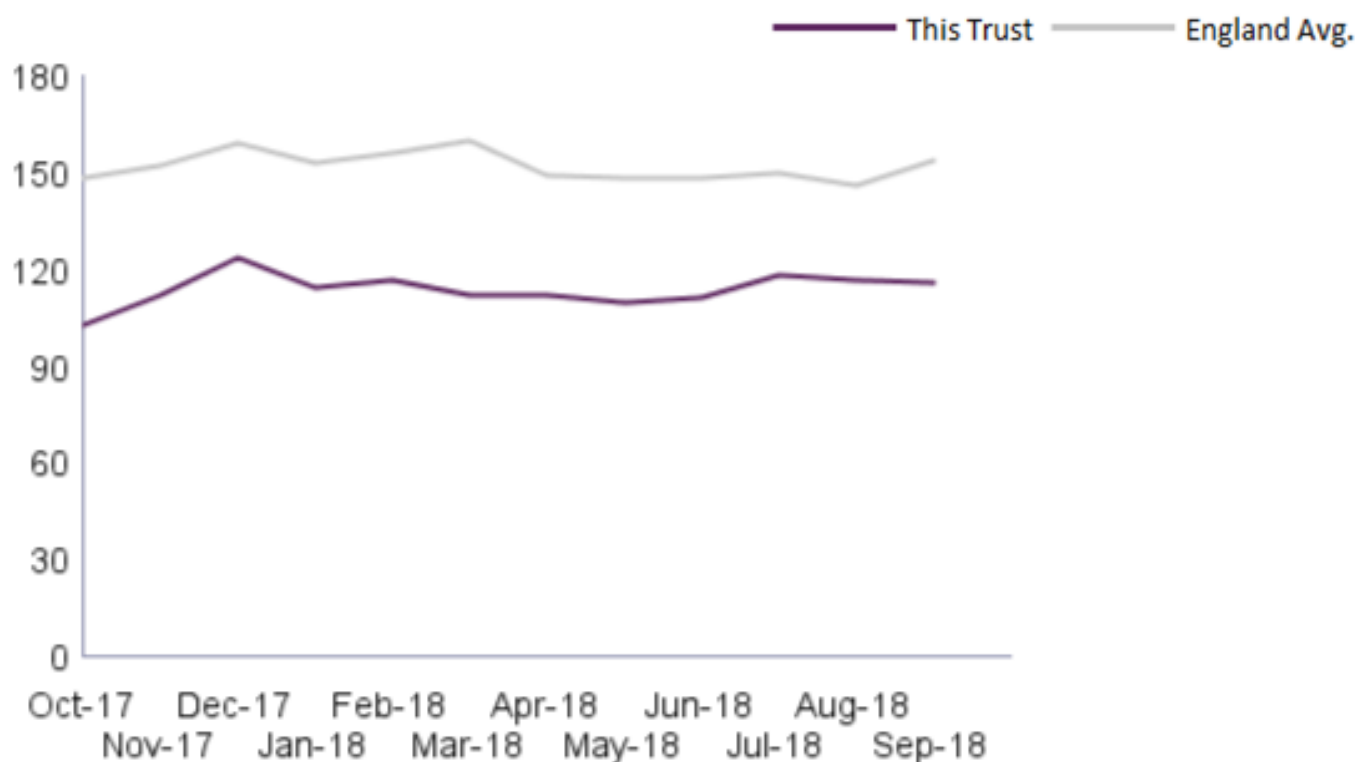
(Source: NHS Digital - A&E quality indicators)

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department was better 124 than the mean average of 209 when comparing the mean length of stay in the department (minutes).

For the most recent complete month prior to our inspection (Dec 2018) the emergency department daily attendance ranged from 30 to 63 daily attendances with an average of 47 patients.

Information provided by the trust showed that between July to December 2018 there were 9958 attendances at Friarage urgent and emergency care department of these 1,523 were paediatric 0-18 years attendances. This averaged at approximately 47 adults and 8 paediatric patients per day attended the department. The most common attendance for adults was for minor illness 4344 attendances, and the most common attendance for paediatric patient's injury 630 attendances.

Specific attendance pathways were in place for paediatric attendances, no children were admitted to the service by ambulance at any time. Paediatric patients who self-presented were treated in the department if presented with minor injury, or if presented with minor illness were

signposted by reception staff and then, to the paediatric assessment unit located in the hospital. Out of hours paediatric patients were signposted to a co-located GP (OOH) or James Cook University hospital (depending upon the clinical presentation or wait time for GP-if greater than 30 minutes).

We were not assured that the paediatric pathways were always followed to ensure children, who self-presented, were seen and treated by the correct staff. In one set of notes we reviewed we saw that a paediatric patient self-presented to the department following a fall from a high level, this patient was not transferred despite the mechanism of injury meeting potentially meeting trauma criteria guidelines.

From 9pm to 8am the medical registrar in clinical decisions unit (CDU) was responsible for triaging direct ambulance admissions into the hospital, all ambulance patients were admitted to the CDU and not to the department. There was a standard operating procedure for this. We spoke with two ambulance staff who highlighted confusion about this process and provided information which showed that for similar presentations, advice and attendance options differed. Staff working in the department also highlighted similar issues around access to the GP OOH services.

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information, supplied by the department showed that the service attendance rate was 18,564 which was lower than the mean average of 87,099, this information also showed that the department had a maximum of 74 daily attendances, with a better than average ambulance handover time and a better than average percentage of patients seen within four hours. Information also showed that patients spent less time in this emergency department 124 minutes on average compared with the mean of 209 minutes. The department was better when comparing the attendance to the admission rate (conversation rate) 17% than the mean average of 28%.

No waiting times were displayed to the public to indicate how long they would have to wait to be treated, we discussed this with staff who said that patients could ask staff working in the department and they would inform them.

Learning from complaints and concerns

From October 2017 to September 2018 there were 30 complaints about urgent and emergency care services. The trust took an average of 28 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 subjects of complaints are shown below:
- Patient Care: 26
- Admin/policies/procedures (including patient record): one
- Values & behaviours (staff): one
- Appointments: one
- Communications: one

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

The trust had a process that addressed both formal and informal complaints that were raised by patients or relatives.

The service had systems in place for reporting, monitoring and learning from complaints. The service had a complaints policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating complaints. We saw information displayed in ward areas about how to complain or raise a concern.

The emergency department recorded complaints in an electronic system. Staff we spoke with said that themes and trends of complaints were shared with staff at huddles, team and directorate meetings. Staff were knowledgeable of complaints made within the department, they had confidence that complaints were being reporting and investigated correctly and that any learning was being shared to prevent the complaint from occurring again.

From October 2017 to September 2018 there were 17 compliments in urgent and emergency care.
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We reviewed information provided by the trust, collected as part of the NHS benchmarking network emergency care project, this project benchmarked 252 emergency departments. Information we reviewed showed that the department was better (total of 11) than the mean average of 80 complaints per 100,000 emergency department attendances November 2018. However, it also showed that compliments received were worse (total of 54) than the mean average of 94 compliments per 100,000 emergency department attendances November 2018.

Is the service well-led?

Leadership

We found that the unit managers and senior management were knowledgeable and approachable, they appeared visible and approachable for junior members of staff they supported. They had dedicated time for management and support of staff. The unit manager was predominantly office based, however worked weekly clinical shifts to support the department.

The leadership team included a clinical director, service manager and matron, together they formed a clinical delivery leadership triumvirate, staff we spoke with said they were supportive and knowledgeable. A medical director with responsibility for urgent and emergency care was appointed in 2018. Staff we spoke with said the senior management team were supportive and staff felt able to raise concerns if required.

All staff we spoke with were complementary about the culture, communication in the trust.

A "coaching" culture was evident in the department and staff had time out coaching sessions with their clinical teams to allow for leadership development and reflection.

Vision and strategy

A clear vision and strategy was in place for the emergency department, the directorate strategy was prepared in April 2018 and included a number of different workstreams, for example; admission avoidance pathways, processes to support patients to access the right care, first time to achieve the best clinical outcomes and recruitment and retention strategies and plans to achieve financial viability.

Staff we spoke with were concerned about the future plans for the department, however acknowledged that changes needed to occur.

Culture

Staff we talked with described the culture as positive, staff said they said they felt valued by their colleagues and the trust. Staff were proud of the teams they worked in and the care they provided. They were also proud of the inter-hospitals relationships that they had developed for example; with the site co-ordinators and other wards.

They said that morale was good and recognised the positives of working in the department.

The senior management team were proud of staff and the care they delivered and their resilience to pressures that worked in an emergency department brought. The senior management team spoke with us about a listening culture and staff being able to influence the department and make safe changes.

Medical staff we spoke with shared with us the departments positive reputation, between doctors in training. They spoke with us about the support they received in the department.

Staff had access to a raising concerns service called "see hear speak up", staff we spoke with provided positive examples of speaking up and feeling listened too.

The service did not always have multi-disciplinary debrief sessions following traumatic events, staff we spoke with understood the benefits from carrying these out and the senior management team were supportive, the team needed a further period to embed these as a consistent part of emergency medicine.

Governance

The emergency services department, was part of the urgent and emergency care centre. This included the directorates of emergency medicine, acute medicine and critical care. The service had clear governance structures. The triumvirate were responsible for governance within the department, the triumvirate, the emergency department directorate and the centre board all held governance meetings monthly and then escalated to the operational management board and the executive assurance meetings. In addition, performance information was monitored weekly at performance wall meetings, where members of the operational and management teams met to review overall performance including four hours wait times.

We requested to review minutes from governance meetings, minutes we reviewed showed discussion about complaints, incidents, performance and finance.

The two emergency departments had a shared managerial team and shared governance structures. Staff we spoke with said the two departments ran very separately and that staff worked in two very different ways. They also said that they never attended any shared governance meetings. We also reviewed directorate meeting minutes which showed very little documented discussion about the Friarage.

Management of risk, issues and performance

The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services.

Staff working in the department and senior management team were knowledgeable about the about the risks within the department, however not all these risks were documented in the risk register for the department. For example; senior staff within the directorate highlighted their highest risks, they identified the emergency department environment and the risks posed to paediatric and mental health patients. Risk registers for the department, identified eight risks, three rated as high, four rated as moderate risks and one rated as low risks. Four of the eight risks related to a lack of clinical equipment, actions had been taken e.g. requesting additional resources to replace, however resources had not been secured to replace the necessary equipment. Risks had been reviewed in 2018.

The senior management team said that risk register was shared via the directorate meetings, then escalated to the monthly centre governance committee to the operational management board. From there risks were discussed at the risk executive board assurance meeting and escalated to the board.

Quality and safety dashboard information was collected on IPC, falls, pressure ulcers, patient experience, complaints and incident reporting. This information was shared with the emergency department, at directorate meetings.

Information management

Information was used to monitor and manage operational performance of the department, and to measure improvement.

Information provided by the trust, showed that 66.7% of medical staff and 95% of nursing staff had completed information governance training. Compliance rates were below than the trust's target level of training of 90% for medical staff.

Computers were available on the unit. During the inspection, computers were not always locked securely when not in use.

Engagement

Staff were able to provide information which showed they had changed discharge procedures and improved examination processes because of patient feedback.

The patient experience team had gathered information from mental health patients experience of care at South Tees, early analysis was positive and further work was planned to provide further feedback.

The service measured patient and staff engagement through national and local surveys, concerns, complaints and compliments from patients, relatives and staff. The service carried out '1000 voices' surveys to gather feedback on services from patients and used this information to improve patient care.

Staff we spoke with were patient focused and clear about their roles and responsibilities to engage patients and families.

Learning, continuous improvement and innovation

The trust held a yearly celebrating success award ceremony, the service had been nominated on a number of occasions.

The emergency department had recently been awarded third place in a national competition for quality improvements projects and clinical team of the year.

The emergency medicine training department had recently awarded the department with a second-place award for training provision.

Medical care (including older people's care)

Facts and data about this service

James Cook University Hospital and Friarage Hospital are the two acute hospitals forming South Tees Hospitals NHS Foundation Trust. The trust provides acute hospital services to the local population as well as delivering community services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland.

The trust had 75,067 medical admissions from July 2017 to June 2018. Emergency admissions accounted for 32,360 (43.1%), 2,639 (3.5%) were elective, and the remaining 40,068 (53.4%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 27,935

- Gastroenterology: 11,412

- Clinical haematology: 8,361

(Source: Hospital Episode Statistics)

There are 61 medical inpatient beds located at Friarage Hospital, located across three medical wards;

- Ainderby Ward

- Romanby Ward

- Clinical Decisions Unit

The service also provided chemotherapy day treatment services at the newly built Sir Robert Ogden Macmillan Centre.

Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to all staff. Staff were required to complete mandatory training in topic areas such as infection prevention, dementia awareness and information governance.

Staff we spoke with told us they were up to date with most of their mandatory training and were booked onto sessions they still needed to complete.

Training was provided by either eLearning or face to face. Staff told us they received an email when they were due to complete mandatory training. Ward managers kept records of nursing staff compliance with mandatory training and were clear on what training individual staff needed to complete to keep up to date. They accessed up to date information on the electronic staff record.

The ward manager on Ainderby Ward told us that current compliance for staff on the ward was 88.3% and they were working towards improving this.

Staff completed mandatory mental health awareness training as an e-learning package. They also completed a mandatory combined course on the Mental Capacity Act and Deprivation of Liberty Safeguards and a separate course on Safeguarding levels 1-4 depending on the grade of staff. All

staff received dementia awareness training tier 1 and some staff received additional tier 2 training which was delivered in partnership with the local mental health provider.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Nursing staff

For mandatory training courses from October 2017 and September 2018 at trust level for qualified nursing staff in medicine the 90.0% target was met for seven of the 12 mandatory training modules for which qualified nursing staff were eligible. This was slightly better for Friarage hospital medicine department as the 90.0% target was met for eight of the 12 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from October 2017 and September 2018 for qualified nursing staff in the medicine department at Friarage Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Clinical Risk Assessment	1	1	100.0%	90.0%	Yes
Equality and Diversity	89	91	97.8%	90.0%	Yes
Health and Safety (Slips, Trips and Falls)	90	91	98.9%	90.0%	Yes
Dementia Awareness (inc Privacy & Dignity standards)	46	47	97.9%	90.0%	Yes
Information Governance	88	91	96.7%	90.0%	Yes
Fire Safety 3 years	90	91	98.9%	90.0%	Yes
Infection Prevention (Level 1)	89	91	97.8%	90.0%	Yes
Conflict Resolution	27	30	90.0%	90.0%	Yes
Blood Transfusion	56	76	73.7%	90.0%	No
Manual Handling - People	64	88	72.7%	90.0%	No
Immediate life support - ILS	48	62	77.4%	90.0%	No
Adult Basic Life Support	21	28	75.0%	90.0%	No

Medical staff

In medicine trust-wide the 90.0% target was met for none of the 11 mandatory training modules for which medical staff were eligible and this was the same at Friarage hospital.

A breakdown of compliance for mandatory training courses from October 2017 and September 2018 for medical staff in the medicine department at Friarage Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health and Safety (Slips, Trips and Falls)	17	30	56.7%	90.0%	No

Equality and Diversity	18	30	60.0%	90.0%	No
Information Governance	17	30	56.7%	90.0%	No
Fire Safety 3 years	17	30	56.7%	90.0%	No
Infection Prevention (Level 1)	16	30	53.3%	90.0%	No
Adult Basic Life Support	9	20	45.0%	90.0%	No
Dementia Awareness (inc Privacy & Dignity standards)	3	7	42.9%	90.0%	No
Basic Life Support	6	8	75.0%	90.0%	No
Blood Transfusion	9	22	40.9%	90.0%	No
Manual Handling - People	9	21	42.9%	90.0%	No
Conflict Resolution	2	5	40.0%	90.0%	No

During the inspection we asked senior management about the low compliance of medical staff with mandatory training. They advised us that mandatory training was taken seriously and they currently did not have further data updates to change the current position reported. The service managed medical and dental training at both centre and directorate level rather than as the medical care core service. The responsible officer and the corporate team were working hard with individual directorate areas to improve compliance at a local level to meet the target.

Safeguarding

Safeguarding structures and processes were embedded and established within the organisation. We saw that the trust had current 'adults at risk' and 'safeguarding children' policies in place that staff could access on the trust's intranet.

Staff had a good knowledge and understanding of the trusts safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff gave examples of safeguarding referrals they had made and alerts they had raised in relation to vulnerable adults and children.

Safeguarding training completion rates

The trust set a target of 90.0% for completion of safeguarding training. At trust level in medical services the 90.0% target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible. At Friarage Hospital medicine department the 90.0% target was met for all of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 and September 2018 for qualified nursing staff in the medicine department at Friarage Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 3 Additional)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 3)	1	1	100.0%	90.0%	Yes

Safeguarding vulnerable adults	89	91	97.8%	90.0%	Yes
Safeguarding Children (Level 2)	83	90	92.2%	90.0%	Yes

Trust-wide in medicine the 90.0% target was met for three of the five safeguarding training modules for which medical staff were eligible. At Friarage Hospital medicine department the 90.0% target was met for two of the four safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 and September 2018 for medical staff in the medicine department at Friarage Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 3)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 3 Additional)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 2)	18	29	62.1%	90.0%	No
Safeguarding vulnerable adults	16	30	53.3%	90.0%	No

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

Additional safeguarding training sessions had been implemented at differing times for medical staff to increase compliance. We were assured by senior management that training remained high on the agenda and would be tracked by service managers in both clinical centres for acute and general medicine.

Cleanliness, infection control and hygiene

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene.

Hand-washing facilities were available throughout all wards we visited. Personal protective equipment (PPE) including aprons and gloves, and sanitising hand gel were also available. We saw staff using PPE when completing clinical tasks. They followed the bare below the elbows recommendations which met national best practice guidance, correct handwashing technique and use of sanitising hand gels was seen.

Patients with infections were barrier nursed in side rooms and appropriate signage was in place on the door. We saw side rooms were available on all the wards we visited. Not all side rooms however had their own bathroom and on one ward we saw bathrooms that had no sinks. Staff told us that regular infection prevention control (IPC) audits where undertaken and the hospital were aware of the increased risk of infection due to some of the facilities.

The service carried out monthly IPC audits. Audit data was shared at the monthly performance wall for discussion and review with clinical matron colleagues. The wall provided the opportunity to review and discuss the data and identify any common themes, and to identify relevant actions/training. We reviewed the hand hygiene audit results for the period July 2018 to December 2018 which showed Ainderby Ward scored 100% for all six months and Romanby Ward scored 100% for five months and 90% for one month.

We reviewed 12 pieces of reusable equipment and all the items appeared to be visibly clean and ready for use. We saw that staff used 'I am clean' stickers when equipment was ready for use.

The hospital had an IPC team that were available to provide support and guidance to the wards. The IPC team were able to flag any patients with any infections on the wards electronic white board, they could also use the board to provide guidance to staff on areas such as positive results, requirements for isolation or room cleaning.

We reviewed cleaning schedules for some of the wards we visited. We saw daily, weekly and monthly cleaning schedules for the wards. All wards displayed hard copies of the cleaning schedules in lockable wall mounted frames. Monitoring was undertaken by the domestic supervisory team on a monthly basis and rated in accordance to the 2007 Hospital Standards of Cleanliness. These results were displayed and updated each month. The audit results were monitored by the trust monthly infection prevention action group.

Staff completed infection prevention and control training. For the period October 2017 to September 2018, compliance for nursing staff was 97.8%% and 53.3% for medical staff. Information we reviewed showed that from the period 1st April 2017 to 31st March 2018 the trust had 48 cases of *C. difficile*-associated diarrhoea in patients over the age of two. We saw that during our inspection there had been no C. difficile cases in December on any of the medical wards we visited.

Environment and equipment

All wards we visited were tidy, well organised and visibly clean. Cleaning was in progress in the areas we visited with safety signage displayed.

Staff had enough equipment for them to carry out their role and we saw ward assistants on some wards who were responsible for maintaining supplies, stock rotation and store room organisation. The Sir Robert Ogden Macmillan Centre was a newly opened oncology unit and was spacious, clean and well equipped. The centre was built around a central courtyard with landscaped gardens which allowed the main treatment areas to be bright and light. There unit had fourteen treatment chairs and two beds in side rooms.

Wards had a number of bedded bays and side rooms. We saw that there was clear signage on toilet and bathroom doors to distinguish between male and female facilities. The signs were interchangeable and planned to ensure patients dignity was maintained. The exception to this Ainderby Ward. Staff informed us that the signs would be altered to male or female to accommodate the closest bay, but patients would commonly not adhere to the signs. On our visit we noticed that all signs on one mixed ward were male. We discussed this with the ward manager and this was corrected whilst we were on the ward.

We checked 12 pieces of equipment which included, ECG, ultrasound and blood gas equipment as well as observation machines. We found they were in good working order and all had stickers identifying that they had been serviced within the last year and tested for electrical safety. All oxygen cylinders we checked were maintained and stored securely.

Resuscitation trollies had been checked daily by staff on all wards we visited. The trollies were kept unlocked for quick access; staff told us this was trust policy. The trollies were designed to appear closed as the top drawers could not be opened unless the sliding door at the bottom of the cabinet was opened. Replace with; Medicines required for emergency use such as drugs for resuscitation, were stored on each trolley

We saw that equipment for the management and prevention of pressure ulcers was available such as specialist mattresses and cushions.

The endoscopy unit had its own decontamination unit with two decontamination rooms, a clean and dirty side and there were dedicated decontamination staff to clean and process the equipment. Staff reported they could obtain a sterile scope from another site if necessary but this was rare.

Assessing and responding to patient risk

Measures were in place to ensure that staff assessed and responded to patient risk. Nursing staff completed a range of patient risk assessments on admission to the hospital/ward. These included falls, moving and handling, nutrition and hydration and pressure damage risk. All patients were assessed for risk of Venous Thromboembolism (VTE) on admission.

The trust used an updated version of the National Early Warning Score (NEWS2) to measure whether a patient's condition was improving, stable or deteriorating indicating when a patient may require a higher level of care. NEWS2 had been rolled out to all wards in December 2018 and staff had received training. Staff recorded patient observations on an electronic system which calculated the NEWS2 score.

Staff told us that doctors responded quickly when patients deteriorated and the critical care outreach team were also available to respond between 8am and 8pm. Staff told us the critical care outreach team monitored patients NEWS2 scores on the electronic system and telephoned or visited the ward to offer support if a trigger was reached.

The trust completed a monthly audit of NEWS completion and escalation. The audit measured whether appropriate action was taken when a patient triggered a high score. Audit results for the months of October, November and December 2018, showed that compliance was 100% on all wards at Friarage Hospital.

Staff at the Sir Robert Ogden Macmillan Centre told us that if a patient became unwell the medical registrar at the clinical decisions unit provided medical support and the critical outreach team could be contacted if necessary. They said this rarely happened.

On admission all patients had an initial skin integrity body map assessment as part of the adult nursing care pathway. A Braden risk assessment, was used to record mobility, sensory perception, moisture, nutrition, friction and shear risks. The service had a pressure categorisation tool available to staff to identify high, medium and low risks. Measures were 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. We saw a pressure ulcer prevention equipment guide displayed on the wall of Ainderby Ward. We observed intentional rounding being completed by individual staff and observations recorded in individual patient care pathways. The service had a tissue viability lead nurse with link nurses on each ward.

We saw that walking aids and nurse call bells were within easy reach of patients. Anti-slip socks were used for patients at risk of falls who did not have appropriate foot wear. Patients with a high risk of falling were placed in supervision bays close to the nurses' station so they could be easily monitored. Some wards had several beds which could be lowered to floor level if a patient was deemed at high risk of falls.

The trust had a sepsis policy in place to provide best practice guidance to all staff involved in the care of patients presenting with sepsis. 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 NICE guidance. We saw posters displayed on wards about the risk of sepsis.

The trust also used a nationally recognised sepsis-screening tool. Where applicable, we saw sepsis-screening tools in the notes we reviewed. The service had sepsis grab packs on individual wards and units.

There were 12 telemetry beds in the clinical decisions unit with monitors at the nurses' station. Patients requiring close monitoring were placed in four of beds nearest to the nurses' station.

There was access to specialist mental health support if staff were concerned about risks associated with a patient's mental health. The psychiatric liaison team acute hospital liaison service (AHLS) were available seven days a week from 8am to 8pm and outside of these hours outside of these hours staff contacted the crisis team in the community. This service was provided by a local mental health trust. There was a service level agreement in place between the two trusts that ensured referral pathways and information sharing between both staff groups. Staff report very good working relationships with no issues in the system.

The AHLT undertook their own biopsychosocial assessment of the patient and formulated a care plan. South Tees staff did not complete a formal risk assessment for suicide or self-harm, however formal risk assessments for suicide or self-harm were completed by the AHLS. The AHLS targeted maximum response time was 60 minutes. Pending assessment by AHLS, nursing staff would use judgement to assess risk and designate frequent/continual observations using a precautionary approach. Immediate security support was available. They used the enhanced observation guidance which helped staff determine if someone required checking every 15 minutes on needed constant one to one observation.

Nurse staffing

The trust used the safer nursing care tool to calculate ward staffing levels and establishments. This tool considered the acuity and dependency of patients on the ward, although one ward manager we spoke with did not always feel that staffing levels matched patient acuity. We saw that staff were deployed to wards to keep staffing levels safe and that the ward manager sometimes included in the nurse staffing numbers when needed.

Staff levels were reviewed daily at the bed meeting. Staff were sometimes asked to move wards to maintain safe staffing levels. It an issue arose with nurse staffing and needed escalating the ward manager contacted the senior nurse on site who held a bleep.

Display boards at the entrance to the wards showed planned and actual nurse and health care assistant staffing. During the inspection we noted that planned staffing levels were met at night on all wards. During the day health care assistant staffing levels were met, but nursing staffing levels were short by one registered nurse on all wards. We saw that ward managers and clinical sisters were taking responsibility for patient care during these periods.

The planned ratio for registered nurse to patients was approximately 1:6 during the day and 1:11 at night on Ainderby and Romanby Wards. On CDU the ratio was 1:4 during the day and 1:7 at night.

There were some vacancies on medical wards. At the time of the inspection, Romanby Ward had two registered nurse vacancies and one healthcare assistant vacancy which were being recruited to. CDU had two registered nurse vacancies which were filled and waiting for human resources

checks and processes to be completed. Ainderby Ward had one registered nurse and two healthcare assistant vacancies which were currently being recruited to.

If one to one care was required for a patient on the ward, staff told us they could request an additional health care assistant. Ward managers were able to request an additional bank shift.

The service supported nursing associates in training. One health care assistant working on Ainderby ward was due to qualify as a nursing associate in April 2019.

The trust has reported their staffing numbers below as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	162.0	149.4	92.2%
Trust level	618.2	637.7	103.2%

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates
From October 2017 to September 2018, the trust reported a vacancy surplus rate of 1.0% in medicine. At Friarage Hospital they reported a vacancy rate of 10.9%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From October 2017 to September 2018, the trust reported a turnover rate of 8.0% in medicine, which was in line with the 10% trust target. The turnover rate at Friarage Hospital was 14.6%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From October 2017 to September 2018, the trust reported a sickness rate of 4.9% in medicine this did not meet the trust target of 3.5%. The sickness rate at Friarage Hospital was 4.1%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage
From October 2017 to September 2018, the trust reported a bank usage rate of 364.5% an unfilled rate of 13.9% and no agency usage in medicine. The trust use bank staff for extra activities, for example to sit with patients at risk. This is has led to a large bank staff usage rate.

All nursing staff

Site	Bank rate	Agency rate	Unfilled rate
Friarage Hospital	298.2%	N/A	30.8%

Qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
Friarage Hospital	175.4%	N/A	35.0%
Trust level	221.4%	N/A	34.5%

Non-qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
Friarage Hospital	492.1%	N/A	24.1%
Trust level	566.7%	N/A	Surplus of 15.1%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

At our last inspection we found that there was a high level of locum use for middle grade doctors (approximately 40%). At this inspection medical staff informed us that this had been reduced to less than 10%. Work had been undertaken to improve this with a successful programme of international recruitment and the recruitment of two GPs who had become part of the medical team on the clinical decisions unit (CDU). The GPs were being trained to join the specialist register via the certificate of eligibility for specialist registration (CESR). In addition, two advanced nurse practitioners had received a programme of training including independent prescribing and they were included on the middle grade medical rota. We reviewed the medical rota for the previous week and there were no locums used and no gaps in the rota.

There were six general physician consultants covering the CDU and there were no consultant vacancies. A seventh consultant who worked at James Cook Hospital joined the on-call rota for this site. Consultant cover on the unit was from 8.30am to 5pm Monday to Friday, although staff told us that consultant presence was sometimes until 8.30pm. A consultant ward round took place on the unit on Saturdays and Sundays and the consultant reviewed patients on other wards of the hospital if necessary. Outside of these hours a consultant was available on call.

There was active involvement of speciality consultants on CDU. A consultant cardiologist carried out a daily ward round (Monday to Friday) and an elderly care consultant visited the unit to proactively identify frail patients who required rehabilitation.

During the day the consultant carried a bleep and took all referral calls. Out of hours the bleep was passed to the medical registrar. Patient referrals came from the emergency department, GPs, direct from paramedics and from James Cook Hospital for patients needing to be repatriated.

Medical cover out of hours was provided by a medical registrar and a junior doctor with an additional GP until 11pm. The medical team were supported by two nurse practitioners and a consultant on call who was within 30 minutes of the hospital.

From 9pm to 8am the medical registrar in CDU was responsible for triaging direct ambulance admissions into the unit. There was a standard operating procedure for this. Staff told us that the exception to direct access through the CDU was if a patient required resuscitation in which case they would be taken directly to the emergency department.

There are two substantive respiratory consultants who contribute to the acute admissions roster and post-take ward rounds. The respiratory ward (Ainderby) also had a GP trainee, a registrar and three junior doctors.

The trust has reported their staffing numbers below as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	205.9	191.3	92.9%
Trust level	294.2	270.8	92.1%

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy rate of 7.7% in medicine at Friarage Hospital.

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

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 19.5% in medicine, this was not in line with the trusts 10% target. The turnover rate at was Friarage Hospital: 33.2%.

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

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 4.4% in medicine at Friarage Hospital. This slightly exceeded the trust target of 3.5%.

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

Bank and locum staff usage

From October 2017 to September 2018, the trust reported a bank usage of 2.1% and locum usage of 1.0% in medicine. At Friarage Hospital bank usage was 5.5% and locum was 3.8%.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In July 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 297-whole time equivalent staff working in medicine at South Tees Hospitals NHS Foundation Trust

	This Trust	England average
Consultant	44%	42%
Middle career^	5%	6%
Registrar group~	29%	27%
Junior*	22%	25%

^ 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 - Medical (01/07/2018 - 31/07/2018))

Records

We reviewed four nursing and seven medical records at this hospital and found that the standard of record keeping was good.

Staff used a combination of electronic and paper records. Most records were paper based including the initial nursing assessment, risk assessments, pain charts, intentional rounding charts, medicines administration chart and care plans. Nursing staff recorded patient observations on an electronic system.

The records we looked at were completed with legible daily entries and reviews of patient treatment and care. However, we found that although initial nutritional risk assessments were completed, they were not always repeated weekly and some food and fluid charts were not fully completed.

We found medical notes were comprehensive and all patients had a documented history and plan of care. There was clear evidence of medical review within 14 hours of admission, ongoing medical reviews and multidisciplinary involvement where needed.

We reviewed two patient records that clearly documented the mental health needs of the patient and showed involvement from the psychiatric liaison team (PLT). One record showed reviews by the PLT every other day, along with referrals to speech and language therapists and social care. Nursing notes documented key issues pertinent to the patient's mental health, such as not retaining the information about the nurse call bell and its use. The PLT printed off certain mental health documents such as risk assessments and care plans and put a copy in the patient's paper file so that ward staff have access to them.

Nursing records were kept in a folder at the nurses' station with some records being kept in a folder at the end of the bed. Medical records were stored in folders in moveable trolleys with lockable lids. We saw that the lids were closed when not in use, however, most of the trolleys were not locked. Trolleys were located near to the nurse's station to minimise the risk of being accessed by unauthorised people.

Ward mangers carried out a weekly audit of three sets of records as part of the model ward metrics.

Data provided by the trust, showed that 83.1% of medical staff and 93.5% of nursing staff had completed information governance training, the trust target was 90%.

We reviewed the trust wide records audit for both medical and nursing records.

Audit compliance for both audits can be seen below:

Records Audit Overall compliance (average)	Medical Staff	Nursing Staff
October 2018	97%	97%
November 2018	97%	97%
December 2018	96%	96%

Electronic Patient Status at a Glance Board's (e-PSAG) were visible on all units we visited. The boards displayed patient information. On admission the admitting nurse explained to the patient/relatives/carer the purpose of the e-PSAG board and the information displayed. Explicit consent to use a patient's data on a large electronic screen was sought and documented in the patient's notes. Where a patient lacked capacity to consent, the nurse would take a decision, in the best interests of the patient, around the use of this information. The trust had a Standard

Operating Procedure (SOP) for the e-PSAG. We reviewed the SOP post inspection which was in date, version controlled and had a named author.

The trust information governance team had authorised the use of the patient's first name, surname, hospital number, consultant, specialty, admission date (and derived length of stay) as well as their expected date of discharge on the board. Information governance had also approved the use of a standard set of status flags that did not carry wording, letters or icons that could give any concern to patients or indicate any information to visitors on a ward.

All staff using the large screens for managing admissions, transfers and discharges were reminded of their information governance responsibilities and the need to refrain from using the screens to display and/or update patient demographics or other sensitive information.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Medicines, including controlled drugs and intravenous fluids, were stored securely and access was restricted to authorised staff. All stock medicines we checked were in date.

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.

We reviewed the CD audit of ward controlled drugs meeting minutes (October 2018/19, Quarter 3). The audit measured compliance with CD cupboards, stock management, documentation and signature lists. The audit results showed that compliance for clinical areas ranged from 67% to 100% with the average of 92% across the trust both at Friarage Hospital and James Cook Hospital. The raw data for this audit was shared with the clinical pharmacy teams so they could assist in identifying areas of non-compliance within clinical areas as well as sharing areas of good compliance. This was confirmed on inspection by unit managers who gave assurance that lead pharmacists escalated poor compliance and worked with individual wards where further training and awareness was required.

We 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 range. Medicine storage room temperatures were also checked and recorded daily and we saw these were below the recommended level of 25 degrees centigrade.

Medicines and equipment for emergency use were readily available and in date. Liquid medicine bottles were labelled with a date opened sticker and these were within their expiry date. Oxygen was stored and prescribed appropriately.

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 saw useful information for staff on missed doses of critical medicines and key drug interactions displayed on the wall in the medicines storage rooms.

We reviewed seven prescription charts and found they were legible and all had allergies recorded on the front sheet of the chart. All prescriptions were signed and dated and five out of seven had reconciliation checks documented. Missed dosed had a reason documented with the exception of one dose on two of the records which was left blank.

During inspection pharmacy staff told us that omitted dose was one of the key metrics in the Medication Safety Quality Priority for 2018/19. The target was to maintain all omitted doses below

5% and omitted doses of critical medicines below 2%. The compliance results for omitted doses in December 2018 was 2.95% with critical medicines scoring 1.35%. The trust had achieved the target level since May 2018.

Antibiotics were prescribed as per guidelines where appropriate. The in-patient medication administration record had been redesigned to incorporate a mandatory three and seven-day antimicrobial review. The review targeted antimicrobial revision and de-escalation as appropriate.

We found that six patients out of seven had been prescribed appropriate prophylaxis for Venous Thromboembolism (VTE) where this was indicated. One record on CDU the assessment had been partially completed.

The trust had introduced a medicines dashboard which demonstrated compliance in four areas against a target (by ward). The four areas were; controlled drugs (target 100%), omitted dose (target less than 5%), reconciliation within 24 hours (target 80%) and patient experience on how to take drugs (target 9). The dashboards showed monthly variation with coloured arrows. We reviewed the dashboards for September 2018 and found that the medical wards at Friarage had reached their targets in all indicators with the exception of patient experience on CDU which scored 8.75.

A business case had been submitted for a trust wide electronic patient record to the board in December 2018, which included an e-prescribing functionality. Plans to instigate this were on going.

Staff on all ward told us they had good pharmacy cover and we observed pharmacists and pharmacy technicians on wards during the inspection. The Friarage Hospital had recently piloted a seven day (including bank holidays) clinical pharmacy service allowing for additional medicines reconciliations to be completed. The pilot was in the evaluation stage.

There was no trust policy for rapid tranquilisation (RT) for patients with mental health needs. The service followed the local mental health trusts policy for RT. Staff we spoke with were unclear regarding the management of RT and were not following national guidelines. NICE guidance clearly states: 'Rapid tranquilisation is a potentially high-risk intervention that can result in a range of side effects linked to the medication and dose. People given RT need to be monitored at least every hour until there are no further concerns about their physical status'. We looked at the records of two patients who had received RT and there was no evidence that staff had completed regular patient observations following the administration of RT medication. We also found the prescription records were written for post oral/intra muscular injection which was not in line with best practice.

Incidents

Staff we spoke with were aware of the reporting system and could tell us when 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. Staff told us they received quality and safety updates monthly and emails, which included information and learning from incidents.

Staff informed us they received information about received safety alerts. The trust issued safety bulletins from the most recent safety alerts which were displayed on quality performance boards. We saw evidence of this on the wards we visited.

A staff member on the clinical decision unit spoke of an incident in the previous year where a

patient had ligatured in the bathroom. Staff were in handover and the patient was a regular attender for attempts of suicide and self-harm. The patient pressed the nurse call button in the bathroom to alert staff of their ligature. However, staff were unable to clearly identify lesson learned or change in practice following this incident, other than the hospital needed its own spinal board on site which had been rectified.
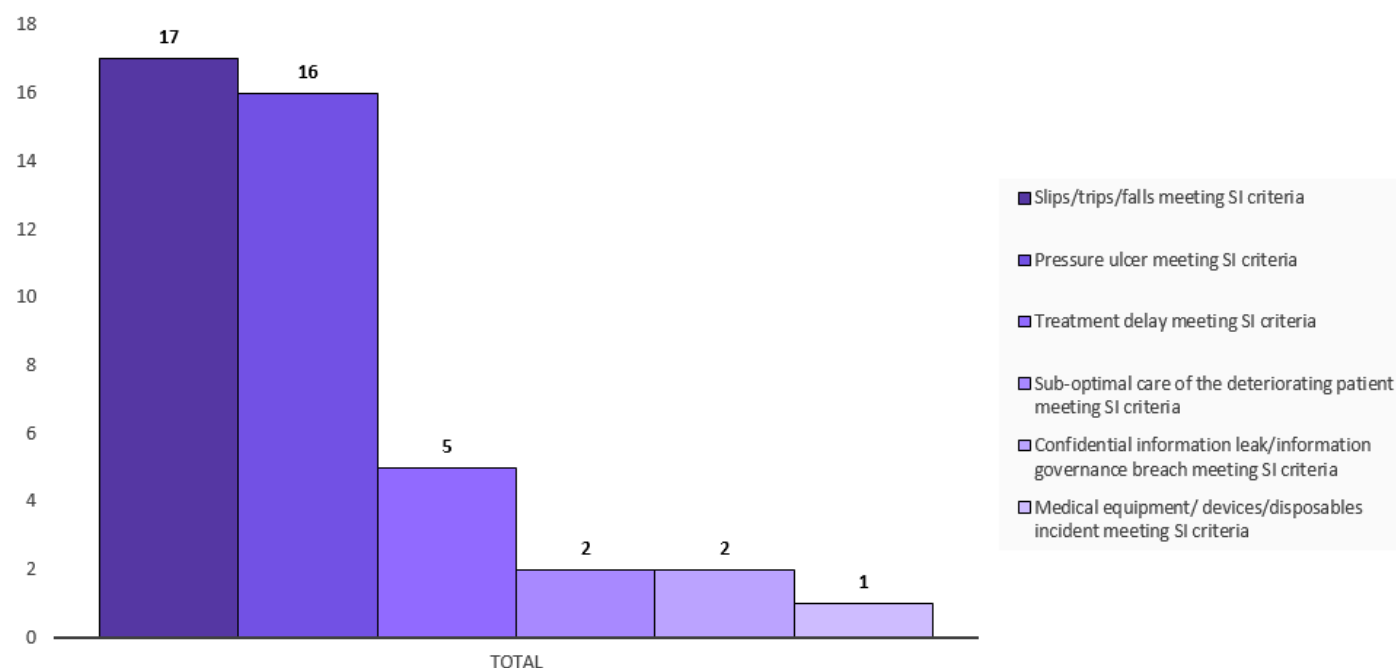
Never Events

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 October 2017 to September 2018, the trust reported no incidents classified as never events

for medicine.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 43 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from October 2017 to September 2018.

Of these, the most common types of incident reported were:

- Slips/trips/falls meeting SI criteria with 17 (39.5% of total incidents).

- Pressure ulcer meeting SI criteria with 16 (37.2% of total incidents).

- Treatment delay meeting SI criteria with five (11.6% of total incidents).

- Sub-optimal care of the deteriorating patient meeting SI criteria with two (4.7% of total incidents).

- Information leak/ information governance breach incident meeting SI criteria with one (2.3% of total incidents).

- Medical equipment/ devices/disposables incident meeting SI criteria with one (2.3% of total incidents).

Friarage Hospital had three serious incidents in medical care services during this period.

(Source: Strategic Executive Information System (STEIS))
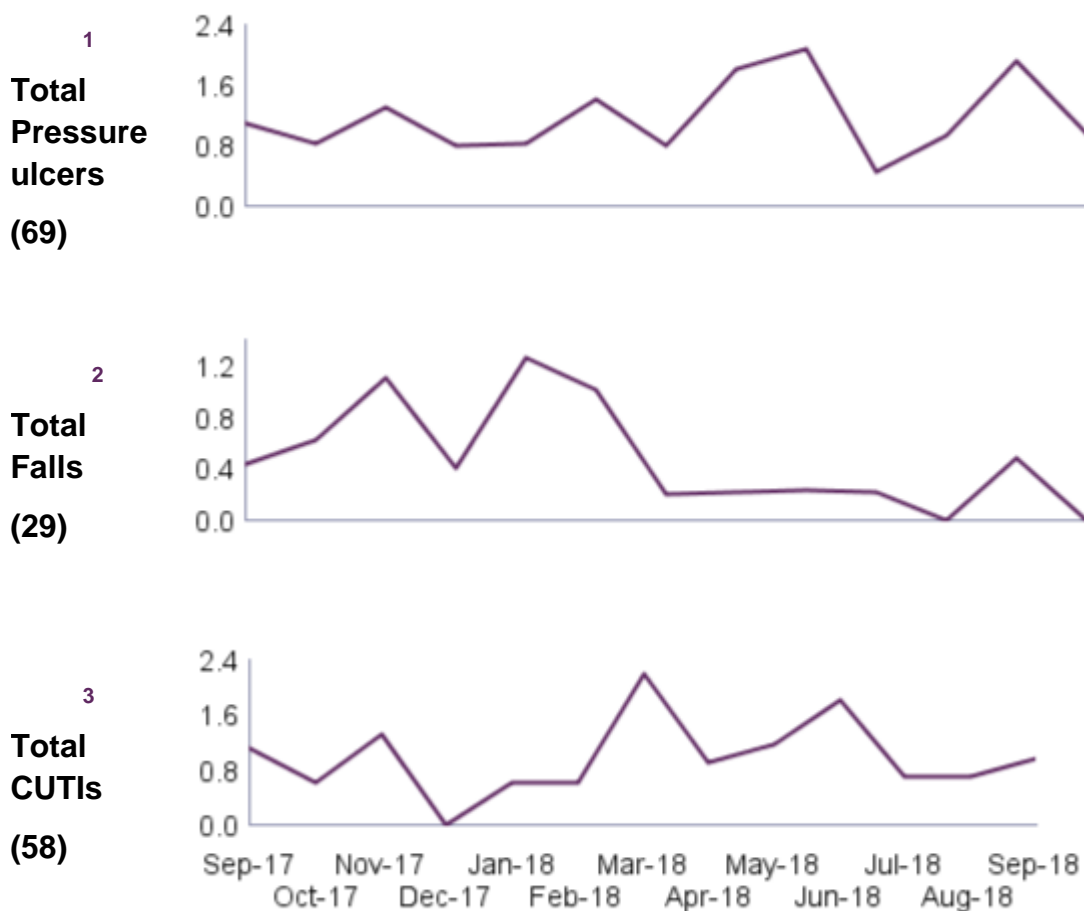
Safety Thermometer

Wards displayed information about safety performance on notice boards at the entrance to the ward. For example; Romanby Ward had two falls, zero pressure ulcers and zero case of Clostridium difficile during the month of December. CDU had no pressure ulcers, no falls and one new urinary tract infections in patients with a catheter.

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 69 new pressure ulcers, 29 falls with harm and 58 new urinary tract infections in patients with a catheter from September 2017 to September 2018 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at South Tees Hospitals NHS Foundation Trust

1 Total Pressure ulcers (69)

2 Total Falls (29)

3 Total CUTIs (58)

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 - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). The trust has a process for managing NICE guidance. All new guidance was distributed to relevant clinical directors by the quality assurance facilitator. The clinical director had the responsibility to review the guidance against current practice and escalate if there were any gaps in compliance. This is discussed at directorate and centre governance meetings and compliance was monitored at clinical standards sub group.

The trust took part in national and local audit. There was a monthly programme of nursing audits for adult in-patient medical wards which included physiological observations, national early warning scores (NEWS 2), infection prevention and control and other patient safety indicators. Results were used to inform ward development plans which identified areas for improvement and actions to improve. Ward managers shared actions plans from audits with staff at their team meetings.

Nutrition and hydration

The hospital had guidelines in place to screen patients on admission for the risk of malnutrition. The hospital used the validated Malnutrition Universal Screening Tool (MUST) and screening was repeated weekly. The hospital used food and fluid balance charts to monitor patient's oral intake. On one ward we visited, we reviewed five patient's MUST assessments and food and fluid charts. We found that in four out of five patients, staff had not updated the MUST assessment weekly. Three of the patients had food and fluid charts started within their nursing notes but these had also not been fully completed.

We saw that red jugs were in use to indicate to staff which patients needed assistance with their fluids. Mealtimes were protected. Extended visiting times allowed relatives to stay and help with meals if they wished.

On the wards we visited, the ward hostess was provided with a daily handover of any patients on the ward with specific dietary requirements, including thickened fluids. The hostess told us the list was updated each night by the nursing staff.

The hospital had a two-week menu cycle with a hot meal and dessert option available at both lunch and evening meal. Evening meals were chosen on the same day by patients allowing most new patients on the ward the option to choose their own evening meal. A range of texture modified and ethnic meals were available.

The wards we visited had support from speech and language therapy and we saw the outcomes of swallow assessments above patients' beds. The swallow assessments highlighted any diet and

fluid requirements the patient may have at their point of care. We saw a patient who was nil by mouth and being fed by a nasogastric tube had been reviewed by a dietitian.

Staff in the Sir Robert Ogden Macmillan Centre told us that patients receiving treatment over lunch time were provided with a choice of soup, sandwich and hot pudding. There was a kitchen were patients and visitors could help themselves to hot and cold drinks. The unit was also developing a recipe of the month board to provide patients with ideas for nutritious meals. Staff reported that they could access dietetic services however, it sometimes took time for patients to be reviewed.

We saw that all patients had access to a water jug on their bedside table and a hot drink and snack round being undertaken in the afternoon.

Pain relief

Patients we spoke with had no concerns about how their pain was controlled and managed. We saw that staff checked that pain relief administered had been effective.

Pain assessment was carried out and recorded in patient notes. Staff used a pain-scoring tool to assess patient's pain levels. Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief was accessed through medical staff, if required.

A specialist multi-disciplinary pain management service was available to inpatients and provided advice and treatment for patients with acute and/or chronic pain.

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 took part in national and local audit and used the results to identify areas for improvement. We saw that the service identified key areas for improvement and had action plans in place to address poor performance.

The service used nursing quality indicators and each ward participated in the audit programme. We reviewed the quality indicators for December 2018. The results for the medical wards at Friarage Hospital were 92% for Ainderby Ward and 76% for Romanby Ward. We saw that results of the quality indicators were discussed with staff at team meetings to raise awareness and drive improvement.

The trust had refreshed the falls prevention strategy reducing the rate of falls per 1000 bed days to 4.7 per 1000 bed days in 2018/19 (year to date) compared to 5.3/1000 bed days in 2017/18.

The endoscopy unit was Joint Advisory Group on Endoscopy (JAG) accredited. To comply with JAG standards, the service ran sessions on different days for male and female patients.
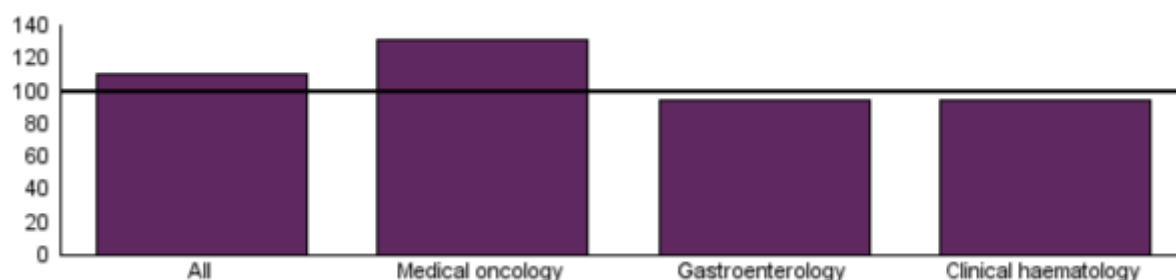
Relative risk of readmission
From June 2017 to May 2018, patients at Friarage Hospital had a higher than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in medical oncology had a higher than expected risk of readmission for elective admissions

- Patients in gastroenterology had a lower than expected risk of readmission for elective admissions

- Patients in clinical haematology had a lower than expected risk of readmission for elective admissions
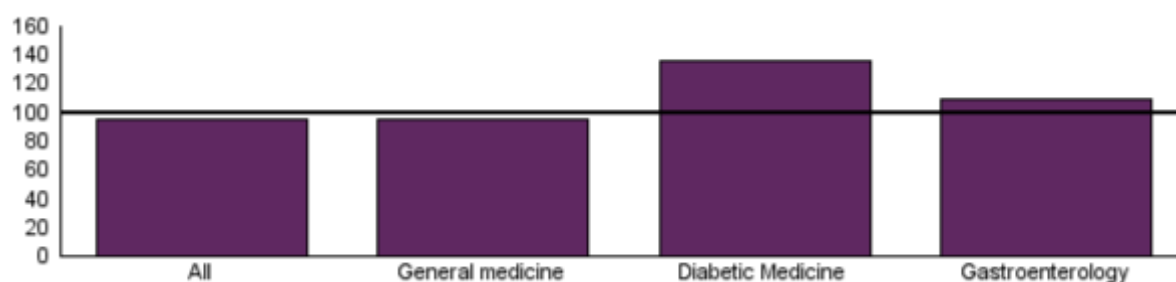
Elective Admissions - *Friarage Hospital*

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.

- Patients in general medicine had a slightly lower than expected risk of readmission for non-elective admissions

- Patients in diabetic medicine had a higher than expected risk of readmission for non-elective admissions

- Patients in gastroenterology had a slightly higher than expected risk of readmission for non-elective admissions

Non-Elective Admissions - *Friarage 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.

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 82.5%, which did not meet the audit minimum standard of 90%. The 2016 figure was 11.5%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 15.9%. This is within the expected range. The 2016 figure was not significantly different to/significantly worse than the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 74.7%. This is better than expected. The 2016 figure was significantly better than the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 66.4%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one year relative survival rate for the trust in 2016 is 35.5%. This is within the expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017: *Friarage Hospital*

The crude proportion of patients who had a vision assessment (if applicable) was 71%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 13%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 13%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 88%. This did not meet the national aspirational standard of 100%.

(Source: Royal College of Physicians)

The trust had refreshed the falls prevention strategy and reducing the rate of falls per 1000 bed days to 4.7 in 2018/19 (year to date) compared to 5.3/1000 bed days in 2017/18.

We reviewed the trust falls prevention strategy action plan (2018-2020) which listed falls prevention, assessment and risk reduction, governance, patient experience and education. The aim of the strategy was to improve patient experience and outcomes, reduce incidence of serious harm, achieve a 5% reduction in falls each clinical year and demonstrate improved compliance with interventions proven to reduce risk.

Competent staff

The service made sure nursing staff were competent for their roles. Managers appraised staff's work performance and provided support and training to deliver safe and effective care.

Staff we spoke with had received their annual appraisal or had it booked with their line manager. They told us they were encouraged and supported with personal professional development and training to fulfil their role including courses outside of the trust.

Registered nurses in the Sir Robert Ogden Macmillan Centre could attend a short course in chemotherapy at the local university to enhance their skills and knowledge.

Newly recruited staff and student nurses told us they were supported by mentors. Newly qualified nurses said they had a preceptorship period of and a supernumerary period when they first joined the trust. Staff told us they were competency assessed during their preceptorship period of six months.

There were clinical nurse specialists and clinical skills educators employed by the trust to provide advice support, education and training to staff in the clinical ward areas.

Registered nurses on the clinical decisions unit followed a training and competency framework which included Electro Cardio Gram (ECG) monitoring, telemetry, blood gases, non-invasive ventilation (NIV) and tracheostomy care. Patients in the acute phase of respiratory failure requiring NIV were cared for on the clinical decisions unit. The Critical Care Outreach Team (CCOT) and advanced nurse practitioners provided training and supported staff caring for patients with this condition.

Patients in the acute phase of respiratory failure were not cared for on the Ainderby Ward

(respiratory). The ward provided care to patients who required NIV with chronic respiratory disease and who did not require a nurse to patient ratio of one to two. Staff on this ward also received training and support from advanced nurse practitioners and CCOT

Junior doctors told us they had good opportunities for training and that there was time for training during ward rounds.

A pharmacist we spoke with told us how the trust had supported her to progress from a pharmacy technician to a qualified pharmacist. She said the trust was always keen to develop their own staff. The pharmacist told us that the trust held regular consultant led seminars which pharmacists could attend. She said they provided an excellent opportunity for learning and development.

We spoke with two registered nurses who started work for the trust as a health care assistant and had been supported to achieve their nursing qualification to become a registered nurse.

Appraisal rates

From October 2017 to September 2018, 81.3% of staff within medical care at the trust received an appraisal compared to a trust target of 80.0%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
Qualified Allied Health Professionals (Qualified AHPs)	28	25	89.3%	Yes
NHS infrastructure support	42	37	88.1%	Yes
Medical & Dental staff - Hospital	310	271	87.4%	Yes
Support to ST&T staff	37	30	81.1%	Yes
Support to doctors and nursing staff	655	526	80.3%	Yes
Other Qualified Scientific, Therapeutic & Technical staff (Other qualified ST&T)	5	4	80.0%	Yes
Qualified nursing & health visiting staff (Qualified nurses)	680	539	79.3%	No
Qualified Healthcare Scientists	39	29	74.4%	No

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

Multidisciplinary working

Staff spoke positively about multidisciplinary team (MDT) working and said they had good working relationships between professions.

We saw good examples of MDT working. Wards held multidisciplinary board rounds Monday to Friday which were attended by the medical staff, nursing staff, therapists and discharge facilitators.

Referral pathways were in place for referral to the speech and language therapist, podiatrist and dietitian. Pharmacist and pharmacy technicians supported wards.

Staff reported they worked very closely with the local metal health trust to meet the needs of patients on the wards. The trust also had safeguarding link nurses and learning disability nurses who liaised with other agencies and community teams.

Specialist nurses were available to offer support, advice and training to staff in several specialist areas.

We saw that involvement from the MDT was documented in patients notes. This included input from the dietitian, physiotherapist, occupational therapist and the frailty team.

Seven-day services

To meet the 14 hours of admission to initial consultant review standard set by the NHS there was an acute physician present in the clinical decisions unit during the day Monday to Friday and a consultant ward round on the unit at weekends. A consultant was available on call during the evening and overnight.

The ambulatory care unit had recently increased it's opening hours and provided a seven-day service from 8am to 8pm.

The critical care outreach team provided a seven-day service during the day to support staff and patients on the wards. Out of hours advanced nurse practitioners were available to offer additional support.

The oncology/haematology service had a seven day 24-hour patient helpline. Calls were triaged by nursing staff using a standard triage tool to assess whether the patient needed to be admitted to the hospital.

Diagnostic pathology services were not available at this site out of hours and weekends. Staff sent pathology specimens to the James Cook Hospital site by taxi at weekends and between 8pm and 8am. A nurse told us that they had reported two incidents when pathology specimens had gone missing after being sent to James Cook.

Health promotion

We saw health promotion information displayed on the wards and around the hospital. For example; information on stopping smoking, local alcohol services, health screening, dementia, carers support and falls prevention.

We saw in patients records that there was a screening tool for smoking and alcohol consumption. 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.

A new stop smoking service for staff had been launched as part of the trusts pledge to go smoke free by the end of March 2019. Provided by occupational health, the 12-week programme was designed to help stop smoking supported by a qualified stop smoking advisor. As part of the trusts smoke free campaign more than 50 staff had already signed up as smoke free champions to help provide stop smoking support to inpatients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. It applies to individuals over the age of 16. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The MCA allows restraint and restrictions to be used but only if they are in a person's best interest. 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).

Staff we spoke with had attended the mandatory training and understood capacity was decision and time specific. They also reported that it was everyone's responsibility to assess capacity. The mental capacity assessment form contained a stage two assessment and a determination of best interests. It identified if an independent mental capacity advocate was required. Although the capacity form was fully completed in all the records we reviewed, it did not always clearly summarise the reasoning behind the best interest decision or identify the names of other people that had been consulted in the making of that decision.

Records we reviewed showed consideration of capacity where concerns had been identified, and included an assessment of cognitive impairment (using the 4AT tool) and a DoLS application where applicable. Staff used a two-stage assessment of capacity in line with the Mental Capacity Act code of practice.

We saw that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation included evidence of discussion with patients and family.

Staff in the endoscopy unit were clear on the process to follow if a patient did not have capacity to consent to a procedure. A specific consent form (consent form 4) was completed by the consultant who carried out an assessment of the patient's capacity and an assessment of their best interest with involvement of the patient's family and those close to the patient.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 73.2% of staff in medical care compared to the trust target of 90.0%.

At Friarage Hospital 79.5% of staff in medical care completed this training which did not meet the trust target of 90%.

Site	Training complete (YTD)	Individuals required (YTD)	Completion rate	Target met
Friarage Hospital	132	166	79.5%	No

Additional mental capacity training sessions had been implemented at differing times for medical staff to increase compliance. We were assured by senior management that training remained high on the agenda and would be tracked by service managers in both clinical centres for acute and general medicine.

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

Staff liaised with the psychiatric liaison team (PLT) for all mental health patients and the PLT would make decisions about required mental health treatment in conjunction with trust staff. PLT staff undertook mental health assessments to identify if a Mental Health Act Assessment was required.

Compassionate care

Staff cared for patient with compassion. We saw staff respond quickly to call bells or requests for assistance. Staff knew their patients well and we saw them accommodating patient choices. We spoke with 15 patients across the inspection, all were happy with the standard of care they received. Patients had drinks available and call bells located within easy reach. We saw staff maintained patient's privacy and dignity by closing curtains.

One patient we spoke to on the oncology day unit was very happy with the care he had received and said, 'staff could not do enough for him'.

Staff spoke about patients with mental health needs, learning disabilities and dementia in a compassionate and kind manner. Feedback from two carers was positive about the understanding that staff showed towards their relative. One carer said, "staff are brilliant" and "I couldn't praise them enough".

The PLACE score for privacy, dignity and wellbeing for 2018 was 84.41%, which was above the national average of 84.16% but below the trust average of 88.7%.

The trust undertook a 1000 voices campaign were face to face interviews were carried out with patients across the hospital to gain feedback on different areas of care. The 1000 voices programme had been in place since January 2017 and involved monthly interviews with at least 8 patients on every ward. Questions were asked across 10 different domains. Information was displayed on the entrance to each ward and the scores where consistently above 9 (out of 10) for all 10 domains.

In response to feedback from the 1000 voices survey about noise at night, the trust had launched The Sleep Helps Healing (Ssh) campaign aimed to protect and support rest in hospital and reduce overnight noise by staff and patients. A protected sleep time was in place between 11pm and 6am and measures such as soft close bins and dimmed lights had been introduced.
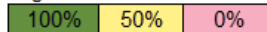
Friends and Family test performance

The Friends and Family Test response rate for medicine at the trust was 6% which was worse than the England average of 25% from October 2017 to September 2018.

Friends and family Test – Response rate between 01/10/2017 to 30/09/2018 by site.

Ward name	Total Resp[1,2]	Resp. Rate	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Annual perf[1]
WARD 26	727	81%	99%							97%	100%		96%		98%
WARD 9	313	14%	100%	100%	100%	92%	89%	100%	95%	100%	100%	92%	100%	95%	97%
PLANNED CARE ADMISSIONS UNIT	232	20%	96%	95%	95%	100%	100%	100%	93%	100%		100%	95%	100%	97%
WARD 25	219	37%	93%	100%	100%		100%	97%	97%	100%		100%	100%	100%	99%
JCEC	182	3%	100%	96%	100%	100%	100%	92%	96%	100%					98%
RAPID ACCESS FRAILTY ASSESSMENT UNIT	140	11%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%
WARD 8	108	9%		93%	93%	100%			100%			97%	100%	100%	97%
AINDERBY WARD	104	31%		100%	100%	100%		100%					100%		89%

(Source: NHS England Friends and Family Test)

Emotional support

We saw that patients were well supported emotionally, and staff were caring and empathetic.

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.

The trust used the butterfly system to identify and support patients living with dementia. We observed this in use. Specialist nurses were available to provide guidance and training to staff on dementia. Some wards had therapeutic timetables displayed showing activities for patient to take part in.

Some wards we visited had day rooms available for patients and families to use. All wards had extended visiting times that allowed patients to be supported longer by friends and family.

The oncology unit provided complimentary therapies for patients and this was also available to patients' relatives. There was a cold cap service to prevent hair loss and a wig fitting service was available to patients requiring this. The unit was supported by Macmillan services who could provide further emotional support for patients and financial advice.

There was daytime access to a psychiatric liaison team and out of hours support was available from the crisis team in the community.

The trust provided emotional support to those who were visiting patients at the end of their life. A 'Dragonfly scheme' had been introduced to provide essentials to visitors such as toiletries, vouchers for the coffee shop and free parking. The scheme had recently been extended to include comfort packs for children who had a relative in hospital.

Understanding and involvement of patients and those close to them

We spoke with 15 patients across the inspection and almost all told us they had been kept up to date with their treatment plans and doctors, nurses and therapists involved them in discussions about their care.

Patients said they had an opportunity to ask questions and felt confident in their responses from staff. The wards worked with relatives, different services and staff to organise and manage discharges.

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 them with their meals.

The trust supported 'John's Campaign', a national initiative to encourage carers to support and stay with people with dementia while they were in hospital. We saw patients admitted with their own hospital passport which staff used to ensure their needs were met. Some wards had information and displays about living with dementia.

The hospital had displays boards which identified the roles of staff and the uniforms they wore to help patients and relatives understand their roles.

Is the service responsive?

Service planning and delivery to meet the needs of the local people

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

For example, the Ambulatory Care Unit (ACU) had undergone a service redesign since our last inspection to change the way patients were managed through their admission. From January 2019 the unit had also extended it's opening hours to include Saturday and Sunday so was now open from 8am to 8pm, seven days a week.

The ACU had nine beds and was staffed by Nurse Practitioners (NPs), junior doctors and GP Hospitalists (fully qualified General Practitioners with a special interest in acute medicine). It received direct referrals from GPs and from the emergency department. The service enabled non-critical patients to be seen quickly, treated and discharged on the same day which relieved pressure on the emergency department. The unit also facilitated an outpatient parental antibiotic therapy clinic which enabled patients receiving regular intravenous therapy to be treated as an outpatient or within the community rather than being admitted to hospital.

Systems were in place to aid the delivery of care to patients in need of additional support. For example, patients with a learning disability or dementia were flagged on the trust's electronic system to highlight additional support that may be required.

The newly opened oncology unit offered chemotherapy to patients across the region, this prevented them having to travel to larger hospitals out of the region for their treatment.

During our inspection we found no mixed sex accommodation breaches.

Meeting people's individual needs

The service took account of patients' individual needs.

Patients with a learning disability were flagged on the electronic patient system. The trust had a learning disability (LD) lead nurse who supported patients by offering advice and support for ward staff. Patients with a learning disability had hospital passports which detailed important information about them including their likes and dislikes. Patients and carers were encouraged to bring hospital passports into hospital with them.

There was a specialist lead nurse for dementia, frailty, falls and delirium and a dementia awareness team. Patients with dementia were flagged on electronic patient systems and to staff at board rounds. Staff were prompted to use the 'forget me not' booklet. The forget me not booklet included information about the patient under the headings 'things I'd like you to know about me' and 'things you need to know to care for me'.
The wards we visited had some dementia friendly adaptations in place including pictures on toilets and bathroom doors. Wards did not have other dementia friendly adaptations such as contrasting colours for walls and floors or coloured toilet seats. Staff told us they could access bariatric equipment is this was needed for a patient.

At the Sir Robert Ogden Macmillan Centre patients sat in central area could look out onto the central courtyard or gardens whilst receiving their treatment. Staff told us that a patient liaison group had been consulted on the design of the building to ensure if met the needs of patients and relatives. The unit had a kitchen were patients and relatives could access hot and cold drinks. The hospital frailty team supported staff across all wards to undertake assessments of patient's needs and had developed guidance documents and tools to support this. These tools included guidance for staff on comfort and dignity interventions and an acute pathway for managing behaviours or psychological symptoms of delirium. The trust also used validated delirium screening tools for patients. If patients were positively screened a 'time to care' bundle was initiated which included a range of social and non-pharmacological interventions to support patients.

Patients with mental health needs were referred to the Psychiatric Liaison Team (PLT) which was provided by a local mental health trust under a service level agreement. Staff reported they had very good working relationships with the team and no issues with the service provided. Referral pathways were in place to ensure information sharing between staff. The service was available seven days a week 8am to 8pm. Outside of these hours the crisis team in the community could be contacted.

For patients who were severely deaf or blind, their communication need was recorded on the critical patient information field of the electronic patient record. To help meet the needs of patients with sensory loss, staff had access to a communication book. Some staff were also able to use the 'face, legs, activity, cry, consolability' (FLACC) communication scale to enable patients to communicate their pain levels non-verbally.

Patient information was available in additional formats including large print. Information updates could also be sent to patients via different formats such as text messages or telephone. During our inspection however, we did not find any information leaflets available in any language other than English. The trust website didn't have any easy to find guidance on information in other languages or formats such as audio or braille.

Staff told us that translation services were available on the phone or face to face. New booking systems had been implemented recently and translation services were now requested via an online booking service. Some wards had information leaflets about how the trust helped to meet individual patients' needs.

We saw evidence that service had appropriate discharge arrangements in place for people with complex health and social needs. Discharge plans were discussed at multidisciplinary team meeting and daily 'board rounds'. Social care staff were involved in these discussions to help facilitate safe discharges. We also saw evidence of staff liaising with other care services within the community.

The Trust offered patient centered visiting across all hospital sites. Visitors were welcome at any time during the day based on each patient's needs and wishes.

Access and flow

At the last inspection we had concerns about the discharge lounge at this hospital. At this inspection we found that the discharge lounge was no longer in use.
The clinical decisions unit helped flow from the emergency department during the day. From 9pm to 8am the unit took direct ambulance admissions following triage from a medical registrar. The

unit had support from a pharmacist to help facilitate discharges and staff told us there was active involvement from specialist clinicians including weekday ward rounds from cardiology and rehabilitation consultants.

The trust had processes in place to ensure that patients being treated on wards that weren't specialist to medicine (medical outliers) were seen daily by a named medical consultant or their registrar.   During our inspection we reviewed an outlier report which listed seven medical patients on non-medical wards, we checked all the patients, and each had been reviewed daily with medical and nursing notes updated and a plan of care with next steps in place.

Patient flow was discussed at daily bed meetings which were held at regular intervals throughout the day. Bed meetings were led by the site resource manager and attended by patient flow leads, discharge facilitators and representatives from different areas across the hospital. There was also a daily delayed transfer of care call that social care teams attended along with clinical staff which allowed complex discharges to be reviewed.

The endoscopy service told us they were achieving all their waiting time targets. They were also able to provide endoscopy slots for patients under the care of James Cook Hospital to help them achieve their waiting list targets. There was no 24-hour gastrointestinal (GI) bleed medical cover at the hospital. Any patients with GI bleeds out of hours would be transferred to the James Cook hospital.

The service had introduced board rounds attended by the multidisciplinary team to reduce delayed transfers of care. A key focus was to review discharge facilitation with the assistance of community networks and support.

The hospital had a robust discharge policy and processes in place. All patients were expected to have an expected discharge date (EDD) given by a clinician with the first 12 hours of admission and a discharge care plan completed. EDD and medically fit dates were recorded into the electronic patient monitoring system which allowed delayed transfers of care and 'stranded patients' to be flagged and easily identified by the flow team and social care. Discharges were discussed on daily ward and board rounds and wards had access to patient flow coordinators.

The hospital had a clear escalation and winter plan to help them deal with extra demand over winter months. The plan included opening additional beds across several different wards rather than accommodating all surge beds within one ward.

There was no cardiac catheter laboratory onsite. Patients needing interventional cardiology were transferred or admitted directly to the specialist unit at the James Cook Hospital. Ambulance staff could contact the Coronary Care Unit (CCU) at James Cook and alert staff of their arrival.

There were no stroke thrombolysis services at this hospital, all acute stroke patients were seen at James Cook for treatment and initial recovery. Once medically fit, suitable patients could be transferred to the rehabilitation unit on site.

Average length of stay

Trust Level

From July 2017 to June 2018 the average length of stay for medical elective patients at the trust was 6.4 days, which is higher than the England average of 6.0 days.
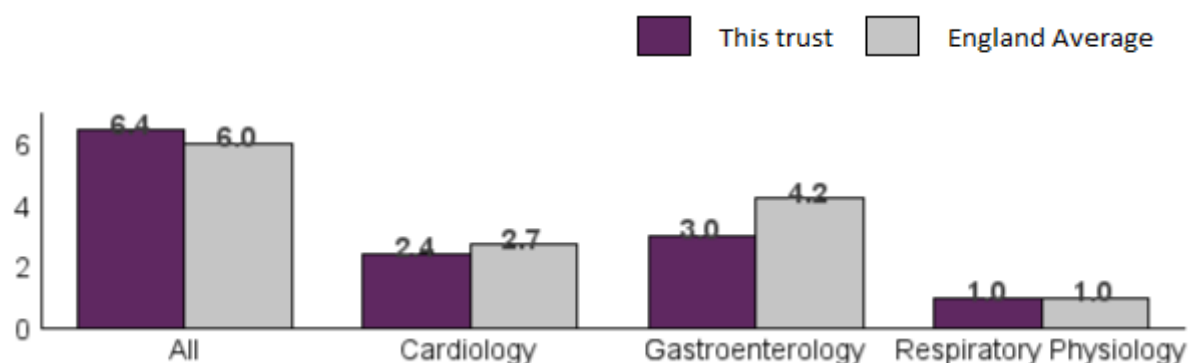
For medical non-elective patients, the average length of stay was 5.2 days, which is lower than

the England average of 6.3 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in cardiology is similar to the England average.

- Average length of stay for elective patients in gastroenterology is lower than the England average.

- Average length of stay for elective patients in respiratory physiology is similar to the England average.

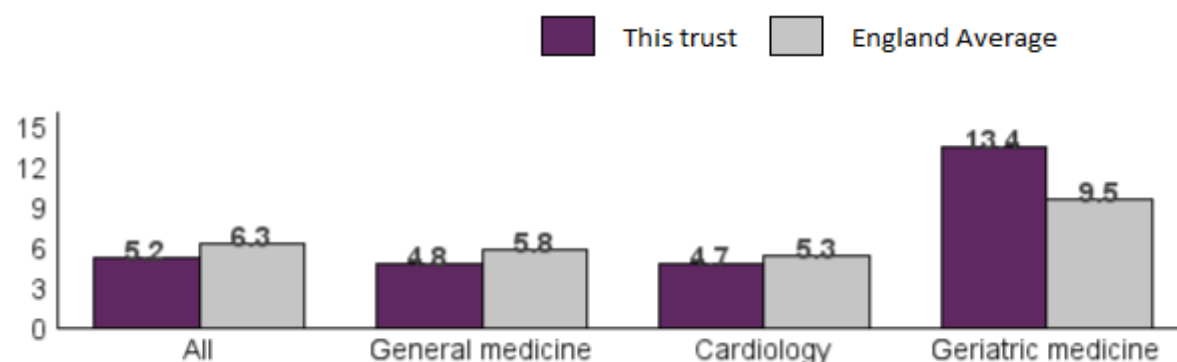**Elective Average Length of Stay – Trust Level**

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

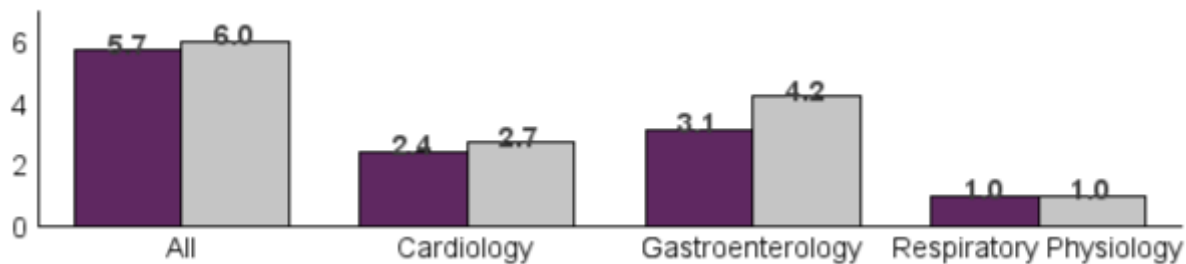Average length of stay for non-elective specialties:

- Average length of stay for elective patients in general medicine is lower than the England average.

- Average length of stay for elective patients in cardiology is lower than the England average.

- Average length of stay for elective patients in geriatric medicine is higher than the England average.

Non-Elective Average Length of Stay – Trust Level

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

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

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in cardiology is lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine is higher than the England average.

Friarage Hospital

From July 2017 to June 2018 the average length of stay for medical elective patients at Friarage Hospital was 4.1 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 5.2 days, which is lower than England average of 6.3 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in gastroenterology is lower than the England average.
- Average length of stay for elective patients in general medicine is lower than the England average.
- Average length of stay for elective patients in medical oncology is lower than the England average.

Elective Average Length of Stay - Friarage Hospital
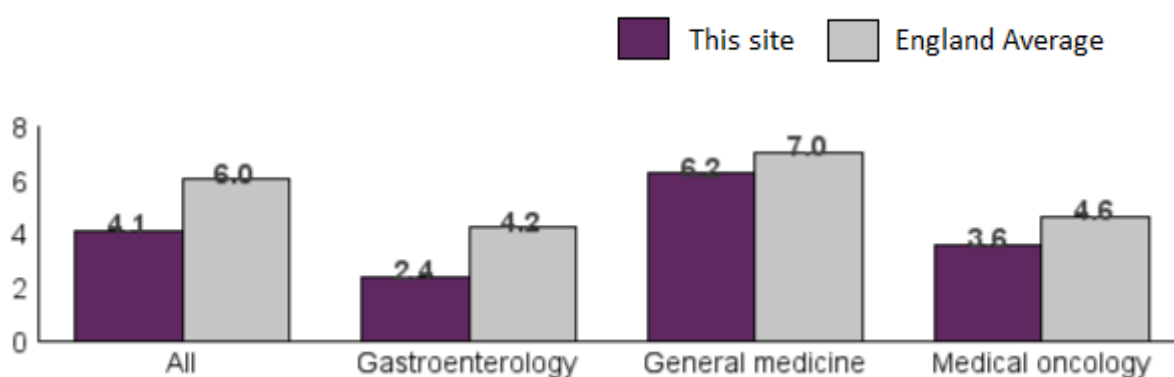
Note: Top three specialties for specific site based on count of activity.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in general medicine is lower than the England average.
- Average length of stay for non-elective patients in diabetic medicine is lower than the England average.
- Average length of stay for non-elective patients in cardiology is higher than the England

average.

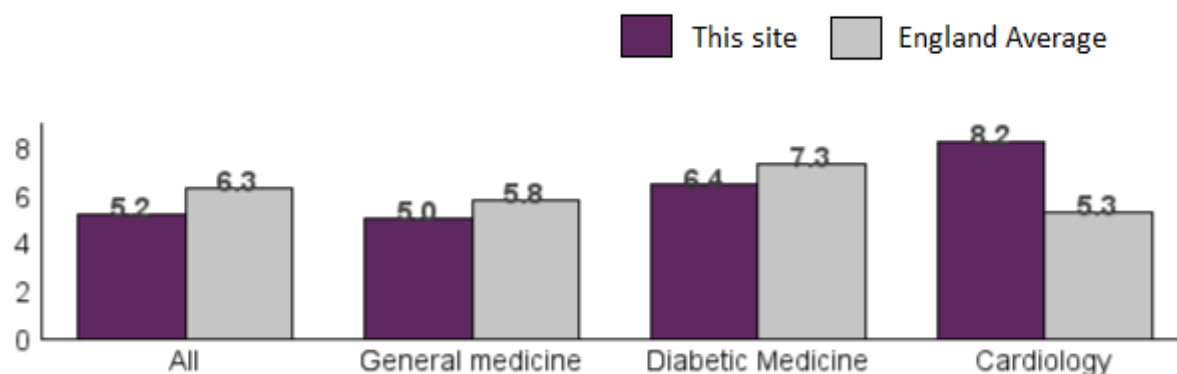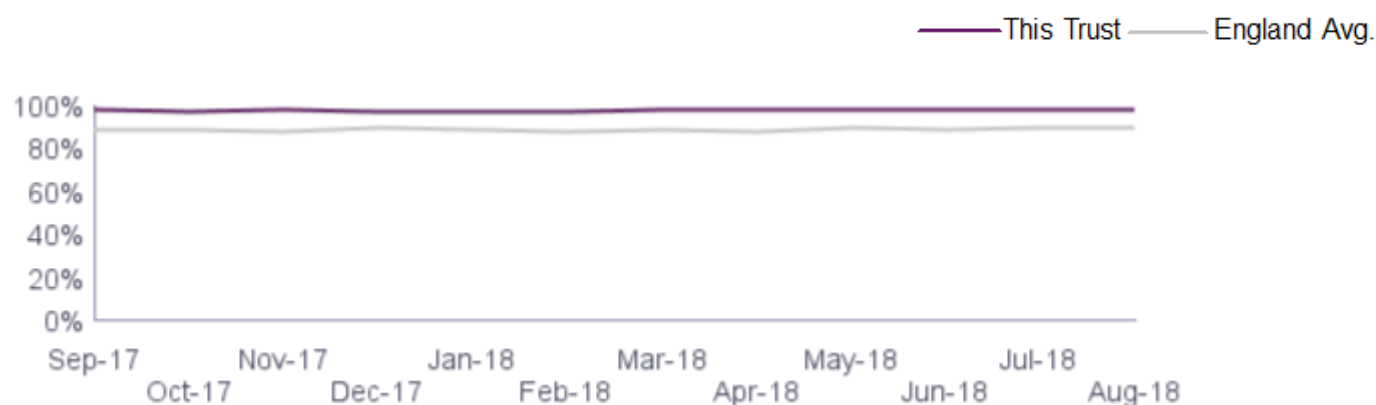**Non-Elective Average Length of Stay - Friarage Hospital**

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 September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for medicine was consistently better than as the England average.

(Source: NHS England)

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

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

Specialty grouping	Result	England average
General medicine	99.2%	96.6%
Rheumatology	98.9%	94.7%
Gastroenterology	98.3%	93.7%
Thoracic medicine	97.8%	93.4%
Neurology	96.0%	90.9%
Cardiology	95.9%	81.9%
Dermatology	94.7%	82.0%

One speciality was below the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Geriatric medicine	84.6%	96.9%

(Source: NHS England)

Patient moving wards at night

From October 2017 to September 2018, there were 3,612 patient moving wards at night within medicine overall and 210 (5.8%) of these were at the Friarage Hospital.

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

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. Information and learning from complaints was shared at handovers, team meetings and in communication books.

The ward manager on Ainderby Ward told us they had received two complaints in the last six months. Staff said they tried to address any concerns from patients and relatives immediately before they escalated into complaints.

Wards displayed patient information leaflets for the patient advice and liaison service (PALS).

Summary of complaints

From October 2017 to September 2018 there were 130 complaints about medical care of which nine related to medical wards at Friarage Hospital. The trust took an average of 35 days to investigate and close complaints, this was in line with their complaints policy, which states complaints should be closed within 40 days.

A breakdown of complaint subject with five or more complaints are below:

- Patient Care: 87
- Appointments: nine
- Communications: eight
- End of life care: five

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

Number of compliments made to the trust

From October 2017 to September 2018 there were 31 compliments within medicine.

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

Is the service well-led?

Leadership

Medical care services were managed across care centres. Each centre had a management structure in place with clear lines of responsibility and accountability. The services within each centre were managed by an overall senior leadership team which included a clinical director, associate chief nurse, service manager and assistant director of operations. Each ward had a ward manager supported by clinical sisters and a clinical matron with overall management responsibility.

Ward managers said they were supported well by their clinical matron and the senior management team. Ward managers told us they saw their matron daily and that the assistant director of nursing

regularly visited the wards. They did not often see the chief executive and the executive team at the Friarage Hospital site.

Medical staff said the management team were supportive and accessible. Junior doctors praised the support and encouragement they received from the consultants.

During this inspection we saw matrons regularly on wards and were told some matrons had undertaken clinical duties to cover staff shortages.

Foundation Year 1 doctors participated in a 12-month foundation leadership and management programme leading to an accredited leadership qualification. A pre-registrar development programme to support aspiring consultants and registrars is to be delivered in 2019, along with a matron development programme.

The trust provided a programme of in-house workshops and masterclasses in leadership and management skills and resilience, designed and delivered by the learning and organisational development team.

Vision and strategy

The trust's organisational strategy had been developed to meet the following priorities:

- Increase patient focus to ensure clinical effectiveness and excellence in both patient outcome and patient experience.

- Increase market focus building strategic partnerships to meet commissioning requirements and ensure long term financial sustainability.

- Increase operational focus to improve capacity and throughput, reduce waste and increase margin to invest in growth.

- Increase the capability of leadership and management teams and develop a high performance culture underpinned by ownership and accountability.

In order to achieve these priorities, the trust had developed a "Target Operating Model 2015 – 2020" which was launched in September 2015 which was delivered through the trust's clinical centres which comprised of:

- Community Centre

- Urgent and Emergency Care Centre

- Specialist and Planned Centre

- Corporate and Clinical Services Centre

Medical care services cut across these centres and each centre had their own statement of strategic intent. The main target for medical care was "To defend specialist and planned care business by becoming the highest quality, lowest cost provider in the market place whilst at the same time remaining focussed on growth in areas and markets of choice".

The trust had re-designed medical services over the past three years. This included the re-configuration of inpatient bed bases, re-designing pathways and moving specialty teams in or out of hospital sites. The trust managed medical patients differently at an inpatient level, focussing on identifying and addressing their needs across the community to better support and prevent admission and when patients did present they presented because of their acute medical need.

Staff we spoke on the ambulatory care unit were aware of the trust strategy and vision.

Culture

Staff we spoke with during the inspection told us there was good teamwork and morale was generally high. They told us their colleagues were friendly and had a 'can do' attitude. Staff told us they always tried to be kind to each other and patient focussed.

We found staff to be highly motivated and focussed on patient care and service development. We saw that staff spoke with each other and patients in a respectful way.

We interviewed a number of staff on an individual basis and held focus group discussions before the inspection. Staff spoke positively about the service they provided for patients with high quality care being a priority. All staff interviewed were clear about their roles and responsibilities, patient-focused, and said they worked well together.

Staff felt able to raise concerns and said they did not feel there was a blame culture. Staff were aware of the freedom to speak up guardian and told us they would raise concerns if they needed to but would be happy to do this with their line manager in the first instance. Medical staff at all levels felt that they could approach their medical director if they had any issues or concerns.

Governance

The medical care service had a clear governance structure for acute and planned care. Governance structures were in place that provided oversight of performance against key performance targets and patient safety measures.

The division was split into four centres; corporate and clinical, community care, planned and specialist care and urgent and emergency care. Each care centre held directorate meetings which fed into both the monthly centre governance board meeting and the monthly centre board performance meeting. Once a month, wall meetings were held for; quality and patient safety, referral to treatment waiting lists, pay/non-pay, human resources, patient flow, delayed transfer of care and performance. Senior staff were encouraged to attend these meetings relevant to individual centres where performance, activity and productivity was discussed, reviewed, challenged and planned.

Wards managers told us they attend the monthly directorate governance meeting at the Friarage Hospital and they discussed falls, incidents, complaints and risk. They also attended a monthly senior nurse meeting held at James Cook Hospital.

We saw that each ward had a quality performance dashboard which displayed audit results, patient feedback, learning from incidents, safety alerts, medicine alerts, ward metrics and other performance measures. These were displayed in staff areas and ward managers told us they reflected areas for improvement and actions needed. The ward metrics were discussed at team meetings and were updated when improvements were made or other areas were highlighted for focus. Each action had a timescale for completion with a responsible person identified to lead.

Each ward held monthly team meetings to share and discuss information with staff. We reviewed the minutes of the team meeting on the clinical decisions unit for December 2018 and noted that safety performance, complaints and incidents were discussed. Minutes were made available to staff who were not able to attend.

Management of risk, issues and performance

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

The senior management team had a clear and comprehensive understanding of the current risks, challenges and pressures impacting on service delivery and patient care. The team were aware of the main risks affecting service delivery and could explain the actions they had taken to mitigate these.

Senior managers for medical care services told us their main risks included recruitment of additional medical workforce and therapists. Mitigating actions were in place including an active recruitment and retention plan and a clear escalation process.

Ward managers could articulate their greatest risks and were clear on how to escalate risks through the incident reporting system and to the matron.

We reviewed the medicine centre risk register, which showed when each risk had been identified and when they were next to be reviewed. It was evident that risks were reviewed regularly and risk ratings were reflective of the mitigations taken.

The trust had contingency plans /policies which contained details about how the trust would respond to an incident or event, which could disrupt services and contained details of the key individuals to support staff.

In addition, there was also a trust major incident plan. This was in date and contained appropriate guidance, contacts and level of escalation based on risk.

Information management

The Accessible Information Standard (AIS) was introduced in 2016 to ensure that people with a disability or sensory loss were given information in a way they can understand. The patient pathway records enabled staff to ask patients if they had any information or communication needs. These were clearly recorded and highlighted in the record and covered disabilities, impairment or sensory loss. We saw contact methods, formats (audio, braille, easy read or large print) and support needed (e.g. interpreter, lip-read, hearing aid) were recorded.

We saw that all patient observations and information was recorded on paper and electronic formats. This gave immediate access to risk assessments, test results and treatment of all patients.

Staff told us the intranet was easy to navigate and they could find training information and access e-learning. Ward managers had access to electronic staff records so they could view appraisal, sickness and training rates.

Information governance training rates for nursing staff were monitored at centre leadership level and compliance was 93.5% for staff within the medical care services in September 2018.

Engagement

The service measured and monitored staff and patient engagement through national and local satisfaction surveys, patient experience information panels and patient stories. Feedback from comments, concerns, compliments and complaints from individual service users and members of the public were used to shape services.

People using the service were encouraged to give their opinion on the quality of service they received. Medical care services carried out '1000 voices' surveys to gather feedback on services from patients. Individual wards displayed their scores on notice boards. For the month of December 2018, we saw that Romanby Ward scored 9.81 out of 10, the clinical decisions unit scored 9.82 out of 10 and Ainderby Ward scored 8.97 out of 10.

A patient liaison group had been consulted on the design of the newly opened Sir Robert Ogden Macmillan Centre. Staff told us they had also been involved in the planning and design of the Centre.

Staff we spoke with told us they felt involved in development of services and this promoted good team working. Staff felt listened to. To improve communication, staff on Ainderby Ward were setting up communication folder and a closed social media page to share information.

Leaflets about the friends and family test, and the patient advice and liaison service (PALS) were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes. We saw thank you cards and letters displayed at the entrances to wards.

Matrons and ward managers were visible on the ward, which provided patients with the opportunity to express their views and opinions.

Learning, continuous improvement and innovation

Staff were rewarded for good practice and innovation by the trust at their annual award evening.

The service had been shortlisted for a Health Service Journal award for the redesign of the patient pathway through the emergency department, the clinical decisions unit and the ambulatory care unit (ACU). The ACU had combined pathways for surgical and medical admissions and could demonstrate that the redesign had reduced the number of admissions into the hospital.

Sir Robert Ogden Macmillan Centre opened in December 2018 and provided state of the art cancer care and support facilities. The centre provided a non-clinical, relaxed and supportive environment for patients and was designed and built upon lessons learnt from similar builds. The centre would enable the expansion of local cancer services. Staff we spoke with were extremely proud of the new facility and services they offered to patients.

The trust had signed up to the 'Treat as One' Strategy 2018-2021. The strategy focused on six key areas of service delivery with the aim of ensuring that patients with potential or pre-existing mental health disorders had their holistic needs appropriately assessed and treated by appropriately skilled staff. The trust's Treat as One Group had already started to pilot a simple screening programme aimed at known vulnerable groups who were more susceptible to developing anxiety and depressive disorders. Screening initially targeted patients with long term conditions, patients with persisting physical symptoms (where no known cause could be identified) and patients with life-changing diseases or injuries. Compulsory mental health training had been introduced.

Surgery

Facts and data about this service

Friarage Hospital has five in patient theatres plus one unit for day case theatre and a minor ops room with dedicated recovery bays within the two areas. The trust covers the following specialities across the two sites:

- Ear nose and throat (ENT)

- General surgery

- Ophthalmology (eyes)

- Oral and maxillofacial surgery

- Orthodontics

- Plastics and burns

- Urology

- Vascular surgery

(Source: Routine Provider Information Request (RPIR) – Sites tab/ https://www.southtees.nhs.uk/services/anaesthetics-and-theatre/theatres/*)*

The trust had 48,148 surgical admissions from July 2017 to June 2018. Emergency admissions accounted for 11,450 (23.8 %), 26,147 (54.3 %) were day case, and the remaining 10,551 (21.9%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory Training

Mandatory training completion rates

The trust set a target of 90.0% for completion of mandatory training.

At trust level in in surgery the 90.0% target was met for three of the five mandatory training modules for which qualified nursing staff were eligible. At Friarage hospital surgery departments the 90.0% target was met for all five mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for qualified nursing staff in the surgery department at Friarage hospital is shown for year to date (YTD) below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Equality and diversity	79	80	98.8%	90.0%	Yes
Health and safety (slips, trips and falls)	79	80	98.8%	90.0%	Yes
Fire safety 3 years	78	80	97.5%	90.0%	Yes

Information governance	78	80	97.5%	90.0%	Yes
Infection prevention (Level 1)	78	80	97.5%	90.0%	Yes

In surgery the 90.0% target was met for none of the five mandatory training modules for which medical staff were eligible. At Friarage hospital surgery department the 90.0% target was met for none of the five mandatory training modules for which medical staff were eligible. We were advised that training was delivered on a rolling basis. It was unclear how the department knew that they were on track to achieve training completion rates with no overall target date.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for medical staff in the surgery department at Friarage hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust target	Met (Yes/No)
Fire safety 3 years	13	19	68.4%	90.0%	No
Infection prevention (Level 1)	13	19	68.4%	90.0%	No
Health and safety (slips, trips and falls)	13	19	68.4%	90.0%	No
Equality and diversity	12	19	63.2%	90.0%	No
Information governance	11	19	57.9%	90.0%	No

Training compliance data was collected on a monthly rolling basis and we were assured that all surgery departments were on trajectory to meet trust training targets for compliance for the year ahead. Managers ensured staff attend their training; for example, on Allerton ward, we saw training highlighted as 'topic of the week' to increase staff focus on completion.

Managers we spoke with explained that staff take responsibility for booking their own training sessions and managers had over-sight of this. One staff member said they received reminders when training was due.

Mandatory training courses were predominantly delivered through e-learning. However, there was some face to face training hosted on site or at James Cook hospital, for practical skills, such as moving and handling.

Training information received from the trust did not include the percentage of staff who had completed sepsis training. Managers we spoke with told us there were named sepsis link-nurses in place for night and day teams and they delivered training on a cascading basis. Staff explained this was a relatively new system and not yet fully embedded.

Safeguarding

We saw the trust had an up to date safeguarding policy accessible on the trust's intranet. The trust had systems and processes in place to protect patients from abuse.

The trust had named lead nurses for adult and children safeguarding and staff said the trust safeguarding team was accessible and supportive when they needed advice about safeguarding concerns; they saw safeguarding as everyone's responsibility.

The Friarage completion rate target for safeguarding adults and children level 1 and level 2 was met by registered nursing staff. This met the Safeguarding Intercollegiate Guidance 2016

requirements. However, the medical staff completion rates were slightly below the trust target.

Staff spoken with advised that they would escalate any concerns to their ward manager, who would inform matron prior to advising the local authority.

When we asked staff in theatre and wards about safeguarding procedures, they described specific circumstances when they had made safeguarding referrals with help from managers and matron. Staff ensured us that they checked with their matron if they were unsure or were concerned about a patient.

One staff member in theatre described how they completed a reflective practice piece of work to demonstrate their own learning about a safeguarding issue and the outcome of the safeguarding referral was discussed with the whole team to ensure learning was shared.

Safeguarding training completion rates

The trust set a target of 90.0% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 at trust level for qualified nursing staff in surgery is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust target	Met (Yes/No)
Safeguarding children (Level 3 additional)	11	11	100.0%	90.0%	Yes
Safeguarding children (Level 3)	11	11	100.0%	90.0%	Yes
Safeguarding vulnerable adults	531	556	95.5%	90.0%	Yes
Safeguarding children (Level 2)	496	545	91.0%	90.0%	Yes

In surgery the 90.0% target was met for all of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 at trust level for medical staff in surgery is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust target	Met (Yes/No)
Safeguarding children (Level 3)	14	14	100.0%	90.0%	Yes
Safeguarding children (Level 3 additional)	14	14	100.0%	90.0%	Yes
Safeguarding children (Level 2)	173	216	80.1%	90.0%	No
Safeguarding vulnerable adults	183	230	79.6%	90.0%	No

In surgery the 90.0% target was met for two of the four safeguarding training modules for which

medical staff were eligible. We were advised that training was delivered on a rolling basis. It was unclear how the department knew that they were on track to achieve training completion rates with no overall target date.

Friarage Hospital surgery department

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for qualified nursing staff in the surgery department at Friarage hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust target	Met (Yes/No)
Safeguarding vulnerable adults	79	80	98.8%	90.0%	Yes
Safeguarding children (Level 2)	78	80	97.5%	90.0%	Yes

At Friarage hospital surgery department the 90.0% target was met for both of the two safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for medical staff in the surgery department at Friarage hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding children (Level 2)	14	19	73.7%	90.0%	No
Safeguarding vulnerable adults	13	19	68.4%	90.0%	No

At Friarage Hospital surgery department the 90.0% target was met for none of the two safeguarding training modules for which medical staff were eligible.

Cleanliness, infection control and hygiene

The Friarage hospital followed the trust infection prevention and control (IPC) policies and procedures available on the intranet. These were underpinned by national guidelines, to manage and monitor infection, essential for patient and staff safety.

Domestic staff we spoke with were aware of infection prevention and control procedures, for example, they used colour coded waste bags, mop heads and aprons. They had good awareness of how to manage control of substances hazardous to health for example, cleaning products were stored safely in a dedicated room with a key pad lock. Products on the domestic's trolley were all in original packaging and not decanted.

. On the wards we observed domestic staff actively cleaning the ward and main areas. We spoke with domestic staff who were aware of policies and processes for cleaning individual ward environments. Flushing of taps to reduce the risk of Legionella was included in their cleaning schedule.

All clinical, reception and waiting areas we inspected were visibly clean and all clinical and non-clinical areas had cleaning schedules and records. However, in the surgical assessment unit, the cleaning records were recorded on a laminated card, which was wiped at the end of each week.

This meant staff were unable to provide historic evidence that areas were always cleaned consistently.

Patient chairs on wards and theatre were upholstered with wipe-clean coverings.

We inspected reusable equipment, for example commodes, syringe drivers, diathermy machines, anaesthetic equipment, electronic observation monitoring machines and resuscitation equipment trolleys. Most clinical equipment we inspected on the wards which had been cleaned was identified with 'I am clean' stickers. The exceptions were some of the reusable medical devices on Allerton ward.

Alcohol hand gel was available in wall mounted dispensers at entrances and exits and at point of care on wards and in theatres. The wards and surgical assessment centre displayed clear instructions and signage to encourage staff and visitors to wash their hands and use alcohol hand gel when entering and leaving the department.

On the wards and throughout the departments we visited, there were sufficient clinical wash hand basins with elbow taps and adequate supplies of liquid soap and paper towels.

We observed staff carrying out hand washing prior to and after patient contact. However, over a few minutes observation on one ward, we observed a registered nurse enter and exit the ward without washing their hands. Staff adhered to the "bare below the elbow" policy.

Staff told us that they had sufficient access to personal protective equipment (PPE), and we saw dispensers for non-latex disposable gloves in a variety of sizes and plastic aprons in the clinical areas. Staff used PPE appropriately.

Rooms were available on all wards for nursing patients in isolation, in accordance with universal precautions. We observed signage in place to advise anyone before entering an isolation room.

All clean utility areas and treatment rooms were visibly clean and tidy. Dirty utility rooms contained products for cleaning reusable equipment. We observed clinical waste and sharps were disposed of correctly.

Linen was stored appropriately on shelving in linen rooms and decanted onto linen trolleys when required on the wards.

Theatres with laminar flow were used for trauma and orthopaedic cases. (Laminar airflow is used to separate volumes of air or prevent airborne contaminants from entering an area). Managers told us the laminar air flow system was old and did not conform to current inspection standards. Theatre refurbishment was on the risk register.

We found waste was managed appropriately in all areas. For example, waste bins contained colour coded sacks in accordance with waste streams and those we checked contained the correct type of waste.

Environment and equipment

Wards and departments, we visited were quiet and calm and there was a sense of order and control.

All routes for fire escapes were clear and there was clear signage indicating escape routes.

The fabric of the clinical areas we inspected was generally in good order. The exception was in older areas of the estate, for example, we saw cracks in the flooring outside theatre three and

wooden bumper bars on theatre three/recovery corridor with some exposed wood. We saw theatre refurbishment was on the risk register.

Clean and dirty utility rooms were tidy.

Storage rooms were mostly well organised and tidy. The exception was in theatre where we found boxes of consumables stacked on the floor due to lack of shelf space.

There was a formalin fume cabinet in a main storage area in theatre, which did not have window ventilation. Formalin containers were dated and there was an appropriate spillage kit. We saw an up to date environmental risk assessment for the use and storage of formalin.

There was a daily check list in place for stores on Allerton ward but the record had been signed on 11th January only; there gaps in the record 7th to 10th January and 12th -13th January.

There were foot-operated waste bins lined with colour-coded sacks and those we inspected contained appropriate waste. Sharps disposal bins in all areas we visited were assembled and labelled correctly, not over-filled and stored off the floor.

Most portable electronic equipment inspected had been safety tested within a reasonable timescale. For example, we looked at endoscopy stacks, microscopes, intravenous fluid pumps, and monitors. The exception was one electronic observation monitoring machine on the surgical assessment unit, which did not have a sticker on it. The trust had systems in place for recording the service and maintenance of other equipment, such as hoists and weigh scales, identified through compliance stickers.

Staff we spoke with confirmed there was adequate equipment to meet the needs of patients, for example, moving and handling equipment and equipment for bariatric patients. Recovery room bays all had capnography monitors.

Patient bed-bays were single sex. All patients had designated bed space, which included a personal locker, bed-table and a call bell. All patients had access to gender-specific toileting and bathing facilities.

We checked the emergency resuscitation equipment trolleys in all the areas we visited. These were clean and contained appropriate items, which were in accordance with Resuscitation Council (UK) guidelines.

We saw each resuscitation equipment trolley had a checking log attached to it for staff to complete when they had undertaken daily and weekly checks, in accordance with trust policy. Most checks were completed consistently Monday to Friday. The exceptions were gaps in the records, which corresponded mostly with weekends and the records did not always state when the department or ward was closed.

None of the trolleys were fitted with a tamper-proof security. This meant there was a risk that equipment or emergency drugs could be removed between checks and would not be available when needed.

The emergency resuscitation trolley located in the surgical assessment centre was shared with the endoscopy unit. A risk assessment was undertaken and demonstrated that its location with the Resuscitation Council UK guidelines of three minutes from collapse to shock, was achievable.

However, staff we spoke with explained in the event the trolley was required in both locations at the same time, the contingency was to use the trolley from theatre. Staff we spoke with were unsure whether this scenario had been risk assessed and were not aware of any practical scenario exercises to test how this would work in practice.

Assessing and responding to patient risk

There was a dedicated surgical assessment unit, operational Monday to Friday from 7.30am to 6pm. The department conducted pre-assessment clinics and accommodated surgical day case patients in reclining chairs, located in single-sex bays. These were used for patients undergoing local anaesthetic procedures and some general anaesthetic cases.

Those patients that required a bed post operatively were transferred to the post-operative surgical day unit (POSDU), where overnight stays could be accommodated if required. POSDU operated Monday 10.30am to Saturday 12.30pm.

Patients were pre-assessed for surgery in accordance with pre-assessment pathways. Most surgical patients were pre-assessed two to three weeks prior to admission, either face to face or by telephone, depending on individual risk assessment. Patients for major orthopaedic surgery were pre-assessed in the out-patient department. Patients were also assessed for delirium and dementia in line with national guidance.

We observed that patients had access to a consultant anaesthetist review for general anaesthetic cases, to determine ASA grade. ASA is the American Society of Anaesthesiologists physical status classification system, for assessing the fitness of patients before surgery.

We reviewed written clinical risk assessments in four sets of records and found they were completed appropriately. These included pressure damage acquisition, malnutrition, falls, moving and handling and infection risk. Where staff had identified patients at high-risk, they had referred them to further services such as specialist nursing teams or dieticians to provide additional support, equipment or assistance.

Safety huddles were held daily at 7.30am on the surgical assessment unit. These were used to allocate patients to named staff and communicate important information about patient care. For example, latex allergy, MRSA status and falls risks.

We observed a safety huddle during the afternoon on Allerton ward. This was attended by health care assistants, nurses, student nurses, ward sister and a pharmacist. The staff discussed clinical investigations patients were waiting for, discharge plans, pain relief, outstanding referrals, dietary needs requiring dietitian review and involvement of family in discharge plans.

There were formal handovers between nursing staff at each shift. For example, on Allerton ward, handover occurred at 7.15am, 10am, 3pm and 7.15pm

There was a comprehensive protocol in place in theatre for in the event of massive blood-loss. There was no cell-saving equipment at Friarage hospital so patients who declined blood transfusion due to personal or religious beliefs were admitted to James Cook hospital.

We observed two surgical cases in theatres and saw good compliance with completion of World Health Organisation (WHO) safer surgery checks. Patient safety briefings were carried out pre-operatively, which included introductions from the clinical team, the order of the list, ASA grade, venous thromboembolism risk (VTE), sedation type and drug of choice and additional equipment anticipated. The team brief check was robust and included sign in, time out and sign out. Patient name, date of birth, surgical site, allergies and skin marking were all checked pre- operatively.

We reviewed four sets of completed checklists in patient records and saw that these were completed appropriately at the time of surgery.

Staff used a national early warning score (NEWS 2) to assess the health and wellbeing of patients. These assessment tools enabled staff to identify if the clinical condition of a patient was deteriorating and required early intervention and or escalation to keep the patient safe.

Nursing staff we spoke with could describe signs and symptoms of a deteriorating patient and gave examples of when they would escalate a concern. We were assured nursing staff escalated any concerns to medical staff promptly.

The trust sepsis and early warning score policy and pathway was in date and version controlled. Staff we spoke with said they had received sepsis training, could articulate the signs of sepsis and were aware of actions required for escalation and treatment.

There was a named resuscitation officer and staff we spoke with told us they had participated in two emergency scenarios in the previous two months. The most up to date resuscitation algorithms were attached to the emergency resuscitation equipment trolleys.

Nurse staffing

The trust reported their qualified nursing staff numbers in surgery in terms of whole time equivalents (WTEs), as below, as of September 2018. The WTE for each person was based on their hours worked as a proportion of the contracted hours normally worked by a full-time employee in the post.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage hospital	101.2	95.5	94.3%
Trust level	600.7	535.9	89.2%

(Source: Routine Provider Information Request (RPIR) –Total staff tab)

Managers used a recognised, safer-care acuity tool to identify staffing needs. Matron monitored staffing levels three times each day and we attended a morning bed management meeting to observed how this information was fed back centrally.

Managers and staff, we spoke with said they felt staffing levels were safe. Planned and actual staffing levels were displayed prominently in clinical areas. On the day of inspection, planned and actual staffing levels matched on Allerton ward but there was one trained nurse less than planned on the early shift on surgical day unit. However, there were only three patients on the unit at time of inspection.

We inspected duty rotas for the previous two- month period in theatres and found the department was suitably and sufficiently staffed with appropriate skill mix. We saw a robust system in place which ensured staff had their meal breaks. Rotas were planned a week in advance for each day and the rota identified staff on call. Those that had been called in were given the following day off.

Vacancy rates
From October 2017 to September 2018, the trust reported a vacancy rate of 9.8% in surgery;
- The James Cook university hospital: 10.9%
- Friarage hospital: 3.4%

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

Turnover rates
From October 2017 to September 2018, the trust reported a turnover rate of 8.0% in surgery, this was in line with the trusts 10% target.

- Friarage hospital: 2.9%
- The James Cook university hospital: 8.8%

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

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 5.6% in surgery, this is not in line with the trust target of 3.5%;

- Friarage Hospital: 4.7%
- The James Cook University Hospital: 5.8%

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

Bank and agency staff usage

From October 2017 to September 2018, the trust reported a bank usage rate of 554.2% an unfilled rate of 17.8% and no agency usage in surgery. The trust use bank staff for extra activities, for example to sit with patients at risk. This is has led to a large bank staff usage rate.

All nursing staff

Site	Bank rate	Agency rate	Unfilled rate
Friarage hospital	192.9%	N/A	44.5%

Qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
Friarage hospital	57.6%	N/A	23.4%
Trust level	284.9%	N/A	28.8%

Non-qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
Friarage hospital	438.7%	N/A	82.8%
Trust level	920.4%	N/A	2.9%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Nursing establishment reviews were completed following National Institute of Clinical Excellence (NICE) guidance, National Quality Board (NQB) guidelines, the use of safe care data and professional judgement.

Acuity and dependency data was collected daily through the safe care national tool (SCNT). The system was used to inform daily huddles. These were conducted to risk assess the daily staffing levels and safely redeploy staff where shortfalls and or patient acuity was high.

We found that bank staff were used in areas where staffing levels fell short. The daily staffing huddle reviewed the use of temporary staffing to ensure the ratio of substantive staffing level to temporary staff was balanced and safe. Patient acuity was also considered when redeploying staffing.

Staff we spoke with told us they felt there was adequate staffing. Rotas were compiled using an electronic e-roster system.

Medical staffing

There was an on-call system in place for consultant cover; for general surgery there was a consultant on site from 8am to 6pm and then on call. For orthopaedics and trauma, there was a

consultant on site 8am to 8pm and then on call.

Theatre rotas identified surgeons and anaesthetists on duty and on-call.

Staff and doctors raised their concerns to us that covering the anaesthetic rota was difficult in recent months and there was heavy reliance on locum staff due to unfilled vacancies. We spoke with a locum anaesthetist at inspection and were assured they were familiar with the facilities at the Friarage hospital, as they had been working there regularly in the last year.

Nursing staff we spoke with on the wards said they had good working relationships with their medical colleagues and that doctors responded promptly when they were called.

Doctors we spoke with told us they felt well supported by their colleagues and described a culture of mutual respect between surgeons.

The trust has reported their staffing numbers below as of September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage hospital	40.57	37.08	91.4%
Trust level	228.3	220.6	96.6%

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy rate of 5.7% in surgery.

- The James Cook university hospital: 6.3%
- Friarage hospital: 4.3%

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

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 19.3% in surgery, this was not in line with the trusts 10% target.

- Friarage hospital: 10.7%
- The James Cook university hospital: 19.7%

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

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 0.7% in surgery, this is in line with the trusts 3.5% target.

- Friarage hospital: 0.0%
- The James Cook university hospital: 0.8%

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

Bank and locum staff usage

From October 2017 to September 2018, the trust reported a bank usage of 2.5% and locum usage rate of 1.1% in surgery.

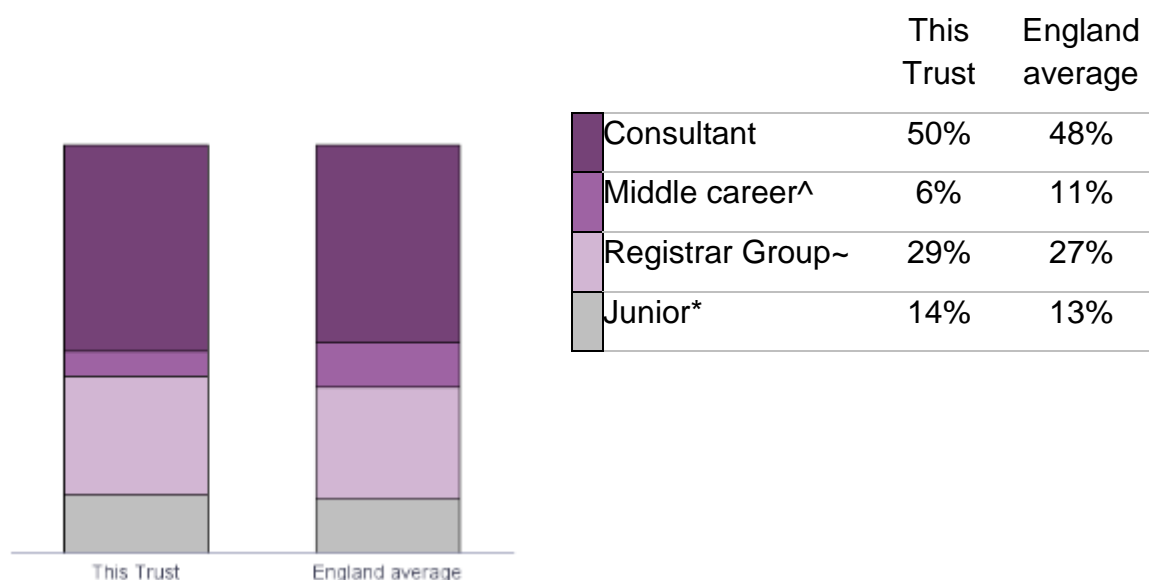- Friarage hospital: bank 6.1%, locum 4.0%

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

From July 2018 to July 2018, the proportion of consultant staff reported to be working at the trust was slightly higher than the England average and the proportion of junior (foundation year 1-2) staff was slightly higher.

Staffing skill mix for the whole time equivalent staff working at South Tees hospitals NHS

foundation trust

	This Trust	England average
Consultant	50%	48%
Middle career^	6%	11%
Registrar Group~	29%	27%
Junior*	14%	13%

^ 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

Nursing and medical records were primarily on paper. Paper records were available for each patient that attended the wards, surgical assessment unit and theatres. Nursing staff used hand-held electronic 'vital pack' devices to record patient observations.

Electronic point of care testing equipment for monitoring blood glucose, was available on the pre-assessment unit and the test fluids for calibrating the machine were dated when opened.

Electronic Patient Status at a Glance Board (e-PSAG) boards were used on the wards we visited. These provided up to date bed occupancy data and key information about patient risks and treatment. The information included flags to identify those living with dementia, patient acuity and discharge plans. The boards ensured that staff also had easy access to clinical information, such as reviews by other members of the multi-disciplinary team and clinical observations.

We saw an up to date standard operating procedure for e-PSAG board use. The procedure stated 'explicit consent to use a patient's data on a large electronic screen is to be sought and documented in the patient's notes. Where a patient lacks capacity to consent, the nurse must take a decision, in the best interests of the patient, around the use of this information. This must also be documented within the patient's notes'. We reviewed four sets of records during the inspection and did not see documented evidence that patient consent had been obtained to display their information on the board.

In the records we inspected, nursing, allied healthcare professionals and medical staff used black ink, had legible handwriting and documentation occurred at the time of review or administration of treatment. We checked care plans and risk assessments in detail. The majority of these were completed accurately and updated regularly and included NEWS 2 assessments, nutrition, fluid balance and hydration charts.

We observed non-compliance with General Data Protection Regulation legislation, which was introduced in 2018. For example, patient records on the surgical assessment and post- operative day unit were stored at the nurses' hubs in open trolleys, which were not lockable. This meant

there was a risk notes could be accessed by unauthorised persons when unattended. We were assured by a manager that two new lockable trolleys had been ordered and the pre-assessment unit was locked when it closed each evening.

Records on Allerton ward were kept opposite the nurses' hub in a lockable cabinet. This was unlocked but always in line of sight and in frequent use.

Medicines

There was an up to date medicines management policy on the intranet, which all staff could access.

We observed largely good management of medicines in all the areas we inspected. The exception was medicine fridge temperature recording. Although they were monitored daily, actions taken when fridges were out of safe temperature range were not always recorded. We observed the maximum temperature was recorded as 11.9 degrees Celsius on fifteen occasions in December 2018 on the Allerton ward.

Controlled drugs were stored securely in wall mounted metal cabinets. Fields in the controlled drug (CD) registers were completed well; all drugs administered were signed for and wastage was recorded. Compliance with completion of the CD registers was checked by a pharmacist who also completed weekly stock checks.

There were colour coded burn-bins available to dispose of waste medicines.

Medication trolleys were locked and stored securely when not in use.

In theatre anaesthetic rooms, we observed drugs drawn up in advance of patients arriving but they were only for that case and syringes were all labelled.

We found that patients had been prescribed appropriate prophylaxis (treatment given or action taken to prevent blood clots) for venous thromboembolism (blood clots) where this was indicated.

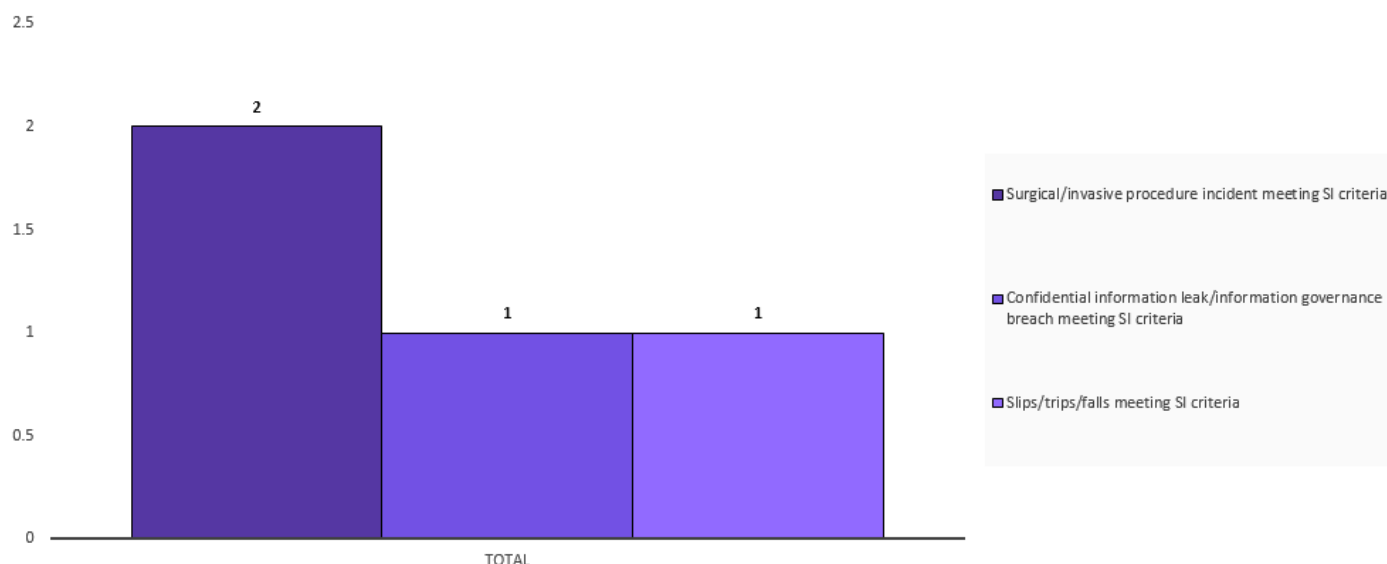## Incidents

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 October 2017 to September 2018, the trust reported two incidents classified as never events for surgery, both of which were due to a surgical/ invasive procedure.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) two of which were due to a Surgical/ invasive procedure, one due to an information leak/ information governance breach, one due to slips/ trips/ falls, in surgery which met the reporting criteria set by NHS England from October 2017 to September 2018.

Site specific information can be found below:

- The James Cook university hospital: three

- Friarage hospital: one

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with said they felt there was a good incident reporting culture. They were clear about how to report incidents on the electronic incident reporting system and said matron visited the wards to gather further information if required. They told us they received feedback about outcomes of incident investigations at team meetings, team huddles and via bulletins. We saw a recently published bulletin displayed on the model- ward boards in all the areas we visited. (Model-ward boards were where quality and safety information was displayed for staff). This described a surgery never event and lessons learned and all staff we spoke with were aware of the incident.

We were told by managers that team meetings occurred at least two-monthly and were planned to coincide with anaesthetic audit days, when there were fewer operating lists. Themes discussed at meetings included operational statistics, complaints, compliments and changes to practice. An example of how practice had changed was the introduction of intentional rounding charts and these had resulted in lower instances of pressure ulcers.

A staff member described a huddle meeting they had attended where increased patient falls were highlighted and an action plan to address this was discussed and agreed. For example, the patient was moved so they were nearer the nurses' hub for increased supervision.

We saw some minutes of team meetings in the surgical assessment unit dated January and May 2018 but staff there and on Allerton ward, were unable to locate any formal minutes of recent ward meetings.

Managers confirmed that although incidents were discussed in staff huddles, these were not documented.

Staff meeting minutes in theatre were displayed on a 'keeping you informed' board.

There was a system in place to cascade safety alerts and these were displayed on the model-ward boards for staff to access. We were told by managers these notices were also discussed in team meetings. One staff member we spoke with described a recent alert they had seen, about insulin syringes.

Regulation 20, duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients and other 'relevant persons' of certain 'notifiable safety incidents' and provide reasonable support, truthful information and a written apology.

Staff we spoke with were aware of the duty of candour and provided us with examples of when they would use this.
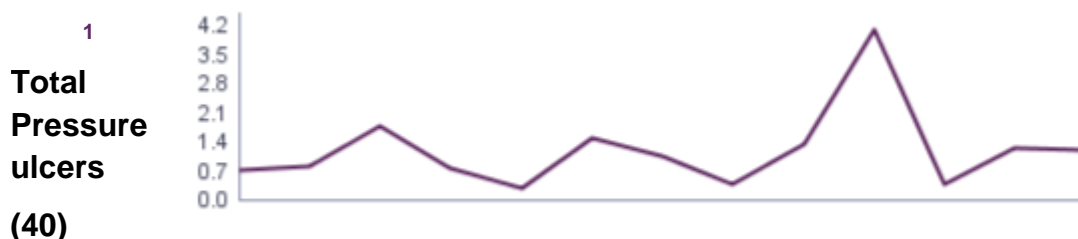
Safety Thermometer

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 40 new pressure ulcers, five falls with harm and 10 new catheter urinary tract infections from September 2017 to September 2018 for surgery.

The graphs below refer to the reporting period September 2017 to September 2018.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at South Tees Hospitals NHS Foundation Trust

1

Total Pressure ulcers

(40)

2

Total Falls

(5)

3

Total CUTIs (10)

Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18

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)

All areas we visited displayed their monthly safety thermometer audit data on the model-ward boards, including pressure ulcer rates and number of days elapsed since last reported pressure ulcers, falls and catheter urinary tract infections.

Is the service effective?

Evidence-based care and treatment

Staff referred to several National Institute for Health and Care Excellence (NICE) guidelines and quality standards, and Royal College best practice guidelines in support of their provision of care and treatment. For example, in theatre, we saw there was a direct link on the computer to the NICE website.

Local policies, which were accessible on the ward and on the trust intranet site, reflected up-to-date clinical guidelines. For example, we saw protocols for VTE prophylaxis, pre-operative anti-coagulation and use of antimicrobial medications, which were all referenced to national guidance. Managers we spoke with explained that consultants had their own preferences regarding VTE prophylaxis and that these were evidence based. We were shown a list of consultants' VTE preferences but these were not formalised document -controlled protocols and these listed preferences were not referenced back to the trust VTE policy. Nor were they signed as agreed by the consultants.

The surgery service was actively involved in local and national audit programmes collating evidence to monitor and improve care and treatment. We saw an annual clinical audit report of activity that specified a range of completed, planned, and ongoing evidence-based reviews. We saw the service had implemented guidance for sepsis screening and management. For example, on surgical day unit, the sepsis management pathway was displayed and included a flow chart, national guidance, clinical forms, a sepsis first hour care bundle and indicators of effective treatment.

The Friarage hospital did not have a dedicated emergency operating theatre in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) standards. However, routine operating theatre lists were planned in advance and emergency cases were always carried out after 5.30pm, by the on-call team as identified on the rota.

Nutrition and hydration

Trust policies were in place regarding fasting times and intravenous fluids, in line with best practice. We saw written information available detailing pre-operative fasting instructions for patients admitted on the day of surgery; no food for six hours before admission time and patients could drink clear fluids up to two hours prior to admission.

We found that surgery services had systems and processes in place to effectively support staff to meet the nutrition and hydration needs of patients and visitors.

Staff identified patients at risk of nutritional and dehydration risk or requiring extra assistance at pre- assessment stage. Staff used the Malnutrition Universal Screening Tool (MUST) tool to identify adults who were malnourished or at risk of malnutrition.

We observed patients being offered food and drinks post- procedure and saw patients supported by nursing staff, to eat and drink if assistance was required.

We reviewed care plan documentation and risk assessments of four patients. These included fluid and food charts, which were fully completed.

A snack trolley service was available between meal times which provided patients the option to purchase additional snacks such as chocolate. We saw regular afternoon hot drinks rounds and drinking water jugs being replenished.

Patients we spoke with felt the quality of food was variable; one patient said, "the food is nice and drinking water was always available", but another patient said, "the food isn't great".

Patients did not have protected meal times due to open visiting time arrangements being implemented. Meal times were 8am, 12 noon and 5pm. Staff supported family members to attend and help their relative during meal times. Staff ensured they assisted, when family members required help or support, when helping patients with eating or drinking.

Post- operative patients and those experiencing nausea and vomiting were routinely prescribed antiemetic medication.

Pain relief

Staff had access to a dedicated pain management team and a palliative care team, to support patients with complex pain needs. The pain team attended the wards weekly and as required. The palliative care team was available as required via an on- call system. Nursing staff explained that doctors reviewed patients' analgesia if required out of hours and at weekends.

Patients requiring epidural pain relief were nursed in intensive care but patient controlled analgesia systems were used on the wards when required.

All patients we spoke with who identified they had experienced pain, said that this had been managed well during their stay and nursing staff had responded promptly when pain relief had been requested.

On the wards we visited we saw pain scores were monitored as part of the NEWS 2 records, using a 0-3 assessment. One nurse we spoke with explained how they used a specialised pain tool to assess patients unable to communicate. The assessment criteria included vocalised sounds, facial expression, raised pulse and blood pressure, changes in behaviour and body movements.
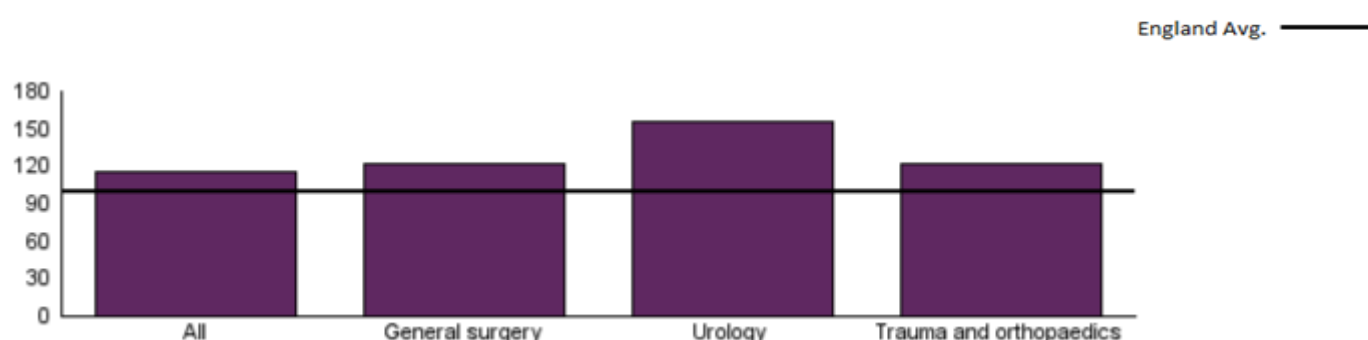
Patient outcomes

Relative risk of readmission

Trust level

From June 2017 to May 2018,

- All patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

- Trauma and orthopaedics patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
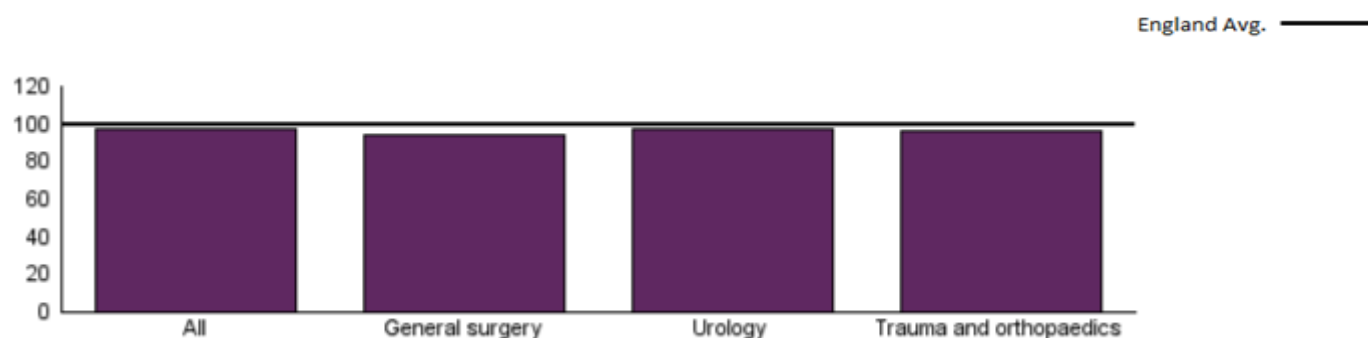
Elective Admissions – Trust Level

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 trust based on count of activity

- All patients at the trust had a slightly lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- Urology patients at the trust had a slightly lower expected risk of readmission for non-elective admissions when compared to the England average.

- Trauma and orthopaedics patients at the trust had a lower expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions – Trust Level

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 trust based on count of activity

(Source: Hospital Episode Statistics - HES - Readmissions (01/06/2017 - 31/05/2018))

Friarage Hospital

From June 2017 to May 2018,

- All patients at Friarage hospital had a lower expected risk of readmission for elective admissions when compared to the England average.

- General surgery patients at Friarage hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

- Trauma and orthopaedics patients at Friarage hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at Friarage hospital had a slightly higher expected risk of readmission for elective admissions when compared to the England average.
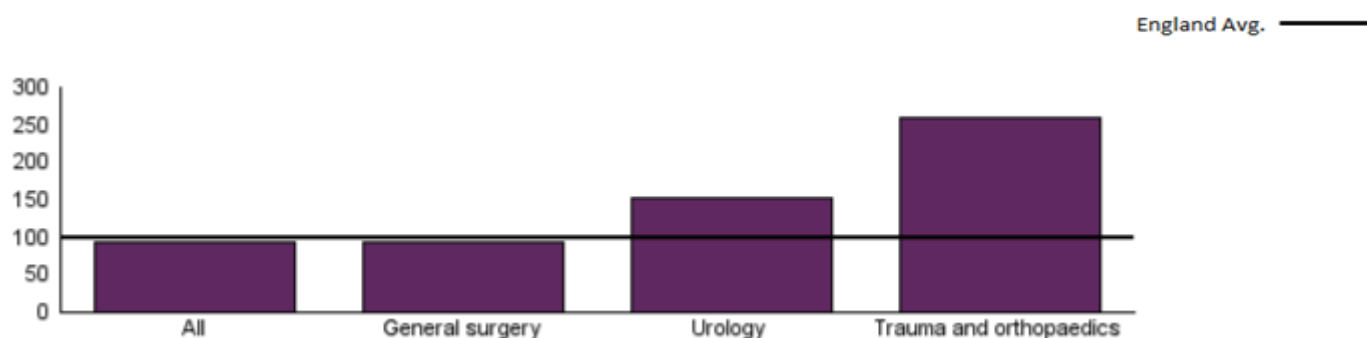
Elective Admissions - *Friarage Hospital*

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 Friarage hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery patients at Friarage hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

- Urology patients at Friarage hospital had a much higher expected risk of readmission for non-elective admissions when compared to the England average.

- Trauma and orthopaedics patients at Friarage Hospital had a much higher expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - *Friarage 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

In accordance with NICE quality standards, the surgery service was involved in data collection activity for numerous national audits such national hip fracture database, bowel cancer audit, national vascular registry, oesophago-gastric cancer national audit and national emergency laparotomy audit.

National Hip Fracture Database

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 6.6% which was within the expected range. The 2016 figure was 7.5%.

The proportion of patients having surgery on the day of or day after admission was 57.8%, which failed to meet the national standard of 85%. This was within the bottom 25% of trusts. The 2016 figure was 70.7%.

The perioperative medical assessment rate was 91.2%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 92.7%.

In 2018 the percentage of patients developing pressure ulcers as recorded on the national database was 98.2% against a national average of 95.5% (putting the trust in the upper middle quartile).

The length of stay was 22.7 days, which falls within the middle 50of trusts. The 2016 figure was 21.6 days.

(Source: National Hip Fracture Database 2017)

Bowel Cancer Audit

In the 2017 Bowel Cancer Audit, 59.5% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than expected. The 2016 figure was 56.4%.

The risk-adjusted 90-day post-operative mortality rate was 3.3% which was within the expected range. The 2016 figure was 3.9%.

The risk-adjusted 2-year post-operative mortality rate was 13.2% which was better than expected. The 2016 figure was 18.2%.

The risk-adjusted 30-day unplanned readmission rate was 11.5% which was within the expected range. The 2016 figure was10.9%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 53.6% which was within the expected. The 2016 figure was 50.9%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.6% for Abdominal Aortic Aneurysms. The 2016 figure was 1.4%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 18 days, this was worse than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 1.1%, this was a within the expected range.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), poor quality data were provided for the age and sex adjusted proportion of patients diagnosed after an emergency admission. This indicates that more than 15% of records had the referral source missing.

The 90-day post-operative mortality rate was 2.3%. This was a positive outlier within the expected range. The 2015 rate was 0.9%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.2%. This was worse than the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit: *Friarage Hospital*

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), the Friarage Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 13 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 10 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 10 cases.

The site was not eligible to be rated for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 5 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 13 cases.
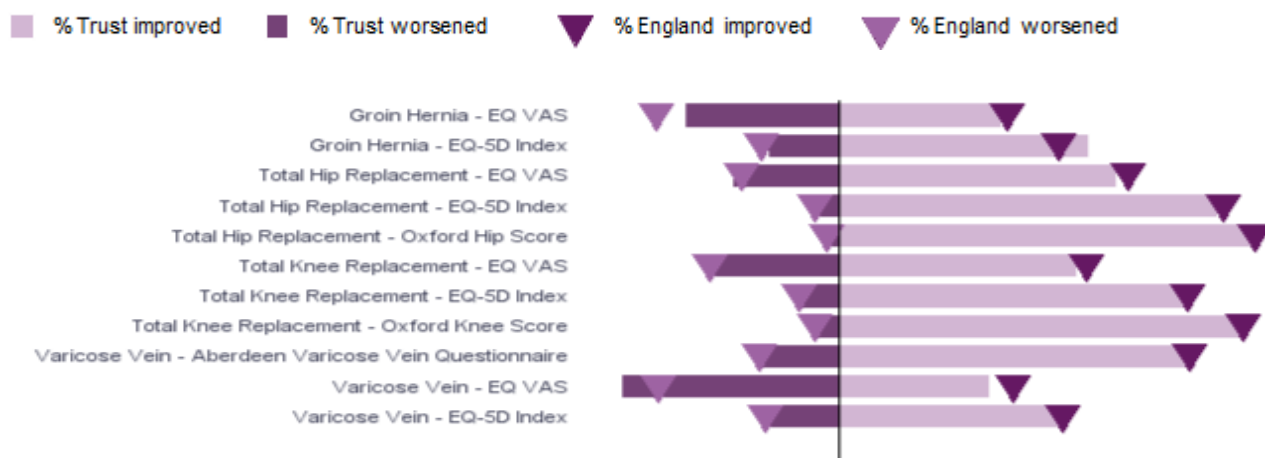

Patient Reported Outcome Measures

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.

In 2016/17 performance on groin hernias was better as the England average. There were less patients reporting they felt worse compared the England average. There were a similar number of patients for EQ-VAS and more patients for EQ-5 index that reported an improvement compared the England average.

For Varicose Veins, performance was about the same as the England average. The results of the Varicose Veins questionnaire and the EQ-5 index were similar to the England average. The EQ-VAS showed that more patient reported they worsened and more patients reported they improved than the England average.

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

For Knee replacements was about the same as the England average.

(Source: NHS Digital)

The trust had a programme of scheduled local audits throughout the year.

We saw patients were assessed for risk of venous thromboembolism (VTE) prior to surgery and the service participated in VTE audits to monitor compliance against policy and best practice. Managers told us they were looking to appoint departmental VTE champions and training had been provided but the role was not implemented yet.

We looked at audit data provided by the trust, for the period July to December 2018, to monitor compliance with NEWS 2 completion and appropriate escalation. We noted there was no data for Allerton ward from August to October 2018 and no data for the months of September and December 2018 for the surgical assessment unit, but the data showed consistently high compliance on Gara ward. At inspection, the records we looked at on Allerton ward had NEWS 2 scores completed correctly.

Audit data provided by the trust, to monitor compliance with MUST assessment within 24 hours and appropriate follow-up action, was reviewed. Results from July to December 2018 showed varying compliance on Allerton ward but an overall improving picture. Surgical assessment unit and Gara ward had good compliance.

Pain scores and evaluation post analgesia audit data, provided by the trust was reviewed for the period June to December 2018. This showed good compliance by surgical assessment unit. There was poor compliance in respect of post analgesia evaluations on Allerton between July and August 2018 but good compliance November to December. Results for evaluations on Gara ward were poor but noted to be improving month on month. The trust told us they were reviewing the audit criteria because it was believed the low compliance scores were due to inconsistent interpretation of the audit question.

The trust had an up to date policy for pre-operative site marking, correct site surgery and correct site regional anaesthesia. The trust provided a copy of the main theatres check list but this was dated for review 2014. Compliance against policy, with completion of WHO safer surgery checks was audited routinely each month. We looked at audit data for the previous nine months and found consistently good compliance across all specialities. This supported what we observed in theatre.

We saw evidence that the service conducted hand hygiene audits and these were conducted by named hand hygiene champions. For example, all staff including allied healthcare professionals and doctors, participated in random checks using a light box to assess effectiveness of handwashing. Infection prevention control audit compliance figures for individual wards was displayed on model- ward boards.

Competent staff

Nursing staff we spoke with said managers supported them with training needs and revalidation.

We spoke with a staff member who was appointed recently. They had received a comprehensive induction on commencement and were supernumerary for the initial two months. They said they felt supported by their manager and nurse colleagues. Another band 5 nurse said they had experienced a very thorough induction.

We saw up to date clinical competency records for staff in theatre, which were held electronically. For example, competency assessments for use of medical devices, monitoring equipment, case specific scrub procedures, specimen collection and management of frozen sections. Staff completing competencies were allocated a mentor and learning records were reviewed at personal development review meetings.

Managers we spoke with said they were on track to complete staff performance appraisals and this concurred with schedules we saw in the clinical areas we visited. All staff we spoke with said they had received an annual performance appraisal in the last twelve months.

Appraisal rates

From October 2017 to September 2018, 77.2% of staff within surgery at the trust received an appraisal compared to a trust target of 80.0%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
Qualified healthcare scientists	31	29	93.5%	Yes
Qualified allied health professionals (qualified AHPs)	25	22	88.0%	Yes

Support to ST&T staff	35	30	85.7%	Yes
Medical & dental staff - hospital	244	196	80.3%	Yes
Other qualified scientific, therapeutic & technical staff (Other qualified ST&T)	157	125	79.6%	No
Qualified nursing & health visiting staff (qualified nurses)	577	443	76.8%	No
Support to doctors and nursing staff	581	431	74.2%	No
NHS infrastructure support	65	48	73.8%	No

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

Multidisciplinary working

We observed well-attended, informal, and structured multidisciplinary team meetings throughout our visit. These meetings considered patient condition, clinical care, and discharge planning. We saw physical therapies being provided by the multidisciplinary team.

We also observed informal discussions between professional colleagues at safety huddles.

Staff we spoke with on Allerton ward told us there were daily visits by a breast care nurse, dietitian, colorectal nurse specialist, doctors, consultants, physiotherapists, occupational therapists and a speech and language therapist was available, as required.

Formal documented input from the multidisciplinary team collective was recorded in the medical records. The entries highlighted involvement in care and treatment planning, discharge processes, and social considerations.

There were clear internal referral pathways to therapy and psychiatric services. All wards had developed strong links with community colleagues when implementing discharge plans and care packages.

Staff we spoke with on the surgical assessment unit and POSDU explained that discharge from the service was nurse-led. They told us surgeons often visited their patients post operatively as a courtesy and visited routinely if their patient had stayed overnight. We saw clear post-operative instructions recorded in notes and we were assured nurses could contact consultants directly to advise on discharge if required.

Medicines to take home were prescribed and dispensed the day prior to discharge as far as possible. On the surgical assessment unit medicines were prescribed by the on-call surgeon and fit-for-work certificates were prepared in theatre in advance of discharge.

Staff we spoke with explained discharge information was sent to general practitioners (GPs) promptly via the e-discharge system. However, some consultants chose not to use the system and some GPs were unable to access e-discharge. In these cases, a discharge summary was printed and sent by post, resulting in some delays.

Seven-day services

Nurses and junior medical staff were available seven days a week, twenty-four hours a day with support from senior (middle grade) doctors and consultants, available on-call. There was a matron available, seven days a week including overnight.

There was a diabetes centre at Friarage hospital and the specialist nurse was available 9am to 5pm Monday to Friday.

Staff had access to a dedicated pain management team available Monday to Friday and on-call as required out of hours by an anaesthetist. There was a palliative care team available on call twenty-four hours a day, seven days a week who were available to support with palliative pain needs.

Occupational therapy, physiotherapy and dietitian service were available Monday to Friday when needed and there was an on-call service out of hours.

The trust safeguarding team was available Monday to Friday. Out of hours, staff contacted the duty matron for advice and support as required.

There was access to interpreters in the hospital (often doctors) and interpreter services via switchboard, seven days a week, including out of hours via a translation phone service.

Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Patients also had seven-day a week access to diagnostic services and emergency therapies provided through on-call services.

Health Promotion

We saw a wide variety of information leaflets available for patients, carers and visitors in public areas, including for example, smoking cessation, infection prevention and advice about flu vaccination.

Health promotion was also incorporated into the surgery pre-assessment process.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

The trust reported that from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 64.6% of staff in surgery compared to the trust target of 90.0%.

The breakdown by site was as follows:

Site	Training complete (YTD)	Individuals required (YTD)	Completion rate	Target met
Friarage hospital	111	136	81.6%	No

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

Staff could access an up to date consent to examination and treatment policy on the intranet, which was referenced to current mental capacity legislation and described how consent was obtained when people lacked the capacity to make decisions.

There were no young persons on the wards at the time of this inspection but the policy referred to Gillick competency.

The policy did not describe a best-practice two-stage consent procedure. We noted the process of obtaining informed consent initiated in surgery pre-assessment, through provision of information. However, this was not always documented on the consent forms we saw in patient records. We looked at the care records of four patients on the surgical wards at Friarage hospital. Consent forms were completed comprehensively; risks and benefits of surgery were documented and all forms were saw were signed and dated.

Staff at band 5 and above had been trained to undertake mental capacity assessments. Managers explained they had experience of applying for deprivation of liberties orders and training was undertaken as part of safeguarding. We found that most of nursing staff had a clear understanding of the Mental Capacity Act and the Mental Health Act, including best interest decision making processes. We were advised that capacity assessments were undertaken if the registered nurses had concerns about a patient's ability to make decisions about their mental care.

Is the service caring?

Compassionate care

We observed patient satisfaction and friends and family feedback data displayed on model-ward boards. Satisfaction scores were high; for example, one ward had received an overall satisfaction rating of 9.34 out of 10. Metrics scored included dignity and respect, involvement, good doctors, good nurses, kindness and compassion, pain control, cleanliness and hand hygiene.

We observed patients being treated with dignity and respect in all areas we visited. In theatres and wards, staff were seen to observe patient's dignity by ensuring that curtains were closed around them.

There were windows in the theatre transfer bay with obscured glass and blinds. Patients waiting wore gowns, dressing gowns and slippers. This area was shared by male and female patients and a screen was available to allow segregation.

All patients we spoke with reported that their privacy was maintained throughout their stay. One patient said, "I feel safe and well cared for". They told us their call bell was always to hand and when activated, the nurses attended promptly. However, we observed that call bells on Allerton ward were not always answered quickly when staff were attending a huddle.

Another patient said, "staff are nice; I feel well cared for and I feel safe".

Staff were seen to help patients at meal times to ensure food and drinks were within reach and appropriately prepared for them.

Staff we spoke with described how they cared for a patient at their end of life and enabled

them to enjoy a special early Christmas celebration with their spouse and children. Open visiting was extended and the immediate family members were accommodated nearby to allow them time together and space to be on their own when they wanted, and a place for the children to sleep.

On another occasion, a wedding was held at the hospital, in accordance with the wishes of a

patient at their end of life.

However, during the time the huddle was occurring we observed call bells were not answered for approximately five minutes. In addition, the huddle was held in an open area which meant there was a risk patients and relatives could hear what was being discussed.

Friends and Family test performance

The friends and family test response rate for surgery at South Tees Hospitals NHS Foundation Trust was 10% which was worse than the England average of from October 2018 to September 2018. A breakdown of response rate by site can be viewed below:

Friends and family test response rate at South Tees Hospitals NHS Foundation Trust, by site.

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	
WARD 36	423	21%	88%			95%		100%	100%	100%		89%	100%	97%	98%
WARD 7	355	43%	96%	94%	94%	93%	100%	98%	100%	100%	100%	97%	100%	95%	97%
POSDU	327	20%		100%	100%		100%		100%			100%	100%		100%
GARA WARD	319	44%	98%				100%	96%	100%		100%	100%	100%	100%	91%
Surgical Admissions Unit	249	7%		96%	97%	100%			100%	97%		100%			98%
WARD 5	179	18%	100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	99%
WARD 6	168	29%	100%	93%	93%	100%	100%	100%	100%	100%	100%	88%	100%	100%	97%
WARD 37	152	13%		97%	97%	100%	100%	91%	100%	100%	94%	87%			96%
SPINAL INJURIES REHABILITATION UNIT	131	96%	100%					100%	100%	100%	100%				100%

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).

[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.

Note: sorted by total response

(Source: NHS England Friends and Family Test)

There was no data for Allerton ward in the information provided.

Emotional support

We saw senior nursing staff and doctors were visible on wards and patients and relatives could speak with them when they wanted to.

Spiritual support was available to patients and their families at all times, for example a multi-faith chaplaincy service. We observed a chaplain visiting the wards.

Clinical nurse specialists were available within surgery and attended wards to provide additional support and advice to patients for example, breast and stoma care.

Understanding and involvement of patients and those close to them

We spoke with two relatives on Allerton ward who said they were very satisfied and "nothing needs improving". They said the surgery team always involved them and kept them updated on plans for care and discharge. One remarked that "I cannot fault them".

A patient we spoke with felt they were kept well informed about their plan of care and their relative was involved in planning for discharge, although they were not aware of an estimated discharge date.

A range of information and advice leaflets were available in the areas we visited; these included discharge information, specialist services and support groups that were available.

Wards had open visiting times that allowed greater time for friends and relatives to be part of a patient's care and to visit at their convenience.

Is the service responsive?

Service delivery to meet the needs of the local people

The service worked in partnership with clinical commissioning groups (CCGs) and other providers across clinical networks to deliver both elective and non-elective surgical treatments, in a way that met the needs of local people.

Patients were seen at pre-assessment appointments where they were assessed whether they were suitable for surgery. This also gave patients an opportunity to ask questions about their surgery.

The facilities and premises were accessible to all patients.

Meeting people's individual needs

We saw that staff cared for patients as individuals and strived to meet their individual needs. We saw patients being treated with dignity and respect by addressing them as they wished to be addressed and closing curtains and doors as necessary.

The ward managers confirmed that the needs of all patients, irrespective of age, disability, gender, race, religion, or belief were considered. We asked staff how they ensured people's individual needs were met.

On one ward, there were four dementia care champions in place. They described how the staff worked with the mental health liaison team and provided one to one support for patients as required.

We saw an information folder for staff to refer to, containing up to date guidance on mental capacity and deprivation of liberties, care plans (pain, safe environment guidance and nutrition), risk assessments and leaflets

During the inspection we observed initiatives in place, to improve care of those living with dementia. For example, the wards had adopted the butterfly scheme, which enabled family carers to teach staff how to help people who needed memory support whilst in hospital, and the forget-me-not scheme, which discreetly identified patients living with dementia. The wards had dementia friendly signage on bathroom and toilet doors.

Staff stated that they could access support from the lead nurse for learning disability and initiatives to enhance the care of those with a learning disability were in place. For example, most patients had a 'this is me' hospital passport, which detailed personal preferences, likes/dislikes, anxiety triggers, and interventions, which were helpful in supporting them during difficult periods.

The trust employed an advisor for learning disability and autism and they visited the wards routinely in response to the electronic patient admission flagging system. They were available for patient appointments and admissions and supported the staff to make reasonable adjustments on the wards, such as ensuring availability of single rooms. There was also a dedicated room in the surgical assessment centre, which could accommodate patients wishing to bring their carer.

Staff informed us that they had ease of access/referral into psychiatric services for those patients requiring this care, when needing mental capacity act and deprivation of liberties.

All wards and the surgical assessment centre displayed up to date information leaflets for patients and carers about specific health topics and signposting to other services. For example, how to

access home from hospital services, Macmillan cancer care, advocacy support, breast care, smoking cessation help, Patient Advice and Liaison Services (PALS), and complaints process.

However, all information leaflets we saw were in English language only and staff we spoke with did not know where to obtain other language versions. Staff explained that interpreter services were available via language line and face to face.

The trust had chaplains who provided access to multi-faith facilities within their communities. Staff accommodated faith preferences, and this was facilitated by the chaplaincy service or at the bedside. We observed a Chaplain visiting on one of the wards.

Staff we spoke with explained that they could access bariatric equipment from central equipment storage and other wards when this was required. This included access to special beds, commodes, wheelchairs, bariatric hoist and chairs.

High-low beds were available for patients at high risk of falls.

One ward we visited observed protected sleep time from 11pm to 6am. Staff explained this followed feedback from the Trust's 1,000 Voices patient survey which identified noise at night as the main area that could be improved to help make a patient's hospital stay more comfortable.

Actions taken included reducing general noise levels and speaking volume, closing doors quietly, purchasing bins with soft-close lids, reducing light levels, conducting clinical interventions only when necessary (vital signs monitoring) and ensuring phones and televisions were switched off at 11pm.

Visiting was permitted 8am to 8pm but visitors were asked to leave if patient care interventions were required.

Access and flow

On one ward we visited, there were seven medical outlying patients. Staff we spoke with felt this was unusually high as there were usually one or two patients per week. Medical doctors maintained responsibility for their care.
Managers we spoke with told us instances of delayed transfers of care (DTOC) were improving due to social services providing care packages more quickly.

Discharge to assess processes were in place to ensure people that did not require an acute hospital bed, but that required care services, were provided with short term funded support to be discharged to their own home (where appropriate) or another community setting.

Managers we spoke with on the wards told us patient movement was kept to a minimum and it was rare to move patients after 10pm. However, fit patients were sometimes moved to the post-operative surgical day unit before discharge.

Bed management meetings occurred at 8am, 1pm, 3pm and 5pm every day. These were attended by representatives from all departments including theatre, to ensure access to beds for elective surgery patients.
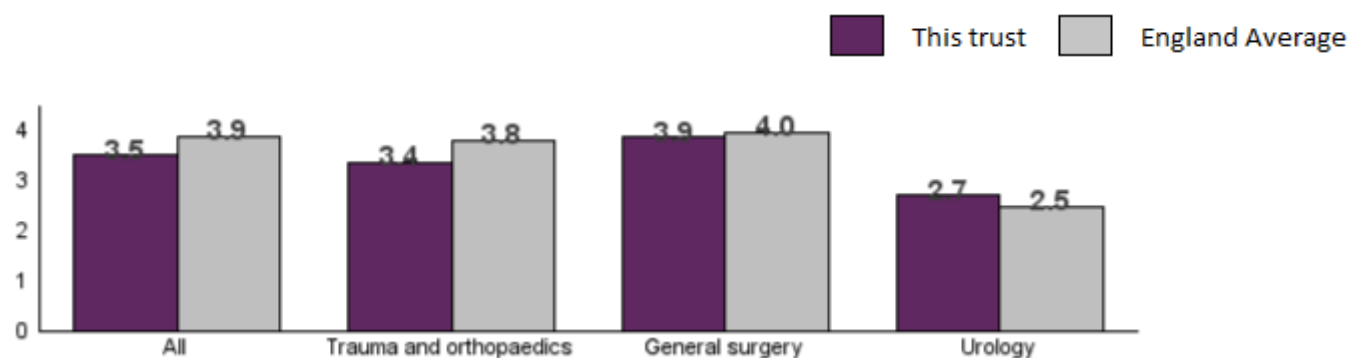

Average length of stay

Trust Level – elective patients

From July 2017 to June 2018, the average length of stay for all elective patients at the trust was 3.5 days, which is lower compared to the England average of 3.9 days.

- For trauma and orthopaedics elective patients at the trust was 3.4 days, which is lower compared to the England average of 3.8 days.

- For general surgery elective patients at the trust was 3.9 days, which is as expected compared to the England average of 4.0 days.

- For urology elective patients at the trust was 2.7 days, which is as expected compared to the England average of 2.5 days.

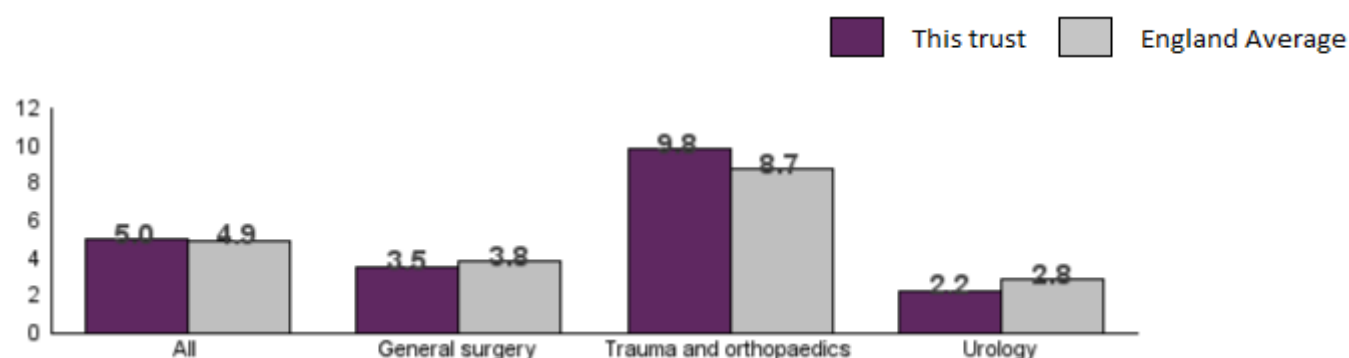**Elective Average Length of Stay – Trust Level**

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

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 5.0 days, which is as expected compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at the trust was 3.5 days, which is lower compared to the England average of 3.8 days.

- The average length of stay for trauma and orthopaedics non-elective patients at the trust was 9.8 days, which is higher compared to the England average of 8.7 days.

- The average length of stay for urology non-elective patients at the trust was 2.2 days, which is lower compared to the England average of 2.8 days.

Non-Elective Average Length of Stay – Trust Level

Note: Top three specialties for specific trust based on count of activity.
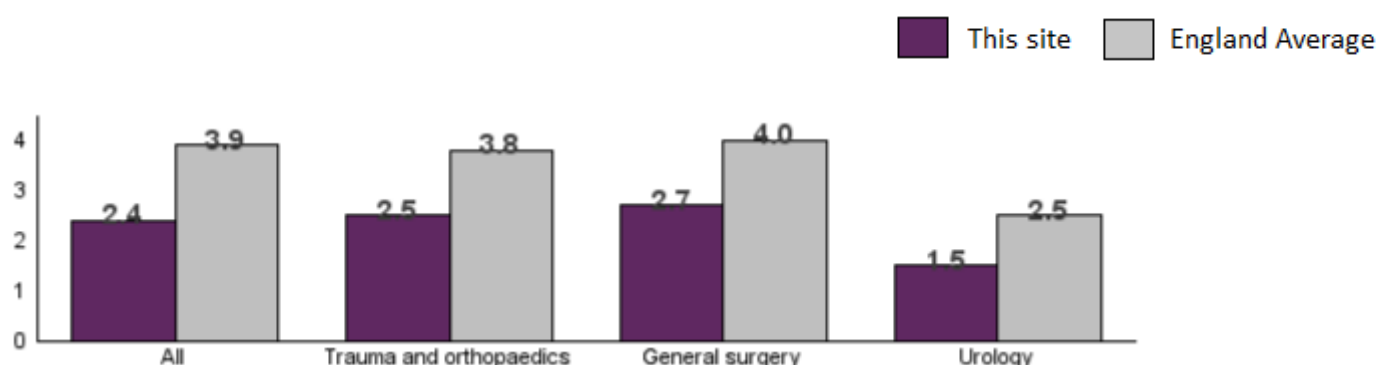
Friarage Hospital - elective patients

From July 2017 to June 2018, the average length of stay for all elective patients at Friarage hospital was 2.4 days, which is lower compared to the England average of 3.9 days.

- The average length of stay for trauma and orthopaedics elective patients at Friarage hospital was 2.5 days, which is lower compared to the England average of 3.8 days.

- The average length of stay for general surgery elective patients at Friarage hospital was 2.7 days, which is lower compared to the England average of 4.0 days.
- The average length of stay for urology elective patients at Friarage hospital was 1.5 days, which is lower compared to the England average of 2.5 days.

## Elective Average Length of Stay - Friarage hospital

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

Friarage hospital - non-elective patients

The average length of stay for all non-elective patients at Friarage hospital was 3.2 days, which is lower compared to the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients at Friarage hospital was 3.0 days, which is lower compared to the England average of 3.8 days.

- The average length of stay for urology non-elective patients at Friarage hospital was 2.4 days, which is lower compared to the England average of 2.8 days.

- The average length of stay for trauma and orthopaedics non-elective patients at Friarage hospital was 16.2 days, which is much higher compared to the England average of 8.7 days.

Non-Elective Average Length of Stay - Friarage hospital
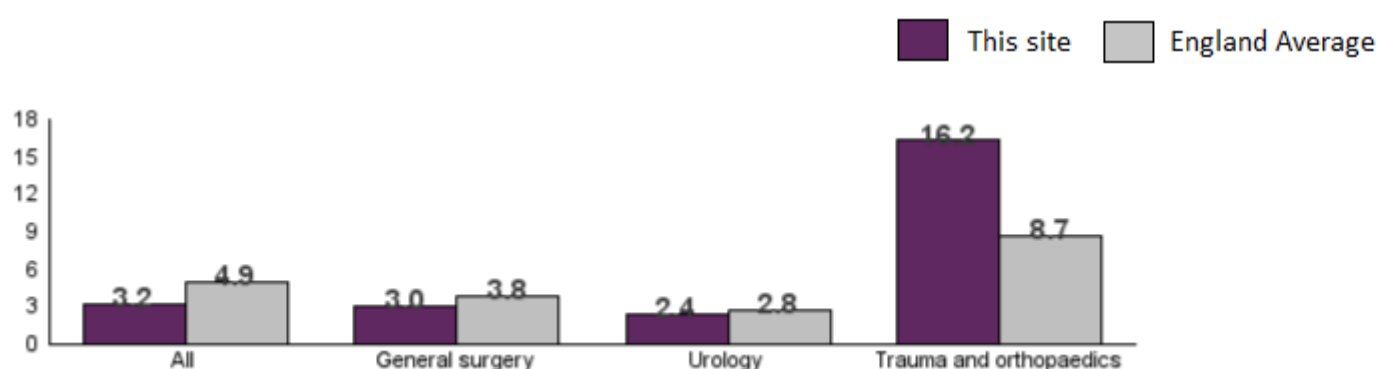
Note: Top three specialties for specific site based on count of activity.

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

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was consistently better than the England average. The trusts RTT within 18 weeks dipped in March and April 2018 to similar to the England average. The trust latest month RTT within 18 weeks, in August 2018 was 72.0%.

———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	95.3%	79.6%
ENT	91.2%	63.1%
Plastic surgery	84.8%	81.1%
Neurosurgery	82.5%	69.9%
General surgery	77.6%	72.6%
Ophthalmology	68.3%	68.2%
Oral surgery	63.9%	59.4%

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

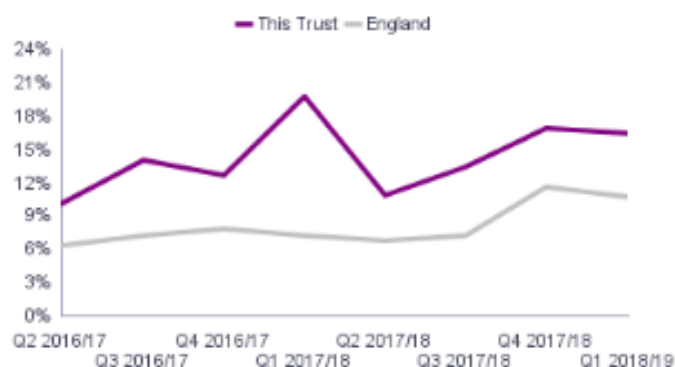| Specialty grouping	Result	England average
Urology	73.5%	76.7%
Trauma and orthopaedics	59.3%	60.0%

Cancelled operations

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 showed a consistently worse than the England average. With the most cancellations in Q1 2017/18, the trust cancelled 121 surgeries. Of the 121 cancellations 20% weren't treated within 28 days. The trust then improved in Q2 2017/18, with 110 cancelled surgeries 11% of which weren't treated within 28 days. Performance then showed a trend of decline up to Q4 2017/18, the trust cancelled 202 surgeries. Of the 202 cancellations 17% weren't treated within 28 days. The latest quarter Q1

2018/19, the trust cancelled 122 surgeries. Of the 122 cancellations 16% weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - South Tees Hospitals NHS Foundation Trust

Cancelled Operations as a percentage of elective admissions - South Tees Hospitals NHS Foundation Trust

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

(Source: NHS England)

Managers we spoke with on the surgical assessment unit told us they felt cancellations to be an almost daily occurrence and cited overrunning theatre lists causing lack of theatre time. We were informed some patients were cancelled for clinical reasons, for example having a cold on the day of surgery.

While we were in theatres, we observed two major surgery cases cancelled for the following day because there were no beds available on the intensive care unit. The staff were reallocated.

Learning from complaints and concerns

Summary of complaints

From October 2017 to September 2018 there were 142 complaints about Surgical Care. The trust took an average of 36 days to investigate and close complaints, this is in line with their

complaints policy, which states complaints should be closed within 40 days.

Friarage hospital: There were 13 complaints, nine were due to patient care, three were due to appointments and one was due to communication.

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

The trust had a version controlled complaints policy detailing principles of handling comments, concerns and complaints. Staff were aware of the policy and could source this electronically on the intranet. The trust had a system in place to encourage complaints and compliments, with a view to improving services for patients.

Staff we spoke with said they would seek to resolve a concern informally in the first instance but complaints were dealt with formally if necessary. The governance arrangements in place ensured that lessons learned from complaints were shared amongst staff. Staff we spoke with confirmed this.

Patients, and carers could provide feedback to the trust in several ways, for example by completing feedback cards and on-line. The trust complaints and feedback process was open and accessible to all who were eligible to use it.

We saw notices displayed within the services showing how to complain which signposted patients or their carers or relatives to the trust's patient advice liaison service (PALS) for support in making a complaint. Leaflets were available to patient and their families advising how to submit a compliment, comment, concern or complaint.

We discussed complaints with staff. Staff told us response times for complaints were met with support from the trust's PALS team. All written compliments/complaints received by the complaints team were logged in the PALS department.

Staff stated that face to face complaints were met with sensitivity and resolved on the day if possible to prevent ongoing concern.

Number of compliments made to the trust

From October 2017 to September 2018 there were 39 compliments within surgery for the trust of which four were at Friarage Hospital.

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

We saw 'thank you' cards displayed in the wards we visited. One patient had described their experience as "like a five-star hotel".

Is the service well-led?

Leadership

The trust was led by a chief executive, medical director for urgent and emergency care, medical director for medical care, medical director for community care, medical director for corporate clinical services, education and research, director of nursing and director of finance. We met and spoke with them during and after inspection.

Staff perception of senior management visibility was variable. For example, staff we spoke with on the surgical assessment unit and POSDU felt their immediate senior managers were visible and

approachable. However, one of the two surgical wards had not had a ward manager in post for an extended period of time; which impacted on leadership capacity at this hospital. Staff felt senior managers above matron level, were not always visible and they were 'finding things hard with no leader'.

Staff we spoke with said they did not know when a new manager would be appointed and told us band 6 staff were managing some of the management workload, supported by matron in the interim.

Staff also raised concerns to us about lack of administrative and secretarial support which meant correspondence and reports were sometimes delayed.

There was a senior matron for surgery who covered Friarage and James Cook hospitals and they were contactable by telephone when not on site. Staff said they were comfortable to approach matron for support or if they wished to raise a concern.

Vision and strategy

The trust vision was to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement. The values included putting patients at the centre of everything they do, continuously improving quality and using resources to the benefit of the wider community.

The trust clinical services strategy was to be the specialised cancer, cardiovascular, trauma, children's and neurosciences provider for the North of North Yorkshire and the South of the North East, and to provide integrated healthcare for local communities. Four strategic objectives define their clinical services strategy:

- To be the major provider of specialised services in the South of the North East and northern North Yorkshire

- To be the predominant provider of integrated secondary and community services in Middlesbrough, Redcar and Cleveland, Hambleton and Richmondshire

- To realise significant quality and efficiency improvements through the integration and transformation of secondary and community services

- To realise significant quality and efficiency improvements through major service innovation every year.

Staff we spoke with below manager level were not aware of the trust strategy going forward.

Culture

Staff at all levels spoke passionately about their work, and about the quality of care delivered. Staff spoke openly about some of the staffing difficulties faced on the wards but described their commitment to deliver the best possible care at all times.

We observed staff working together on the wards and felt a sense of 'pulling together' to get the job done. We saw staff from a variety of specialisms and grades of staff working together effectively.

Staff morale was variable and staff expressed concerns about staff moves to backfill other wards and raised concerns to us about the lack of a ward manager on Allerton ward. However, they said they felt proud of how they had worked together to overcome these difficulties.

All staff we spoke with told us their immediate line managers and clinical leaders were professional, supportive and helpful. Nursing and junior medical staff described their senior peers as "supportive and approachable". Staff felt there was no issues with bullying and all staff we asked were aware of the whistleblowing policy.

Staff we spoke with said they recognised the need for changes to be implemented but considered the amount of changes and speed of change in the organisation added to existing pressures.

Student nurses said they were satisfied with the support received from their mentors and were never left unsupervised. The trust received a 'placement of the year' nomination from a local university.

Governance

All staff we spoke with knew how to access policies and procedures on the trust intranet.

There was a clear governance structure in place which ensured quality and safety information was cascaded from 'ward to board' and back down.

Service managers attended daily 'wall' meetings, where information about key performance indicators was presented and discussed. This included safety reports, patient satisfaction feedback, complaints, lessons learned from serious incidents, infection prevention and control, venous thromboembolism, falls and pressure ulcers.

Governance metrics were presented as dashboards each month and displayed on model-ward boards, for all staff to see. Managers explained it was their responsibility to ensure all staff were aware and did this through staff huddles around the model-ward board, staff meetings and written bulletins.

Staff in theatre met at least every two weeks to discuss incidents and theatre business.

Management of risk, issues and performance

We saw the trust had a risk management policy which described the trust risk management strategy and roles and responsibilities. All staff could access it on the intranet

Business continuity plans had been developed and implemented for critical services at Friarage hospital. Staff we spoke with on the wards said they were aware there was a business continuity plan in place and managers had overview of this. They explained major trauma cases were sent to James Cook hospital and it was therefore not routine for table top scenario exercises to be conducted at Friarage.

Was saw that the surgical centre had an active risk register in place which identified risk, controls, gaps in control and action plans. All risks had review dates in place with evidence of updates.

Information management

Policies and procedures were held electronically on the trust intranet and all staff we spoke with could access the system.

Important governance information was cascaded to teams via huddle meetings although the content of these meetings was not documented.

We saw copies of some team meeting minutes and communication books held in manager's offices for staff to read when they had opportunity but there was no robust system in place to provide assurance that all staff had accessed, read and understood the minutes. The content of them varied for example, some minutes did not indicate matters arising from previous meetings and there was no allocation of actions being taken forward.

Patient records were predominantly on paper. The exception was the use of hand held electronic vital pack machines for recording vital signs. Senior managers we spoke with after inspection told us they were aware the trust was 'paper heavy and IT light'.

Managers we spoke with explained how statistical data held electronically was analysed to provide patient focused care. For example, they could see via Electronic Patient Status at a Glance (e-PSAG) boards, which patients were on which wards at any one time, see previous admissions information and pick up any trends or alerts, which might be a trigger for further actions such as safeguarding.

Engagement

Leaflets about the friends and family test, and PALS were available on all ward and reception areas. Internet feedback was gathered along with complaint trends and outcomes.

Ward sisters and matrons were visible on the ward, which provided patients and visitors with opportunity to express their views and opinions.

Discussions with patients and families regarding decision making was recorded in patient notes. We saw thank you cards and letters displayed at the entrances to wards.

We were told by staff that their line managers engaged with them well, for example, through bulletins, team briefs and safety huddles.

Staff we spoke with told us they could voice their opinions and speak with the ward sister and matron, receive feedback and discuss any concerns. However, numerous staff felt senior managers were not very visible.

Learning, continuous improvement and innovation

We spoke with staff who were supported to develop their careers through college and university-based learning and in-house leadership development programmes.

The surgical service was reviewing different ways of delivering services, for example, senior staff were encouraging upskilling of staff to undertake competency based extended roles including phlebotomy and male catheterisation.

Staff in theatre recovery had been nominated for a 'friends of Friarage, Nightingale award' in recognition of patient centred care.

We saw evidence that senior leaders actively sought ideas for projects and innovative ideas from staff and asked for their involvement. For example, in theatre a new suction vacuum system to remove body fluid waste more safely and economically was installed. This was in accordance with infection prevention best practice and reduced the risk of dangerous spillages.

Managers had also developed and piloted innovative ways of staffing theatre recovery. They explained the 'empty recovery' model, whereby dual-skilled operating department practitioners and registered nurse recovery staff followed the patient into theatre then through to recovery, thus limiting handover times and improving efficiency. This resulted in better continuity of care for

patients. Managers explained they had presented this innovation at an operating theatre summit and were submitting an article to a national journal. Other trusts that knew about this innovation had expressed interest in this model because of the work at Friarage hospital.

Diagnostic imaging

Facts and data about this service

The main radiology departments are in The James Cook University Hospital, Middlesbrough and Friarage Hospital, Northallerton. The two main departments provide services 24 hours a day, seven days a week

General radiography is also provided to the community hospitals of Redcar, Guisborough, East Cleveland (Brotton) and the Friary Hospital, Richmond.

Advanced practice radiographers are also based at both James Cook and the Friarage radiology departments, who perform and provide imaging procedures and reports in general radiography, CT, MRI, breast imaging, ultrasound scanning and fluoroscopy.

The trust provides a range of services in diagnostic imaging including:

- Radiology

- Mammography

- Neuroradiology

- Ultrasound

The inspection was unannounced (Staff did not know we were coming). We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings. At this inspection we inspected and rated all key questions except for effective. During the inspection of the diagnostic department at Friarage Hospital we spoke with 13 staff, five patients, three relatives and reviewed five patient records.

(Source: Routine Provider Information Request ACUTE – Context)

Is the service safe?

Mandatory Training

The department required all staff to complete mandatory training in topics such as infection prevention and information governance. The trust target for completion of mandatory training was 90%.

During the inspection, we asked leadership for compliance rates for training, we were told the department did not have access to this data. Following the inspection, the trust was unable to provide retrospective data therefore we were not assured how the department monitors mandatory training compliance. The department reported the data for mandatory training to be out of date and therefore appearing less compliant. We saw evidence of mandatory training compliance being discussed at governance meetings.

Manual handling and basic life support however both topics was mandatory for all clinical staff in the department however was not included in the mandatory training data. The department had a manual handling champion who was responsible for training staff in manual handling. Following our inspection, the trust submitted the current compliance for manual handling in Radiology which was 82.5% this was below the trust target of 90%. The current compliance for basic life support in Radiology was 69.6%.

We spoke with three staff regarding mandatory training compliance. All told us they could access

training and their manager received alerts when training was due. All staff reported to have sufficient allocated time to complete mandatory training. During the inspection, three members of staff reported to be up to date with training. However, staff told us they felt some training was not adequate for example some training was provided as e-learning rather than face to face.

The department made sure all diagnostics and radiology staff had undergone specific training in handling radioactive and hazardous substances in line with their roles and responsibilities.

Trust level

Below is the breakdown of compliance for mandatory training courses from October 2017 to September 2018 at trust level for medical and dental staff in diagnostics:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Equality and Diversity	18	18	100.0%	90.0%	Yes
Health and Safety (Slips, Trips and Falls)	18	18	100.0%	90.0%	Yes
Information Governance	17	18	94.4%	90.0%	Yes
Infection Prevention (Level 1)	17	18	94.4%	90.0%	Yes
Fire Safety 3 years	16	18	88.9%	90.0%	No

In diagnostics the 90.0% target was met for four of the five mandatory training modules for which medical and dental staff were eligible. Medical staff worked across James Cook University Hospital and Friarage Hospital.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 at trust level for qualified AHPs in diagnostics is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health and Safety (Slips, Trips and Falls)	117	128	91.4%	90.0%	Yes
Information Governance	116	128	90.6%	90.0%	Yes
Equality and Diversity	115	128	89.8%	90.0%	No
Fire Safety 3 years	110	128	85.9%	90.0%	No
Infection Prevention (Level 1)	107	128	83.6%	90.0%	No

In diagnostics the 90.0% target was met for two of the five mandatory training modules for which qualified AHPs were eligible.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 at trust level for scientific, therapeutic and technical support staff in diagnostics is shown below:

Name of course	Staff trained	Eligible staff	Completion	Trust	Met

	(YTD)	(YTD)	rate	Target	(Yes/No)
Information Governance	66	72	91.7%	90.0%	Yes
Equality and Diversity	62	72	86.1%	90.0%	No
Health and Safety (Slips, Trips and Falls)	60	72	83.3%	90.0%	No
Fire Safety 3 years	54	72	75.0%	90.0%	No
Infection Prevention (Level 1)	48	72	66.7%	90.0%	No

In diagnostics the 90.0% target was met for one of the five mandatory training modules for which scientific, therapeutic and technical support staff were eligible.

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

Safeguarding

Safeguarding processes were embedded and established within the Trust. During our inspection we saw that the trust had 'adults at risk' and 'safeguarding children' policies in place that staff could access on the trust's intranet. Staff told us they knew about female genital mutilation, how to access the policy on the intranet and what action to take should they have any concerns about patients attending the department. There was information on the hospital intranet about how to report safeguarding concerns about patients. Staff also told us if they were unsure what action to take, they would speak with their line manager or the safeguarding team within the trust for advice. Staff we spoke with knew about the trust safeguarding team. Any previous safeguarding information would be shown on the patient record for staff to see.

The trust set a target of 90.0% for completion of safeguarding training. NHS England guidance states clinical staff working with children and young people should complete Safeguarding level 3 however the trust reported one eligible staff member for safeguarding level 3. Staff reported to be up to date with safeguarding training. The training was provided via e-learning but staff interviewed stated they would prefer face to face training which they thought would be better for engagement and focus.

One staff member told us they had attended non- accidental injury training as part of their continuous professional development. Staff reported prevent radicalisation was part of the safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 at trust level for medical and dental staff in diagnostics is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 3 Additional)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 1)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 3)	1	1	100.0%	90.0%	Yes
Safeguarding Children (Level 2)	16	16	100.0%	90.0%	Yes

Safeguarding vulnerable adults	17	18	94.4%	90.0%	Yes

In diagnostics the 90.0% target was met for five of the five safeguarding training modules for which medical and dental staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 at trust level for qualified AHPs in diagnostics is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding vulnerable adults	119	128	93.0%	90.0%	Yes
Safeguarding Children (Level 2)	117	128	91.4%	90.0%	Yes

In diagnostics the 90.0% target was met for two of the two safeguarding training modules for which qualified AHPs were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 at trust level for scientific, therapeutic and technical support staff in diagnostics is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 2)	49	54	90.7%	90.0%	Yes
Safeguarding vulnerable adults	64	72	88.9%	90.0%	No
Safeguarding Children (Level 1)	5	18	27.8%	90.0%	No

In diagnostics the 90.0% target was met for one of the three safeguarding training modules for which scientific, therapeutic and technical support staff were eligible.

Cleanliness, infection control and hygiene

Staff could access the trust infection prevention and control policies on the Trust intranet. These were underpinned by national guidelines, to manage and monitor infection for patient and staff safety. We looked at COSHH (Control of substances hazardous to health) policies and found them to be in date. Any substances hazardous to health such as cleaning products were safely stored.

During our inspection we looked at the cleanliness of the department. All areas including clinical rooms, corridors and waiting area were clean and uncluttered. We saw evidence of bimonthly infection, prevention and control meetings for the radiology department and the trust's health care acquired infection monthly update included actions for the radiology department. There were cleaning schedules in place and these showed regular cleaning of the department and the equipment being used. Staff wiped down equipment between patients and used a disposable paper covers on beds, this was changed after every patient. Sharp bins were signed, dated and not over ¾ full as according to policy. There were processes in place to manage clinical waste within the department.

There was sufficient personal protection equipment such as gloves and aprons available to staff and we observed staff adhered to 'bare below the elbow' guidance. Staff ensured any infectious

patients received treatment at the end of the list and domestic staff carried out a thorough cleaning of the treatment room to prevent the potential spread of infection after treatment.

There was hand gel and an adequate number of sinks around the department and posters around to promote hand washing infection control. However, during our inspection we saw three staff not washing their hands as according to Trust policy. The trust provided the hand hygiene audit for the radiology department at the Friarage Hospital. The information showed between July 2018 to December 2018 x-ray and ultrasound achieved 100% compliance with hand hygiene apart from in November 2018 the X-ray department achieved 70% this is significantly below the trust target of 90%.

During the inspection we observed staff not constantly following the Trusts infection prevention and control policies, we found the warmer which stored contrast medication used for CT scans was unclean with layers of old spilt medication and dust. The fluoroscopy room did not follow safe disposal policy, we saw an open top bin used to dispose of plastics, tins and metal and we observed one example of equipment not being wiped between patients.

Environment and equipment

The department provided x-rays, ultrasound scans, CT, MRI and fluoroscopy. The x-ray department had clear signage for controlled area x-rays and 'do not enter' areas to warn staff and patients of the risks of radiation. X-ray rooms had illuminated signage to inform patients when it was safe to enter and there were clear warnings for patients about MRI and CT scanner safety such as metal objects close to the MRI scanner. Non-magnetic equipment had 'MR safe' stickers for use in the MRI room. The MRI unit was accessible to staff only with secure access. We saw rooms displaying the diagnostic reference levels. Staff had individual keys that could show who had accessed the rooms. The department had adequate storage.

The department had sufficient seating in the waiting room. The department had toilets available for patient and relative use and there were four changing rooms opposite the x-ray rooms. Magazines and patient information leaflets were available in the main waiting room of the department.

All equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and safety checked. There were maintenance and repair contracts in place. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. The department had business continuity plans in place to manage mechanical breakdown or IT system failures including using equipment at James Cook University Hospital and rearranging appointments. Staff reported the orthopantomogram to be well used, during our inspection it stopped working. Staff followed the correct procedure by reporting the fault and taking the equipment out of action. During our inspection, we checked the service log and found pumps in two rooms were out of date for servicing. We requested the department's maintenance log, eight pieces of equipment at the Friarage radiology department were out of date for servicing. All equipment should have portable appliance testing (PAT), during our inspection all equipment we checked had up to date PAT stickers.

The department's resuscitation trolley was located in the CT area. The resuscitation equipment used for the x-ray area was shared and stored in the emergency department, it was easy for staff to access. The trolley was checked regularly in line with trust policy to make sure all emergency equipment was in place and in date. During our inspection, we checked the resuscitation trolley

and it was in date and within trust guidelines.

The department had a satisfactory amount of lead aprons to protect staff from over exposure to harmful rays. All staff were allocated a dosimeter to wear. These were sent away regularly for monitoring and assessment. Any concerns with abnormally high doses were highlighted to the member of staff responsible. We spoke with a member of staff who described to us the action they would take if a dosimeter showed an abnormal reading. This was in line with the trust process. Staff reported they received the appropriate equipment training for their role.

There were also protective aprons available for patients who needed, for example, pregnant women. We saw evidence that the protective equipment was checked however we saw one apron which was an infection control risk due to appearing worn and the material coating was frayed, this did not correlate to the description on the visual checklist infection control.

The trust provided a radiation physics report to the radiation protection committee (RPC). This report highlighted staff doses information. The report also highlighted three risk assessments in the service required review. Results were not available at the time of inspection.

Assessing and responding to patient risk

Policies, procedures and local rules were in place for radiology. We checked these and found the local rules in the dental rooms had not been updated since 2011. Local rules elsewhere were displayed around the department and in date. Staff could demonstrate good awareness of the local rules. There was an ionising radiation medical exposure regulations (IRMER) policy for the use of diagnostic x-rays. This had a review date of December 2021. Ionising Radiation (Medical Exposure) Regulations (IRMER) sets out the responsibilities of duty holders (the employer, referrer, IR(ME)R practitioner and operator) for radiation protection.

The trust had arrangements in place to seek advice from an external Radiology Protection Advisor (RPA) in accordance with relevant legislation. The hospital had a service level agreement (SLA) in place with the RPA at a neighbouring trust. The RPA was easily accessible through regular meetings or telephone contact. The department participated in the national audit radiation survey however results were not available.

The service had access to a medical physics expert and staff told us they were accessible. Following the inspection, the trust submitted the medical physics expert report for South tees hospital November 2018.

The department had appointed and trained three Radiation Protection Supervisors (RPS) with plans to train an additional staff member. Their role was to ensure equipment safety and quality checks and ionising radiation procedures were performed in accordance with national guidance and local procedures. We saw evidence of this happening. Staff were aware.

All staff were observed to be wearing body dosimeters (dose meters) on the front of their torso. A radiation dosimeter is a device that measures exposure to ionizing radiation. Staff told us they changed their dosimeters monthly. We saw the dosimeters were in date and had their expiry date on back.

We observed diagnostic reference levels (DRLs) were on display in the X-ray rooms. Risk assessments, including COSHH risk assessments, were all up to date.

Staff described how they would ensure pregnancy tests were performed for patients aged between 12 and 55 who were unsure of their pregnancy status.

We observed staff completing the 'paused and checked' checklist. used in radiology departments

for procedures. The pause part of the checklist indicates patient, anatomy, user checks, systems and settings checks, exposure and draw to a close. Staff we spoke with could describe the pause and check during the inspection.

The trust had a safety alert system on the patient record. If there were any associated risks staff needed to know about a red, amber or green alert flagged up, all clinical staff we spoke with knew about this system.

The department had a major incident policy in place including a major incident list to call staff in. During the inspection we found staff members had changed and the major incident list was not updated with the new staff. Staff we spoke with were aware of major incident policy and procedure.

Staffing

There was a standard operating procedure for reduced staffing levels, including cancelling mandatory training when staffing levels were poor. During our inspection we spoke with management regarding staffing, the table below shows the overall sickness for the department between September 2018 to December 2018 for all staff including medical, nursing and administration. The trust target for sickness rates is 3.5%:

Month	Sickness
September 2018	3.03%
October 2018	4.15%
November 2018	4.66%
December 2018	3.99%

The overall rate of sickness is above the trust target for every month apart from September 2018. The average rate of sickness is 3.95%, which is above the trust target.

Medical and dental

The trust had significant problems recruiting radiologists despite actively trying to recruit. The trust continued to try to recruit as a continuous process. There were links with the local university to recruit radiography students on qualifying. Management reported, to manage staff shortages, they were looking at developing current staff. The department had four associate practitioners due to start. There was a long-term plan to develop the associate practitioner by offering staff the opportunity to become a radiographer after two years. The department told us they are planning for the future with the student liaison role working across both sites and the local university to increase recruited radiography students on qualifying.

The trust has reported their staffing numbers for diagnostics below as at September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	4.7	2.0	42.2%
The James Cook University Hospital	26.3	17.6	66.8%
Trust level	31.1	19.6	63.1%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Staff reported medical emergency cover was prioritised however this impacted on elective work. At the time of the inspection, the department was outsourcing some of its routine and straightforward reporting such as MRI and CT to external companies. If urgent advice or reporting was required out of hours, staff accessed one of the outsourced companies. Staff reported issues

with outsourcing, for example outsourced reporting do not have full clinical picture. Radiologist were not always present in the department but could be contacted at James Cook University Hospital.

There were out of hours radiologists on call, overtime was offered to staff to cover the rota. We saw in the trauma reporting radiographers meeting; bank holidays and weekend cover was discussed. The out of hours rota was available up to June 2019, there were lists of weekends without cover for staff to complete where able.

During the inspection we spoke with management who reported the current budget for medical staffing was 30.8WTE however to cover the service safely 36WTE radiologists were required, at the time of the inspection the service was running on 17.4WTE. This could be split into the various subspecialties within the department as shown below:

	Actual WTE December 2018	Predicted WTE April 2019	Required WTE	Met
Diagnostic Neurology	1.5	1	4	No
Ears, nose and throat	1.2	1.2	2	No
Chest and cardiac	1.5	1.5	3	No
Gastrointestinal	2	2	3	No
GU	0.6	0	2	No
Gynaecology	2	1	2	Yes
Paediatric	0.8	0.8	2	No
Musculoskeletal	0.6	0.6	4	No
Nuclear medicine	1	1	2	No
Lymphoma	0	0	2	No
Interventional	3.5	2.5	6	No
The Friarage Hospital	2.6	2.6	4	No

The service did not meet the required staffing for any subspecialty apart from gynaecology, however based on predicted staffing none of the subspecialties would achieve the required staffing.

Vacancy rates
From October 2017 to September 2018, the trust reported a vacancy rate of 38.8% for medical staff in diagnostics.

- The James Cook University Hospital: 35.4%
- Friarage Hospital: 57.8%

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

Turnover rates
During our inspection, we spoke with clinical and management staff in plain film x-ray, we were told medical staff turnover was a challenge because people came straight from university or overseas, stayed for a few years, gained experience, and then moved on to other modalities or organisations where they were paid at a higher grade.
From October 2017 to September 2018, the trust reported a turnover rate of 14.9% for medical staff in diagnostics.

- Friarage Hospital: 0.0%
- The James Cook University Hospital: 16.6%

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

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 5.7% for medical staff in diagnostics. This is significantly higher than the Trust target of 3.5%.

- Friarage Hospital: 0.0%
- The James Cook University Hospital: 6.4%

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

Bank and locum staff usage

We spoke with the manager of the general radiology department. They told us they used regular locums and offered overtime to all staff from all sites to cover vacant shifts.

Staff told us if the department was at risk of being short of medical staff, radiographers would come from other sites to cover. Staff moved between the Friarage hospital and James Cook University Hospital as needed to cover gaps in the rota.

From October 2017 to September 2018, the trust reported a bank usage rate of 0.4% and locum usage rate of 8.5% in diagnostics.

(Source: Routine Provider Information Request (RPIR) – Bank Agency Locum)

Allied Health Professionals (AHPs)

*This staff group includes diagnostic radiographers who use a range of techniques to produce high quality images to diagnose an injury or disease.

The trust has reported the AHP staffing numbers for diagnostics below as at September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	24.2	23.3	96.2%
The James Cook University Hospital	78.7	56.6	71.9%
Trust level	147.9	122.2	82.6%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

At the time of the inspection there were 2.53 band 2 vacancies waiting to recruit, three whole time band 3 vacancies. One band 5 and 1.6 band 7.

From October 2017 to September 2018, the trust reported a vacancy rate of 19.0% for AHP staff in diagnostics.

- The James Cook University Hospital: 25.6%
- Friarage Hospital: 6.3%

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

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 7.0% for AHP in diagnostics.

- Friarage Hospital: 17.4%

- The James Cook University Hospital: 5.1%

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

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 2.9% for AHP in diagnostics. In December 2018 sickness was 4% this was above the trust target for sickness at 3.5%. For December 2018 short term sickness was 0.78% and long-term sickness was 3.20%.

- Friarage Hospital: 2.3%
- The James Cook University Hospital: 3.1%

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

Support to scientific, therapeutic and technical staff

*includes support staff such as assistant practitioners and radiography helpers.

The trust has reported their scientific, therapeutic and technical staffing numbers for diagnostics below as at period September 2018.

Site	Planned WTE Staff	Actual WTE staff	Fill rate
Friarage Hospital	8.9	8.9	100.0%
The James Cook University Hospital	41.7	42.4	101.7%
Trust level	62.3	62.8	100.9%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy surplus rate of 4.6% for scientific, therapeutic and technical staff in diagnostics. At Friarage Hospital the surplus was 5.6%.

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

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 4.0% for scientific, therapeutic and technical staff in diagnostics. At Friarage Hospital this was 0.0%.

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

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 5.1% for scientific, therapeutic and technical staff in diagnostics. This was significantly higher than the trust target of 3.5%. However, at Friarage Hospital it was 3.4%

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

Records

The department ensured individual care records was managed in a way to keep patients safe. We looked at the record keeping system used in the department. It was linked to the patient's main record. The system made sure all relevant fields of information were completed and results were easily accessible to relevant personnel. When patients attend from wards, ward staff would bring the patient notes.

The department used electronic records and digital images accessible to all appropriate staff for viewing. Reports were available digitally and were part of the electronic patient record.

Staff could check the emergency department system to make sure any anomalies on x-rays or scans had been picked up by the medical staff in the emergency department who would look at the image before a reporting radiographer or radiologist would.

X-ray results were emailed or posted to GPs; the timeliness of this was dependent upon how quickly the x-ray or scan was reported. Staff informed us reporting time for CT scans was 2 weeks. Reporting times was discussed in the Radiology senior staff team meeting, at the meeting on 26th November 2018 it was stated the GP plain film reporting was taking approximately 6-7 weeks to report. Due to the ongoing issues with reporting time, the department had complaints from local GP practices.

Medicines

The department ensured the proper and safe use of medicines. The department had an administration of medicines policy and staff could tell us about the policy and where to access it. We observed medication including contrast being administered safely and according to the trust policy. We observed staff checking allergies on consent forms prior to injecting patients. Staff we spoke with were aware of the side effects and contra indications and carried out checks with patients to ensure their safety.

We checked the storage of medicines across the diagnostic and radiology departments at James Cook University Hospital. We found medication was stored safely and securely and was rotated to make sure no medicines were out of date. Medicines were stored above floor level in locked rooms with restricted access. We checked medicines and found these were all in date. The department did not store or use controlled drugs. The department used specific radiology related contrast media on this site. This was stored safely and securely in a locked room in a warmer.

Fridge temperatures were recorded and monitored daily. Medicines should be stored at the correct temperature to ensure they do not become ineffective or harmful. We checked the fridges and found medicines to be in date and stored in an organised manner. The fridge was in a locked and secure room.

We saw many patient group directives (PGD) were used across the department. A patient group directive allows registered health professionals (such as nurses) to give specified medicines to a predefined group of patients without them having to see a doctor. During our inspection we saw PGD's used for administering contrast injections and saline. All the PGD's were signed for and in date.

Incidents

The department did not manage incidents as according to Trust policy. During our inspection, we were not assured staff were able to recognise incidents and report incidents appropriately. We were told shared lessons learned did not happen consistently.

Staff received incident training in their induction however there were staff who had been working in the department for long periods without any update training. The department had access to an electronic incident reporting system and staff we spoke with were aware of how to report incidents. We were told there was a 10-day incident reporting time for incidents. Staff reported they did not receive feedback from reporting or see shared learning from incidents. The reporting

system alerted the complaints lead, patient liaison lead and the appropriate manager. Some staff told us they should report more however, they didn't because of time pressures, lack of understanding of what an incident is and feeling "nothing will be done".

In July 2018 the department at James Cook University Hospital had a serious incident regarding cross contamination and involved numerous patients. All staff we spoke to regarding this incident showed good insight and could explain how practice had improved including changes to procedure to reduce the risk of future patient harm. We followed the process of this incident and saw evidence of a root cause analysis report. Apart from this incident staff could not give any other examples of incidents in the department.

During the inspection, we reviewed an extravasation (leakage of intravenous fluid which can cause damage to patient skin) reported as an incident and noted on the radiology information system as per the policy. However, we followed six incidents and found two did not follow the correct policy of reporting as IRMER incidents. Recent reported incidents were discussed at safety huddle meetings and the departments governance meetings. Trends or themes of incidents were not monitored according to the departments management.

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 October 2017 to September 2018, the trust reported no never events for diagnostic imaging.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) one due to HCAI/ infection control incident in diagnostics and one SI due to treatment delay, which met the reporting criteria set by NHS England from October 2017 to September 2018.

(Source: Strategic Executive Information System (STEIS))

During the inspection, staff demonstrated they understood the principles of duty of candour, being open and honest and told us if they made a mistake, such as an incorrect x-ray, they would inform the patient and then report it as an incident.

Is the service effective?

Evidence-based care and treatment

The department followed national and local guidance in the treatment of patients. Staff could describe working to the National Institute of Care and Excellence (NICE) guidelines, the Society of Radiographer guidance and the Royal College of Radiologists guidance.

Guidance was available on the intranet for all staff to refer to if they were unsure. Staff told us they followed best practice, guidelines, policies and procedures. During the inspection, we checked policies and found them to be in date and appropriate.

Patients were given advice about action to take if their condition deteriorated. Staff informed us information leaflets for patients about specific conditions and procedures was posted out prior to any procedures.

The service had access to a radiation protection advisor (RPA). The RPA was responsible for completing the annual radiation protection advisor report. The trust submitted the report for November 2018, which included management of safe radiation, facilities and equipment, personal monitoring and radon.

We asked staff about the three-point checklist which ensured the correct patient received the correct procedure. Staff we spoke with were aware of the three-point check list and reported it to be embedded in practice.

Nutrition and hydration

Patients attending appointments were not always in the department for a long period of time and therefore did not require food or fluid. The departments had water fountains available for patients to access cold water and there were café facilities and shops selling food and drinks within the hospital which patients and relatives could access.

There was a nutritional policy that staff were aware of and followed. During our inspection, staff showed us the policy. The policy was in date and appropriate to the clinical environment.

Pain relief

The departments generally did not administer pain relief for patients, there was limited pain relief kept in a locked medicine cupboard, as according to the Trust policy. Patients brought to the department from wards or from the emergency department had usually received pain relief before being brought to the department. If a patient was in pain, the staff contacted the referring ward to let them know.

When pain relief was required it was prescribed and administered by qualified staff in line with departmental policies and procedures. We observed staff asking patients about their pain levels and ensuring any procedure was carried out in the least painful way.

Patient outcomes

The department monitored the effectiveness of care and treatment however we were not assured the department was using the findings to improve them.

We asked the trust for evidence of ongoing audits within diagnostic services. The evidence sent to us showed the radiology audit plan for 2019. The audit plan consisted of 45 audits including marker audit, CT contrast checklist compliance and patient identification audit. The plan included frequency of review, audit lead and monitoring. The trust provided a selection of these audits, listed as follows:

- The radiology marker audit for January 2018 to January 2019.
- MRI on call audit for November 2017 to November 2018.

- Neuroradiology audit 8 April 2016.
- Neonatal x-ray quality for June 2016 to August 2016, due to be reviewed after six months.

The neuroradiology and neonatal x-ray quality audits were not current. All the audit data the trust submitted did not include review dates or action plans therefore we could not be assured how effective the audits were.

There was a monthly outsourcing audit. We saw evidence of error audit meetings and Marker and ID audit, this was planned for February 2019.

No audit information was on display. When we spoke with staff, they reported to be unaware of any audits.

The department used a dashboard for collecting and monitoring data. There was dashboard data available for both cancer target performance and general departmental performance. There are plans to display performance data on staff notice boards but there was no data displayed at the time of the inspection. Staff told us dashboard data is not discussed at team meetings.

The department reported no ongoing clinical trials

We discussed discrepancy meetings with staff and the manager. They told us discrepancies were discussed with staff and meetings held at weekly in line with the Royal College of Radiologists guidance. If concerns about the performance of individual staff members were noted at the discrepancy meeting this would be addressed by the manager with the individual.
There was a radiology senior staff team meeting for radiologists which was held monthly and reporting radiographers had also attend this meeting. The trust submitted evidence of the monthly trauma reporting radiographers meeting.

Staff received ongoing image quality feedback, there was a paper template to support this. Staff we spoke with reported it had been beneficial and had helped improve image quality. The feedback also monitored any patterns of issues. Staff reported this had led to a reduction in issues.

The Surgical Safety checklist was introduced by the World Health Organisation (WHO) in 2008, the aim was to reduce the number of surgical deaths world-wide. The checklist was designed to underpin safe practice and foster more effective communication between clinical teams (WHO, 2009). The Royal College of Radiologists (RCR) in collaboration with NPSA developed a checklist specific to interventional radiology, adapted from the WHO Surgical Safety checklist (RCR, 2009) along with a set of standards for their implementation, (NPSA, RCR, 2010). This checklist had been further modified by the Radiology department at South Tees Hospitals NHS Foundation Trust in order to fit best current practice within the division. The Trust submitted the radiology WHO safer surgery checklist audit for James Cook University Hospital and informed us plans were in place for the Friarage radiology department to be audited from February 2019. The trust plans to continue monthly audits and the target is to achieve 100% compliance by July 2019. During our inspection, staff reported there was ongoing work to embed the WHO checklist process, the trust provided evidence of the WHO checklist action plan this included identified issues, solutions and target dates. The WHO checklist action plan was in date.

During our inspection we saw patient safety checklist for allergies and administering contrast used prior to contrast injection.

Reporting

The radiology backlog monitoring report provided by the trust updated 4 February 2019 showed

total reporting backlog and reporting backlog by modality. The department had a backlog of reporting due to the shortage of radiologists. The total number of exams waiting eight days or more was 962, the trust did not provide the backlog for each modality.

The change from 12 September 2018 to 4 February for the number of exams waiting for reporting from eight days to eight weeks by modality was as follows:

- CT, 92% decrease.

- Fluoroscopy, 77% decrease.

- MRI, 72% decrease.

- Plain, 98% decrease.

- Ultrasound, 82% decrease.

- Other, 98% decrease.

The change from 12 September 2018 to 4 February for the number of exams waiting for reporting over eight weeks by modality was as follows:

- CT, 46% decrease.

- Fluoroscopy, 49% decrease.

- MRI, 66% decrease.

- Plain, 99% decrease.

- Ultrasound, 36% decrease.

- Other, 76% decrease.

The change from 12 September 2018 to 4 February for the number of exams waiting for reporting eight days to eight weeks by priority was as follows:

- Two weeks wait, 97% decrease.

- Urgent, 92% decrease.

- Routine, 95% decrease.

- All, 95% decrease.

The above data shows the department has improved its report backlog for every modality. The trust stated reporting backlog has been addressed and will focus on monitoring reporting time against key performance indicators.

The Core business integration of sustainability (CBIS) monitored the departments performance, at time of inspection 82.2% reported within 8 days of order for department over both sites.

Competent staff

The service made sure nursing staff were competent for their roles however we were not assured managers appraised all staff's work performance.

Staff reported they were encouraged to develop professionally, there was additional course availability, and were supported by managers to do so. Staff told us there was "lunch time learning"; advanced nurse practitioners educated others on various topics for example x-ray of an elbow. Staff could eat their lunch through the sessions to encourage attendance. However not all

staff we spoke with were aware of the "lunch time learning" sessions.

Staff told us the support for revalidation was good. Radiologist's revalidation every five years and qualified nurse's revalidation every three years. The process included sign off on competencies, evidence of continuous professional development, evidence of feedback, feedback, any involvements in complaints or incidents.

Staff reported the department had a good induction process, profession specific competencies were included as part of the induction. Newly qualified nurses had a period of preceptorship as part of their induction, staff we spoke with reported they had a supernumerary period of preceptorship.

Staff we spoke with reported to follow the Trusts lone worker policy. The trust submitted the policy, the policy was appropriate but was last reviewed November 2017, there was no review date provided.

Staff reported they found the appraisal process purposeful and worthwhile. Staff we spoke with reported they received supervision and peer support regularly, this was not recorded, therefore we did not see any evidence. However, we saw evidence of reporting radiographers having regular peer reviews, as it was discussed in the trauma reporting radiographers meeting.

Appraisal rates

From October 2017 to September 2018, 75.7% of staff within diagnostic imaging department at the trust received an appraisal compared to a trust target of 80.0%. Medical and dental staff fell significantly below the trust target as only 60% were up to date with their appraisal. Staff we met during inspection told us they had received an appraisal during the past year. During the inspection, we asked management for up to date appraisal data for the department, they reported to be unable to provide this.

A split by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
Qualified nursing & health visiting staff (Qualified nurses)	14	14	100.0%	Yes
Support to doctors and nursing staff	15	13	86.7%	Yes
Qualified Healthcare Scientists	36	30	83.3%	Yes
NHS infrastructure support	16	13	81.3%	Yes
Support to scientific, therapeutic and technical support staff	73	54	74.0%	No
Qualified Allied Health Professionals (Qualified AHPs)	126	91	72.2%	No
Medical & Dental staff - Hospital	20	12	60.0%	No

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

Multidisciplinary working

The department staff included various professionals such as radiologists, radiographers, sonographers, receptionists and registered nurses who worked together to deliver effective care however we were not assured the department always engaged with the wider organisation.

Radiologists attended gynaecology, neurology, urology and cancer pathway meetings as regularly as possible. Reporting radiographers attended the chest multidisciplinary meetings twice a month. These meetings discussed patient diagnoses and treatment options with specialists such as surgeons and oncologists. During our inspection, staff reported issues with radiologists not always attending meetings. Staff would travel between sites meaning there was a lot of travel time and prioritising meetings was challenging with radiologist staffing issues. Staff reported not achieving key performance indicators, delaying the patient pathway and increased clinical risk is impacted if staff cannot attend multidisciplinary meetings However, the department had started to use videoconferencing to improve attendance of meetings.

We observed good examples of teamwork within the department; healthcare professionals working well together to support each other and to provide effective patient care.

The departments at Friarage Hospital worked with the outpatient's department and specialties to provide x-rays and scanning services for inpatients, the emergency department and outpatients. Radiologists worked on site, however they could report on films from any location that had a reporting station.
Radiologists on site also carried out clinical interventions with patients using radiological guidance such as biopsies, injections and placement of stents. These interventions involved working with specialties and staff from other disciplines.

During the inspection, staff reported good communication links with GPs. The department had recently received complaints from GPs regarding reporting times. Staff stated they communicated with GPs by telephone, emails, meetings and reports. Radiographers in the MRI modality told us they collaborated with the electrophysiologist to scan patients with pace makers. We observed good communication between the x-ray department and the emergency department, for example, a verbal patient hand over. Staff in the department told us the inpatient wards did not always follow fasting times due to poor communication, this impacted on the patients waiting time.
We spoke with five members of staff who worked in the emergency department and had professional relationship with the diagnostic department. All reported good relationships and good communication between the departments.
During inspection we noticed staff of different professions wearing different uniforms, this made it clear for patients to see what role they were. There was information around the department to explain the uniforms.

Seven-day services

The Friarage diagnostic department was open 9am to 5pm daily with access to James Cook University Hospital out of hours. The department ran one late night evening till 8pm with a sonographer and sonographer assistant. There was 24-hour CT cover for inpatients and the emergency department. The department was open on bank holidays including two hours on Christmas day for ultrasound scans.
The James Cook University Hospital diagnostic department was open 8am to 8pm weekdays and 9am to 5pm on weekends. Neuroradiology was available 24 hours a day, seven days a week. Images could be reported 24 hours a day and there was outsourced reporting cover in place backed up by an on-call radiologist employed by the trust.

Health Promotion

The department did not have posters and leaflets to promote patient health, such as information about stopping smoking or healthy diet. We asked staff if they spoke with patients about promoting good health, they told us they would only intervene if the patient asked for advice or if they thought the patient was in immediate danger or harm.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

During our inspection we found consent to care and treatment was always sought in

line with legislation and guidance.

Staff demonstrated how to access the up to date policies and procedures on the intranet, including mental capacity legislation and gaining consent when people lacked the capacity to make decisions.
During the inspection we asked staff about the mental capacity act and best interest. A best interest decision is a decision made on behalf of a patient by clinicians when the patient is unable to make decision themselves. All staff we spoke with showed good understanding.
We spoke with staff about obtaining consent form patients who had learning difficulties or were living with dementia. They told us if the patient was unable to identify themselves they would not perform the examination. We were unable to corroborate this as there were no such instances during our inspection.
Staff knew their responsibilities to explain procedures, possible side effects and complications during, or because of, a procedure and to make sure the patient could understand and retain the information before taking consent. We observed three staff members asking for consent appropriately including explaining the procedure and getting the patient to sign documents. During the inspection we saw the MRI safety checklist had a prompt to document consent.

For plain film x-rays, verbal consent was obtained from patients. The process included staff informing patients of the risks of having an x-ray and the contraindication of x-raying when patients had some conditions or were pregnant. Staff told us when a patient was pregnant or suspected they were, staff would discuss the risk of an x-ray on the unborn child and supported patients to make a decision.

At the time of the inspection, the compliance for mental health awareness training was 100% for all staff members.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 65.3% of staff in the diagnostics department at The James Cook University Hospital, compared to the trust target of 90.0% as shown in the table below:

Site	Training complete (YTD)	Individuals required (YTD)	Completion rate	Target met
The James Cook University Hospital	115	176	65.3%	No

We were told at the time of the inspection, the Mental health capacity (MCA training) compliance was 88% for all staff across both sites in the diagnostic department. This was a significant improvement; however, it was still below the trust target. The trust did not report Deprivation of Liberty Safeguards training during the same period.

Is the service caring?

Compassionate care

Staff provided compassionate care. We spoke with five patients and three relatives during our inspection of the Friarage Hospital diagnostic department. Patient feedback during the inspection was positive. Staff introduced themselves to patients and patients were provided with the opportunity to ask questions. All the patients we spoke with told us they had been treated with courtesy and respect. Patients told us they had their dignity preserved as they were treated and staff made sure they were covered and not left exposed.

We observed 12 interactions between patients and staff, Staff were kind, patient and caring with patients as they supported them on and off beds, out of wheelchairs and on to scanning and x-ray apparatus. We asked four patients who all told us reception staff were helpful and professional. Patients reported plenty of time for them to ask questions and be listened to, even though the department was very busy.

The department did not participate in the friends and family test therefore there was no results on display. There were no inpatient survey results.

Emotional support

Staff provided patients with emotional support during their attendance at the departments if it was needed in the form or reassurance and explanations. Staff interacted and communicated with patients during scans.

Anxious patients were not rushed and were given time to get used to the environment. For example, patients worried about having a CT or MRI scan could visit the department prior to their appointment to look at the scanner and have staff explain exactly what would happen during the scan. Staff also supported patients with further advice and support and spent time with patients discussing procedures and diagnosis with patients.

Interpreter services are available and, if required, would be booked prior to appointment, however no interpreter services were available without planning.

We spoke with three members of staff who could give examples of how they would adapt practice to ensure a patient's cultural needs were met, such as ensuring appointments fit in around prayer times.

Understanding and involvement of patients and those close to them

The patients and relatives we spoke with said staff explained information about procedures in a way that was easy to understand. Patients and relatives said they were given time to absorb information and then ask questions about their treatment. This also ensured patients fully understood what they were consenting to and any associated risks.

Patients we spoke with told us they had enough information to understand what was going to happen on the day, staff told us information leaflets were sent to the patient before their appointment which explained the procedure.

Patients told us they felt able to ask questions and staff were able to answer them.

Is the service responsive?

Service delivery to meet the needs of local people

The department planned and provided services to reflect the needs of local population. The service worked in partnership with the local clinical commissioning groups (CCGs).

The various diagnostic and imaging departments on site were all located on the ground floor of the hospital with wide doors and corridors, therefore it was easy for patients and relatives to access. The department was well signposted from all hospital entrances and patients told us it was easy to find. All signage in the department was in English only. Car parking on site was limited as there was a lot of demand for parking spaces.
The general radiology department standard opening hours were 9am-5pm, with access to James Cook University Hospital open 24 hours a day.

There was no children's play area or children's waiting area. We asked staff about long waits in the departments. They told us patients did sometimes have long waits, especially if another patient was an emergency. Although waiting lists were designed to allow some capacity for urgent and emergency appointments throughout the day, because of the unpredictability of emergency demand, there were times when routine patients experienced delays.

Staff told us they tried to keep patients informed of delays both when they checked in and throughout their wait if the situation changed however there were no delays at the times we carried out our inspection.

Meeting people's individual needs

During our inspection, we saw staff caring for patients as individuals however there was little evidence of other ways the department accommodated individuals with additional needs.

When we asked staff what support for vulnerable patients there is, the only response from staff was to provide one-to-one support. Staff told us there was a learning difficulties lead nurse for the trust, however there was no additional support for patients with learning difficulties. The department did not use the butterfly scheme to identify patients with dementia and the environment had limited adaptations to become dementia friendly, we saw dementia friendly signs on the toilets. The department did not have a dementia champion. There were no specific quiet areas for patients with sensory needs or who did not like to be in busy areas due to health conditions in the general x-ray department however, we asked staff how they would support such patients and they told us patients would be supported to be seen quickly. There were no such patients in the department at the time of the inspection and therefore we were unable to see this in practice.

Staff told us they could access interpreters for patients as required for spoken languages and for British Sign Language for planned appointments only. Staff collected patients from the waiting areas and took them to the scan room. This was helpful for patients who were deaf, but we were not clear if staff used any other method than calling someone's name out as there was no display system for people waiting for appointments in the waiting areas. Staff could add an alert to the record if someone needed additional support related to a disability e.g. a hoist.

Staff told us information was sent out to patients about treatments offered by the radiology departments prior to any treatment. There were no leaflets or posters displayed in the department. Additionally, there was no information about how to access the leaflets in other

formats such as large print, Braille, easy read or other languages.

The department had a bookings team responsible for booking appointments for the service. The booking team offered alternative appointments and a choice of appointments if required. Patients told us they found the booking service flexible in appointment times.

Hoists were available if needed and shared with other departments in the hospital. The department could accommodate bariatric patients and bariatric equipment was available when required. Staff had received training in the use of bariatric equipment. The department was accessible for wheelchair users and wheelchairs were available within the department. The department had pressure relieving equipment available as required.

Access and flow

The department did not always meet waiting times targets. The trust submitted their internal performance data for radiology cancer performance weekly meeting matrix between August 2018 to December 2018. Overall, data showed the department was not meeting most target key performance indicators. The target key performance indicator for appointments within 48 hours was 80%, for all specialisms, the department did not achieve this between August 2018 - December 2019. The target key performance indicator for patients examined within five days was 80%, for all specialist's areas, the department did not achieve this between August 2018 - December 2019. The trust's internal key performance indicator for reporting within eight days was 80%, the department did not achieve this between August 2018 to December 2019 on average the department achieved the key performance indicator of reporting results within eight days for 58.5% of all radiology cancer cases between August 2018-December 2018.

Diagnostic waiting times (percent waiting 6+ weeks)

Between September 2017 and August 2018, the percentage of patients waiting more than six weeks to see a clinician was higher than the England average until March 2018 when the trust dropped lower than the England average and has remained lower until the latest month of August 2018. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows six plus weeks percentages over time.
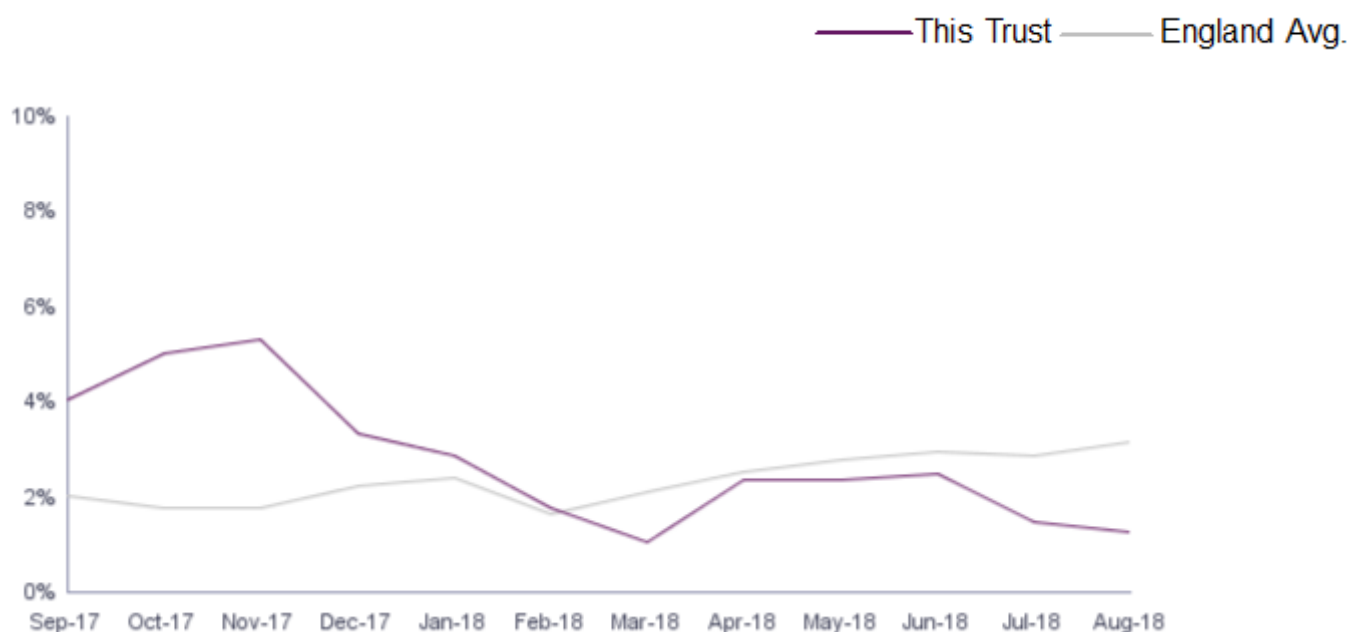
(Source: NHS England – Diagnostic Waits)

Managers we spoke with told us they are currently achieving the six-week waiting time, however they had not achieved it consistently in the previous twelve months. Managers told us the current action plan was to ensure targets continue to be met. Managers told us most referrals were within the six-week waiting list indicator and the service held monthly meetings to check where the department was with breaches in waiting times for the service.

The department bookings team could identify which appointments were urgent using a numbered system. Staff we spoke with told us this was how prioritisation of appointment bookings were done. Patients could contact the service bookings teams and arrange alternative appointments if required.

We discussed inpatient demand with managers in the trust. They told us inpatient referrals were given priority, particularly from the emergency department followed by the wards. Priority was then given to two-week urgent referrals, urgent referrals and then routine referrals. Patient flow within the department could be affected by emergency referrals taking precedence. Staff reported waiting times could be more than one hour with no information available to patients regarding anticipated waiting times. There was a standard operational procedure for CT and MRI referrals from the emergency department, referrals could be made without prior discussion, staff reported this was to help with the flow of patients and stated there were no issues with inappropriate referrals.

The department managed winter pressures by holding regular planning meetings through the year, these were attended by the operational manager.

Learning from complaints and concerns

The department had access to the complaints policy on the intranet. Staff were aware of the policy and how to access the policy.

During the inspection, management showed us how complaints, incidents and risks were stored and reported on the incident reporting system. All complaints made were routed through the Patient Experience Team (PET), the PET team direct complaints to the appropriate team or individual, for example to the chief executive, patient liaison service (PALS) or to the diagnostic department. Complaints were logged on to the incident reporting system by the PET team and given a reference number.

The department had a complaints and PALS lead who received all complaints for the diagnostic department. The complaints were then allocated to the appropriate person to lead the investigation. Any formal complaints or those that involved moderate harm or above would be looked at immediately. Even if it was judged the harm category was not appropriate, they would leave the harm level as logged until the end of the investigation.

Management reported lessons were learned from complaints. However, we were not assured complaints regarding patient harm were declared as serious incidents and we were not assured learning was always followed. The department displayed no data or information regarding previous complaints or associated data. We did see evidence of complaints discussed in the governance meetings.

Summary of complaints

From October 2017 to September 2018 there were four complaints about diagnostic imaging. The trust took an average of 37 days to investigate and close complaints, this was in line with

their complaints policy, which stated complaints should be closed within 40 days. The department reported they were meeting the complaint response timeframe set out by the policy. This could be extended to 60 working days by agreement with the complainant.

A breakdown of complaints is given below:

- Patient care: two

- Communications: one

- Access to treatment or drugs: one

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

During our inspection, we were told there were nine formal complaints, 19 PALS concerns and five PALS enquiries for 2019 so far. We examined five complaints in detail on the incident reporting system. These were selected at random. Out of the five complaints we checked, all audit trails were good, and responses were made/in process within the 25 days. We saw outcomes were explained clearly in the letters. Three of these complaints related to late results for patients. Staff reported the major complaint theme was lateness of results. Two complaints appeared to describe patient harm because of late results, both complaints were considered for the serious incident process but dismissed.

During the inspection, none of the patients or relatives spoken with knew how to make a complaint, nor was there any information about the process. There was no information about the PALS team.

Staff reported concerns and complaints were a fixed agenda point on monthly team meetings. Staff within smaller staff teams used complaints and concerns as part of daily safety huddles and stated incidents from the wider trust were communicated to them.

Number of compliments made to the trust

We saw evidence of compliments being discussed in the governance meetings. From October 2017 to September 2018 there were 17 compliments within diagnostic imaging.

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

Is the service well-led?

Leadership

The Leadership team and front-line staff told us there had been several changes to the management team from December 2018. A new governance structure had been implemented and there had been changes to the leadership structure. The business intelligence unit was in the process of reviewing each directorate's performance. We were told that if a service was deemed to be "failing" it was temporarily managed to turn it round, we were told the trust had identified radiology as "failing" and plans were in place to put radiology under temporary management.

The department had an overall lead for diagnostics and four managers who reported to the diagnostics lead. The department had 18 various lead professionals, for example radiology medicines lead, IR(ME)R lead and communication lead, these leads were supported by the four modality managers/senior nursing sisters depending on the speciality. There were also various champions, for example MRI champion and incident reporting champions, management told us they were looking at giving the champions protected time away from clinical work.

Each manager was responsible for a different specialist area such as CT, MRI, Ultrasound, medication and communication. The communication manager was on maternity leave with no cover at the time of the inspection.

Managers were aware of the challenges facing their departments and the target key performance indicators. They understood the challenges in relation to performance, demand, staffing and risks. During the inspection managers could not tell us about staff performance, they reported data regarding mandatory training was out of date or incorrect. There was a monthly radiology senior team meeting.

Overall, staff were positive about senior staff and leaders in the department. Staff told us the department leadership team was approachable and supportive, and there was a visible leadership presence in the department.

The nursing team in the department was led by the senior nursing sister who provided clinical and professional supervision.

The majority of staff we spoke with told us they knew who the chief executive was and felt the trust had changed in a positive way.

Vision and strategy

The department had a vision and strategy however this was not embedded. The Leadership team told us the vision was to be a service which patients were happy to attend, work closely with the wider organisation, have a happy workforce with good continued professional development for staff and to be an employer of choice. We evidence of the vision documented however this was not dated. We spoke with staff during the inspection who were unaware of the departments vision, we could not see any evidence of staff involvement in the departments vision.

The department's vision was in line with the trusts vision, to be recognised nationally for excellence in quality, patient safety, patient experience, social engagement and continuous improvement.

The leadership team told us the strategy for diagnostic and radiology services was to fully integrate with the trust and region, to improve job planning and to explore home reporting however, progress with the strategy was ongoing and not fully embedded with frontline staff. We spoke with staff who were not aware of the department's strategy.

Culture

During our inspection, we found there was good collaborative working between the staff at the Friarage Hospital and James Cook University Hospital. A lot of staff we spoke with at the Friarage Hospital worked across both sites.

Staff we spoke with told us there was a "positive culture" with good teamwork between the different modalities on site. Staff reported the department to have an open and honest culture. Junior staff told us they felt supported by more experienced colleagues.

The departments were patient focussed and staff worked together to make sure patients had a good experience. Staff spoke positively about the service they provided for patients and were aware of the importance of providing a quality service with a positive patient experience.

Governance

The department had recently implemented a new governance structure and the service had a full-time radiology governance lead and governance coordinator. The trust provided a governance structure which showed there were four modality managers.

The department held monthly clinical governance meetings, these were chaired by the governance lead and attended by the department's various lead professionals. These meetings discussed finances, incidents, backlog, standard operating procedures and preparations up-coming inspections. Incidents discussed in the clinical governance meeting were allocated to the involved team to investigate.

The department also held a bimonthly clinical diagnostic and support services centre radiology governance meeting. These meetings discussed incidents, sickness, mandatory training, vacancies, non-medical referrers and standard operational procedures. We saw evidence of these meetings and issues discussed being actioned, however there were no deadlines for actions to be completed by.

Staff told us the radiologists gave feedback to the radiographers about the quality of the images. Quality assurance systems and feedback was made via the departmental computer system. We saw examples of this during the inspection as some radiographers showed us their feedback, mostly positive but with some constructive advice. Following the inspection, we saw the log of feedback for radiographers, however this was not dated.

The service outsourced parts of the MRI and CT reporting to manage with the backlog of reporting. Managers told us the service escalated issues to the outsourcing provider and the outsourced provider would send the trust a report on the outcome. There were key performance indicators with the outsourcing provider. There were governance processes in place to ensure externally reported images were scrutinised and managers told us they had sought assurance from each outsourcing support provider of their governance processes to ensure they were at least as robust as those of the trust.

Meetings were held with the Radiation Protection Advisor (RPA) and Radiation Protection Supervisor (RPS), which were recorded. The department had regular radiation safety committee meetings where the radiation protection supervisors and diagnostics manager attended, we saw the minutes of the meetings which discussed incidents, personal monitoring review, reporting from medical exposure and MRI safety.

We saw evidence of monthly mortality and morbidity meetings and error and audit meetings. The department held weekly discrepancy meetings for radiologists and reporting radiographers. Staff also told us senior radiographers meet regularly. Feedback from medical staff was speciality meetings were well established, but unfortunately not always well attended due to staffing.

Information management

Staff had access to the required information systems. For example, staff had access to documents, policies, procedures and protocols electronically. Staff had access to the required radiology systems and password protection was used for the various systems. The radiology systems used in diagnostic imaging provided electronic access to scans. Some information such as scan and x-ray reports were shared with GPs however this was done with the agreement of patients.

The trust had information governance policies and procedures in place to ensure information was stored securely and protected patients' privacy and security. Information governance training was part of mandatory training, at the time of the inspection the compliance for all staff was 95.4% which was above the trust target of 90%.

The department collected information used to monitor and manage performance. There were measures in place to monitor and manage the performance of the department against local and national indicators. These were observed by the leadership team.

Management of risk, issues and performance

During our inspection, we had concerns the risks managers told us about were not documented on the risk register. We also found incidents were not being reported or when incidents were reported the correct process was not being followed, this was also not on the risk register.

We requested the trust submitted an up to date copy of the radiology risk register. The three risks identified were risk of not meeting waiting times due to radiologist capacity, risk of delay in radiology reporting and risk of misdiagnosis from radiology and pathology results. Each identified risk was assigned a current and target risk level, control in place and gaps in control were acknowledged and an action plan was documented with a review date. All risks identified were within the review date and had a clear owner.

Managers told us the three main risks to the service were workforce, introduction of electronic systems and finances. To mitigate the staffing risk, managers told us there was a working group, currently ongoing recruitment, planning ahead and speaking to staff in training; there was also involvement in engagement pieces of work and the wider network. To mitigate risks associated with the introduction of picture achieve and communication system (PACS) and electronic patient record (EPR) there were ongoing working groups and managers told us they were investing in upskilling staff to manage finances.

In July 2018 the department at James Cook University Hospital had a serious incident regarding cross contamination and involved numerous patients. All staff we spoke to regarding this incident showed good insight and could explain how practice had improved including changes to procedure to reduce the risk of future patient harm. We followed the process of this incident and saw evidence of a root cause analysis report.

In terms of the increased demand, managers told us they were considering what they could do to meet this. The service had moved to seven days working with extended hours to address this. Managers told us they were having discussions currently about how to plan for future demand.

All pregnant staff had completed risk assessment and were on amended duties.

Engagement

The trust did not supply us with any evidence to demonstrate engagement with patients who used the diagnostic and radiology services at the Friarage Hospital. The trust did not have a patient group for diagnostics however staff stated they would encourage patients to join other patient groups. There was a friend of the Friarage group which local community could support the hospital and were involved in fundraising for a new MRI scanner.

There were no comment cards or patient liaison leaflets. The department did not participate in the friends and family tests. Staff were in the process of developing a patient questionnaire for feedback on patient experience.

There was engagement with staff through team meetings across the department. The trust had provided evidence of staff meetings. Staff reported to be involved in the development of policies and improving practice. Two staff members said they felt empowered and involved in changes within the department.

The trust confirmed the Radiology department did take part in the national staff survey however due to the small sample size the results were not able to be distributed at department level.

Learning, continuous improvement and innovation

Staff were unable to provide us with any examples of innovation in the department.

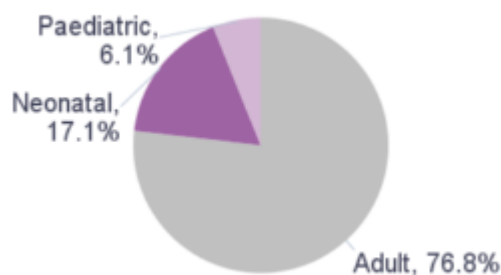The service was moving further towards paperless reporting.

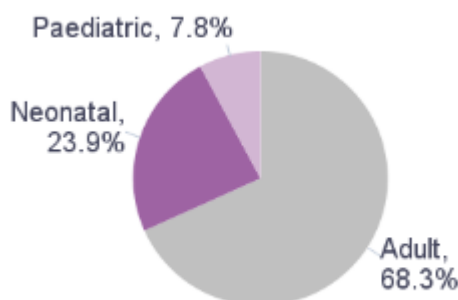# Critical care

Facts and data about this service

The trust has 82 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, South Tees Hospitals NHS Foundation Trust and England.

This trust

England

(Source: NHS England)

The Friarage hospital had six critical care beds and was a combined intensive care unit (ICU) and high dependency unit (HDU). The unit provided level two (patients who require pre-operative optimisation, extended post - operative care or single organ support) and level three (patients who require advanced respiratory support or a minimum of two organ support) care to adult patients. The number of beds in use varied depending on need and flexed between level three and level two as required. After our inspection, a reconfiguration of services meant in March 2019, the unit closed.

The hospitals critical care facilities admit critically ill patients from Middlesbrough and surrounding areas and regional referrals via the Critical Care Network.

Since the last inspection of this trust, critical care services across both sites have been consolidated so that they are delivered through one clinical centre - Urgent and Emergency care.

ICNARC data from 1 April 2017 and 31 March 2018 for the ICU/HDU unit at the Friarage Hospital showed that there were 257 admissions with an average age of 65 years. Of these:

- 37% were planned admissions from theatre following elective surgery

- 27% were from ward areas

- 14% were admitted following emergency surgery

- 8% were unplanned admissions from the emergency department or outside of the hospital

- 7% were unplanned admissions from theatre following elective surgery

- 4% were from another acute hospital (not critical care)

- 2% were planned or unplanned transfers from another critical care unit

- 1% were from another critical care unit (repatriation)

The average (mean) length of stay on the unit was 1.2 days.

The unit did not accept paediatric admissions, however in an emergency situation a bed may be used to stabilise the child until the dedicated intensive care transport service for children arrived.

The critical care outreach team (CCOT) provide a supportive role to medical and nursing staff on the wards when they are caring for deteriorating patients or supporting patients discharged from critical care. The outreach team offer a 12-hour service, seven days a week. The critical care service is part of the North of England Critical Care Network.

Is the service safe?

Mandatory Training

Mandatory training completion rates
The trust set a target of 90% for completion of mandatory training. The mandatory training data provided showed variances in the number of staff eligible for different training modules. It was unclear why there was a variance, particularly in areas such as basic life support and conflict resolution which are usually completed by all staff.

We reviewed mandatory training information for nursing staff on site which was reflective of the figures shown below. Overall compliance was 89%, this was just below the trust target.

Training comprised of face to face and e-learning modules. Staff reported they sometimes struggled to attend face to face training because of staffing shortages, and that some e-learning was completed in their own time.

There were systems in place which enabled individual staff and their managers to be alerted when training was due for renewal. We were concerned about the compliance with training compliance for immediate life support for nursing and basic and immediate life support for medical staff. We were not aware of any specific action plans to address this. It is noted in the critical care services directorate meeting minutes from 10 December 2018 that there was to be no training until after Christmas.

Sepsis training was provided by the trust however it was not included as part of the mandatory training data provided. Staff told us they had undertaken face to face sepsis training and it was also included as part of the trust induction programme.

Friarage Hospital critical care department
A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for qualified nursing staff in the critical care department at Friarage Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Mentor Update	4	4	100.0%	90%	Yes
Falls prevention inpatient training	1	1	100.0%	90%	Yes
Information Governance	17	17	100.0%	90%	Yes
Equality and Diversity	17	17	100.0%	90%	Yes
Anaphylaxis awareness	2	2	100.0%	90%	Yes
Fire Safety 3 years	17	17	100.0%	90%	Yes
Triennial Review	4	4	100.0%	90%	Yes
Advanced life support - ALS	1	1	100.0%	90%	Yes
Infection Prevention (Level 1)	17	17	100.0%	90%	Yes
Health and Safety (Slips, Trips and Falls)	16	17	94.1%	90%	Yes
Manual Handling – People	16	17	94.1%	90%	Yes
Dementia Awareness (inc Privacy & Dignity standards)	14	15	93.3%	90%	Yes
Conflict Resolution	12	13	92.3%	90%	Yes
Basic Life Support	12	14	85.7%	90%	No
Adult Basic Life Support	8	10	80.0%	90%	No
Prevent -WRAP	13	17	76.5%	90%	No
Blood Transfusion	13	17	76.5%	90%	No
Immediate life support - ILS	3	7	42.9%	90%	No

At Friarage Hospital critical care department the 90% target was met for 13 of the 18 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from October 2017 to September 2018 for medical staff in the critical care department at both sites is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)

Falls prevention inpatient training	5	6	83.3%	90%	No
Information Governance	29	36	80.6%	90%	No
Anaphylaxis awareness	3	4	75.0%	90%	No
Equality and Diversity	27	36	75.0%	90%	No
Health and Safety (Slips, Trips and Falls)	27	36	75.0%	90%	No
Fire Safety 3 years	26	36	72.2%	90%	No
Advanced life support – ALS	5	7	71.4%	90%	No
Infection Prevention (Level 1)	24	36	66.7%	90%	No
Adult Basic Life Support	11	17	64.7%	90%	No
Blood Transfusion	16	29	55.2%	90%	No
Dementia Awareness (inc Privacy & Dignity standards)	7	14	50.0%	90%	No
Advanced paediatric life support – APLS	1	2	50.0%	90%	No
Basic Life Support	6	13	46.2%	90%	No
Prevent -WRAP	13	36	36.1%	90%	No
Manual Handling – People	9	26	34.6%	90%	No
Conflict Resolution	3	11	27.3%	90%	No
Learning Disability Awareness Training	0	2	0.0%	90%	No
Immediate life support - ILS	0	4	0.0%	90%	No

Across the critical care department at the trust, the 90% target was not met for any of the 18 mandatory training modules for which medical staff were eligible.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Safeguarding training completion rates
The trust set a target of 90% for completion of safeguarding training.

There was a trust safeguarding policy which could be accessed via the intranet. We were told there was a policy for rapid tranquilisation, however, when asked, staff were unable to locate this.

Staff we spoke with could describe what may be seen as a safeguarding concern and how they would escalate this. However, we found limited understanding around female genital mutilation (FGM) and the mandatory reporting required for this.

There were named lead nurses for adult and children's safeguarding at the trust as well as a safeguarding team who were available for advice.

Friarage Hospital critical care department
A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for qualified nursing staff in the critical care department at Friarage Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding vulnerable adults	17	17	100.0%	90%	Yes
Safeguarding Children (Level 2)	17	17	100.0%	90%	Yes

At Friarage Hospital critical care department the 90% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses from October 2017 to September 2018 for medical staff in the critical care department at the James Cook University Hospital is shown below:

Name of course	Staff trained (YTD)	Eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding Children (Level 2)	29	36	80.6%	90%	No
Safeguarding vulnerable adults	27	36	75.0%	90%	No

At the James Cook University Hospital critical care department, the 90% target was not met for two of the two safeguarding training modules for which medical staff were eligible.

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

Cleanliness, infection control and hygiene

The unit was visibly clean, tidy and dust free and hand hygiene points were visible at the entrance. Empty bed spaces had checklists completed to indicate they were clean and ready for the next patient. We also observed completed daily and weekly cleaning checklists.

We found appropriate waste segregation and disposal systems in place. Sharps bins were also seen, they were not overfilled and had completed labels.

We observed staff interactions with patients were compliant with key trust infection control trust guidelines, for example hand hygiene and the use of personal protective equipment (PPE).

The CCOT had a daily record of each central line that was inserted. As part of their follow up of patients who had been transferred to ward areas, they ensured they were removed as soon as they were no longer required.

One hundred percent of staff had completed mandatory training in infection control and prevention. This exceeded the trust target of 90%. There was an identified link worker for infection prevention and control (IPC). Part of their role as to ensure staff were aware of availability and dates for training and support staff with e-learning.

Between 1 April 2017 and 31 March 2018 there had been 1.2 unit acquired infections in blood per 1000 patient bed days, this was in line with similar units.

ICNARC data showed there had been no unit acquired cases of methicillin resistant staphylococcus aureus (MRSA), clostridium difficile or vancomycin-resistant enterococci (VRE) this site. This was unchanged from the data seen in the, getting it right first time (GIRFT), Intensive and critical care review report from September 2018.

The dashboard for the unit also showed that from September 2018 to February 2019 there had been no unit acquired infections. There was a lack of effective processes to ensure that both data

submissions to ICNARC were correct and when anomolies were identified they were acted upon, for example infection rates.

Care bundles were in place to prevent ventilator associated pneumonia (VAP). Monthly audits were undertaken looking at areas of compliance for regular observations and ongoing care. Data was provided from August 2018 to January 2019, 100% was consistently achieved for both areas at the Friarage hospital.

The incident data for critical care from February 2017 to February 2018 showed there were 168 incidents related to infection control across both sites. The majority of these (156) related to the category 'unsafe/inappropriate clinical environment. From our observations and discussions with staff, issues were highlighted with the unit's ability to isolate patients with an infection. This was mainly due to staffing problems, which meant isolation rooms could not safely be used to provide patient care.

We reviewed incident data on site during the inspection and between March 2018 and December 2018 for this unit. There were ten incidents relating to patients not being isolated because of staffing shortages.

During our inspection at the Friarage the three patients on the unit each had an infection, they were being isolated within the main bay. The side room was not being used due to staffing shortages. The issue of not being able to use the isolation room due to staffing problems did not feature on the service's risk register.

Environment and equipment

Access to the unit was via an intercom with a security camera. Mixed sex accommodation for critically ill patients was provided in accordance with the Department of Health guidance and managed in line with agreement with commissioners.

The unit had windows allowing natural light in. There were five bed areas in the main bay and an isolation room. The bed areas were very restricted for space and non-compliant with Department of Health, Health Building Note (HBN) 04-02, in terms of the space around and at the foot of the bed. The space was needed to allow for unobstructed circulation of staff or equipment and for infection prevention and control reasons.

Each bed space also did not have their own hand wash basin.

There was no curtain system in place, dividing screens were between beds with moveable screens put in place when patient care was being provided. These did not provide 100% visual privacy as outlined in HBN 04-02.

It was noted during our inspection that the isolation room on the unit also did not meet the HBN 04-02 best practice guidance for critical care units as it did not have a lobby or the appropriate ventilation in place.

Theatres were closely located providing easy access and there was central monitoring in place to allow oversight of patients.

Storage areas were organised, with doors locked. We checked 22 pieces of equipment and found evidence of up to date electrical safety testing. We inspected a wide selection of consumable items in resuscitation trollies and store rooms in the different units we visited. We found all packets were intact and within expiry dates.

The replacement of equipment was part of the trust wide capital replacement programme. There was adequate equipment in the unit to meet the needs of patients. We saw that specialist equipment was available for patients with a high body mass index (BMI) when required.

Appropriate emergency equipment was available at each bed space. There was a centrally located resuscitation trolley, a transfer trolley and bag. We found evidence of daily checks being completed and contents in line with Resuscitation Council (UK) guidelines. We did note that tamper proof seals were not used, this meant staff could not be fully assured that items had not been removed between checks.

Training for new equipment introduced to the unit was provided by the manufacturer and training and competency checks were carried out by clinical educators. There were also key trainers identified for specific pieces of equipment.

Equipment training compliance was recorded on a spreadsheet maintained by the two clinical educators. We requested training compliance figures and current compliance for critical care. We were only provided with information for the staff working on general ICU and generic HDU at The James Cook University hospital.

The information showed training for 34 pieces of equipment. The equipment and staff compliance were red, amber and green (RAG) rated. Red pieces of equipment included ventilators, infusion pumps and blood gas machines. Attached to the spreadsheet was guidance on training percentage targets for high risk (red rated) equipment.

We could not be assured that the staff at this unit had the appropriate training for the equipment being used as this information was not provided. Incident data reviewed on site showed an incident where staff were unsure if a piece of equipment to support a patients breathing had been used correctly.

Assessing and responding to patient risk

The critical care outreach team (CCOT) provided cover seven days a week for 12 hours during the day. Overnight cover was provided by the hospital out of hours team.

The CCOT played a vital role in supporting staff on the wards when patients become unwell. They had several other roles including, providing support for patients with tracheostomies or requiring non-invasive ventilation. They also reviewed patients who were discharged from ICU to ward areas. A list of patients who were discharged was provided to the CCOT each day who ensured patients were reviewed by them on the ward within 24 hours.

The trust used the national early warning score system, version two (NEWS) as a tool for identifying deteriorating patients. The wards had an electronic system for recording patient observations. This allowed the CCOT to remotely view any patients with elevated NEWS scores.

There was a clear escalation policy in place for when patients had an elevated NEWS score; despite this, we were concerned by some information in the serious incidents reported by the trust. There were two serious incidents where trust and national guidance was not followed in relation to raised NEWS scores which led to adverse outcomes for the patients involved.

The CCOT used a 'ward watcher' system to provide information and oversight of any unwell patients or patients who have moved from critical care to ward areas. The system included data from the electronic observation system to identify any patients of concern, as well as any patients identified by the medical and surgical teams.

The system was used for handover between the CCOT and the hospital at night team handover.

All the staff we spoke with highlighted concerns over the nurse staffing compared to numbers of patients on the unit. Staff were clear that patient safety was always prioritised, however, staff described, and we observed situations where risks were present to patient care because of these issues.

We directly observed the challenges of repositioning patients when there were shortages of staff, and staff told us they would often not have the sufficient numbers of staff to regularly and safely reposition patients. This was particularly applicable to this site where there may only be two members of staff on duty. Staff told us they would seek assistance from other areas to help with repositioning patients.

From reviewing incident data, we saw there had been several pressure ulcers reported. Data from February 2018 to February 2019, across all areas of critical care showed there had been 118 incidents related to pressure ulcers. Forty-seven of these were related to devices, the remainder were because of skin damage due to pressure; one of these was reported as a serious incident due to its severity.

For the same period there were two incidents where patients had deteriorated and required admission to critical care. This could not be facilitated due to staffing shortages in critical care so on both occasions the patients were transferred to wards. This presented a significant risk.

Incident data specific to this site was viewed during the inspection. We saw that staff had reported incidents of pressure damage that had occurred because patients were not been repositioned as regularly as they should have because of staff shortages. This was a significant concern.

We raised concerns about pressure damage with the chief nurse and the chief executive during the inspection and were told the majority of incidents were device related and unavoidable. From reviewing the data, it was evident this was not the case, for example, some related to oxygen tubing and anti-embolism stockings. Most of the device related incidents resulted from the use of nasogastric bridles. This is a piece of equipment used to secure a feeding tube in place.

Information on pressure ulcers was collected via unit dashboards. Information from September 2018 to February 2019 showed, except for October and November, there had been one grade two pressure ulcer each month. In January there had been a grade three/four pressure ulcer.

As we still lacked assurance on patient safety related to pressure damage we wrote formally to the trust raising our concerns following the inspection. We requested weekly assurance information be sent for his site until the unit closed.

The GIRFT report from 2018 identified that over a quarter of admissions to this unit occurred overnight. The report stated this was very difficult to manage with the current staffing. The admissions occurred when there was no intensivist on site. Whilst there would be an anaesthetist available they may not have specific critical care training. This presented a risk.
The report also identified that some patients requiring prolonged weaning were transferred to the Friarage. Concerns were highlighted over nurses and physiotherapists being able to maintain their

skills in advanced respiratory support to care this patient group, as they were small numbers. Patients who take a long time to wean are a special group and whilst placing them in Friarage may ease capacity issues elsewhere it is questionable whether they receive the necessary expert MDT support these difficult patients require.

Previously if a patient required a tracheostomy this procedure would be done in theatre. Current practice was that this was done on the unit, with challenges to the medical cover at this site this also presented a risk and would require forward planning to ensure appropriate cover and experience was available. The GIRFT report questioned whether this was appropriate practice.

Information from the National Emergency Laparotomy Audit showed that twice as many patients who had a laparotomy at the Friarage end up in critical care unplanned than nationally. The GIRFT report recommended that the trust reviewed the data and emergency laparotomy cases should be done at the James Cook hospital sight. Since the inspection the unit at the Friarage closed so these issues no longer pose a risk to patient safety.

Sepsis screening tools and pathways were in use, staff were aware of these and we saw evidence of them in the patient records we reviewed.

We observed completed daily bedside safety checks. Within patient records risk assessments and care bundles were completed, for example, for falls and moving and handling.

Staff we spoke with knew how to access the mental health support. There was access to specialist nurses and crisis teams.

Nurse staffing

Nurse staffing guidance and standards from D16 NHS standard contract for adult critical care and GPICS describe minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients' ratio for level two patients. The guidance also recommends consideration of a supernumerary coordinator during peak periods of activity with units of less than six beds.

The service had a network peer review in June 2016. This identified that urgent consideration of 24/7 staffing strategies needed reviewing. The report also stated *"operationally the unit runs with three nurses per shift; this is extremely challenging. Logistically, it is more difficult to complete clinical tasks such as patient repositioning and mobilisation".* The review recommended an increase in the number of health care support workers to support the nursing workforce.

When we visited the unit, we observed the vulnerability of staffing and the challenges with providing patient care. We saw there were two registered nurses on the night shift and no health care support workers. There were two level three and a level two patient, which meant there should have been a minimum of three registered nurses on the shift. This was not in line with GPICS staffing recommendations. Staff would not be able to leave the unit to have a break and assistance would have to be sought from other areas in the hospital to assist with basic care needs such as the repositioning of patients.

Staffing information and patient numbers and dependency levels were being recorded hourly each day by the nursing staff. We reviewed this information on site as well as information recorded on

the nurse in charge information sheet. We found each day from the 1 February to the 20 February 2019 staffing levels did not meet GPICS recommendations.

For example, on the 7 February 2019 for 40 minutes there were four level three patients with only two registered nurses and one health care support worker. One patient was transferred to another unit however this still left three level three patients and only two registered nursing staff. On the 19 February 2019 there were to level three and two level three patients on the unit between midnight and 4pm. There were two registered nurses on duty. On the 20 February for a 24-hour period there were two level three patients and one level two patient with two registered nurses on duty.

All the staff we spoke with raised concerns over nurse staffing. We were told caring for more than one level three patient was a common occurrence and we found evidence of this. Staff also told us they would complete incident forms over staffing issues. We saw evidence of this from the data we reviewed on site, however the number of incident forms was less than the number of staffing shortages we saw from reviewing rotas.

We were very concerned about the nurse staffing levels during our inspection and the impact this was having on patient safety and individual staff members. Without exception medical and nursing staff told us they felt the need to 'justify' when asking for support with nurse staffing from colleagues at the James Cook site.

We attended bed meetings and further meetings specifically about critical care capacity. We were concerned that the significant staffing issues we saw were not highlighted at these meetings. Nurse staffing also did not feature on the critical care risk register.

Planned and actual staffing numbers were displayed. Electronic rostering was in place which incorporated the safe care staffing tool. The senior management team told us staffing shortages would be reported via 'red flags' on this system. We requested data on the number of red flags reported in critical care at this site. The data provided by the trust from July 2018 to February 2019 showed there had been four. This supported our concerns that nurse staffing was not recognised as a significant issue by the senior team.

We raised our concerns about nurse staffing to the senior management team during the inspection to the chief nurse and the chief executive and we formally wrote to the trust raising our concerns following the inspection. We were provided with assurance that staffing levels were appropriate for the number and levels of patients being cared for. In March the critical care unit at the Friarage closed.

Gaps in staffing were covered by moving staff between areas and staff working additional shifts; there was some use of bank staff. Agency staff were use very rarely. Support with staffing was also provided by senior nurses who may have been planned to work non-clinically.

We observed the nurse handover which was detailed and comprehensive with any safety issues identified.

There was no specialist clinical pharmacy input at this site. This was not in line with GPICS recommendations, which state, there must be a critical care pharmacist for every unit, with services provided at least five days per week, including attendance at consultant-led Multidisciplinary ward rounds.

Pharmacy staff supported with the 'top up' of stock medications and the pharmacy department could be contacted for advice.

From speaking with physiotherapy staff and reviewing patient records, we saw that patients received therapy each day. However, it was a challenge to deliver the respiratory and rehabilitation elements of patient care as the physiotherapy staff covered other areas in the hospital. An increase in specialist pharmacy and physiotherapy provision were recommendations from the 2016 peer review of the service.

We reviewed staffing establishment figures on site which are shown below.

Site	Planned WTE registered staff	Actual WTE registered staff
Friarage Hospital	16.26	14.72

There were two WTE band five staff due to start and one band six nurse due to leave which would bring their actual WTE to 15.72.

Site	Planned WTE unregistered staff	Actual WTE unregistered staff
Friarage Hospital	2.71	2.6

Turnover rates
As at October 2017 to September 2018, the trust reported a turnover rate of 10.8% in critical care this in not in line with the trust 10% target;

- Friarage Hospital: 23.0%

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

Sickness rates
As at October 2017 to September 2018, the trust reported an overall sickness rate of 5.9% in critical care, this is not in line with the trusts 3.5% target;
- Friarage Hospital: 12.6%

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

Bank and agency staff usage
From October 2017 to September 2018, the trust reported a bank usage rate of 67.9% an unfilled rate of 48.1% and no agency usage in critical care;

All nursing staff

Site	Bank rate	Agency rate	Unfilled rate
Friarage Hospital	7.2%	N/A	60.9%

Qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
Friarage Hospital	6.0%	N/A	57.0%

Non-qualified nursing staff

Site	Bank rate	Agency rate	Unfilled rate
Friarage Hospital	19.2%	N/A	99.0%

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The critical care services had a clinical director. The consultant cover at the Friarage site was not in line with GPICS recommendations. There were significant challenges with the medical rota as the Royal College of Anaesthetists withdrew anaesthetic and ITU trainees from this service in 2016/2017.

There were three consultants based at this site providing medical cover, one of these was part time. The requirement was for eight consultants. Despite ongoing recruitment, the remaining post had not been filled.

Information provided by the trust showed that between April 2018 and March 2019, 96 sessions were covered by consultants at James Cook University hospital using either flexible anaesthetic sessions or additional sessions. One hundred and ten sessions covered were by anaesthetists from this site at the expense of an elective list.

Consultants were often travelling between the two sites to review patients. From the patient records we were able to review we were assured patients were reviewed by a consultant within 12 hours of admission. From reviewing incident data on site, we did see one incident of a delay in patients being reviewed by a consultant. Staff told us that consultants were not always able to attend within 30 minutes due to travelling times. This was not in line with GPICS recommendations.

The consultant to patient ratio was in line with the recommended range of 1:8 to 1:15. However, block working was not in place to deliver continuity of care for patients. The staff we spoke with said at times this could cause problems with consistency and changes in treatment plans.

Overnight cover at this site was provided by a middle grade anaesthetist, with a consultant available on call as required. This present a potential risk with overnight admissions as there was no intensivist on site. The rota was heavily reliant on locum doctors, for example, in February 2019, 23 out of 28 nights were covered by locums. These were regular locums who were familiar with the unit.

There were recognised challenges with filling the middle grade staffing rota. Information provided by the trust showed that there should be seven doctors to meet the staffing requirements. At the time of inspection there was one permanent middle grade doctor with a further two on zero hours contracts.

Support with any gaps was provided by associate specialists and the consultants. Information provided showed between April 2018 and March 2019 (planned cover) there were 319 sessions covered by a Locum. There were concerns over how sustainable this was.

It had been identified in the 2016 network peer review of the service that staffing strategies needed urgent consideration and that the withdrawal of anaesthetic and ICU trainees meant the appointment of advanced critical care practitioners and other trust doctor appointments was essential. These concerns were included as part of the action plan following the review, however at our inspection we found the situation to be unchanged.

There was an identified risk on the risk register that the critical care medical rota could become unsustainable. Following our inspection, a decision was made to realign services and the critical care unit at the Friarage was closed.

Records

Paper records were in use and nursing and medical records were stored securely in a cupboard behind the nurse's station. Information provided by the trust showed 100% of nursing staff had completed information governance training, this exceeded the trust target of 90%. There were plans to implement electronic patient records, which would include a critical care module. This was not expected to be in place until 2022.

We reviewed three sets of nursing and medical records in detail looking at care plans and risk assessments. Nursing records were accurate, fully completed and in line with trust and professional standards. Specific critical care proformas were used. We were told a record keeping audit was undertaken every three weeks.

Care bundles and pathways were in use for specific conditions or procedures. There was evidence in the notes we reviewed of assessments which focused on details other than physical health needs, for example, mental health conditions and emotional needs.

The critical care admission and discharge documentation was in line with the National Institute for Health and Care Excellence (NICE) CG50 acutely ill patients in hospital. A daily critical care assessment form was completed and on discharge from the unit a summary document was completed. CCOT staff confirmed that discharge information was thorough with clear escalation plans for individual patients.

We saw staff complete the, safe patient transfer bundle for discharges to the ward document. This detailed, pre-transfer checks to be completed, a detailed handover and post transfer checks once the patient had arrived on the ward.

The physiotherapy team completed records that met the National Institute for Health and Care Excellence (NICE) CG83 (rehabilitation after critical illness) requirements during a patient's stay in critical care.

Following the inspection, we were provided with a copy of the trusts SOP for referral and admission to critical care. It was noted this was due for review in January 2019. This detailed the timeframes and pathways for admission to critical care referencing some of the standards within Guidelines for the Provision of Intensive Care Services 2015 (GPICS).

Medicines

We reviewed three medicine charts and found these to be completed in line with trust and national guidance. None of the medicine charts had not been reviewed by the pharmacist, this was reflective of the lack of pharmacy cover.

The allergy status had been completed on each of the charts. There was a separate section of the chart for prescribing antibiotics with clear review timescales in place, this was in line with national guidance. Oxygen and preventative treatment for venous thromboembolism (VTE) were also prescribed.

During our inspection we found medicines were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed controlled drug records and saw that accurate records and checks were completed.

We observed fridge temperatures were monitored and recorded in line with trust policy. Staff could explain the process of escalation if fridge temperatures were outside of the safe temperature ranges.

Pharmacy staff could be contacted for advice to support patients withdrawing from drugs or alcohol. There was on line guidance available for staff regarding intravenous drug infusions.

Medicines updates were included as part of the services learning bulletin, for example the most recent ones included information on the antimicrobial's guidelines having been updated.

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 October 2017 to September 2018, the trust reported no incidents classified as never events for critical care.
(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS
In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) related to pressure ulcer(s) in critical care which met the reporting criteria set by NHS England from October 2017 to September 2018.
(Source: Strategic Executive Information System (STEIS))

Incidents were reported on an electronic system. All the staff we spoke with were aware of how to report incidents and gave examples of what they would report. Staff told us most incidents reported related to staffing shortages and the impact on patient and staff safety.

We reviewed incident data on site and saw 16 incidents from March 2018 up to the time of inspection, where the nurse staffing levels had not been sufficient to meet the needs of patients. These involved nurses caring for more than one level three patient, which was not in line with GPICS recommendations.

Other patient safety incidents reported included challenges when managing emergency situations

due to having only two staff members on duty.

We observed a learning from events bulletin from February 2019. This explained a review of serious incidents had shown a delay in recognising and reporting patient safety incidents. Actions following this included reminding staff it is their responsibility to report, and departments should be reviewing incidents daily and discussing actions to prevent a reoccurrence.

Critical incidents were a standing agenda item on the critical care services senior staff meeting. This meeting had recently been reintroduced to the service. There was some evidence of discussion about incidents, but it was limited. Brief details of the incident were recorded but no actions or learning.

Senior nurses recognised that safety huddles needed to be better established. We were told they took place as part of the nursing handover. We observed this taking place during the handover we observed.

The matron for the service had sight of all incidents and all incident rated moderate and above were reviewed by the patient safety team. Incident forms were also reviewed by a designated consultant and any learning shared. Senior staff told us themes of incidents related to staffing, a lack of isolation rooms and pressure ulcers.

There were various systems in place to feedback learning from incidents. Information was sent via email, shared at team meetings or via closed social media groups and via safety bulletins.

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.

Critical care specific mortality and morbidity meetings took place weekly, which was in line with GPICS recommendations. Feedback from consultants we spoke with was this process was embedded within the service. All staff were invited to attend. Case reviews took place as well as learning from care that had gone well to share good practice. Learning and any changes in protocols were shared via email. The service also had mortality and morbidity meetings with other specialities, for example, neurosurgery and colleagues in the emergency department.

Safety Thermometer

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 was displayed for individual areas in critical care as part of the urgent and emergency care summary. This included information on infection rates, falls and category two and category three and four pressure ulcers.

We reviewed data from September 2018 to February 2019 for this site. During this time there had been no falls, four category two pressure ulcers and one category three/four pressure ulcer.

We saw information on the current focus of the month. This related to pressure ulcers. Actions for staff included ensuring risk assessment tools were completed, repositioning patients, and the appropriate use of equipment and dressings.

Is the service effective

Evidence-based care and treatment

Polices and guidance were accessed on the trust intranet. We were told there was a protocol for each procedure and these were updated by consultants. We experienced difficulties in locating specific polices and guidance.

Following the inspection, we requested the policy for sedation and restraint. We found these were in date with author and version control. These were based on guidance from National Institute for Health and Care Excellence (NICE), the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).

The trust was part of the North of England Critical Care Network. The last peer review of the service had been in 2016. There had been a GIRFT Intensive and critical care review in September 2018, this looked at each of the critical care areas. The report covered 14 metrics, for example, length of stay and admission and discharge outcomes, as well as looking at staffing and multidisciplinary team input.

We were provided with a copy of the services action plan in response to the GIRFT report. Many of the areas of concern were resolved by the unit closure at this site.

The service collected data for ICNARC in order to, benchmark itself with similar units and monitor performance. There was a lack of effective processes to ensure data submissions to ICNARC were correct and when anomolies were identified they were acted upon, for example infection rates.

We were provided with the audit plan for critical care. Between April 2018 and March 2019 eight audits had been completed. These covered a wide range of areas from sepsis and airway assistance to documentation and communication with families. For the same time period there were five audits that were ongoing. These included topics such as managing alcohol withdrawal and correct prescribing and administration of MRSA treatment.

The service had a guideline for delirium screening and diagnosis. The trust policy identified non-pharmacological treatments and approaches to use prior to looking at pharmacological interventions. We saw evidence of screening for delirium in each of patient records we reviewed in line with NICE guidance.

We saw information on screening, assessment and management of sepsis.

We saw admission and discharge documentation was in line with the NICE CG50 acutely ill patients in hospital. We saw evidence of outreach team activity data collection. This included

information on the number of patients followed up on discharge from critical care and the number of visits they had. The data showed that each patient had a minimum of two visits. The data also showed the number of referrals to the service and that each of these were seen by the CCOT.

In addition to this data set the CCOT also conducted audits looking at the management of deteriorating patients. These included sepsis and fluid balance recording. We were provided with a gap analysis of the CCOT requirements as outlined in GPICS, the service was fully compliant.

The service leads were aware that further work needed to be done to provide care that was in line with NICE CG83 rehabilitation after critical illness. The service was challenged as funding had not been approved which would support full compliance, this particularly related to psychological input for patients.

The service had developed a comprehensive patient information leaflet, the critical care rehabilitation manual. This contained information about the patient journey from intensive care to discharge home. It included pictures and descriptions of the various pieces of equipment and information on resources and support once patients were at home.

We were not told during the inspection, but information provided after the inspection explained there was a multidisciplinary rehabilitation after critical illness working group. This was led by one of the CCOT. All patients discharged from critical care were screened and those at greatest risk were followed up. We also saw from departmental minutes that progress against this guideline was discussed.

Nutrition and hydration

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We saw this had been completed in each of the patient records we reviewed.

The unit had an emergency feeding protocol in place. This provided guidance for staff on feeding patients who were unable to eat and needed to be fed by nasogastric tube. This meant there was no delay in the feeding of patients if a dietitian was not available.

There was access to a dietitian and they would visit the units were also available out of hours on an on-call basis. The provision was in line with GPICS recommendations.

During our inspection we saw that water was available for those patients able to drink and assistance was provided as required for those patients. We found fluid balance charts were fully completed in each of the records we reviewed.

Pain relief

There was access to an acute pain team to provide advice; they worked with the multidisciplinary team. Pain relief was discussed on ward rounds and reviewed by the pharmacy team.

In the three records we reviewed we found evidence of pain scores being completed and appropriate action taken in response to any indication a patient was experiencing pain. The trust used a pain scale which was recorded on the patient observation tool at the patient bedside.

We were provided with audit data relating to pain charts being present and pain assessment being undertaken following the administration of analgesia. The data from October 2018 to January 2019 showed 100% compliance was consistently achieved.

The patient and relatives we could speak with reported pain control being effective and that it was provided in a timely way.

Patient outcomes

ICNARC Participation
The trust's ICU and HDU areas contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide. The Friarage hospital critical care unit also participated in ICNARC. The ICNARC data was collected by a data clerk who worked closely with the clinical team to collate information.

We used data from the annual report from 1 April 2017 to the 31 March 2018.
(Source: Intensive Care National Audit Research Centre (ICNARC))

Hospital mortality (all patients)

The Friarage Hospital
ICNARC data for the Friarage hospital showed the risk adjusted hospital mortality ratio was 0.72 in 2017/18. This was within expected range.

Number of cases	Metric	2017/18	National aggregate	Asp Standard	Comparison
255 admissions	Risk-adjusted hospital mortality ratio (all patients)	0.72	1.0	None	Within expected range

Hospital mortality (for low risk patients): The Friarage Hospital
ICNARC data for the Friarage hospital showed the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.29 in 2017/18. This was within expected range.

Number of cases	Metric	2017/18	National aggregate	Asp Standard	Comparison
205 admissions	Risk-adjusted hospital mortality ratio (all patients)	0.29	1.0	None	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

The unit at the Friarage had an unplanned readmission rate within 48 hours of 0.5% for the period of 1 April 2017 to 31 March 2018. This was lower (better) than the rate for similar units which was 1.5%,

Sepsis formed part of the services annual audit plan. This included an audit of compliance against the sepsis bundle, training and the use of sepsis champions. It was unclear where audit

results were discussed as we saw no evidence in the meeting minutes we reviewed.

The physiotherapy team completed a national rehabilitation outcome measure called the 'Chelsea Critical Care Physical Assessment Tool', a scoring system to measure physical morbidity in critical care patients.

Competent staff

Appraisal rates

From October 2017 to September 2018, 76.3% of staff within critical care at the trust received an appraisal compared to a trust target of 80%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met
Medical & Dental staff - Hospital	40	38	95.0%	Yes
Qualified nursing & health visiting staff (Qualified nurses)	313	239	76.4%	No
Support to doctors and nursing staff	73	49	67.1%	No
Qualified Allied Health Professionals (Qualified AHPs)	1	0	0.0%	No

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

Data we were shown on site for nursing staff working in critical care at this site showed 78% had undergone a recent appraisal. The ward manager described the plans that had been put in place to complete those which were outstanding.

All new staff both medical and nursing attended a corporate induction when starting at the trust. A local induction was completed by all new staff. Registered nursing staff had an induction week for then a six-week supernumerary period. During this time support was provide by the clinical educator and a mentor. Training was provided covering a range of topics from body systems to stoma care and human factors.

Information provided by the trust showed that 33% of nurses in the service had a post registration award in critical care nursing. The information was not broken down by site, so it was unclear how many staff at the Friarage held this qualification. This was not in line with the GPICS minimum recommendation of 50%. The trust had a trajectory of 48% by the end of the academic year as there were 16 staff currently undergoing this training.

We spoke with the two clinical educators, they were in dedicated roles in line with GPICS recommendations. They provided a variety of education and maintained central records for equipment training, steps and post-registration training on the units.

The clinical educator who covered this site covered other areas at James Cook and spent one day a month at the Friarage. GPICS recommendations are that there should be one whole time equivalent educator per 75 staff. We were provided with information that two further posts had been approved in December 2018, these had not been appointed to at the time of inspection.

All registered nurses in critical care are required to complete step one of the National Competency Framework for Adult Critical Care Nurses within 12 months of commencing employment on the units. Step one competencies have been designed to provide core generic skills required to safely and professionally care for the critically ill patient in a general critical care unit under the supervision and support of a mentor, lead assessor and /or practice educator.

We were only provided with training data for staff working on the ICU and HDU at the James Cook University hospital. From this data overall percentages with step competencies was not evident. However, it was seen that steps training for levels one to five was undertaken.

Staff rotated between units as required to support staffing shortages. From the information we were provided with, we lacked assurance that staff had the necessary skills and training to be able to provide care to patients on critical care as full training compliance data was not provided. We also lacked assurance over how the skills and competencies of staff fed in to the rota to ensure an appropriate skill mix at all times in each unit.

Additional study days were provided by staff in areas such as airway management and ventilation. There were identified link workers in each area, for areas such as tissue viability and moving and handling.

Doctors reported there were good teaching opportunities for medical staff on a range of conditions. There was a weekly consultant led teaching programme on a Wednesday and a middle grade teaching programme was in development. There was also access to a simulation centre to support training.

Multidisciplinary working

During our inspection we observed good multidisciplinary team (MDT) working. This was supported by the various staff we spoke with and in the patient records we reviewed.

It was recognised by the staff in the units and the inspection team that the effective MDT working played a significant role in providing effective care and treatment for patients. Particularly with the staffing pressures we observed. We observed a number of situation where staff supported each other to deliver care when there were staffing shortages.

There was a lead physiotherapist and dietitian for critical care. Access to speech and language therapy and nurse specialists was available when required by referral. Pharmacy and microbiology staff could be contacted by phone.

MDT staff did not accompany medical staff on the ward round. Physiotherapy staff confirmed that in line with GPICS recommendations they could provide the respiratory management and rehabilitation components of care. They reported this was a challenge as they covered other areas as well as critical care. Physiotherapy input had been highlighted as an area which needed further input in the 2016 Network peer review, to support a more robust service.
As previously discussed there was no critical care pharmacy provision which meant GPICS standards were not met.

The CCOT liaised with allied health professional as required as part of their role. They also ensured ward managers were aware of any unwell patients there may be on their wards and the plan of care.

Seven-day services

Consultant led ward rounds took place daily. Consultant cover was available twenty-four hours a day, seven days per week, on an on-call basis.

Pharmacy staff were available Monday to Friday and there was an on-call service at weekends and out of hours.

Physiotherapists provided treatment seven days a week with an on-call service available overnight.

Speech and language therapy were offered Monday to Friday.

X-ray, computerised tomography (CT) scanning, interventional radiography and endoscopy was accessible 24 hours a day, seven days a week.

Health promotion

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. Staff told us the pharmacy department and consultants would provide advice and support in such situations. Nicotine patches could also be prescribed and provided to patients if required

The multidisciplinary team provided health and self-care advice to patients to support them to manage their own conditions.

A range of patient information leaflets were available for patients and families. This included information such as preventing blood clots and smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Mental Capacity Act and Deprivation of Liberty training completion
The trust reported that from October 2017 to September 2018 Mental Capacity Act (MCA) training was completed by 59% of staff in critical care compared to the trust target of 90.0%.

The breakdown by site was as follows:

Site	Training complete (YTD)	Individuals required (YTD)	Completion rate	Target met
Friarage Hospital	14	19	73.7%	No

The trust did not deport report Deprivation of Liberty Safeguards training during the same period.
(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

MCA training was done face to face, consultant staff were aware they needed updating with this training.

Despite training compliance being below the trust target, the staff we spoke with demonstrated good understanding of the mental capacity act and deprivation of liberty safeguards.

Staff were unable to find the policy on restraint whilst we were on site, however this was provided after the inspection when requested. Staff were aware of the process if a patient required any form of restraint. Staff told us where possible this would be avoided.

In the records we reviewed there were daily prompts to undertake Richmond Agitation-Sedation Scale (RASS) scores and screening using the Confusion Assessment Method (CAM) for ICU. These are used to measure the agitation, sedation or delirium levels of a patient. We saw that where appropriate these had been completed and appropriate actions taken.

The falls assessment chart included a screening tool for dementia. This was completed as appropriate in the records we reviewed.

Staff we spoke with demonstrated a good understanding of consent, and where possible, would always seek consent from patients.

Is the service caring?

Compassionate care

We were only able to speak with one patient and three relatives during our inspection. The patients and relatives we could speak with were positive about the care given. Feedback was that staff were friendly and encouraging.

Despite the staffing challenges, we observed all members of staff providing care for patients' in a kind and compassionate way. Staff communicated with patients in a caring manner regardless of whether they were conscious or unconscious.

Staff calmly provided care and attended to the needs of their patients. Some staff did comment at times staffing pressures impacted on their ability to deliver the level of care they would like.

The lack of curtains meant providing privacy and dignity for patients was more of a challenge. We observed staff using additional screens, whilst you couldn't see the patients when stood outside they did not provide 100% privacy for patients when care was being delivered.

Areas had link nurses for privacy and dignity whose responsibilities were to encourage staff to become dignity champions, support environmental changes to enhance privacy and dignity and feedback findings dedicated meetings.

Staff respected religious, cultural and social needs of patients and their families. We saw evidence of this in the notes we reviewed.

The focus of the month within critical care was on protected sleep time, to try and distinguish between day and night and provide rest time for patients.

The service won the team winner for outstanding contribution to patient care in 2018, as part of the trust's annual awards.

Emotional support

We observed staff providing emotional support during our inspection.

The use of patient diaries was established on the intensive care units and we saw these being completed during our inspection. Patient diaries can help patients to understand what has been happening whilst they have been critically ill. Patients who have been in a critical care environment often report memory loss and some may suffer from psychological problems. Research has found patient diaries help to fill in some missing gaps and have also given the patient understanding as to how poorly they have been. Information explaining their purpose was provided to relatives.

The CCOT looked at both physical and emotional needs of patients when they reviewed them on the wards following discharge from critical care. They used both of these factors to determine the number of visits required by individual patients.

Non-physical risks were included in the critical care rehabilitation pathway document. This included prompts for patients in areas such as reoccurring nightmares and anxiety.

The service had developed a support group as part of the ICU steps charity. This group was for patients who had been on ICU and their families. It was run by former patients, relatives and health professionals, to provide ongoing support after discharge from hospital. The group also aimed to promote the recognition of the physical and psychological consequences of being on ICU.

There was also a comprehensive leaflet to support patients and relatives, with information on getting back to a 'normal' routine and providing practical advice and places to seek further support.

A bereavement service and multi faith chaplaincy services were available on site and staff could access these for patients. There was access to the palliative care team including an out of hours advice line.

Understanding and involvement of patients and those close to them

We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment. The relatives we spoke with said they felt informed and involved with the care of their relative.

We saw a document 'getting to know your loved one, can you help?' in some of the records we reviewed. This document was for relatives to complete and asked questions about, likes and dislikes, family and hobbies.

With support from the palliative care team and donations from families, the Dragonfly scheme had been developed to provide essential items to relatives who were staying in hospital with their loved ones. The items were in a bag with the Dragonfly logo and this also gave relatives discounted meals.

We observed medical and nursing staff taking time to explain what was happening to relatives, so they understood the care and treatment.

Staff could describe using communication tools such as ABC boards, picture boards.

The trust was committed to drive awareness and culture surrounding organ donation. Staff worked closely with the specialist nurse for organ donation to provide care and support to both relatives and patients at the end of life. The units had a lead organ donation specialist nurse, who was always available.

Is the service responsive?

Service delivery to meet the needs of the local people

The department worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.

The service recognised the need to change services offered by critical care, particularly around the sustainability of service at this site. Following the inspection, a decision was made to close the unit at the Friarage.

The service was involved in the regional critical care operational delivery network.

The service had follow up clinics in place, however these were unfunded, and we were told they ran on 'goodwill'. Predominantly patients from the ICU were referred to the clinic. The GIRFT report identified the clinics were only available to about 6% of the patient population and prioritised by risk. There was no psychology input in to the clinics. If patient needs were identified referrals were made via their general practitioner.

The unit had challenges with the facilities and environment. There was limited space around bed areas and the isolation room was not compliant with HBN 04-02.

Arrangements were in place to manage patients with complex long-term weaning problems and the service had access to a home ventilation team.

The Butterfly scheme and unit champions were used to support those patients living with dementia.

There was provision for relatives to stay overnight although this was outside of the critical care unit. There was a relative's room within the unit which had a sofa and facilities to make a hot drink. There were cafes and vending machines in the hospital for relatives to have meals and snacks.

Meeting people's individual needs

Staff we spoke with knew how to access interpreting services for patients whose first language was not English. Translation could be provided face to face or over the telephone. Communication aids such as letter boards were also available.

Staff we spoke with told us they could access bariatric equipment to care for patients as required.

Initiatives to enhance the care of those with a learning disability were in place. Hospital passports were in use. These detailed personal preferences, triggers, and any interventions which were helpful in supporting individual during difficult periods.

Staff recognised the importance of involving relatives and carers for any patient with additional needs. The patient records that we reviewed reflected that individual needs were assessed, and care planning was informed by this.

The critical care outreach team reviewed all patients who were discharged from intensive care to ward areas.

The service was involved with patient orientated research to reduce noise in the critical care environment.

Access and flow

Access and flow was a challenge at this site due to nurse staffing numbers. Regular bed meetings took place each day which were attended by a critical care consultant. The matron for critical care was also available to support the escalation process in terms of access and flow.

Data was requested on the number of cancelled elective operations because of no critical care capacity. Monthly information from January 2018 to February 2019 showed the number of cancellations raged from zero to 20. This information was not broken down by site.

From the three patient records we reviewed we could not find evidence that patients were admitted to critical care within four hours of a decision being made as this was not clearly recorded.

The GIRFT report from 2018 also highlighted that fewer patients were being admitted directly from theatre to critical care following emergency laparotomy surgery compared to the national average. The led to high numbers of unplanned admissions to critical care from ward areas. The figures in the report were 7.7% compared to the national average of 3.2% for the Friarage hospital. The report stated this represented a capacity and quality of care issue.

Staff told us they felt there had recently been an increase in the number of readmissions to the unit with patients being moved to ward areas too soon. We were provided with some specific examples of this. Incident data for the previous 12 months did not show any cases of patient harm from patients being transferred out from critical care too soon.

Bed occupancy

From September 2017 to October 2018, South Tees Hospitals NHS Foundation Trust has seen adult bed occupancy remained higher than the England average. The largest rate of bed occupancy was seen in August 2018. A slight improvement was seen from November 2018.

Adult critical care Bed occupancy rates, South Tees Hospitals NHS Foundation Trust.
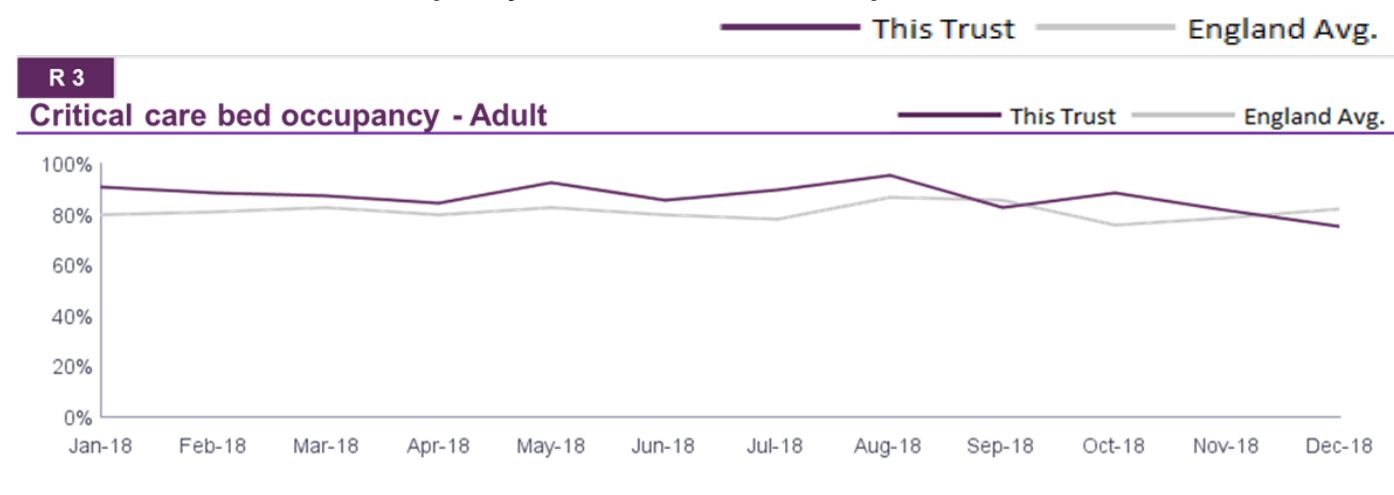
Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.
 (Source: NHS England)

Delayed discharges
Data for 2017/2018 for the Friarage hospital intensive care unit, showed there were 1,095 available bed days. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 0.4%. This was much better when compared to similar units who had a rate of 4.9%. At this site the percentage had been consistently below (better) when compared to similar units since 2013.
(Source: Intensive Care National Audit Research Centre (ICNARC))

Non-clinical transfers
Data for 2017/2018 for the Friarage hospital intensive care unit, showed there were 270 admissions, of these 0.7% were non-clinical transfers to another unit. This was higher (worse) when compared to similar units who had a rate of 0.2%, however it remained within the expected range.

Non-delayed out of hours discharges to the ward
Data for 2017/2018 for the Friarage hospital intensive care unit, showed from 208 admissions, 2.4% were non-delayed, out-of-hours discharges to the ward. This figure was slightly higher (worse) when compared to similar units but the figure was within the expected range.
(Source: Intensive Care National Audit Research Centre (ICNARC))

The GIRFT report highlighted there over a quarter of admissions to the unit occurred overnight and that one in 20 patients were discharged home from critical care. The action plan following receipt of the GIRFT report stated the service would continue to monitor delays in admission to critical care.

Learning from complaints and concerns

Summary of complaints
From October 2017 to September 2018 there were two complaints about critical care, both regarding patient care. The trust took an average of 70 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 40 days.
(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust
From October 2017 to September 2018 there were two compliments within critical care.
(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. There was also information encouraging relatives to speak to the nurse in charge if they had any concerns to try and resolve any issues before they escalated.

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.

Is the service well-led?

Leadership

Since the previous inspection all areas within critical care at both sites had been brought under the same management structure. The GIRFT report from 2018 identified that whilst this was viewed as a positive step, further closer working was still required. This was evident from our observations and discussions with staff. Also, from information requested following the inspection. The focus was felt to be on the general ICU and HDU areas at the James Cook University hospital with other areas, including the Friarage not included in discussions and information not provided for them.

The lack of information and inclusion of all areas meant we could not be assured that the corporate team understood the all challenges to quality and sustainability within critical care as a whole.

From discussions with the clinical leadership team it was clear they had an understanding of the current challenges and pressures impacting on service delivery and patient care. Consultants had direct access to the chief executive as they chaired the critical care strategy group meetings, however feedback to the inspection team from focus groups was that they did not feel they had a strong clinical voice.

There was a lead consultant and a lead nurse for critical care and the CCOT. Leadership of the service was in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards. GPICS recommendations would be to consider a supernumerary coordinator at peak times for this unit, but current staffing levels would not allow for this.

We could not be assured that training and development of staff for succession planning was in place to enable sustainable leadership, as equipment training, and information on staff competence training was not provided for this site. Appraisal rates were also below the trust target. Appraisals are used to identify learning and development needs of staff.

There were challenges with the medical leadership on the unit. This was because of a lack of continuity and the challenges to covering the medical staffing rota. However, we did observe regular communication with the on-call consultant at the James Cook site during our inspection.

From our observations and from speaking with staff, it was clear that staff had confidence in the nursing leadership on the unit. The clinical leadership team were visible and approachable. The matron visited the unit regularly. However, there was a strong feeling amongst the staff we spoke with that there was a lack of understanding about the acuity and related staffing requirements for patients on the unit.

Vision and strategy

The vision for the unit was ultimately dependent on the reconfiguration of critical care services across the two hospital sites.

At the time of inspection there was uncertainty over the future of critical care at the Friarage staff felt unsettled over what may happen.

There were plans to open a PACU at the James Cook site to support with access and flow for those patients who required an extended recovery period and whose needs could be met outside of the critical care units.

Each of these areas had been under discussion for a number of years and financial constraints within the trust had prevented them being achieved. They were identified in the peer review of the service in 2016 and in the GIRFT report in 2018.

We were provided with the trust-wide critical care strategy from 2017; it included sustaining the service at the Friarage. The vision of the changes mentioned above fed into the overall strategy which had four aims. These were

- Maintain high standards of patient care, manage capacity and demand

- Development of the critical care service

- To attract, develop and retain a highly skilled sustainable workforce

- To achieve financial viability

Each of the aims had strategic objective which sat below them with some broad actions to meet them and metrics which could be used as a measure of success. No time scales were attached to these.

The strategy did not detail where responsibility lay or where monitoring of progress against the strategic aims would take place. It was also unclear how staff and the public fed in to this. Staff we spoke with spoke about uncertainty with the future of critical care.

Following the inspection, a decision was made to close the critical care unit at the Friarage hospital. We were provided with an action plan that stated PACU would be operational by April 2019.

Culture

Staff we spoke with told us they felt proud of the team work on the unit. The size and pressures within the unit meant they heavily relied on each other's support to provide care 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.

There was a clear focus of patient centred care and teamwork, support between colleagues was strongly evident throughout the different areas we visited for both nursing and medical staff.

We were told following a college visit the service was identified as the most popular critical care training unit in the region.

Staff morale within the CCOT team was good. The team felt they worked well and supported each other. They had monthly cross site meetings.

Whilst the commitment of staff to provide the highest level of care they could was evident, staff morale in the unit was low. This was predominantly due to staffing numbers and the challenges to providing care which went alongside this.

We observed staff not able to take breaks as there were only two staff on duty. Staff told us they felt frustrated with constantly feeling the need to justify the staffing requirements for the unit. This came from medical and nursing staff, each gave examples of being questioned by colleagues from the James Cook site over whether patients were 'actually level three' or if a patient 'really needed to be on intensive care'.

From speaking with the senior team, we were not assured that they were aware of how staff felt working at this site and the daily stress and challenge they faced because of medical and nursing staffing.

Medical staff reported good support between colleagues and nursing staff, however, some medical staff felt their concerns weren't always listened to by the corporate leadership team.

Governance

Critical care was part of the urgent and emergency care centre. This included the directorates of emergency and acute medicine. Recently all areas of critical care had been brought in to this structure.

Operational critical care meetings had been re-established, monthly governance and weekly mortality and morbidity review meetings were in place.

Meeting minutes included little details of lessons learned and actions taken in response to incidents and audits. It was unclear how this information was then shared with staff at unit level. From our observations and discussions with staff, Safety huddles were not well established.

We lacked some assurance about individual staff's awareness of their roles and responsibilities. This was because incidents were not always reported, we were concerned that issues had also not been appropriately identified and escalated. In particular, those of nurse staffing and associated patient harms.

We were provided with a gap analysis against the GPICS recommendations in relation to nurse staffing. This was not reflective of what we saw on inspection. For example, they had recorded themselves compliant for 1:1 care, this is not what we observed during our inspection.

Management of risk, issues and performance

There was a critical care risk register which contained five risks. We were concerned that the risks identified during our inspection did not all feature on the risk register. Namely, nurse staffing and the number of pressure ulcers.

The concerns over medical staffing and the sustainability of this at the Friarage site was contained within the risk register, as well as the risk of patients being ventilated outside of ICU due to capacity and demand, and cardiac HDU not meeting national guidelines.

The GIRFT report identified the Friarage as a significant and worrying issue. This was because of the level of work being undertaken with the work force challenges. The decision to close this unit obviously addressed these risks.

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.

The risk register gave a current and target risk level for each risk. However, it did not contain any detail on mitigating actions, so it was unclear how the level of risk would reduce.

There was no evidence of regular review of the risks. For example, the risk related to capacity and demand and ventilated patients outside of ICU had been on the risk register since September 2014, the next review date was April 2019.

It was unclear from our discussions with staff and reviewing meeting minutes how information related to performance was used to monitor quality and identify when action should be taken. For example, issues related to pressure damage did not seem to feature despite the incident data identifying concerns.

The dashboards for individual units identified when infections or pressure ulcers had occurred. This showed there was varying performance. The corporate team had identified this was showing a sustained downward trend in acquired pressure damage. This what not the case. We were concerned that information being viewed at this level was providing false assurance over patient safety issues.

We were not provided with training compliance and overall percentages for all staff. This meant we could not be assured that staff in all areas had the relevant experience and training for the patients they were caring for.

Information management

The admission, discharge and transfer documentation was in line with best practice and NICE guidance.

Staff received training on information governance and were aware of the importance of managing confidential patient information. We found that records were stored securely within the unit.

Blood results, x-rays and scan results could be accessed electronically, mobile workstations allowed these to be reviewed at the patients' bedside.

The service contributed to the ICNARC data collection, however it was unclear due to a lack of detail how much of this was discussed at meeting and how this information was then shared with staff to address any issues.

Engagement

We saw notice boards that were used to share patient safety information, however from reviewing meeting minutes we found limited discussions around incidents and performance data and actions in response to these. It was also unclear how managers assured themselves that information had been passed on, and how this information was then shared with staff on the units.

We were told there would sometimes be team debriefs after difficult situations. This was a good opportunity for proving support to colleagues and sharing good practice and areas for improvement.

Staff did not feel involved and informed about what was happening in the trust in relation to critical care services. There was uncertainty and staff were concerned when they would be told about the future of the unit.

There was staff engagement by recognition and reward of their work. This was done via an annual awards event where staff and teams were nominated and received awards,

There were systems in place to obtain feedback from patients. Feedback was obtained using a system called 1000 voices. The questionnaire asked about several different areas related to care and treatment from cleanliness to communication.

The ICU steps sessions were an opportunity for patient and relative engagement. They were also able to contribute to the development of the service and research studies being undertaken.

Informal feedback was also obtained from the CCOT when they reviewed patients after discharge from critical care and from follow up clinics.

Learning, continuous improvement and innovation

The service was involved in the regional critical care operational delivery network.

The service had employed advanced critical care practitioners (ACCP's) and others were training. They would support the medical workforce in HDU areas.

Information provided showed the service was a desirable location for trainees with high rates of success.

There was a well-established mortality and morbidity review process, this also involved other services within the trust and looked at complex cases which had been managed well to share good practice, as well as patient deaths.

Other quality improvement that were being looked at included, introducing ultrasound meetings and formalisation with radiologists for storing images and delivering mentoring for the trainees and upskilling nurses looking at airway skills and safety of intubation.

The service was involved in seven research studies and recognition had been given due the high numbers recruited. Examples included, adaptive sepsis looking at using inflammatory markers to guide antibiotic usage.