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 sites at the trust

The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) is one of the largest teaching hospitals in England providing academically led acute, specialist and community services for adults and children to a large and diverse population across the North East and Cumbria.

The Trust operates across a number of locations including acute sites along with the Campus for Ageing and Vitality (CAV) and Centre for Life and a number of community sites.

A list of the acute hospitals at The Newcastle upon Tyne Hospitals NHS Foundation Trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary</td>
<td>Queen Victoria Road, Newcastle upon Tyne, NE1 4LP</td>
</tr>
<tr>
<td>Freeman Hospital</td>
<td>Freeman Road, High Heaton, Newcastle upon Tyne, NE7 7DN</td>
</tr>
<tr>
<td>Campus for Ageing and Vitality</td>
<td>Westgate Road, Newcastle upon Tyne, NE4 6BE</td>
</tr>
</tbody>
</table>

(Source: Trust website)

The trust has 1,691 beds (1,468 general and acute, 96 maternity and 127 critical care) which
include the Great North Children’s Hospital (218 beds) on the Royal Victoria Infirmary site.
The trust employs a workforce of 12,496 which comprises of 1,598 medical staff, 3,705 nursing staff and 7,193 other grades of staff.

In the 12 months prior to our inspection the trust saw:

- 26,312 elective inpatient spells;
- 114,324 day cases;
- 54,087 emergency inpatient spells;
- 130,090 non-elective inpatient spells;
- 201,262 attendances at ED and walk-in centres;
- 286,850 new outpatient appointments;
- 682,808 review patient appointments;
- 291,242 outpatient procedures.

There are six registered locations as follows:

**Royal Victoria Infirmary**, which provides:

- Urgent and emergency care
- Medical care (including older peoples care)
- Surgical care
- Critical care
- Maternity services (Regional Fetal medicine, Midwifery led and consultant led)
- Children’s and young people’s services;
- End of life care
- Outpatient services and Diagnostic imaging.

**Freeman Hospital**, which provides:

- Medical care (incl. the regional cancer unit)
- Surgical Care (incl. the regional cardiac centre)
- Critical Care
- Children’s and Young People’s services
- End of life care
- Outpatient services and Diagnostic imaging

**Campus for Ageing and Vitality**, which provides:

- Medical Care
- Outpatient services

**Dental Hospital**

**International Centre for Life**

Hosting the Newcastle Fertility Centre and regional Northern Genetics Service which together provides infertility advice and a diagnostic and "genetic counselling" service for genetic related disorders.

**Regional Drug and Therapeutics Centre**
A multi-disciplinary team, comprising of pharmacists, physicians, scientists and support staff set up as a non-commercial, not for profit NHS organisation hosted by the Newcastle Upon Tyne Hospitals NHS Trust, which is responsible for employing all the staff.

Financial position

- The trust was forecasting a break-even position
- The turnover for 2018/19 is forecast to be £1,087,000
- NHSI – The trust reports a Financial Risk Rating of ‘1’. On a score of 1-4, this reflects an organisation with a low level of financial risk
- NHSI single oversight framework segmentation – providers with maximum autonomy

Is this organisation well-led?

Leadership

The trust was led by the board of directors who were responsible for the day to day running and management of the trust.

The board structure comprised of the chair, the chief executive, five executive directors, and seven non-executive directors and five non-voting executives.

- Chief executive (CEO) had been in post since 2018
- Trust chair had been in post since 2017
- Medical director had been in post since 2013
- Executive chief nurse was seconded to post in 2018 and the appointment was made substantive in 2019
- The chief operating officer has been in post since 2018
- Director of finance was appointed in 2009

Executive directors held responsibility for the day to day running of the trust whilst the non-executive directors brought external expertise to the organisation and provided advice and guidance to the executive team. Our discussions with members of the senior team confirmed they were engaged and worked well together providing appropriate challenge at board level. We heard of examples where non-executive challenge to directors had influenced change at board level.

The trust board of directors had a range of experience, skills and knowledge to perform its role.

The leadership team could describe how they monitored patient safety, quality and performance and the metrics and information used to support this. Senior leaders demonstrated an understanding of the priorities and challenges facing the trust. For example, workforce and financial performance. These challenges were key to the overall strategy for the trust and were also included in the corporate risk register and Board Assurance Framework.

During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of healthcare providers are fit and proper to carry out this important role. We reviewed five director’s files in total, of which two related to non-executive directors, two related to the newest appointments, including the chair and one included the longest serving director. We also reviewed the trust’s Fit and Proper Person Procedure (January 2019). We found the trust was compliant with the Fit and Proper Persons Requirement.

The trust had a leadership and talent management strategy 2018 - 2021, which was identified as
core to the trust’s refreshed strategy. This strategy identified the direction for the next three years to further attract, grow, develop and retain Newcastle upon Tyne Hospitals trust and system leadership capacity and capability for now and the future, to ensure a leadership which was representative of the population and safeguarded the core value of “putting patients at the heart of everything we do”.

The trust’s workforce strategy (2018) detailed how they intended “to be the preferred employer, recruiting, training and developing a sustainable workforce capable of adapting and providing healthcare services which meet demands for care - the ‘Employer of Choice’”.

This would be achieved by:
- Professional and leadership development, including talent management and succession planning
- Centre of excellence providing high quality education, training and development
- Workforce strategy and planning informed by robust data; aligned to service demand, financial sustainability and use of technology (right staff; right skills; right place and time)
- Facilitate workforce transformation and change

During our inspection and ongoing monitoring of the trust we found staff confirmed the trust’s drive and focus on developing future leaders was evident and staff were very pleased with the support they were given.

**Board Members**

Since our previous inspection in January 2016 there had been several changes at board level. The previous CEO left the trust in January 2017 the medical director and then director of business and development shared the role until April 2018. At our recent inspection only, the medical and finance directors had been in post over five years. One non-executive director had joined the board in 2018. The non-executives told us they had confidence in the executive leadership and were kept up-to-date and well-informed.

Of the all board members at the trust, none were Black, Asian and Minority Ethnic (BAME) and 35.7% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>12.5%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>35.7%</td>
</tr>
</tbody>
</table>

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

Of the executive board members at the trust, there were none who were of a BAME background; 66.7% were female. Of the non-executive board members there were none who were from a BAME background, this meant that BAME groups were not represented at board level. However, the board had acknowledged this and were due to shortlist for an additional non-executive director specifically looking to increase the diversity of the board. Female non-executives made up 12.5% of the board.

We saw a clear distinction between the executive and non-executive roles and functions of the board. The non-executive directors chaired the main board committees and each committee had an executive lead. The committees included finance and investment, clinical governance and quality, audit and remuneration; these committees provided support, oversight and insight around performance and goals. There was a separate nominations committee which was chaired by a public governor.
The chief executive undertook formal appraisals of the executive board, and the chair undertook appraisals of the chief executive and non-executive directors. The chair’s appraisal was undertaken by the senior independent director and the vice chair and the outcome of which was shared with governors. The chief executive’s appraisal was undertaken by the chairman and shared with the renumeration committee. These appraisals were linked to objectives, and we saw evidence of this within the personnel files we reviewed.

All staff we spoke with spoke positively about the chief executive and many said she had visited their directorates and ward areas. During the core service inspection, we noted that feedback from staff remained positive and from our previous inspection, had improved regarding the visibility of the senior leadership team. This was further evidenced in the 2018 staff survey which showed 49.5% of staff reported good communication between senior management and staff, this was a 1.7% increase from the previous year (2017) and a 5.7% increase from our previous inspection (2015).

There was a comprehensive programme of quality walk-rounds which were undertaken by the chief executive, chairman, executive and non-executive directors.

We found during our inspection and from monitoring the trust throughout the year, the board was forward thinking. It considered matters which were vital to the success and strategic direction of the trust. There was continued focus on strategy, the culture, talent management and succession, and investment for the business of the trust.

The trust had invested in an internal transformation and financial improvement team, which complemented the already established service improvement team. The responsibility of this team was

- to scope, plan and deliver cost improvement opportunities identified in regional and national benchmarking exercises;
- to provide co-ordination of multiple trust-wide work streams;
- to investigate and progress potential opportunities highlighted within the Model Hospital following triangulation with the findings of get it right first time (GIRFT) and RightCare;
- to provide oversight across a range of efficiency-related metrics.

Vision and strategy

At the time of our inspection the trust’s vision, goals and core values were nearing the end of the review process. We were informed that the NHS 10-year plan would be reflected throughout the refreshed strategy. However, the current vision, goals and core values were due to be refreshed in 2019.

The trust’s vision was:

To be ‘the health service for Greater Newcastle’ and a leading healthcare provider.

The trust’s strategic goals were:

- “Putting patients first and providing care of the highest standard focusing on safety and quality
- Working in partnership to deliver fully integrated care and promoting healthy lifestyles to the people of Newcastle.
- Being a nationally and internationally respected leader in research and development underpinning our pioneering services.
• Enhancing our reputation as one of the country’s top, first class teaching hospitals, promoting a culture of excellence in all that we do.
• Maintaining sound financial management to ensure the ongoing development and success of our organisation”.

The trust’s core values were:

• Putting patients at the heart of everything we do.
• Patients come first
• People and partnerships are important
• Professionalism at all times
• Pioneering services
• Pride in what we do.

Frontline staff could articulate the trust’s vision to us and all staff we spoke with knew that the quality of care and the patient were at the heart of the trust’s core values.

Annually trusts must produce an operational plan which should be submitted to NHS Improvement. The trust’s 2018/19 plan detailed its performance and how it intended to continue to deliver safe, high quality services for its patients whilst maintaining operational, clinical and financial sustainability.

Culture

The trust’s strategy, vision and values underpinned a patient centred culture. All staff we spoke with during our core service and well-led inspections were overwhelmingly positive, and proud to work for the trust and their team. There was a clear message that quality of care was prioritised over financial performance.

We saw leaders demonstrate and encourage compassionate and inclusive working relationships among staff so that they felt respected, valued and supported. There were processes in place to promote and support staff well-being.

Flourish at Newcastle Hospitals was launched in January 2019 and was identified as the cornerstone initiative to encourage staff to get involved with promoting well-being in the workplace with new challenges and opportunities every month. Since the launch the initiative had a let’s move let’s talk and let’s work better campaign. There was a tool kit for staff to help them start the conversation. All staff we spoke with were positive about this scheme and it had a positive impact on their health and well-being.

During the inspection, staff we spoke with felt empowered to make improvements and raise concerns. Within the trust there was a strong focus on learning from incidents, sharing good practice, quality improvement initiatives and safe innovation.

Staff we spoke with talked positively about the CEO and how she had encouraged a change in culture at the trust since she took up post. We saw all staff were engaged and positive and willing to speak with us. All staff described the CEO and board as being highly visible, open and approachable; we also found board members and the senior management team worked well together. Front line staff were passionate about providing the best care they could for their patients.

NHS Staff Survey 2017 – results better than average of combined acute and community trusts
The trust has 20 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11. % appraised in last 12 months</td>
<td>90%</td>
<td>86%</td>
</tr>
<tr>
<td>KF13. Quality of non-mandatory training, learning or development</td>
<td>4.11</td>
<td>4.06</td>
</tr>
<tr>
<td>* KF20. % experiencing discrimination at work in last 12 months</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>KF21. % believing the organisation provides equal opportunities for career progression / promotion</td>
<td>91%</td>
<td>85%</td>
</tr>
<tr>
<td>* KF28. % witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>24%</td>
<td>29%</td>
</tr>
<tr>
<td>KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.85</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.78</td>
<td>3.67</td>
</tr>
<tr>
<td>* KF17. % feeling unwell due to work related stress in last 12 months</td>
<td>33%</td>
<td>38%</td>
</tr>
<tr>
<td>* KF18. % attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>49%</td>
<td>53%</td>
</tr>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>4.10</td>
<td>3.75</td>
</tr>
<tr>
<td>KF8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.94</td>
<td>3.89</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.45</td>
<td>3.27</td>
</tr>
<tr>
<td>KF6. % reporting good communication between senior management and staff</td>
<td>38%</td>
<td>33%</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>4.05</td>
<td>3.90</td>
</tr>
<tr>
<td>KF3. % agreeing that their role makes a difference to patients / service users</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.85</td>
<td>3.69</td>
</tr>
<tr>
<td>* KF22. % experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>* KF23. % experiencing physical violence from staff in last 12 months</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>* KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>24%</td>
<td>27%</td>
</tr>
<tr>
<td>* KF26. % experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>22%</td>
<td>24%</td>
</tr>
</tbody>
</table>

*Indicates key findings where lower scores are better than higher scores.
(Source: NHS Staff Survey 2017)

In the 2018 NHS Staff Survey, 47% (6,655) of staff members completed the NHS staff survey this is an increase from 2017 of 32.6%. Results showed 70% (7) themes scored significantly better than others in the sector these were:

<table>
<thead>
<tr>
<th>Question</th>
<th>NuTH</th>
<th>Sector</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 1 Equality, Diversity &amp; Inclusion</td>
<td>9.4</td>
<td>9.19</td>
<td>+0.22</td>
</tr>
<tr>
<td>Theme 2 Morale</td>
<td>6.45</td>
<td>6.25</td>
<td>+0.20</td>
</tr>
<tr>
<td>Theme 6 Quality of Care</td>
<td>7.67</td>
<td>7.53</td>
<td>+1.4</td>
</tr>
<tr>
<td>Theme 7 Safe Environment – Bullying &amp; Harassment</td>
<td>8.35</td>
<td>8.18</td>
<td>+0.17</td>
</tr>
<tr>
<td>Theme 8 Safe Environment – Violence</td>
<td>9.62</td>
<td>9.55</td>
<td>+0.7</td>
</tr>
</tbody>
</table>
Theme 9  Safety Culture  

<table>
<thead>
<tr>
<th></th>
<th>7.15</th>
<th>6.81</th>
<th>+0.34</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme 10  Staff Engagement</td>
<td>7.35</td>
<td>7.12</td>
<td>+0.23</td>
</tr>
</tbody>
</table>

There were 30% (3) themes which were the same as others in the sector and there were no scores which were identified as significantly worse than others in the sector.

**NHS Staff Survey 2017 – results worse than average of combined acute and community trusts**

The trust has four key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF29. % reporting errors, near misses or incidents witnessed in last month</td>
<td>88%</td>
<td>91%</td>
</tr>
<tr>
<td>KF15. % satisfied with the opportunities for flexible working patterns</td>
<td>41%</td>
<td>51%</td>
</tr>
<tr>
<td>KF24. % reporting most recent experience of violence</td>
<td>60%</td>
<td>67%</td>
</tr>
<tr>
<td>KF27. % reporting most recent experience of harassment, bullying or abuse</td>
<td>44%</td>
<td>47%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

The questions in the 2018 NHS staff survey do not fully reflect those in the 2017 survey and therefore it is difficult to draw a direct comparison between the results.

**Staff Diversity**

The trust provided the following staffing breakdowns by Ethnic group:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Ethnic group</th>
<th>A – White – British/Irish/Any other white background</th>
<th>B – BME - British</th>
<th>C – BME - Non-British</th>
<th>E – not stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td></td>
<td>6.6%</td>
<td>1.3%</td>
<td>0.9%</td>
<td>0.3%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td></td>
<td>13.5%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td></td>
<td>4.3%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Public Health &amp; Community Health Services</td>
<td></td>
<td>0.1%</td>
<td>0.0%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td></td>
<td>6.1%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Qualified ambulance service staff</td>
<td></td>
<td>0.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td></td>
<td>3.9%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td></td>
<td>26.4%</td>
<td>1.8%</td>
<td>1.6%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td></td>
<td>2.0%</td>
<td>0.0%</td>
<td>-</td>
<td>0.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td></td>
<td>21.5%</td>
<td>0.7%</td>
<td>0.2%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td></td>
<td>4.9%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

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

The trust had several well-established staff forums for diverse groups including an armed forces network, Black, Asian and Minority Ethnic (BAME), Disability and Lesbian, Gay Bisexual and transgender (LGBT). The trust actively promoted equality of opportunity and being the ‘employer of choice’. To do this the trust had launched an equality champion programme, to support inclusion across the workforce. The aim of this programme was to have a network of champions across the trust who would assist in the progression of equality and inclusion for all. Each staff
The forum had detailed terms of reference and supported a number of staff awareness sessions throughout 2017/18.

The patient services equality objectives October 2016 to September 2020 action plan had been developed in partnership with local agencies and were aligned to the human resources equality objectives and action plan 2018-19. We found each objective had appropriate actions documented against them, a lead measure and a target date.

**Gender pay gap**

Gender pay gap legislation requires all employers of 250 or more employees to publish their gender pay gap as of 31st March 2017. The trust employed over 14,400 staff in a range of roles, including administrative, medical, allied health and managerial roles. The trust used the national job evaluation framework for agenda for change staff to determine appropriate pay bandings. This meant there was a clear process of paying employees equally for the same or equivalent work.

In March 2018 the trust submitted their first gender pay reports; it was based on data from March 2017. The gender profile of the trust was:

<table>
<thead>
<tr>
<th>Profile</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff</td>
<td>22%</td>
<td>78%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff group</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Proportion of male and female full-pay relevant staff in each quartile of the Trust’s pay distribution

The lower quartile represented the lowest salaries in the trust and the upper quartile represented the highest salaries in the trust. The trust employed more women than men in every quartile.

The mean gender pay gap for the whole of the public-sector economy was 17.7%.

*(Source: Office of National Statistics – October 2017)*

At 25.4% the trust’s mean gender pay gap was above that for the wider public sector. This was reflective of the pattern in other NHS trusts where there are more women in lower pay bands, and a predominantly male workforce in the higher banded medical and dental professions.

**Workforce race equality standard**

There is a requirement for NHS Healthcare providers to implement and report on workforce race equality standard (WRES) in the NHS standard contract. WRES is in place to ensure employees from BAME backgrounds have equal access to career opportunities and receive fair treatment in the work place. NHS providers are expected to show progress against a number of indicators of workforce equality.

Alongside WRES, NHS organisations use the equality and diversity system (EDS2) to help in discussion with local partners including local populations, to review and improve their performance for people with characteristics protected by the Equality Act (2010). By using the EDS2 and the WRES, NHS organisations can be helped to deliver the public sector equality duty.

There are nine WRES indicators, four of the indicators focus on workforce data, four are based on data from the NHS staff survey, and one indicator focusses on BAME representation on the
The scores presented below are the un-weighted questions level score for question Q17b and un-weighted scores for key findings 25, 26 and 21, split between white, BME staff, as required for the 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.

<table>
<thead>
<tr>
<th>KF25</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</th>
<th>Your Trust in 2017</th>
<th>Average (median) for combined acute and community trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>White</td>
<td>24%</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>19%</td>
<td>27%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White</td>
<td>22%</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>23%</td>
<td>29%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White</td>
<td>91%</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>83%</td>
<td>73%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues?</td>
<td>White</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME</td>
<td>11%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Of the four questions above the following question showed a statistically significant difference in score between White and BME staff:

• KF21: Percentage of staff believing that the trust provides equal opportunities for career progression or promotion.
• Q17b: In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The trust had an action plan which related to their 2017 staff survey; staff side representatives we spoke with were positive about the culture within the organisation. It was clear from these discussions that the trust was proactively working in partnership with unions, and staff were positive about the senior management team and the changes which had occurred since our previous inspection.

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
The trust’s sickness absence levels from September 2017 to August 2018 were similar to the England average, except for January to March 2018 where absence levels were higher than the average.

(Source: Friends and Family Test)
General Medical Council – National Training Scheme Survey

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

(SOURCE: General Medical Council National Training Scheme Survey)

Feedback received during our focus groups was overwhelmingly positive about the training opportunities for junior doctors based within the trust.

Accessible information standard

From 1st April 2016 onwards, all organisations which provided NHS Care have been legally required to follow the accessible information standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and
communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. It covers the needs of people who were blind, deaf, deafblind and/or who had a learning disability. AIS exists also for people who had aphasia or a mental health condition which affects their ability to communicate.

The trust was committed to delivering AIS and were aiming to achieve implementation through working with local third sector organisations. The trust had successfully bid for NHSE funding to develop ‘Nutshell Cards’, designed to enable patients with specific needs to inform staff on arrival of their requirements. The trust had reconfigured the electronic patient record across acute and community settings to capture and share patient’s communication needs and alert staff in the future. The trust worked with patient groups representing those with protected characteristics to design a patient engagement portal which met their specific communication needs. The trust were the first in the region to work with Deaflink to develop services aimed at providing 24 hour, seven day access to video remote British sign language interpretation to ensure patients who were seen in an emergency or out of hours had access to interpretation services.

Governance

The trust had in place governance processes to support the delivery and ensure quality and performance information was reviewed and escalated appropriately. The trust governance structure was designed to ensure that quality and patient safety issues and concerns were identified at ward level, discussed by each of the directorate management teams before being escalated to the sub committees of the board. Although the governance structure appeared complicated we did not find any examples of where there had been insufficient oversight in any core service.

The committees of the board included:

- Audit committee (which had overall responsibility for ensuring the effectiveness of the other committees)
- Risk Management and assurance committee
- Infection prevention and control committee
- Safeguarding committee
- Information governance committee
- Clinical governance and quality committee

In total there were 14 sub-committees of the board.

The board had recently engaged an external review of the governance structures in preparation for the reviewed strategy. The board were implementing the recommendations which included a renewed committee structure and reducing the number of sub-committees to six. The aim was to improve the accountability framework for quality assurance and clinical governance that would better map out lines of reporting from ward to board whilst identifying areas for further improvement.

There was a trust wide systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. Actions identified from clinical audits were monitored by the clinical governance and quality committee which reported to the trust board. Actions from internal audit were monitored by the trust’s executive team and audit committee to ensure implementation and review.
The audit committee had responsibility for independently monitoring, reviewing and reporting to the Board on all aspects of governance, risk management and internal control. The trust’s Board Assurance Framework (BAF) was the primary source for informing the audit committee regarding risk, along with the risks rated 20 and above identified on the corporate risk register. The non-executive chair of the audit committee recognised the need to further improve the internal audit programme to ensure the full implementation of internal audit recommendations.

The BAF is a method of setting out the most important risks facing the organisation and sets out a control framework that organises and categorises risks and highlights where the gaps in control are. Maintenance of the BAF was the responsibility of the Trust Secretary and Director of Quality and Effectiveness. Following the external review of governance within the trust, the BAF was undergoing a refresh and the trust had taken steps to improve the BAF to make it clearer to identify assurances and gaps. The updated BAF was due to be in place from April 2019 and be aligned to the new strategy. At the time of our inspection the board agreed that in its current form the BAF was not fit for purpose.

**Board Assurance Framework**
The trust provided their Board Assurance Framework, which details five strategic goals and the underpinning objectives. A summary of these is below.

<table>
<thead>
<tr>
<th>Strategic Goal</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Putting patients first and providing care of the highest standard focusing on safety and quality</td>
<td>Put patients and carers first and plan services around them</td>
</tr>
<tr>
<td></td>
<td>Consistent achievement of core standards / key performance targets and drive down waiting times</td>
</tr>
<tr>
<td></td>
<td>Maintain our outstanding CQC rating / Maintain compliance with all regulatory requirements</td>
</tr>
<tr>
<td></td>
<td>Deliver a first class patient experience overall</td>
</tr>
<tr>
<td></td>
<td>In line with the trust's Patient Engagement Strategy to continue to listen to and learn from service user feedback as part of our broader strategy to improve patient experience</td>
</tr>
<tr>
<td>B. Being a nationally and internationally respected leader in Research and Development underpinning our pioneering services</td>
<td>Enhance and sustain the Trust's Programme of Research &amp; Development inc with Newcastle University; and also implement and lead the innovation agenda</td>
</tr>
<tr>
<td></td>
<td>Continue to develop Newcastle Academic Health Partners, a joint NuTH and Newcastle University initiative, which forms the basis of Newcastle Academic Medical Science Centre</td>
</tr>
<tr>
<td></td>
<td>Increase commercial trial participation and income</td>
</tr>
<tr>
<td></td>
<td>Undertake a joint programme of research activity, which will translate to tangible benefits in patient care and priority areas</td>
</tr>
<tr>
<td></td>
<td>Active member of Academic Health Science Network (AHSN) and Northern Health Science Alliance (NHSA)</td>
</tr>
<tr>
<td>C. Working in partnership to deliver fully integrated care and promoting healthy lifestyles to the people of Newcastle and beyond</td>
<td>Contribute to the narrowing of the health inequalities 'gap' in Newcastle and surrounding environs</td>
</tr>
<tr>
<td></td>
<td>Reduce emergency admissions and readmissions</td>
</tr>
<tr>
<td></td>
<td>Maximise the benefits of Newcastle Community Services;</td>
</tr>
</tbody>
</table>
and Reduce the over-reliance on hospital services
Contribute to the wider integration of health and social care services in the city
Continue to provide active leadership and assist in shaping the Health and Wellbeing Boards
Contribute to the Public Health agenda for staff and patients
Contribute to regeneration / economic growth across the city

D. Enhancing our reputation as one of the country’s top, first class teaching hospitals, promoting a culture of excellence in all that we do
Maintain our extensive, high quality service portfolio
Consistent achievement of all targets and continuing to deliver a first class patient experience
Maintain our position as a leader of high quality clinical research and development
Continue to deliver high quality training and development
Continue to recruit and retain the very best staff
Lead on the provision of sustainable health services - locally and nationally

E. Maintaining sound financial management to ensure the ongoing development and success of our organisation
Maintain a Finance and Use of Resources Rating of 3
To deliver all CIP targets / operational efficiencies at all levels
Enhance the use of business intelligence to assist us in sustaining and developing business and income
To maximise income through commercial activities to reinvest in NHS care
Maximise the strategic benefits of Service Line Reporting & Management and Patient Level Information & Costing Systems

(Source: Trust Board Assurance Framework – RPIR P106 2017/18)

Management of risk, issues and performance

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£1.03b</td>
<td>£1.04b</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£13m</td>
<td>£11m</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£1.02b</td>
<td>£1.03b</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£5m)</td>
<td>(£24.5m)</td>
</tr>
</tbody>
</table>

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

NHS Improvement had identified that cash balances remained strong in 2018/19 and the trust is forecasting a year end cash balance of £96m. In addition, it was identified that financial risks were actively identified, mitigated and managed by the trust.

20171116 900885 Post-inspection Evidence appendix template v3
The trust has a one-month reporting cycle from ward to board which ensured the most up to date financial positions were presented and discussed at Trust Board, this meant that timely action could be taken.

**Trust corporate risk register**

The trust provided a document detailing their 13 highest profile risks. Each of these have a current risk score of 15 or higher.

<table>
<thead>
<tr>
<th>ID</th>
<th>Title</th>
<th>Description</th>
<th>Rating (current)</th>
<th>Rating (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3343</td>
<td>Board approved Estates Strategy</td>
<td>Lack of Board approved estates strategy that is required to enable the objectives of the Trust to be delivered.</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>CIP delivery (non-delivery carries financial risk)</td>
<td>The 2018/19 Trust plan includes a large cost improvement target (approx. £30m). If that is not achieved the plan will not be met. There is an on-going challenge to deliver the national cost efficiency target without compromising quality.</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>2263</td>
<td>Contracting and data challenge risk</td>
<td>A higher level of demand than has been contracted for must be achieved in order to deliver the I &amp; E position within annual plan submitted to NHS Improvement.</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>2897</td>
<td>Financial risk due to CCG Value Based Commissioning Policy</td>
<td>Risk of financial losses due to CCG mandated prior approval scheme for 'procedures of limited clinical value’ (tonsillectomies, bunions and the like). Services have to seek prior approval (obtain a ‘PAT’ ticket) and CCGs will not pay for activity that proceeded without one from 1st August 2017.</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>3165</td>
<td>Inability to provide blood transfusion service due to staffing shortages</td>
<td>There is a risk that the blood transfusion service cannot be provided 24/7. This is due staff retention problems within Blood Sciences.</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>3323</td>
<td>Inadequate management of Air Handling Systems</td>
<td>Air Handling Systems pose the great potential to affect large numbers of people in the event of bacteria or virus manifesting itself in the respective distribution networks.</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>3320</td>
<td>Inadequate processes &amp; governance around Asbestos management</td>
<td>Inadequate governance around Asbestos management caused by lack of structure including comprehensive policy being in place</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>3309</td>
<td>Inadequate UPS and</td>
<td>Mains power outage with a risk of failure of</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>3306</td>
<td>Risk of human error in handling of blood samples</td>
<td>There is a risk that the blood transfusion service cannot be provided 24/7. This is due to staff retention problems within Blood Sciences.</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>3300</td>
<td>Risk of human error in handling of blood samples</td>
<td>There is a risk that the blood transfusion service cannot be provided 24/7. This is due staff retention problems within Blood Sciences.</td>
<td>15</td>
<td>10</td>
</tr>
</tbody>
</table>
IPS systems (Mains power issues)  | the backup system and also inadequate IPS system.  
---|---
2710 Loss of training and education income  | The Medical Education and Training budget is being reduced by £12 million. This is being phased over 4-5 years starting with a reduction of £2.5 million in 2014/15 and then a further £2.5 million each year after that. This has resulted in the removal of a number of medical training posts and a consequent reduction in staff to cover various specialties.  
3340 Medical gases & medical gas pipeline system quality/safety risk  | Condition: Non compliance with Medical Gas Pipeline System HTM 02 which is required to ensure the quality/purity and safe operating systems to ensure no contamination of medical gases (oxygen, medical air, vacuum systems/suction).  
2881 New Models of Care in Surrounding Localities  | Work is moving on a pace to introduce new, system-based governance models in Northumberland. This could result in capped funding in future with a neighbouring FT provider having control over resources for services currently provided by this Trust.  
2863 There is a national and local shortage of a range of essential staff groups.  | There is a national and local shortage of Band 5 registered nurses, sonographers, radiographers, highly specialised IT roles, clinical coders, cardiac physician and certain estates roles.  

(Source: Trust Corporate Risk Register RPIR P106 Corporate risks 30.10.18)

**Delayed Transfers of Care (DTOC)**

A national target was set to reduce delayed transfers of patient care to the level where they occupied no more than 3.5% of available NHS bed days by September 2017.

In March 2018 the trust reported 1,729 delayed bed days, a loss of 55.77 bed days compared to the 35.86 target. Some 85% of the delays could be attributed to the NHS but delays due to social care had increased; this was mainly due to patient choice and delays in arranging care packages, which were also a feature of the NHS attributed delays.

(Source: Annual report 2017-2018)
The trust were part of advanced health care home vanguard, this meant there were close working relationships with care homes. The trust wrote to all care homes in the local area and asked if they had concerns regarding discharges and admissions. The care homes were invited to an away day and gathered themes. Issues identified were around

- Miscommunication.
- Care homes asked why, soiled clothes were sent home with patients – the trust had no facilities to wash them and couldn’t destroy them.
- The time taken for care homes to assess patients and take them back.
- The length of time carers had to stay in A&E with patients.

The trust developed a compact (agreement) between the care homes and the trust. All stakeholders signed the compact and nominated individuals within care homes were responsible for implementing it. This had reduced delayed transfers of care. Now that they knew each other, care home managers rang ward sisters and discussed patients.

The trust had ‘Time to Think’ beds in the community. These beds were for patients whose families were struggling to decide about place of care. The trust paid for three weeks for a time to think bed near a family’s home. These beds were in care homes, which gave the family breathing space to enable them to decide on long term care, prior to location and finance being finalised. This was available to anyone where long term care was required. Consideration was also given to the individual needs of the patient as to whether it was appropriate for them to be placed in a short stay bed.

The care co-ordination team based in the emergency assessment suite was a multidisciplinary team consisting of senior nurses, physiotherapists and occupational therapists. The team input to the emergency department and assessment suite, and clinically assessed any patients referred to them. The team work 8.00am to 18.00pm Monday to Friday. For those patients who presented out of hours the team retrospectively looked at patients who attended and were classed as elderly/frail and went to visit them. The trusts main frailty service was based at the front door, options for frail patients included return to home, admission to intermediate care or fast track to acute wards. The trust was also involved with the acute frailty network which was led by NHS improvement.

The trust worked closely with local authorities and community services in the region. The trust had developed a shared assessment with Northumbria for Hexham, this meant that assessments were mutually accepted. However, for patients who were due to be discharged to Durham or Cumbria this was reported to a challenge.

The trust identified that other trusts were not taking their patients back. Regional review was organised, and an agreement reached for a regional repatriation policy. The policy was introduced in August 2018, and the trust had seen a significant drop in delayed transfers of care since then. All trusts now repatriated patients from the Newcastle upon Tyne Hospitals NHS Foundation Trust within 48 hours of the patient being well enough to transfer. Not all trusts in the region were compliant with the policy. Staff we spoke with informed us that some patients would wait four to five weeks to be repatriated.

Infection prevention and control (IPC)

There was an infection prevention and control team, with a dedicated doctor who was also appointed as the director of infection prevention and control (DIPC). The IPC team reported to the clinical policy group monthly.
The IPC team took an MDT approach to investigating health care acquired infection (HCAI) and a route cause analysis (RCA) was undertaken to try and identify common themes and identify good practice. The findings of the RCAs and trends were discussed at the serious infection review meeting (SIRM).

There was an infection improvement forum where the team reviewed operational issues and provided direction and support to each directorate. Each directorate had a health care acquired HCAI action plan. The IPC team regularly presented at the monthly patient safety briefings. The team proactively worked with directorates where a spike in HCAI had been identified. The team worked with clinicians to undertake a multidisciplinary route cause analysis. For example, the team identified a rise in the number of surgical site infections following spinal surgery, this was identified at 3.5%. The team worked with clinicians to develop a surgical site infection bundle which included a care plan for surgical wounds. This work saw the number of surgical site infections following spinal surgery reduce to 1.4%.

Quality improvement methods were used to minimise the risk of patients acquiring heath care associated infections. The trust aimed to achieve the national ambition of a reduction in gram negative bloodstream infections including ‘Escherichia coli’ (E. coli) by 50% by 2021. The team used statistical process control (SPC) charts which were shared monthly with clinicians. The team had a dedicated analyst who was able to compare three months of data including antibiotic usage. The ownership of the SPC charts was given to the directorate which was found to improve the sustainability of the improvements.

The IPC team were involved in cohort one of the urinary tract infection collaborative, which was developed by NHS Improvement. The trust worked closely with the clinical commissioners and the frailty groups so learning could be cascaded. There was an increased focus on education for care home staff which was delivered in a collaborative way. This MDT working also included GPs and work included looking at the holistic needs of patients including hydration.

(Source: February 2019 Quality Report)

The trust had an average MSSA bacteraemia rate of between 15-20 cases per 100,000 bed days which was worse than the average national rate of ten per 100,000 bed days. Information provided by the trust showed the total number of MSSA cases reported in January 2018 had decreased by four compared to the previous month.
The trust performed better than the national average for MRSA bacteraemia and the total for the year to the time to date (April 2018 to February 2019) was less than one per 100,000 bed days.

The Trust’s objective for the year 2018/19 for C. difficile was 76 cases which was set by NHS Improvement. There were four cases for C. difficile in January 2019 which brought the total to 64 cases. However, the trust had successfully appealed 22 cases and there were a further five being considered for appeal. Therefore, the trust had 42 cases counted against the objective, this was an improvement from the same period in 2017/18 where there were 63 confirmed cases.
The national ambition was to reduce Gram Negative bacteraemia – E. coli buy 50% by 2021. However, the trust saw an increase of seven cases in January 2019 from the previous year.

**Mortality**

The hospital standardised mortality ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital was higher or lower than would be expected. A score of 100 means that the number of deaths is similar to what would be expected; a higher score means more deaths; a lower score means less deaths. For the latest published figures (January 2018 to December 2018) the HSMR at the trust was 94 (Source: RPIR).

The standardised hospital mortality index (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. For the same period (October 2017 to September 2018), the SHMI was 98 (Source: RPIR). The HSMR and SHMI were reviewed and reported to the trust mortality surveillance group which was chaired by the medical director on a quarterly basis. In addition, the HSMR and SHMI were reported to the board monthly.

The trust had a proactive approach to investigating and improving mortality rates. We met with the mortality leads and heard all deaths were discussed in mortality and morbidity meetings within directorates. The trust mortality leads were part of the regional mortality group and shared wider learning.

Unexpected deaths triggered a more detailed and structured judgement review (based on the PRISM methodology). Mortality leads presented those reviews at departmental mortality meetings. Learning from those meetings was fed into directorate governance meetings and to the mortality surveillance group to review any themes. The mortality surveillance group monitored mortality data, learning from deaths, and reported to the clinical governance and quality committee and trust board. The board received a formal mortality report on a quarterly basis.

We reviewed a random sample of five mortality reviews and found them to be of good quality, lessons were learned and were shared through several mechanisms, these included, safety briefing, clinical risk group, and direct communication with the clinical policy group.

**Information management**

There was evidence of integrated reporting which was used to support decisions made at board level, and performance information was used to hold senior leaders and staff to account. We saw that information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant, with plans to address any weaknesses in performance.

The sub-committees of the board received large amounts of information and to aid focus and consideration of key issues each committee submitted summary sheets along with full reports should the board members need more detail.

The trust used performance dashboards to enable appropriate oversight and challenge. These were RAG (red, amber and green) rated. Trends were visible due to the trust using ‘run charts’ to show improvement or decreased performance. We attended a board meeting during the year and saw board members challenged data and information provided on serious incidents.
Following our previous inspection, the trust had invested in digital programmes, this included electronic records in the emergency department and electronic white boards on the wards. The trust was also in the process of implementing an electronic observations system.

The trust was leading on the great north care record (GNCR); this was a new way of sharing medical information across the North East and North Cumbria, which could be accessed by authorised health and social care practitioners. This would mean that key information about a persons’ health such as medications, details of hospital admissions and treatments could be shared between different healthcare services to include, out of hours and ambulance services.

The information management and technology strategy (2016-2020) identified the development of a platform to connect voice, short messaging service, applications and web services. There were 10,000 to 12,000 digital strategies included an application to interact with multiple services for example diabetic services.

The trust had a range of other specialist clinical systems which were managed locally within the directorates whilst corporate information managed the larger trust systems. The chief information officer spoke highly about engagement and involvement from clinicians; they told us they had a lot of support from the chief operating officer and the trust secretary who helped remove barriers to progression.

The trust was a global digital exemplar (GDE) which was an internationally recognised NHS provider which delivered improvements in the quality of care, through the world-class use of digital technologies and information. The trust was taking new deliveries of brand new GDE services and applications for example robotics for use in surgery.

There was a senior information risk owner (SIRO) who was accountable for the management of all information assets and any associated risks and incidents, and a Caldicott guardian who was responsible for the management of patient information and confidentiality. There were good working relationships between the SIRO and Caldicott guardian.

The trust had carried out an NHS information governance data security and protection toolkit to assure itself. The toolkit was an online system which allowed organisations to assess themselves or be assessed against information governance policies standards. The assessment considered the following areas:

- Information governance management,
- Confidentiality and data protection assurance,
- Information security assurance,
- Clinical information assurance,
- Secondary use assurance,
- Corporate information assurance.

The trust self-assessment was reviewed by NHS digital and the score of ‘satisfactory’ (the highest possible score) was confirmed. (*Source: NHS Digital. Version 14.1 2017-2018*)

**Engagement**

**Patient and public engagement**

There was a range of methods in place to engage with patients and the public to shape and improve services. Senior leaders had used information from patient experience feedback and public sector equality duty compliance reports to include views from people with protected characteristics.
Learning, continuous improvement and innovation

There was an embedded and systematic approach to improvement, which made use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the organisation to learn. There was a strong focus on learning and improvement throughout the organisation at all levels; the trust participated in a large amount of research and clinical trials to seek improvements to patient care and outcomes.

We saw learning was shared effectively and used to make improvements. There was a patient safety briefing which shared lessons learned from serious incidents and never events. Learning points bulletins had been produced covering various topics, including never events, venous thromboembolism prevention and discharge planning. Lessons learned were posted on the Trust intranet to ensure wide distribution across the organisation. In addition, a learning from serious incidents bulletin was produced and posted on the intranet as well as being made available in hard copy.

The trust had developed an innovation strategy (2015) which provided support aimed to provide expertise to staff who had ideas and solutions. The diagram below demonstrates the innovation strategy in pictorial form.

(Source: Innovation, Service and Quality Improvement @ Newcastle Hospitals)

The trust had developed a research and innovation hub, which was a space in which innovators could meet, discuss their ideas to assist and support creating a solution. Based within the Hub is a research and innovation tracker administration took place. The trust had developed this tracker to provide staff with a platform to submit their ideas. The ideas are then triaged and leads assigned to that every staff member is supported by an expert in that field. The tracker also provided real-time updates and ensured each project in progress is reviewed appropriately.
Complaints process overview

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3 days</td>
<td>95%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>20 – 60 days</td>
<td>Quarter 1: 86%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 2: 75%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints, please</td>
<td>Up to 60 days</td>
<td>100%</td>
</tr>
<tr>
<td>indicate what that is here</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of complaints resolved without formal process in the last 12 months?

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

Number of complaints made to the trust

The trust received 544 complaints from September 2017 to August 2018. Medicine core service received the most complaints with 247 (45%).

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>250</td>
<td>46.0%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>79</td>
<td>14.5%</td>
</tr>
<tr>
<td>Other</td>
<td>58</td>
<td>10.7%</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>39</td>
<td>7.2%</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>25</td>
<td>2.6%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>14</td>
<td>2.6%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>14</td>
<td>2.6%</td>
</tr>
<tr>
<td>AC - End of life care</td>
<td>12</td>
<td>2.2%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>11</td>
<td>2.0%</td>
</tr>
<tr>
<td>CHS - Community Dental</td>
<td>10</td>
<td>1.8%</td>
</tr>
<tr>
<td>CHS - Adults Community</td>
<td>9</td>
<td>1.7%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>8</td>
<td>1.5%</td>
</tr>
<tr>
<td>No core service assigned</td>
<td>6</td>
<td>1.1%</td>
</tr>
<tr>
<td>CHS - Sexual Health</td>
<td>6</td>
<td>1.1%</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>5</td>
<td>0.9%</td>
</tr>
<tr>
<td>CHS - Children, Young People and Families</td>
<td>3</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other - ASC service</td>
<td>1</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

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

Compliments

From April 2017 to March 2018 the trust received a total of 49,293 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>25,120</td>
<td>51.0%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>9,271</td>
<td>18.8%</td>
</tr>
<tr>
<td>Service accredited</td>
<td>Accreditation scheme name</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------</td>
<td></td>
</tr>
<tr>
<td>NCCC Radiotherapy and wards certified since 1998, most recent recertification 2016 and next due 2019</td>
<td>Certification for radiotherapy and chemotherapy services (BSI ISO9001:2015)</td>
<td></td>
</tr>
<tr>
<td>NCCC and GNCH transplant services accredited since 2015 and next due 2019</td>
<td>Accreditation for Blood and Marrow Transplant services (JACIE)</td>
<td></td>
</tr>
<tr>
<td>NCCC Myeloma Service - July 2018</td>
<td>Clinical Service Excellence Award for Myeloma (Myeloma UK)</td>
<td></td>
</tr>
<tr>
<td>NCCC Macmillan support and information service in May 2018 achieving level 5 (highest) and next due May 2021</td>
<td>Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
End of life care at this trust was delivered by all clinical staff supported by the senior nurse for specialist palliative care, end of life care, lead clinician and teams of specialist palliative care nurses, consultants, health care assistants and administrative staff. These roles supported all staff to deliver end of life care across the trust (community and acute settings) through education, training, audit, research, documentation, and clinical availability. A core function of this service was monitoring, and reporting on standards of care, and compliance against local, regional, and national guidance. The service actively sought user experience feedback in order to improve care. The trust did not have any inpatient palliative care, or specialist palliative care beds. End of life care was delivered in all acute clinical areas.

The specialist palliative care service offered advice and holistic assessment of patients with complex specialist needs. It consisted of four clinical teams, three in the acute setting based at Freeman Hospital main site, Northern centre for cancer care, Royal Victoria Infirmary (RVI) and a Newcastle community based team. All teams were supported by a Senior Nurse for palliative and end of life care and lead clinician. Each team consisted of nurse specialists, consultants in palliative medicine, Macmillan end of life healthcare assistants and administrative/clerical support staff. There was an additional hospital team; enhanced supportive care team which included a Macmillan funded occupational therapist, and physiotherapist along with a clinical nurse specialist.

(Source: Acute Provider Information Request – Acute context tab)

The trust had 1,800 deaths from July 2017 to June 2018.

(Source: Hospital Episode Statistics)

This report predominantly focuses on the inspection of services provided by the specialist palliative care medical, nursing and administration team, the mortuary staff and the chaplaincy and bereavement teams.

We inspected the whole core service and looked at all five key questions. In order to make our judgements, we spoke with a total of five patients and 45 staff from different disciplines. We observed daily practice and viewed seven sets of records of patients at this hospital. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Is the service safe?

Mandatory training

At our previous inspection in 2016, the Specialist Palliative End of Life Care (SPEoLC) service was meeting the trust target of 95% compliance with mandatory training, with the exception of the chaplaincy team.

At this inspection, information provided by the trust showed compliance for this site had deteriorated, with nursing staff meeting the 95% target in only one of 13 training courses. However staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.
All trust staff received an introduction to palliative and end of life care at the trust induction session, which included information about the team, how they could be contacted, the five priorities of patient care, and the care of the dying document.

We discussed manual handling training with the mortuary staff. This was done as part of their mandatory training. There were three manual handling facilitators working within the mortuary department who received regular training updates and disseminated information to staff.

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training.

The trust did not provide medical staffing data against this core service.

A breakdown of compliance for mandatory training courses from April 2018 to September 2018 at the trust for qualified nursing & midwifery staff and health visiting staff in end of life services is shown below:

### Trust wide

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Patient Falls</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>19</td>
<td>17</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>19</td>
<td>15</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>19</td>
<td>15</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Local Induction</td>
<td>4</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff failed to meet the trusts 95% completion target for nine out of 13 mandatory training modules; four modules met the 95% target and the lowest scoring module was local induction with 50%.

For the last financial year period of April 2017 to March 2018 nursing staff within end of life services achieved a 98% completion rate for mandatory training against a trust target of 95%.
Freeman Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of Staff Falls</td>
<td>16</td>
<td>16</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of Patient Falls</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>16</td>
<td>13</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>16</td>
<td>13</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>16</td>
<td>13</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>16</td>
<td>12</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Local Induction</td>
<td>4</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff at the Freeman Hospital failed to meet the trusts 95% completion target for 12 out of 13 mandatory training modules; the lowest scoring module was local induction with 50%, prevention of staff falls achieved 100%.

For the last financial year period of April 2017 to March 2018 nursing staff within end of life services at the Freeman Hospital achieved a 97% completion rate for mandatory training against a trust target of 95%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Bereavement, chaplaincy and mortuary staff were meeting the trust’s 95% completion target in three of 13 modules. This data was not available by site as all staff work across both sites.

Safeguarding

We spoke with specialist palliative care nurses who were able to clearly explain their responsibilities in relation to safeguarding patients. They were able to share examples of when they had needed to submit safeguarding concerns for patients in their care. They told us that they had not experienced any difficulties in obtaining advice, and that this was available 24 hours a day.

Monthly SPEoLC multidisciplinary meetings were attended by safeguarding team members.

We discussed safeguarding with ward staff caring for patients approaching the end of their life, and they could outline their responsibilities in relation to safeguarding patients and gave examples of recent practice. We saw contact details for safeguarding teams clearly displayed in ward areas.

The trust set a target of 95% for completion of safeguarding training. Staff were meeting the trajectory to complete safeguarding training by end of March 2019 and could easily access training as required.

The trust did not provide medical staffing data against this core service.

A breakdown of compliance for safeguarding training courses from April 2018 to September 2018
at the trust for qualified nursing & midwifery staff and health visiting staff in end of life services is shown below:

Trust wide

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff failed to meet the trust’s 95% completion target for two out of three safeguarding training modules; the lowest scoring module was safeguarding adults level 2 with 84%.

From April 2017 to March 2018 nursing staff within end of life services achieved a 96% completion rate for safeguarding training against a trust target of 95%.

Freeman Hospital

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff at the Freeman Hospital failed to meet the trust’s 95% completion target for all three safeguarding modules.

From April 2017 to March 2018 nursing staff within end of life services at the Freeman Hospital met the trust target of 95%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

We visited several areas in which palliative and end of life care were provided, including hospital wards, the mortuary and bereavement offices. All areas appeared clean, tidy and well maintained. We saw that personal protective equipment, including gloves and aprons, was readily available, and there were appropriate handwashing and hand decontamination facilities in all areas.

We observed a transfer of a patient into the mortuary. Porting staff treated the deceased with respect and all appropriate infection control measures were used. Mortuary staff told us that there was a robust handover process for patients entering the mortuary and we saw that this was completed at all times.

The mortuary was clean and odour free. Staff spoke passionately about their infection control measures and standards of cleanliness. Fridge temperatures were monitored electronically, and estates staff were automatically alerted if temperatures were out of range.

The trust conducted bimonthly environmental cleanliness audits, comprising a matron’s monthly check, hand hygiene checks and infection prevention and control practice. For the previous year,
areas where patients receiving end of life care had been cared for such as Surgery, Medicine and Urology averaged over 95% compliance.
(Source: data request DR049, DR050 EoL IPC audits)

**Environment and equipment**

There were no specific end of life beds for patients at this hospital. We visited Urology, Surgery and Medical wards where patients at the end of life were being cared for. We found all wards to be clean and tidy, uncluttered and in good decorative order.

The trust used two types of syringe drivers to deliver drugs to patients receiving end of life care. One type was used for inpatients, and these were stored centrally in an equipment library. We heard from several staff that they did not have any problems accessing these and they were always available when needed. All staff using these devices had their competency assessed and centrally recorded.

When patients were discharged, they were transferred onto a second, smaller device, a stock of which was held by the end of life team. Specialist nurses fitted these in the hospital, and care of the device was then transferred to the district nursing team who would visit the patient shortly after their arrival home. This meant that patients’ pain was controlled well, and we found no evidence of patients who had been using a syringe driver being transferred without one in place. We saw that all eligible specialist nurses were compliant with their training and their competency sheets were up to date.

Monthly compliance reports were automatically generated; these identified staff within the Directorate recorded on the electronic database, and the devices each individual was registered to use. This report was routinely shared with Directorate Managers and ward level reports have also been produced on request.

The mortuary viewing room had been refurbished using charitable funds. It was neutrally decorated, with a calm and peaceful environment. There was an arrow on floor in the chapel of rest to indicate direction for prayer. Both mortuaries had ceiling hoists and lifts available to access the refrigerators.

The mortuary had capacity for 95 patients including one bariatric fridge and five that while not specifically bariatric in design, were significantly wider than normal. There were five freezer spaces suitable for longer term storage of bodies. Staff could use extra spaces at the RVI if needed.

**Assessing and responding to patient risk**

Patient referrals to the SPEoLC were received by the team secretary and passed to the team coordinator for triage. Follow up and assessment was then arranged, or advice given. New referrals were also discussed and triaged at the daily morning team meeting, where the team’s workload and current patients were discussed and reprioritised. The team aimed to ensure patients saw the same nurse where possible. The team’s comprehensive education on general wards meant that ward staff were clear when to make a referral to the team.

We were told that an end of life pathway would be initiated following discussion with the patient, their family, and the multi-disciplinary team involved in their care. A plan of care for the dying person was introduced, based on the five priorities of care, which was an individualised care plan and communication record.
Alert notices were in use in the mortuaries attached to fridges, for example for patients with similar names and for those with pacemakers or implantable defibrillators.

Each directorate had a directorate liaison officer whose role was to ensure that arrangements were in place for the timely dissemination, action and review of national and local alerts. The trust monitored centrally the response of each directorate to each alert and followed this up where this had not been timely. We were therefore assured that alerts would reach the right people and be followed up in a timely way.

**Nurse staffing**

The SPEoLC team consisted of band six and band seven nurses. We were told that staff recruitment was not usually an issue, and turnover and sickness rates were low.

The trust provided us with data for the last financial year (April 2017 to March 2018) and then for April to September 2018, the fill rate has declined at both sites for nursing staff and as of September 2018 the fill rate is 50% for this core service.

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned staff WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE LFY</th>
<th>Planned staff YTD (Apr-Sep-18)</th>
<th>Actual Staff WTE YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freeman Hospital</td>
<td>11.3</td>
<td>13.0</td>
<td>17.0</td>
<td>15.0</td>
<td>115%</td>
<td>88%</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

From October 2017 to September 2018 nursing staff in end of life had a 9% vacancy rate compared to the trust average of 12% there was no target set by the trust for vacancy rates. (Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From October 2017 to September 2018 nursing staff in end of life had a 36% turnover rate compared to the trust average of 5% there was an 8% target. (Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From October 2017 to September 2018 nursing staff in end of life had a 1% sickness rate compared to the trust average of 4% there was an 3% target set by the trust for sickness. (Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From October 2017 to September 2018 substantive nursing staff covered 95% of hours available for this core service, 5% was covered by bank staff when needed.
Medical staffing

Consultants worked across the hospital sites and community. They also provided an out of hours on-call telephone advice service. Trainee doctors worked with the team and were fully involved with patient care. Undergraduate training was provided to junior doctors at induction.

The trust’s medical staffing met commissioning guidance for specialist palliative care.

We spoke with a member of the medical team who told us that they worked part time across both sites and also provided advice remotely through the on call telephone advice system. This hospital also supported GP trainees within the team. They felt that the service was busier, but safe, and put this down to greater awareness of their role.

Vacancy rates

There were no vacancies for this core service for the period from October 2017 to September 2018.

Turnover rates

The trust reported one member of the medical team leaving in the 12 months prior to December 2018.

Sickness rate

The trust reported a sickness rate of 1.86% for the 12 months to December 2018.

Bank and locum staff usage

From October 2017 to September 2018 medical staff in end of life had a 1% bank usage rate.

<table>
<thead>
<tr>
<th></th>
<th>Total hours available Hrs</th>
<th>Bank Usage Hrs</th>
<th>Agency Usage Hrs</th>
<th>NOT filled by bank or agency Hrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of life total</td>
<td>11,627</td>
<td>127</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trust total (medical</td>
<td>1,746,066</td>
<td>45,659</td>
<td>1,629</td>
<td>0</td>
</tr>
<tr>
<td>staff)</td>
<td></td>
<td>Percentage: 3%</td>
<td>Percentage: 0%</td>
<td>Percentage: 0%</td>
</tr>
</tbody>
</table>

The trust’s chaplaincy, mortuary and bereavement services teams had low sickness rates, low turnover and low vacancy rates for the previous 12 months.

Records

We looked at seven sets of medical records for end of life patients at this hospital. All were stored securely. The team used an electronic healthcare record system, which linked with the community and local hospices. All patients were registered on this system and documentation was completed electronically, then printed for inclusion in hospital notes. We viewed several printed versions of notes completed by the team and all were written clearly with attention to detail and comprehensive treatment plans.
We saw that information in patient’s notes included medication history, pain management, microbiology information, documentation of discussions with the patient about their physical and emotional wellbeing, ongoing plan of care, and discharge planning. Ward staff told us that the notes provided by the SPEoLC team were always clear and helpful.

The trust used the regionally adopted ‘Care of the Dying Patient’ booklet. Staff explained that although this was the trust’s preferred documentation, it would not be implemented if this was against the patient’s wishes. For example, if a person did not believe or did not want to consider that they were dying, the booklet would not be used to avoid further distress. Medical staff told us that introduction of the booklet could be challenging as there were some longstanding taboos surrounding the discussion of death. Work was ongoing to produce the booklet electronically, which would provide an increased focus on the five priorities of care and would prompt staff to record a patient’s preferred place of death at the earliest appropriate opportunity.

We spoke with staff who regularly used the Care of the Dying documentation and they told us that, although it was a large document, they found it straightforward to complete and thought it took patients’ needs and wishes into account.

The team regularly audited use of the care of the dying patient booklet. Their most recent audit showed it was being used in 20 of 25 cases. In the five cases where it was not being used, all of the information was available elsewhere in the patient’s notes. This was an improvement on the previous 2017 audit which showed the document was being used in 65% of cases.

**Medicines**

Prescribers on wards used pre-defined order sets for the end of life and the prescribing of anticipatory medicines. These order sets contained a predetermined selection of medicines in line with trust policy. When these order sets were accessed by ward staff, an automatic email alert was sent to the end of life / palliative care teams and chaplaincy staff to alert them to this. We did not see any completed prescription charts at this site as anticipatory medicines removed the need for these.

We looked at medicine records for one patient receiving end of life care. Medicines for this person were in a syringe driver (small infusion pump used to gradually administer medicines continuously over a set period of time). The reasons for the use of this infusion were clearly documented in the person’s notes. However, we found that staff were not adhering to trust policy as they had not recorded that they had checked the infusion as regularly as directed.

The end of life care team audited prescribing at the time of death. A member of medical staff was in the process of reviewing 52 sets of prescription charts and notes to check whether what was prescribed was appropriate with actions and learning to follow. A January 2018 review of prescribing at end of life found that the recent addition of oral replacement gel to anticipatory drug order sets was still to be fully embedded, but that standards of prescribing remained high.

At our last inspection we saw that syringe drivers were disconnected when patients were being discharged from hospital to the community, and different devices reconnected when the patient arrived at home. We were concerned this posed a risk of patients experiencing breakthrough pain. At this inspection, we found that patients’ syringe drivers were changed to different devices prior to discharge rather than being disconnected. This was done by SPEoLC nurses, and we were told that nurses from the local hospices provided out of hours support if necessary. We saw no reported incidents in relation to the transfer of patients with syringe drivers.
Incidents

Staff understood their responsibilities to raise concerns, to record safety incidents and near misses and knew how to report them appropriately. They were aware of the incident reporting procedure. Learning from incidents was used as an education opportunity for all staff and we saw discussion around recent incidents taking place at the team meeting. Feedback was given to staff involved.

Incidents were reported using an electronic system and those relating to the end of life team came direct to the team leader for review. These were then discussed and formed a standing agenda item at each team meeting. We reviewed a set of incidents with a common theme and found that these were well documented with clear actions taken and lessons learned.

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 within end of life 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 no serious incident (SIs) in end of life care which met the reporting criteria set by NHS England from October 2017 to September 2018.

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

Policies used by the service were available for staff to access on the trust intranet. These included a range of pathways and guidance which reflected national evidence based best practice and guidelines. The trust had an implementation policy for National Institute of Health and Clinical Excellence guidelines and a sub-committee of the trust board was responsible for monitoring compliance. Non-compliance was escalated to the trust board.

Specialist nursing staff told us they were well equipped to treat patients with a mental health condition and liaised with the psychiatry team daily in such cases. Staff knew how to refer to the drug and alcohol service, should they need to do so.

We asked how staff would manage patients with challenging behaviour. They told us that effective use of communication skills was at the centre of all patient interactions. They would talk to the patient and allow them the opportunity to discuss any issues or anxieties. They gave us examples of patients with mental health problems who had required referral to the psychiatric liaison team; joint care plans had been developed, reviewed and modified as necessary. Security staff had been commended for the compassionate way in which they supported a patient experiencing acute mental health symptoms and for the relationship they built with the patient. We were told that if patients needed monitoring on a one to one basis, this could be quickly arranged.

The team at this site were taking part in an Enhanced Supportive Care CQUIN, which included the recruitment of a physiotherapist and occupational therapist as part of the Enhanced Supportive Care (ESC) team. As of January, this team were not receiving new referrals as they had a high
number of patients already involved in the model which they needed to complete safely. The team was working on a piece of evaluation work to show the added benefit to patients of this extra support.

The team worked closely with end of life link nurses on wards, who met regularly with nurse specialists from the team. As part of these meetings, the group would collaboratively assess real discharge case studies, improving link nurses’ confidence and ability to correctly assess and grade a patient. Link nurses were given a clear role description, purpose and key activities.

The team were part of the pilot to develop a Public Health England dataset for palliative care in 2015. They have rolled out and continued with the use of this dataset and this was observed to be in use at daily team discussions.

The most recent visit to mortuary services by the Human Tissue Authority (HTA) concluded that despite some minor shortfalls, several strengths were identified. The associated action plan to rectify the three minor shortfalls provided by the trust was appropriate and set reasonable targets for completion. All three were reassessed and found by the HTA to have addressed the issues identified.

**Nutrition and hydration**

We checked 13 sets of patient notes across both sites. In all cases, a nutritional assessment had been included in the notes. Where appropriate, fluid balance charts were also present.

The trust audited nutrition and hydration as part of their ongoing real time end of life care audits. In 85% of cases in the most recently published audit, an assessment was made regarding the patient’s ability to eat and drink. 59% of patients were documented to have an impaired or unsafe swallow.

There was evidence in patients’ notes that a discussion regarding hydration and nutritional requirements had taken place with the patient in 27% of cases and in 100% of cases where the patient was capable.

In 100% of cases there was a documented discussion with relatives/carers regarding hydration and in 86% of cases there was a documented discussion with relatives/carers regarding nutrition.

**Pain relief**

The team told us that following recent media interest in incorrect doses of medication for pain relief, they conducted a gap analysis, supplemented with regular medication audits.

The team were using a specially designed pain scale for patients who cannot clearly articulate their needs as part of the care of the dying patient booklet. We saw in patients’ notes that this had been appropriately used and completed. Where pain was not being controlled, we saw an increase in painkilling medication had been given, and the reason for this was documented in the patient’s notes. As part of their ongoing audit programme, the team had identified that use of the bespoke pain scale was an area that could be improved in terms of more widespread use on wards. They were planning education programmes with the aim of further improving this position.

**Patient outcomes**
The SPEoLC teams had contributed to the Public Health England national palliative care dataset pilot which measured, analysed and compared some of the key outcomes that mattered most to people who received specialist palliative care.

The trust did not participate in the Gold Standard Framework (GSF) scheme. There had been a similar local scheme, funded by the local clinical commissioning group, but funding for this had now ceased.

End of Life Care Audit: Dying in Hospital 2016

The trust participated in the End of Life Care Audit: Dying in Hospital 2016 and performed better than the England average for all five clinical indicators. The trust answered yes to seven of the eight organisational indicators, answering no to the question “Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday?”

(Source: EoLCA – End of Life Care Audit – Dying in Hospital)

Competent staff

The SPEoLC nursing and medical teams showed evidence of continuous postgraduate training and learning, covering topics such as dementia, medical ethics and law, advanced communication skills and practice development. This included studying to degree or masters level in palliative care.

The medical team provided input into third year and final year training for medical students to make sure all had at least a basic understanding of palliative care during which time they covered the five priorities of care. They also provided 20 minute education sessions to medical staff working in the assessment suite. The medical team also jointly delivered education with the heart failure team.

End of life nurses had visited wards or areas to deliver training on the use of the Care of the Dying Patient booklet. A total of 274 staff took part in the training over five days. Staff told us that there was more of a recognition following this training about the importance of discussing a patient’s preferred place of death as early as possible.

The wards we visited all had link nurses for palliative and end of life care. We spoke with a link nurse who regularly attended meetings and ensured relevant information was disseminated to staff. Staff told us that they felt there was more exposure to palliative and end of life care for doctors and nurses in training, which had helped to raise awareness and improve communications with patients and relatives. It was felt by staff of all levels that the education and support provided by the SPEoLC team was invaluable, and information or guidance was always available, either from the team directly or from their dedicated intranet page.

We heard from staff on a medical ward that the end of life link nurse attended meetings regularly with the specialist end of life team and enjoyed them. The ward sister would attend in their absence if needed.

There was no specific clinical educator role within the team, however other members of the team were providing a wealth of formal and informal training opportunities, supported by good links with the trust’s central clinical educator team. Nurse specialists invited the trust education team to attend their quarterly subgroup meetings.

One of the team’s healthcare workers told us that they felt well supported and that the team culture was very positive. They were able to debrief with their manager if anything had particularly upset them, and they were also offered reflective practice sessions for their own wellbeing.
Nurse specialists entering the end of life team were supernumerary for the first six months in post. They did see patients but were also offered a wealth of other shadowing and development opportunities, such as spending time with local hospices, the transplant team and identifying their own opportunities. We spoke to a new member of staff who told us that they were amazed how supportive the organisation was and that although they have been seeing patients and continued to do so, they had felt invested in and given space to develop into the role.

The team provided two five day courses a year for qualified staff providing comprehensive training on end of life care. This included a whole day on communication, and another on advanced care planning. Some places were ringfenced for staff attending from the community or from local care homes. This course was advertised internally and externally and was regularly oversubscribed.

The team also provided a one day shorter course twice a year for qualified staff giving more of an overview of the topics covered in the longer course.

The team provided a one hour slot of training as part of the trusts HCA Academy programme for aspiring health care assistants, and also fed into the trust’s preceptorship programme. They were looking to build a bespoke training session for health care assistants already in post as they recognised this was a gap in the current offer. We discussed training with two ward-based healthcare assistants and they both told us they had received education and support from the SPEoLC team and from ward colleagues, and that they always felt comfortable asking for help and advice.

The team was also involved in teaching provided by the trusts healthcare academy, in induction and preceptorship programmes, and in provision of communications training such as the ‘sage and thyme’ course: a workshop which focused specifically on communicating with people who were worried or emotionally distressed. The palliative care team leader was a ‘sage and thyme’ facilitator and had run five pilot sessions of this training in 2018 which had been very successful; training was to be continued in 2019.

The chaplaincy team were all appropriately and substantially qualified in their field, including specialist knowledge in areas such as child death and child bereavement, issues around faith and organ transplantation, and wider ethical issues. They also provided training to staff and external organisations including ethics and bereavement sessions, student nurse sessions, and attended trust inductions.

**Appraisal rates**

The trust provided us with appraisal rates for end of life for the April to September 2018, only one staffing group met the 90% target set for the period covering up to March 2019.

Whereas the appraisal target for March 2018 was 80% this core service missed the target with a completion rate of 65%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff Required Year to Date</th>
<th>Staff Received An Appraisal - Year to Date</th>
<th>% Of Staff Received An Appraisal YTD</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
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<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>13</td>
<td>10</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
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</table>
Medical staff appraisal rates were 62.5% at the time of our inspection.

Multidisciplinary working

We observed a consultant led multidisciplinary team meeting attended by medical and nursing staff, therapy staff, healthcare assistants and discharge coordinators. The team discussed patients and their current needs using the recently developed national palliative care indicators set. The team used a ‘phase of illness allocation in accordance with phase definition’ flow chart developed as part of this set, which determined the level of anticipated intervention in terms of changes to the care plan. We saw evidence that any learning points for action were logged and themes were scheduled for discussion at the monthly clinical governance meeting.

We saw examples of effective multidisciplinary working on wards: ward staff told us that, whenever possible, the process of referring patients to the SPEoLC team would involve the whole of the ward team involved in a patient’s care. They also worked alongside specialist nurses and doctors for support with specific conditions. Staff told us they felt discussions and treatment planning was much more open, and they felt much more empowered when caring for people at the end of life, particularly due to the support they received from the SPEoLC team.

We saw in one patient’s notes that they had received input from a palliative care nurse specialist, ward nurses, a specialist end of life health care assistant and chaplain within the space of two days.

Two specialist Macmillan nurses based within the local ambulance trust attended the end of life team’s meetings for shared learning opportunities and to improve links.

We saw that SPEoLC meetings involved staff from other areas, such as from safeguarding and learning disabilities teams. We heard examples of when legal advice had been required, and the trust’s legal team had provided timely and helpful support. The team also had good working relationships with pharmacy services and specialty teams within the hospital.

A member of the team worked closely with heart and lung transplant teams to change the perception of palliative care in order to offer this service more proactively to this group of patients, who historically did not receive it. They had been awarded the Dundas Medal (a national palliative care award) in 2018 for this work.

Seven-day services

The team provided a seven day service to patients and their families. On weekdays, consultants, doctors and nurse specialists reviewed patients daily. At weekends, reviews were conducted by nurse specialists. They were supported by an on call hospice advice line with direct access to consultant advice.

Mortuary staff did not routinely work at evenings or weekends but were on call to come in if a body needed to be released during these periods. They told us they did not have any problems releasing a body in a timely manner if all paperwork was complete and were therefore able to meet the needs of those faiths requiring prompt burial.
Bereavement services staff did not work at weekends or during the evenings and cover out of hours was provided by reception staff managed by the team who had been given additional training to cover immediate and basic needs until specialist staff were available. The chaplaincy service provided 24-hour cover and, out of hours, aimed to respond within one hour.

Radiology and pharmacy services were available out of hours, either directly or on an on-call basis, and allied health professionals such as physiotherapists were available at the weekend.

**Health promotion**

The service promoted the national Dying Matters weeks annually. The team told us that last year they held stalls at both sites, encouraging both patients and staff to discuss death and dying, and also highlighting the work of other services such as local hospices. They talked about plans for a death café for the coming year.

We saw Macmillan support leaflets were readily available in many areas and provided guidance for patients and their relatives in a range of subjects, including emotional, financial and therapy information.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.

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

We looked at the trust’s policies for consent and mental capacity act, including DoLs. We found that these were in date and contained appropriate references to legislation such as the mental capacity act, equality and diversity and the human rights act.

Specialist end of life care nurses told us that they accessed mental capacity act and deprivation of liberty safeguards training on a rolling programme, available online.

The team had been involved in the development of the regional ‘deciding right’ app and associated resources, aimed at emphasising the partnership between the individual, carer or parent and the clinician and placing the Mental Capacity Act (MCA) at the centre of shared decision-making. The resources and app were accompanied by training for professionals and the team was in the process of cascading this to GPs and clinical educators.

To illustrate the importance of the programme and the effect it could have on patients and their families, a patient representative was attending trust board to share their experience.

We checked five ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) forms at this site. All forms were well completed, with good documentation, and detailed notes. These were all countersigned by a consultant, dated, and stored in the front of the patient’s paper notes.

The trust provided a copy of their most recent audit of DNACPR documentation (August 2018) which confirmed our findings that forms were almost always being completed appropriately and
that this was an improving picture. Actions were in place to address any measures that had deteriorated since the previous audit.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for mental capacity training courses from April 2018 to September 2018 at the trust for qualified nursing & midwifery staff and health visiting staff in end of life services is shown below:

**Trust wide**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
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<tr>
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<td>19</td>
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<tr>
<td>Mental Health Act</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
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</table>

Nursing staff achieved 100% completion for both mental capacity training modules.

From April 2017 to March 2018 nursing staff within end of life services achieved a 100% completion rate for mental capacity training against a trust target of 95%.

**Freeman Hospital**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>16</td>
<td>16</td>
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<td>95%</td>
<td>Yes</td>
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<tr>
<td>Mental Health Act</td>
<td>16</td>
<td>16</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
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</table>

Nursing staff at the Freeman Hospital achieved 100% completion for both mental capacity training modules.

From April 2017 to March 2018 nursing staff within end of life services achieved a 100% completion rate for mental capacity training against a trust target of 95%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

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**Is the service caring?**

**Compassionate care**

We observed patients being treated with dignity and respect. We observed a number of interactions between staff, patients and relatives. Staff were polite and professional in their approach. We observed staff responding compassionately to patients’ pain, discomfort and emotional distress in a timely and appropriate way.

Confidentiality was respected in staff discussions with people and those close to them.

Staff spoke about patients with complex needs in a respectful way and demonstrated a non-judgemental attitude.
Patients we spoke to told us their care had been good. They knew what the plan was for their care and where appropriate, had spoken with staff about their preferred place of death.

Chaplaincy staff told us that if a person died without sufficient income or next of kin to provide a funeral, the trust would arrange this for them.

A member of the bereavement services team voluntarily arranged and provided flowers for the chapel of rest viewing areas and funerals for people with no next of kin.

Ritual washing facilities were available at the RVI for those families wishing to use them.

We spoke to two members of portering staff. They told us that they had received training on how to sensitively transport a deceased patient to the mortuary. They knew how to use protective equipment, and how to book the patient in on arrival. They had also received general moving and handling training. One porter also commented that they always felt welcomed by mortuary staff on arrival.

Bereavement services staff offered a comprehensive ‘one-stop-shop’ service to families, organising paperwork, visits to the chapel of rest, and discussions with doctors as required. Staff told us they were proud to be in this important role and that patients remained ‘our patients until they leave the hospital’. Practical advice would be given regarding the death certificate, funeral services, mortuary services and administration procedures. Patient’s property was returned through the bereavement services team when necessary, to avoid relatives having a potentially upsetting visit to the ward.

One of their most important tasks was arranging for doctors to meet with families who still had questions or concerns about the patient’s care in the last days of life. This played an important role in the grieving process and also prevented worries or niggles developing into complaints. Out of hours arrangements were made through hospital reception teams, and staff always ensured that paperwork and death certificates were available in a timely manner, for example if needed for religious reasons.

**Emotional support**

We saw staff of all grades going to extraordinary lengths to support and comfort dying patients and their relatives. Staff worked beyond the end of their shift and out of hours to provide extra support and care and made special arrangements for those nearing death.

Staff we spoke with had received training in breaking bad news. They told us that they had to be prepared for a range of emotions, needing to adjust their approach according to a person’s reaction, and ensure all interactions were conducted as sensitively as possible.

We saw in one patient’s notes the difference effective emotional support had made. Within the space of a week, with intensive support from the team, the family had gone from a position of denial and non-acceptance of the seriousness of the patient’s condition, to discussing funeral plans with the patient and chaplaincy staff.

The mortuary had a good sized viewing / relatives room, which was well decorated and tidy. Mortuary staff explained that while this room is normally used to support families, they had also recently supported a member of medical staff who had been upset at the unexpected loss of a patient.

Mortuary staff provided hand and footprints of babies if the families would like them, and locks of hair from any patient could be sealed in a variety of shaped lockets for families to keep. Staff had
recently introduced matching bracelets available in a wide variety of colours and sizes, one each for both parents, and one for baby. Feedback was very positive.

A healthcare assistant told us of a person they had recently supported who had young children. The person was struggling to explain their situation to their family, especially as their children were so young. The healthcare assistant found books and teddies for the children and matching memory bracelets for the whole family. They supported the patient to use these to discuss their condition with their family.

As part of their ongoing work to improve experience for patients and their families. Staff told us they walked the route from wards to the mortuary to see how they could make this less challenging for families.

We saw in one patient’s notes that staff had arranged for a family member who was due to get married in the coming months to have a blessing at the bedside facilitated by the chaplain, so the patient could attend the ceremony.

The team had a newly developed psychological wellbeing practitioner role, which could increase access to brief, low intensity cognitive behavioural therapy (CBT) interventions for patients with mild to moderate psychological difficulties.

Chaplaincy staff provided emotional, practical and spiritual support to both staff and patients. This included sitting with patients when a visit had been requested and offering their services to all patients identified as nearing the end of their life. In the previous 12 months, chaplains had provided 671 care of the dying patient visits across the trust.

The chaplaincy team also provided memory boxes and individually selected resources for the families they supported. They had received dozens of Greatix notifications, thank you’s and acknowledgments for their work with end of life patients and the support they offered to staff caring for these patients.

**Understanding and involvement of patients and those close to them**

We spoke with patients and asked if they were given enough information about their care and treatment. One patient said they asked for staff to give them very little information, they would rather it was discussed with their family, and staff had respected this. Another patient told us that they had asked for as much information as possible, and for it not to be ‘sugar-coated’: staff had been very honest and direct about their condition, which they greatly appreciated.

A staff nurse on a medical ward told us that they did not limit the amount or age of visitors to patients who were nearing the end of life. Visiting times were open, provided that the visitors were not disruptive and respected the needs of other patients on the ward. One patient had extended family with them at all times and this was closely monitored to ensure this did not impact on other patients. Ward staff also told us that many patients have their own community faith leaders or pastors who are also invited to visit whenever they wish.

The team were using patient diaries with people and their families. These could transfer from the community into hospital and vice versa. They were a simple means of patients recording anything that was important to them, or for someone like a healthcare assistant to record for the family what they had discussed or done together, such as having read a book to the patient. They were in no way meant to replace any discussions with nursing staff but were more of a communication aid for families and the patient.
The trust’s regular bereavement survey showed a range of overwhelmingly positive responses with the majority of patients’ families feeling that they had been involved in their loved ones’ care and treatment. Their questions were fully answered and on the whole care had been appropriate. Although the survey made recommendations there was no associated action plan for improvement.

The team’s most recent patient experience audit was positive. Having switched to using interviews with patients and their families rather than questionnaires, they found their responses were more thorough and more constructive feedback on how they could improve was received.

Patients spoke about the team as being very supportive and answering their concerns thoroughly. Some of the recurring issues were to do with environment, specifically when it had not been possible to accommodate a patient reaching the end of their life in a side room. Patients said they had changed their perceptions about palliative care as a result of meeting the team and that they valued the time to chat and explore their condition.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

End of life services were planned to meet the needs of the local population, to ensure patients received co-ordinated care that was accessible and responsive to people’s needs. We saw good partnership working between the hospital and community teams, local hospices, primary care providers and the ambulance service.

The Trust was active in the locality wide Northern Palliative Care Partnership and was driving forward improvements in care and experience across the North East including the implementation of the care of the dying patient document and leading on training and dissemination of information for the Deciding Right initiative. The team was working to embed the six strategy headings into the work of the locality Northern Palliative Care Partnership.

The trust had audited its recording of patients’ preferred place of death following our previous inspection and found an improving picture comparable to national figures. The SPEoLC team were continuing to promote the importance of discussing this with patients and refining the ways in which they captured this data to improve future audits.

Health care assistants put together comfort packs for families staying with patients nearing the end of their life. These contain a number of items such as travel pillows, toiletries, and a pen and pencil. Families in receipt of these would be able to stay with their loved one rather than having to leave them to go home to fetch such items and we heard that this had a big impact and the packs were well received. A health care assistant told us they had come in as a volunteer over the Christmas period to make sure no families missed out.

A member of the nursing team on a medical ward told us that they found it easy to refer a patient to the end of life team and they usually visited new patients the same day. Audit showed that 87% of hospital patients were visited the same day, rising to 97% of patients who received a visit either the same day or following day.

The team was in the final year of delivering an Enhanced Supportive Care pilot project, supporting over 200 patients at any one time. This provided holistic support cancer patients with palliative care at an earlier stage in their treatment. The team included physiotherapists, occupational therapists, specialist nurses and consultants. As patients received joined up care, largely accessed at home, the team had seen a reduction in the number of emergency admissions for
patients with certain types of cancer. The pilot was ongoing and further evaluation work was planned.

We discussed gaps in paediatric and transition palliative care services with senior staff: we were told that, although there was no specific service, there was a multidisciplinary team for children, teenagers and young adults with cancer and non-cancer diagnoses. The team worked alongside paediatric doctors to carry out joint reviews; it was felt that progress had been made, but the trust was working with specialist commissioners to drive further improvements.

We saw that the minutes of the Palliative and End of Life Care Strategy Group included evidence of planning services with the local community in mind. Representation from other areas of the hospital helped the team to keep a close eye on potential increases in demand and other local changes.

We saw an audit of usage of the palliative care advice line, which provided most of its advice out of hours, to doctors and nurses. This service had seen a decrease in use in the previous year, particularly by hospital out of hours staff. All calls requiring a call back by a consultant were returned promptly, and a third of calls required at least one follow on call.

Meeting people’s individual needs

Staff told us that they would move dying patients from a bay into a single room if possible so that they could ensure patients privacy and dignity was maintained and so relatives could stay with the patient overnight and have more room.

The team had an equalities sub group working on gathering views from patients whose views could be harder to hear. They had implemented the ‘when someone is dying’ leaflet in Czech, Arabic and Polish as well as large print. Training for staff on issues relevant to the lesbian, gay, bisexual, transgender and questioning (LGBTQ) community around end of life was planned and would be led by a transsexual person from the local community.

We also saw that this group was planning work around prisoners and the detained community, refugees, transition patients, people with a mental health or neurological condition and others. The group had an action plan for each piece of work and monitored equity of access to ensure they were doing the right things for the right people.

One of the team’s consultants was working with a homeless, drug and alcohol charity to identify people who were potentially nearing the end of their life earlier so appropriate support could be found. This included training the charity’s workers in basic triage skills, as this group of patients could be wary of medical professionals and working with a local hostel to provide a suitable environment for someone who was nearing the end of life but without permanent accommodation to go to.

We spoke to a member of the chaplaincy team who told us they had visited four patients that day having been alerted by the electronic system. During visits, the team spoke to patients and their families about the support they offered, left them a small slip with their contact details and placed a sticker in the patient’s notes to show they have visited. Chaplaincy staff supported people’s spiritual needs regardless of faith, including the needs of staff.

All of the chaplaincy team were Church of England chaplains; however they had a close network of honorary chaplains from a variety of faiths. Chaplains and honorary chaplains aimed to respond to a request for a visit within one hour if possible, 24 hours a day, seven days a week.
Regular Sunday services were held, and Muslim prayer sessions took place every Friday. Once a month, chaplains provided a service for people who had experienced bereavement during pregnancy.

The site had two quiet rooms, located at opposite ends of the hospital, for people to pray or have some quiet, contemplative time. We saw both rooms and found them to be well decorated and suitable for a variety of uses. Both contained torahs, prayer mats and other items suitable for a variety of faiths.

Ward staff told us there was a learning disabilities team who were available for support and guidance, and who would work alongside patients and relatives, for example to support with communication needs. Members of the learning disabilities team attended the SPEoLC monthly multidisciplinary team meetings.

Bereavement services staff provided booklets in a range of other languages such as Urdu, Arabic and Slovak, and told us that they accessed telephone or face to face translation services if needed. Tablets were available to staff to provide an internet video linked British sign language (BSL) signing service for patients who had a hearing impairment. Staff told us they had not experienced any problems with availability of this or any other translation services.

Staff were able to access community health care funding for patients whose preferred place of death was in the community should they need extra caring support in their preferred setting. They gave an example of a patient who wished to die in their local hospice but needed a healthcare assistant to support them. This was funded for them and the person was able to die in their preferred place of death.

We spoke to one of three end of life healthcare assistants providing specialist support to patients and their families. Their role was to spend time with families, check what conversations had taken place and what could still be done to better improve the experience of patients and their families. We observed another healthcare assistant bringing trays of tea to assembled family members around a dying patient’s bedside. They sat with the family and discussed their concerns.

We heard how healthcare assistants also arranged reduced car parking costs for visiting families and handed out comfort packs so that people could stay with the patient for longer.

We saw in one patient’s notes that they had told staff they had trouble retaining information, and so had asked for an honest picture of their condition to be reiterated frequently, with their partner present. This was honoured, and we could see that this information was repeated a number of times to aid the patient’s understanding.

It came to the attention of a local gas utility company that there were delays in the discharge of people going home to die, because they had a gas fire in the room where their bed would be, and it did not have a gas safety certificate. Obtaining a certificate was often expensive and time consuming. The gas company had agreed to provide this service, free of charge, either on the day of referral or the next morning, depending on the time they were contacted.

Chaplaincy staff ran a clothing bank for patients, provided food bank vouchers, covered some travel costs for visiting relatives, provided phone chargers, books, CDs and wash kits for families in need, and worked with a local charity to request emergency shelter for pets of people living on the streets when they were admitted to hospital.

**Access and flow**
Referral of patients for palliative or end of life care was done, following a multidisciplinary discussion with those involved in a patient’s care on the ward, either by telephone or using the trust’s intranet referral system. The referral was received by the SPEoLC team and triaged to determine who should assess the patient and what level of support was required. Specialist palliative care nurses reviewed and triaged all referrals in to the team. Where necessary patients could be referred for an additional review by a palliative care consultant.

The team told us they had seen an increase in referrals from all areas of the hospital, as awareness of the need for high quality palliative and end of life care had been raised. Staff were more proactive in determining the priorities of the patient, planning support and arranging discharge.

We observed a morning team board round. Specialist nursing staff, HCAs and doctors were present. The team discussed every end of life patient, including new referrals, and whether each individual would need their input that day. All new referrals were scheduled for a visit the same day. People’s medical needs including pain control and nausea were considered, and also wider family needs such as car parking discounts. Patients who had not yet expressed a preferred place of death were highlighted and a doctor was allocated to visit one of these patients to see if they would be willing to discuss this.

The end of life team had implemented a traffic light rating system to help plan for a patient’s discharge. Red discharges were urgent and priority, amber less so, and green applied to a patient who could wait a little longer. A discharge checklist was printed and attached to the front of the patient’s notes, and both ward staff and the end of life team could contribute to putting things in place to facilitate discharge. Specialist nurses explained that red discharges would normally be overseen within the team, with amber and green discharges being ward led. A recent audit of red discharges showed that on the whole, people were going home in a timely way. The team’s discharge sub-group, having completed this audit, had begun to work on a review of electronic incidents relating to discharges to see what further improvements could be made.

Nursing and medical team members told us that they felt these were being more widely used on wards and recognised as the useful prompt they had designed them to be. Staff told us that physiotherapists and ward staff actively moved discharge along at weekends and this had improved dramatically over the last eight years, providing something that felt much more like a seven day service.

Specialist nurses told us that since the end of life team had had access to a specific end of life ambulance service provided by the local ambulance trust, there had been far fewer issues with timeliness or appropriate support during discharge.

We saw the mortuary team worked hard to facilitate the release of patients in a timely manner, and staff provided an on-call service enabling patients to be released out of hours if necessary. For any patients who were unidentified or needed to remain in the mortuary for extended periods due to legal or funding reasons, permission from the coroner or patient’s family was requested, for deep freezing or embalming purposes.

We saw evidence that discussions about the patient’s preferred place of death took place as soon as was deemed appropriate, and that this was documented in the patient’s notes. The trust’s May/June 2017 audit of end of life care documentation showed that people’s preferred place of death was articulated in 85% of cases. 100% of these were fulfilled.

**Learning from complaints and concerns**
We discussed the handling of complaints with senior staff. The palliative care team leader was a facilitator on the ‘sage and thyme’ communications course, and effective communication was at the centre of the complaints process. We were told that staff felt it was important to recognise and acknowledge the distress and worries of those involved; allow them to express their concerns and let them know they were being heard; provide a helpful response; involve them; and work together to plan a solution.

Specialist nursing staff told us that they received few complaints, but that these would come through their executive lead and then be fed back to them. They worked hard to address concerns informally before they developed into complaints and this was evidenced by the low number of complaints. As the service relied on general wards or units to provide information in a timely way, it was not always within their power to close complaints within the trust 60 day deadline for complex complaints.

Complaints were a standing agenda item on team meetings and we saw from team minutes that these were regularly discussed.

**Summary of complaints**

Between September 2017 to October 2018 there were 11 complaints for end of life services, the trust took an average of 68 days to close complaints which is not in line with their complaints policy which states complaints should be closed within 20-60 days (up to 60 days for more complex complaints).

- Freeman Hospital – eight complaints

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

**Is the service well-led?**

**Leadership**

The service had managers at all levels with the right skills and abilities to run a service providing high quality sustainable care. There was a clear management structure at directorate and departmental levels. Leaders knew about the quality issues, priorities and challenges in the department.

The nursing and medical teams were established, with experienced staff that provided clinical and professional leadership. Staff told us that they were well supported in their roles and had a clear understanding of their responsibilities. They said leaders were visible and approachable. Ward staff told us that the SPEoLC team were well known to them and easily accessible.

The Specialist Palliative Care and End of Life teams were divided between two directorates. The Medical Staff were in the Cancer Services Directorate and the rest of the staff were in Patient Services Directorate. For clinical governance purposes the medical staff were within a directorate with a Medical Clinical Director. The service reported to the Deputy Director of Nursing and Patient Services and had a direct link into Trust Board. The Trust Board received an update paper twice a year.

There was a dedicated non-executive and executive director aligned to the team. While the current non-executive director was quite new in post, the team had made contact with them and invited them to team meetings. The team spoke positively about the change brought about by the previous non-executive director who obtained funding to move to seven day services.

There was no operational manager post within the team, which was jointly consultant and nurse led. The team recognised that this role would further strengthen their leadership, and conversations had taken place at an executive level with a view to implementing this.
The team’s meeting minutes included sections considering wider corporate priorities as well as those of the patient services directorate, meaning that locally, leadership was well positioned to be actively contributing to these.

**Vision and strategy**

The team strategy (2018-2021) had been developed with careful consideration for the local population’s needs, and current best practice. Six strategic aims had been developed as follows;

- each person is seen as an individual,
- each person gets fair access to care,
- maximising comfort and wellbeing,
- care is coordinated,
- all staff are prepared to care, and
- each community is prepared to help.

The team were committed to achieving these aims, which, were discussed regularly at team meetings. A quarterly strategy group meeting with representatives from other directorates provided the team with a further sense check on progress. Leaders spoke positively about the distance already travelled in achieving these.

We saw that the trust’s core values were clearly displayed in all ward areas we visited and in the mortuary offices. These were: patients come first; people and partnerships are important; professionalism at all times; pioneering services, and pride in what we do. Also displayed were the core behaviours expected of all staff: enabling our vision; demonstrating our values; commitment to service delivery; and achieve results for patient care.

**Culture**

The trust promoted the philosophy that caring for the dying was everyone’s responsibility and provided the skills and tools to enable staff to consistently and compassionately undertake this. We spoke to staff on general wards where end of life care patients were being nursed. They echoed the sentiment that end of life care was everyone’s responsibility and the hospital support palliative care team were accessible, effective and worked collaboratively with staff on the wards, whether in person or remotely. We found that staff on general wards had been supported to provide high quality palliative care to patients on their ward, which demonstrated the ‘upskilling’ culture of the SPEoLC team.

Staff told us they felt respected and valued. Staff felt supported in their work and were provided with opportunities to develop their skills and competencies, which was encouraged by senior staff. The team held twice yearly away days to strengthen teamwork, attended by the head of nursing, plus twice yearly the team held joint meetings with their community colleagues.

Staff working in the mortuary had a very positive culture and spoke with purpose and at length about their pride in their colleagues and the service they provided. We were told by mortuary staff that they did feel valued for their work and had very positive relationships with other members of staff and families of patients.

We observed a monthly team meeting, held at the Freeman Hospital, which, alternated between the sites. There were 23 people present, including doctors, nurses, healthcare assistants, administrative staff and allied health professionals. Discussion was very open and honest and
every person attending contributed in some way to the discussion. The team were supportive of each other’s actions and opinions and recognised outstanding practice amongst their members. They were collaborative, respectful and offered appropriate challenge. The team also discussed and suggested next steps and the dissemination of learning.

The trust had developed ‘greatix’ awards, which recognised the achievements of staff and enabled the sharing and celebration of successes. We were given examples of a nurse successfully managing a complex discharge under pressure and security staff who had been involved with a patient, who were commended for their compassion and effective relationship building.

**Governance**

The end of life team had a comprehensive programme of audits offering good oversight of their progress and position against strategy and targets. Audits of prescribing, use of the care of the dying patient document, recording of patients’ preferred place of death, efficacy of rapid response discharge planning were all regularly completed.

We saw the implementation and use of the care of the dying patient document was discussed at the team’s January 2019 team meeting. Although the document was not being used in 5 of 25 cases, the team identified the information that should be held there was present elsewhere in the patient’s records in 100% of cases. Where the document was not being used, explanations were given as to why it was not appropriate.

The Palliative and End of Life Care Strategy Group was chaired by the medical lead with representation from a variety of staff including different departments within the trust. The governance system supported the strategy and provided assurance to the board.

**Management of risk, issues and performance**

The team did not hold its own separate risk register, and risks were held on the wider patient services register. However, there were only three risks for the team, and the leadership team were able to articulate these.

We were told the biggest risk at the time of our inspection related to the potential loss of the enhanced supportive care (ESC) team if further funding could not be secured. The team was currently funded to operate until June 2019; discussions around the future of the team were ongoing. The wider register was searchable, and we saw it was straightforward to view just the team’s risks.

Senior staff told us another potential risk was related the on-call out of hours advice system. This was often provided by the hospital’s consultants and was not commissioned, so was recognised as being a vulnerable service. Regular joint meetings took place with local hospices to discuss possible changes and improvements to this service. Use of this service was regularly audited.

The trust’s mortuary contingency plan included robust procedures covering lack of capacity at one or both sites. Experienced mortuary staff told us they had never had to implement these procedures due to both mortuaries being full, but they knew what to do should this occur.

A major incident plan was in place, and this site had its own directorate summary, available on a single side of A4 for quick and easy reference.
Information management

There was a comprehensive end of life resource and information section on the trust’s intranet site, and we saw that policies and guidelines were available to staff on here. We observed the updating and reviewing of policies being discussed at the hospital SPEoLC team meeting.

The SPEoLC teams had a social media page which they used to share projects, strategies and information across the trust.

We saw that computers used in ward areas and both mortuaries were password protected when not in use. Mortuary staff told us that any information they needed to send electronically was done from a secure email account.

We witnessed porters transferring patients to the mortuary and saw that there was a comprehensive patient identification and registration system in place, which was explained to us in detail by the mortuary staff. We saw that alerts were in use in the mortuary, for example for patients with the same or similar names.

The current records and information management system used by the trust was a local system; senior staff told us the possibility of a regional system was being explored. A local GP was leading a project to introduce new software which would enable local systems to link together.

The SPEoLC team recognised that access to care after death education and information needed to be improved upon, following feedback from staff and link nurses. They were working with chaplaincy, mortuary and bereavement services staff to facilitate this, and to support staff to learn about other areas and processes.

Engagement

Ward staff told us there was much more awareness of palliative and end of life care, and they felt much more involved, due to the training and support they received from the SPEoLC team.

The trust conducted bereavement surveys twice yearly. It had been noted in the most recent survey that there was a need to improve completion rates of the care after death form. Staff had worked with the wider bereavement services team to agree that more verbal prompts would be used to encourage ward staff to complete this documentation.

During dying matters week in May 2018, specialist staff raised awareness with wider staff about their role. They gathered views on how their service could improve and also let staff know how they could access the comprehensive end of life care training on offer.

The end of life team conducted a patient experience audit twice yearly. Patients and their families were satisfied with the service. However, because patients were usually seen by a number of different services or people, they could struggle to recall exactly who the end of life team were and what their impact had been. The team were looking to review their methodology and revisit questions to refine this for the next audit.

Learning, continuous improvement and innovation

Since our last inspection there had been positive improvements in the management of patients with syringe drivers during discharge, following the purchase of new ambulatory devices. No incidents regarding these had been recorded.

Regarding preferred place of death, the recording process had improved, and teams were more aware of the data collected. Care available in the community had improved, engagement with the
ambulance service was good, and staff were more aware of the importance of discussing preferred place of death with patients.

Care of the dying documentation had been relaunched to raise staff awareness and improve engagement. The end of life team leader had visited wards to provide staff with information and support, and also to gain staff feedback: 274 staff had been involved over five days.

Staff awareness and engagement in end of life and palliative care was also addressed using newsletters, flyers cascaded to staff groups, and through staff induction. We saw that good morale within the service had a positive impact on staff in other areas.

At each team meeting, a slot was scheduled for learning from specific issues. We observed a team member describing a complex case where it was not clear where, to who and when to release a patient’s personal effects. The team offered insight and suggestions and the team member was congratulated for their work in reaching a conclusion acceptable to all parties.

One of the palliative care consultants led the most recent Northern Regional Palliative Care Physicians Group meeting, focussing on patients on the pathway to heart transplantation.

Every four to five weeks, the end of life team attended group supervision with a clinical psychologist. This gave them the opportunity to discuss any cases that had been particularly difficult or troubling, and to offer peer support. Staff told us that these sessions were very open and honest, with no role demarcation, and all staff were happy to contribute. The sessions were protected time, enabling staff to prioritise their own wellbeing.

Mortuary staff had been nominated for the national NHS unsung heroes award in 2018. Although they were not successful, they felt pride in having raised awareness of their service which they told us was often overlooked.

The trust led nationally on a piece of work overseeing the withdrawal of ventilation in a home setting for patients with motor neurone disease and the team was part of a national committee informing best practice. The team have conducted more withdrawals of ventilation than anyone else in the country and their findings have been presented internationally.

The SPEoLC team had a funded research place with the northern palliative care partnership and had been looking at use of cannabinoids in treatment of cancer pain. Senior staff told us they aspired to be more active in research projects in the future.

The SPEoLC teams had contributed to the Public Health England national palliative care dataset pilot which measured, analysed and compared some of the key outcomes that mattered most to people who received specialist palliative care.

A member of the team had been awarded the Dundas Medal (a national palliative care award) in 2018 for their work with heart and lung transplant teams and their patients. This group of patients did not normally receive palliative care due to the perception that a transplant would offer hope and a new lease of life, however high mortality rates showed there was an unmet need. Prior to the intervention, less than 10 transplant patients received palliative care per year. In the first year of intervention, this rose to 45. The wider SPEoLC team supported patients through difficult times, either towards recovery or, if this was no longer an option, to facilitate transfer to a patient’s preferred place of death. Feedback from patients and staff was overwhelmingly positive and changed perceptions that palliative care was only for people who were expected to die.
### Diagnostic imaging

#### Facts and data about this service

The imaging specialties at the RVI included computed tomography (CT), magnetic reasoning imaging (MRI), Ultrasound, Plain Film X-ray, Fluoroscopy, Gamma cameras and single photon emission computed tomography (SPECT) CT.

Dual energy x-ray absorptiometry (DEXA) imaging was principally provided at the Freeman Site and Interventional Radiology was largely provided at the Freeman Site.

PET CT imaging is provided through an external provider utilising a mobile unit based at the Freeman Hospital.

Nuclear medicine was provided at the Freeman hospital.

There were around 499,985 examinations provided across the trust for diagnostic imaging between April 2017 and March 2018. This included approximately 66,780 CT examinations, approximately 81,970 diagnostic ultrasonography, approximately 28,370 fluoroscopy examinations, 52,375 MRI examinations, Approximately 260,000 plain film x-rays and approximately 575 SPECT CT examinations.

The nuclear medicine department carried out approximately 12,000 procedures across the trust each year.

(Source: Acute provider information request – context)

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

The service had an ionising radiation medical exposure regulation (IR(ME)R) inspection from the Care Quality Commission (CQC) in July 2018. Following the IR(ME)R inspection an improvement notice was issued, and this was removed prior to this inspection following submission by the trust of a compliant action plan.

During the inspection we visited the main x-ray department, fluoroscopy, ultrasound, Magnetic Reasoning Imaging (MRI) and Computed Tomography (CT) at the Freeman Hospital. During the inspection we spoke with 20 staff, 13 patients and reviewed four records.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

#### Is the service safe?

**Mandatory training**

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

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training.

**Freeman Hospital**

A breakdown of compliance for mandatory training courses as of September 2018 at Freeman Hospital for qualified nursing staff in diagnostic imaging is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Basic Life Support</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Patient Falls</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>6</td>
<td>5</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>6</td>
<td>5</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>6</td>
<td>5</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>6</td>
<td>4</td>
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<td>95%</td>
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</tr>
<tr>
<td>PREVENT</td>
<td>6</td>
<td>3</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Basic Life Support</td>
<td>4</td>
<td>1</td>
<td>25%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging at the Freeman Hospital, the 95% target was met for six of the 12 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses as of September 2018 at Freeman Hospital for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of Staff Falls</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>19</td>
<td>17</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>19</td>
<td>17</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>19</td>
<td>15</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>19</td>
<td>15</td>
<td>79%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>19</td>
<td>14</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Basic Life Support</td>
<td>7</td>
<td>5</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>19</td>
<td>11</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>20</td>
<td>9</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Local Induction</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging at the Freeman Hospital, the 95% target was met for one of the 12 mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses as of September 2018 at Freeman Hospital for qualified Allied Health Professionals in diagnostic imaging is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines Management</td>
<td>119</td>
<td>119</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>119</td>
<td>118</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>119</td>
<td>105</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>118</td>
<td>101</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>119</td>
<td>98</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>119</td>
<td>98</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>119</td>
<td>91</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>119</td>
<td>91</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>118</td>
<td>84</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>119</td>
<td>83</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Basic Life Support</td>
<td>75</td>
<td>36</td>
<td>48%</td>
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<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was met for two of the 12 mandatory training modules for which qualified AHPs were eligible at Freeman Hospital.

The overall completion rate for the period April – September 2018 was 79%, compared to 96% for 2017/18.

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

Mandatory training was provided as a mixture of e-learning and face to face learning.

Staff completed mandatory training across the service. Where mandatory training was not up to date for staff, managers told us staff were booked on to training to ensure it was completed. Managers were also asking staff to complete the mandatory training as required. Staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.

The department manager’s maintained oversight of the mandatory training compliance and told us this was discussed at the executive team meeting. There was also trust oversight of mandatory training as it was part of the board papers, for example in December 2018.

The radiation protection supervisors completed a two-day course led by the regional medical physics team and there was a two-yearly refresher course available to staff. The radiation protection supervisors provided annual updates around good practice to staff as required.

Safeguarding

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

Safeguarding training completion rates

A breakdown of compliance for safeguarding training courses as of September 2018 at trust level for qualified nursing staff in diagnostic imaging is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
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<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>6</td>
<td>5</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>18</td>
<td>14</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as of September 2018 at trust level for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>20</td>
<td>18</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>44</td>
<td>38</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>44</td>
<td>33</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as of September 2018 at trust level for qualified Allied Health Professionals in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>185</td>
<td>143</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>187</td>
<td>144</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>119</td>
<td>90</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which qualified AHPs were eligible.

**Freeman Hospital**

A breakdown of compliance for safeguarding training courses as of September 2018 at Freeman Hospital for qualified nursing staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>6</td>
<td>5</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>6</td>
<td>5</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>6</td>
<td>5</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible.
A breakdown of compliance for safeguarding training courses as of September 2018 at Freeman Hospital for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>19</td>
<td>17</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>19</td>
<td>17</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>19</td>
<td>14</td>
<td>74%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as of September 2018 at Freeman Hospital for qualified Allied Health Professionals in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>119</td>
<td>92</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>119</td>
<td>90</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>119</td>
<td>86</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which qualified AHPs were eligible.

The overall completion rate for the period April – September 2018 was 75%, compared to 93% for 2017/18.

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

The trust had a trust wide safeguarding adult’s policy and guidelines with an expiry date of 28 November 2021. The trust had a child protection and safeguarding children policies and procedures document with an expiry date of 18 January 2020. The service had safeguarding radiology meetings and the trust provided a radiology directorate skeletal survey referral process August 2017 which had a review date of August 2019. The trust provided information highlighting the trust had a quarterly safeguarding committee and the trust safeguarding team provided guidance and support to staff.

Staff we spoke with during the inspection were aware of safeguarding and could describe how they would report a safeguarding concern, for example contacting the safeguarding team at the trust if they had concerns. During the inspection there were safeguarding posters on display in the departments.

Managers told us staff in the children’s x-ray area of the department were trained to level three children’s safeguarding and staff in other areas of diagnostic imaging were trained to level two children’s safeguarding. The trust provided information stating that staff who worked with children for more than 50% of their time required level three safeguarding training. Staff had access to a trust wide safeguarding team for additional advice as required.

Information provided by the trust highlighted there were three radiographers in the children’s x-ray area and 2.2 whole time equivalent radiologists and the information showed that two
radiographers had level three children’s safeguarding and one member of staff was booked to attend the course. Information provided by the trust showed that two radiologists were compliant with level three children’s safeguarding training and one consultant was booked onto the safeguarding level three children’s training refresher course.

Staff we spoke with during the inspection could describe using the three-point identification check in the department to check identification of patients and could describe the ‘pause and checked’ checklist which was used. The three-point identification check included name, date of birth and address. The ‘paused and checked’ checklist was on display in departments during the inspection. The ‘paused and checked’ poster is a clinical imaging operator 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 in cardiac x-ray told us they were trained to level two safeguarding for adults and children and that there were not many children attending the department. The department had a safeguarding children and adult’s poster on display in the control area.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

Areas visited were visibly clean and tidy. During the inspection we saw staff adhering to ‘bare below the elbow’ guidance. Hand sanitiser was available for use in the department and there were hand washing sinks available in various areas visited. Staff told us departments received daily cleaning. There were hand washing guidance posters on display in departments. There was waste disposal for various types of waste available across the department.

Staff told us ultrasound probes were cleaned after each patient with cleaning wipes. Scanning beds were wiped down after each patient as needed and a new paper cover was put on the scanner bed. Staff in the lung function service described the various cleaning of equipment such as cleaning some equipment with cleaning wipes and that some equipment needed to go to the sterilisation unit for cleaning. Staff told us they would follow manufacturer’s cleaning requirements for equipment.

Staff told us patients who may have a communicable disease would be scanned at the end of the day or before lunchtime and the rooms would be cleaned as appropriate afterwards.

Hand hygiene audits were completed in the department. The trust provided environmental cleanliness reports for November 2018. Radiology was included in this report and 97.24% compliance for the monthly matrons check, 96% compliance for hand hygiene opportunity, 92% for hand hygiene technique, 100% compliance for infection, prevention and control practice and 96.82% for total environmental cleanliness. Although there was no action plan attached to these reports.

The cardiac x-ray compliance with infection, prevention and control and staff knowledge of this was 96.7% between January 2018 and December 2018. This included aseptic non-touch technique and infection, prevention and control. Staff in the echocardiogram department told us equipment was cleaned after each use as required.

Hand hygiene results on display on a ‘how are we doing’ board in the interventional radiology department showed hand hygiene compliance at 100% and departmental cleanliness at 96.7% compliance.
The trust had a radiology directorate and nuclear medicine procedure for the decontamination of the radioiodine suite. The trust had a radiology directorate and nuclear medicine IRR17 risk assessment for contamination in working areas.

The nuclear medicine registered nurses were responsible for infection control across the department.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The department had a main waiting area with reception and seating available. There were toilets available in the department. The service also had separate waiting areas in other specialties across the department. During the inspection areas of the department visited were tidy. The MRI unit had two changing rooms and a waiting room available to patients.

There was signage on display directing patients and visitors to the diagnostic imaging department and signage on display in the department for the various specialties.

The various departments within the diagnostic imaging unit had relevant warning signage on display to highlight restricted areas to staff, patients and visitors. The x-ray areas had lights warning of x-rays. The fluoroscopy rooms had warning signs such as ‘controlled area x-rays’ and ‘authorised persons only’. There were areas in the departments with swipe access to enhance security.

The department was wheelchair accessible along with wheelchair accessible rooms. A hoist was available in the department for use as required to assist with moving and handling. Patients waiting in the main waiting area of the department were visible to the reception staff, although some of the smaller waiting areas were outside clinic rooms.

There were reporting rooms with computers available for staff to use.

Managers told us equipment was logged onto a servicing and planned preventative maintenance schedule. Staff could report faults and issues with any equipment electronically. The trust provided a 2018 radiology equipment list which highlighted the different specialties in diagnostic imaging along with the location, quality assurance performed and quality assurance due dates for equipment used. This equipment list showed that equipment had a previous preventative maintenance date logged and the next preventative maintenance date was documented or documented where it was to be confirmed with the vendor.

The resuscitation trolley in the nuclear medicine department was checked by registered nursing staff. Although this had not been checked consistently daily between July 2018 and September 2018. The resuscitation trolley in the cardiac x-ray department had been checked as required between November 2018 and January 2019.

The resuscitation trolley in the main x-ray department had not been consistently checked between 1 October 2018 and 16 January 2019. There were four dates not recorded in October 2018, two dates not recorded in November 2018 and three dates not recorded in December 2018. January 2019 was completed as required. Another resuscitation trolley in the main x-ray department had not been consistently checked between 1 October 2018 and 15 January 2019. There were three dates during a weekend not documented in October 2018, there were four weekend days not documented in November 2018 and in December 2018 the trolley was not checked on four dates and in January 2019 was not checked on three dates. The weekly checks were completed.
The resuscitation trolley in the interventional radiology unit had three dates not documented between 1 October 2018 and 15 January 2019. The weekly checks were completed. There was a tracheostomy box and there were nine dates between 1 October 2018 and 15 January 2019 where the checks were not documented.

Risk assessments had been completed for various risks across the department. These were stored electronically on the trust systems. The main x-ray department had eight risk assessments on the electronic system. The risk assessment for the Freeman cardio x-ray department had no review date attached. Although managers told us they would address this. There was a radiation risk assessment for DEXA equipment which had a review date of July 2021. There was a radiation risk assessment for lithotripsy which had a review date of April 2021.

The nuclear medicine department also had completed risk assessments in the department and these were stored electronically on the trust systems, for example the risk assessment for ionising radiation 1999. There were 57 risk assessments on the system and eight required review. Managers told us they were going to address this.

The MRI department at the Freeman hospital had the required MR safe stickers attached to equipment in the department.

Staff had the required equipment available and accessible for use. Personal protective equipment was available for use in the department. Equipment such as lead aprons had annual audits to check for defects. Staff wore dosimeters where applicable to monitor exposure to radiation. The radiation protection supervisors participated in the annual radiation protection audit as needed. Screening of lead aprons was completed annually in the CT department and the service had last completed a lead screening audit in June 2018. The local rules in cardiac x-ray detailed the quarterly lead apron visual checks.

The service had 24 hours, seven days a week access to information technology support as required and managers told us they had been working with an external provider to address the challenges around information systems used in the department.

The hospital had a nuclear medicine department which had six ‘Gamma cameras’. There was also DEXA scanning available at the hospital. The hospital provided neuroradiology services and the department had two MRI scanners, one CT scanner and two angiographic and interventional suites. The department provided a transcranial doppler ultrasound service to the North East region.

Staff told us daily quality assurance was completed in the CT department at the Freeman hospital on both CT scanners, where a phantom was scanned. This is a test scan to complete quality assurance on the scanning machines. The nuclear medicine department at the Freeman hospital had three scanning rooms and three clinic rooms.

The interventional radiology waiting area had a limited selection of patient information leaflets and magazines available for patient use. Staff in the interventional radiology department were supported by senior staff to improve the environment and make improvements for the benefits of patients.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
The department had access to an in-house medical physics expert, radiation protection expert and the department had radiation protection supervisors for advice. Staff told us they had access to a radiologist for advice as needed.

Where adults and children patients were clinically unwell or deteriorated in the department, staff would call the hospital resuscitation team and had access to a resuscitation trolley in the department. In the MRI department, the local rules included emergency procedures. The trust provided the flow chart for an unwell patient in radiology CT at the Freeman hospital. The trust provided a standard operating procedure for the radiology directorate for the care of the deteriorating patient in the radiology department with an effective date of 6 February 2019 and an expiry date of 1 June 2021.

The service had local rules in place for staff to follow for their speciality area. There was also a trust wide MR safety group. The MR safety form used in the MRI department was signed by the radiographers and the patient once complete. The MRI safety questionnaire was sent out with the appointment in the post. The DEXA department had local rules for staff to follow and the radiation protection supervisor contact was on display as required. Local rules were on display in the CT department.

The World Health Organisation (WHO) checklist was used in interventional radiology. Staff told us this revised checklist incorporated the local safety standards for invasive procedures (LOCSIPP) as well as National Early Warning Scores (NEWS). Staff could describe the WHO checklist during the inspection and the local safety standards for invasive procedures (LOCSIPP). The service had recently started to audit the WHO checklist.

The trust provided information highlighting the process for sedated patients in the department. For example, staff told us that in the paediatric diagnostic imaging department, a paediatric nurse would be with the patient if they were sedated. The trust had a document for the guidelines for the practice of intravenous sedation in adults with an expiry date of 29 March 2020.

Staff in the department wore dosimeters and the radiation protection advisors would advise staff when they required changing which was two monthly. These were worn to monitor the staff exposure to radiation in the department.

Staff told us patients receiving contrast in the CT department stayed in the department for around 20 minutes after the procedure for safety precautions. Staff completed basic life support training as part of mandatory training.

The CT department had the local and national diagnostic reference levels (DRL) displayed on the wall dated July 2018. Staff told us they would inform a radiologist if an abnormality or something unexpected was seen on a scan in CT.

Managers in nuclear medicine told us referrals were made in line with IR(ME)R guidelines.

The safety forms used in the MRI department included questions to check whether a woman of child bearing age could be pregnant. At the Freeman hospital there was a file with relevant guidelines for MRI and there was a MRI safety handbook available to staff in the control room. There was also a list of authorised personnel available.

Staff used the ‘paused and checked’ checklist in the department to check the correct patient was receiving the correct scan. Results from the 2018 patient satisfaction survey CT department at the Freeman hospital showed 87.1% of respondents said the radiographer or assistant checked their details (Name, address and date of birth) before the scan, 4% of respondents said no and there was no response in 8.9% of respondents. There were 101 returned questionnaires.
Staffing

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

The diagnostic imaging department was open 24 hours a day, seven days a week and therefore there was a shift rota for staff working. This was managed by the departments resources team who managed annual leave and the staff rota to ensure the shifts were covered as required. The resources team was managed by a superintendent radiographer.

There were national challenges with staffing shortages in diagnostic imaging departments, however managers had done various pieces of work to address this challenge and recruit the staff required. The department had completed international recruitment to increase radiographer staffing levels in the department. Managers told us they had been able to overrecruit to the service and there had been active support for the human resource department for recruitment.

Managers told us there were challenges with medical staffing in the children’s department and the action taken to address these challenges included continued recruitment and providing other staff groups additional training to assist in the department.

The trust provided a radiology strategy presentation for 2018/23 showing there were 424 staff and 39 consultants in the radiology service.

The radiology new innovations and quality improvement document provided by the trust highlighted there had been registrar on-call improvement and the services had increased the number of on-call trainees from one to two staff in the evening shifts at the RVI.

The nuclear medicine department at the Freeman hospital had two radiation protection advisors and a radiopharmacist providing advice and guidance. There were three registered nurses in the department.

Nurse staffing

The trust has reported their qualified nurse staffing numbers for diagnostic imaging below for the period April to September 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned staff WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE LFY</th>
<th>Planned staff YTD (Apr-Sep-18)</th>
<th>Actual Staff YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freeman Hospital</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

As of September 2018, the actual staffing level (WTE) for qualified nursing staff in the diagnostic imaging service was:

- 100% of the planned level at Freeman Hospital
  *(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

Vacancy rates

The trust has offered no formal vacancy target, but from October 2017 to September 2018 the trust-wide vacancy rate averaged 6%.

In the diagnostic imaging service, the vacancy rate averaged 15%. Among qualified nursing staff
the vacancy rate was 8%. Among qualified nursing staff in the diagnostic imaging service:

- Freeman Hospital was -1%, (the trust had more than their planned number of staff).
  *(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

To address vacancies the service continued to recruit as required and had trained staff in additional roles to increase flexibility within the service.

**Turnover rates**

The trust has an 8% target for turnover. From October 2017 to September 2018 the trust-wide turnover rate averaged 9%.

In the diagnostic imaging service, the turnover rate averaged 7%. Among qualified nursing staff the turnover rate was zero.

- Freeman Hospital was 0%.
  *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

The trust has a 3% target for sickness absence. From October 2017 to September 2018 the trust-wide sickness rate averaged 4%.

In the diagnostic imaging service, the sickness rate averaged 3%. Among qualified nursing staff the sickness rate was 4%.

- Freeman Hospital sickness rate was 8%
  *(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and agency staff usage**

For qualified nursing staff, from October 2017 to September 2018 the diagnostic imaging service:

<table>
<thead>
<tr>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Diagnostic imaging total – Qualified</td>
<td>27,473</td>
<td>2,284  8%</td>
<td>0  0%</td>
</tr>
<tr>
<td>Trust total – Qualified</td>
<td>6,530,050</td>
<td>139,878 2%</td>
<td>9,662  0%</td>
</tr>
</tbody>
</table>

Qualified nursing was used at the RVI site, bank staff covered 8% of hours and no agency staff were used.
  *(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)*

**Medical staffing**

As of September 2018, the actual staffing level (WTE) for medical staff in the diagnostic imaging
service was:

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned staff WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE LFY</th>
<th>Planned staff YTD (Apr-Sep-18)</th>
<th>Actual Staff WTE YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freeman Hospital</td>
<td>17.3</td>
<td>16.1</td>
<td>16.8</td>
<td>18.2</td>
<td>93%</td>
<td>108%</td>
</tr>
</tbody>
</table>

- 108% of the planned level at Freeman Hospital
  *(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

**Vacancy rates**

The trust has offered no formal vacancy target, but from October 2017 to September 2018 the trust-wide vacancy rate averaged 6%.

In the diagnostic imaging service, the vacancy rate averaged 15%. Among medical staff the vacancy rate was 6% by site:

- The vacancy rate at Freeman Hospital was 2%

To address vacancies the service continued to recruit as required and had trained staff in additional roles to increase flexibility within the service.
  *(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

The trust has an 8% target for turnover. From October 2017 to September 2018 the trust-wide turnover rate averaged 9%.

Among medical staff the turnover rate was 2%. Among medical staff in the diagnostic imaging service:

- The turnover rate at Freeman Hospital was zero
  *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

The trust has a 3% target for sickness absence. From October 2017 to September 2018 the trust-wide sickness rate averaged 4%.

In the diagnostic imaging service, the sickness rate was 1%. Among medical staff in the diagnostic imaging service:

- The sickness absence rate at Freeman Hospital was 1%
  *(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and locum staff usage**

For medical staff, from October 2017 to September 2018 the diagnostic imaging service:

<table>
<thead>
<tr>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
</table>
Filled 1% of its shifts with bank staff and filled no shifts with agency staff and no shifts unfilled. 
(Source: Routine Provider Information Request (RPIR) – Bank Agency Locum)

Medical staff were available on site for advice and as needed.

The trust had three paediatric radiologists but had identified it was under resourced by around three paediatric radiologists. To address this the trust had supported the department in trying to recruit to these roles and there was a dedicated human resource officer to address these issues. The department stated they had repeated attempts to recruit staff and were working with the paediatric directorate regarding the resource to develop a vision for the service and the information provided stated they had support from senior trust staff to consider recruitment strategies.

In the interim the information provided by the trust stated some paediatric scans and other procedures were reported and done by non-paediatric radiologists.

There were national challenges with recruiting radiologists. The service double reported scans where required, although the staffing challenges had made meeting reporting time targets a challenge.

Qualified allied health professional staffing

Managers in neuroradiology told us they had used radiographer locum staff but were continuing to recruit radiographers and during the inspection had two vacancies.

As of September 2018, the actual staffing level (WTE) for qualified AHP staff in the diagnostic imaging service was:

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE LFY</th>
<th>Planned staff YTD (Apr- Sep-18)</th>
<th>Actual Staff WTE YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freeman Hospital</td>
<td>117.7</td>
<td>98.2</td>
<td>110.3</td>
<td>107.9</td>
<td>83%</td>
<td>98%</td>
</tr>
</tbody>
</table>

- 98% of the planned level at Freeman Hospital
(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

The trust has offered no formal vacancy target, but from October 2017 to September 2018 the trust-wide vacancy rate averaged 6%.

Among qualified AHPs the vacancy rate was 10%.
- The vacancy rate at Freeman Hospital was 16%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

The trust has an 8% target for turnover. From October 2017 to September 2018 the trust-wide turnover rate averaged 9%.

In the diagnostic imaging service, the turnover rate was 8%:
• The turnover rate at Freeman Hospital was 11%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
The trust has a 3% target for sickness absence. From October 2017 to September 2018 the trust-wide sickness rate averaged 4%.

In the diagnostic imaging service, the sickness rate was 2%:
• The sickness absence rate at Freeman Hospital was 2%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

The trust provided information stating the service was at full establishment for paediatric radiographers with one whole time equivalent team lead and two radiographers sharing one whole time equivalent position and that all other shift radiographers would rotate through the area. The service was considering a business case for additional radiographer staff.

Managers told us they had been successful in 2018 in recruiting eighteen more radiographer staff to the service.

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

Records were kept electronically and scans were available electronically after the scan was complete. Records were password protected as required. There was electronic access to scans and results across the trust. The diagnostic imaging departments had access to the trust patient records systems and could access the radiology systems across the different specialties. Records from radiology systems were available across the hospital to medical teams as required.

We checked four patient MRI safety forms which were completed as required.

The service had a project registered for the audit of radiography patient dose data entered onto the radiology systems, although this had not yet started.

The service scanned safety forms onto the systems once they were completed, although there was no regular audit of this.

The trust provided information highlighting they used electronic systems to communicate with general practitioners and reports could be sent to the general practitioners using these systems. The information stated that once a report is written it is sent to the system and this would take approximately 20 minutes.

Medicines
The service followed best practice when prescribing, giving, recording and storing medicines.

The services we visited kept medicines. Medicines in the main department were stored securely in locked cupboards and medicines seen were in date. During the day in the department some medicines such as contrast media would be kept in the scanning rooms for use and not locked away, however they were in a restricted environment with staff in attendance during the day.
We looked at patient group directives (legal framework which allows registered health professionals to supply and/or administered specified medicines to a pre-defined group of patients without them having to see a prescriber) in the Radiology department at Royal Victoria Infirmary and found all to be in date and signed by the appropriate individuals.

We also saw evidence that competency assessments of staff working under these patient group directives had been completed in November 2018.

The nuclear medicine department had a pharmacy scientist working in the department available for advice as required. Managers in the nuclear medicine department could describe the relevant licenses which certain professionals held in the trust and had a folder detailing these licenses.

Registered nursing staff were responsible for ordering medicines from pharmacy each week. There were controlled drug weekly checks and when checked this was up to date with checks. Medicines in the department were stored securely. The service had a medicines refrigerator in the department.

Medicines such as contrast were stored securely in the cardiac x-ray department. Medicines seen during the inspection were in date.

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.

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 linked to diagnostic imaging. *(Source: Strategic Executive Information System (STEIS))*

The radiology service managers told us incidents would be reported through the electronic reporting system and incidents would be investigated by senior staff in the diagnostic imaging speciality the incident occurred. Managers told us they had oversight of incidents as when they were reported they received information of the incident.

Staff we spoke with could describe how they would report incidents on the electronic reporting system.

Managers told us learning from incidents was done through a newsletter which the department created and shared with staff every three months. The department also had three monthly team meetings. Staff we spoke with could describe how they would report incidents in the department.

Staff in the cardiac x-ray department told us they received feedback from incidents automatically through the electronic reporting system and there were monthly staff meetings where incidents could be discussed.

Managers in nuclear medicine at the trust told us that incidents were reported through the electronic incident reporting system and that radiation errors or incidents would be discussed at the radiation protection committee which met every three months.
Staff we spoke with could describe the duty of candour. Duty of candour means the service must be open and honest with patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Managers told us there was a being open policy.

**Breakdown of serious incidents reported to STEIS**

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

Both were treatment delays and one was at the Freeman Hospital:

- In April 2018, at the Freeman Hospital. An MRI was delayed.

These incidents were reported with specialties ("clinical area") Medicine and Accident and Emergency, so are also counted under those core services.

*(Source: Strategic Executive Information System (STEIS))*

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The radiology new innovations and quality improvement document provided by the trust highlighted the service had introduced multi parametric MRI with increased numbers to comply with NICE guidelines and pathway optimisation.

Staff could describe the evidence based care and treatment used across the specialities and how National Institute for Care and Excellence (NICE) guidance had led to changes in practice in diagnostic imaging. Information provided by the trust highlighted responsibility for monitoring compliance with the implementation policy for NICE guidelines was with the clinical effectiveness and audit committee which reported to the clinical governance and quality committee.

Diagnostic reference levels (DRL) were used in the department and these were on display in areas visited. The current national and local diagnostic reference levels were on display in the cardiac x-ray control room. These were audited annually by the medical physics department. The service had an annual IRMER report for diagnostic radiology for December 2017. The service also provided a radiation protection advisor (RPA) diagnostic radiology and radiotherapy report for the trust in December 2017.

The department completed audits in the specialties against their practice and had audits planned. The department contributed to local and national audits to enable benchmarking of their services.

The trust provided an annual clinical effectiveness report for radiology for October 2017 to October 2018. Audits detailed regarding national guidance and best practice included the royal college of radiologist’s national audit of seven-day care in radiology and highlighted the data was submitted to the national audit.

The trust provided a IR(ME)R clinical audit programme. For example, this programme included the scope of audits such as audit of completeness of CT patient safety questionnaires and the date scheduled for further audit was October 2019.

There were local rules documented for the diagnostic use of x-rays in the x-ray department which staff were required to follow. This had a review date of 30 July 2020. All 21 local rules on the electronic systems were within the review date of 2020. Managers told us the MRI local rules at
the Freeman hospital for two new scanners had recently been updated and were approved the week before the inspection.

Managers told us they were working on writing new standard operating procedures for the MRI unit. The department had a MRI safety procedure and an MRI safety file in the department. However, the MRI scanner competencies required updating as the previous entry was from 2015 and not all members of staff had signed the MRI evacuation process documents.

Managers in nuclear medicine told us the next radiation protection report and next medical physics expert report was due in December 2019. These were annual reports.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff could provide food and drinks to patients as required in the department or if patients had been waiting for a period of time in the department or required food and drink. Lunchboxes were available for patients as required.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain.

The department kept a small amount of pain relief. The service did not use any specific tools to monitor pain.

**Patient outcomes**

Managers 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 and specialties within diagnostic imaging and nuclear medicine completed regular audits to enable review of their current practice. The service had discrepancy meetings called learning meetings to review previous reports and highlight any learning from these. These were monthly meetings. Staff in the CT department at the Freeman hospital completed a discrepancy audit every eight weeks, although we were told it was difficult to release all staff to attend these. Reporting radiographers would attend the discrepancy meetings.

The trust participated in national audits such as the Royal College of Radiologists audits. For example, the radiology audit report detailed the Royal College of Radiologists national audit of compliance with UK guidelines for the prevention and detection of acute kidney injury in adult patients undergoing iodinated contrast media injections for CT and this radiology audit report provided by the trust stated they met the current guidelines.

The World Health Organisation (WHO) checklist was used in the interventional radiology department. The trust provided the WHO interventional radiology audit questionnaire which was used to audit the checklist, although the information provided did not detail the recent results from the audit.

The trust provided an annual clinical effectiveness report for radiology for October 2017 to October 2018. This report highlighted an audit for radiology patient satisfaction survey 2018 including radiation risk patient awareness. The main findings highlighted that 95% of patients were happy
with the way they were treated and 73% had received information about the benefits and risks of the imaging examination.

The department were completing an audit of the procedure to identify individual to be exposed to ionising radiation which was being completed between 2 January 2019 and 28 February 2019. The cardiac CT department had completed a radiation protection audit in 2018 over three weeks. This audit showed that out of 39 patients, all patients had their identification checked and that 38 staff out of 39 staff used the lead apron correctly. The audit highlighted that the warning lights were working.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

**Appraisal rates**

The trust provided us with appraisal rates for diagnostic imaging care for the April to September 2018, no staffing groups met the 90% target set for the period covering up to March 2019.

Whereas the appraisal target for March 2018 was 80% this core service met the target with a completion rate of 84%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff Required Year to Date</th>
<th>Staff Received an Appraisal - Year to Date</th>
<th>% Of Staff Received an Appraisal YTD</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>40</td>
<td>35</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>22</td>
<td>19</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>30</td>
<td>23</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>52</td>
<td>36</td>
<td>69%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>71</td>
<td>49</td>
<td>69%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>144</td>
<td>91</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

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

The departments had eight reporting radiographers who told us they completed a post graduate certificate to progress to reporting radiographers. There were also five reporting radiographers in training in the different specialties. Managers told us there was a consultant mammographer and two further staff in training. The radiology new innovations and quality improvement document provided by the trust highlighted there was a cardiac CT radiographer in the service.

There were two consultant radiographers providing further advice and knowledge to the department. There were assistant practitioners providing further support to patients and these staff worked under the supervision of qualified staff in the department. There was a standard operating procedure for assistant practitioners called assistant practitioners performing quality assurance (QA) in the main radiology department which had a review date of 29 March 2020.

Staff could describe the competency based approach to their induction and spoke of supportive teams and colleagues and the structured approach to the induction programme where staff were
able to spend time in each speciality area. Staff described the variety of work undertaken at the trust and the opportunities available and staff were supported in their professional development.

Staff had annual appraisals and told us the human resources department would highlight appraisals required if they had not been completed and there were also prompts on the electronic system used by staff. Staff also had to meet the 95% mandatory training target as part of the appraisal. Superintendent radiographers and managers were responsible for completing staff appraisals. The appraisal year was from April 2018 to March 2019 and therefore was still in progress.

Senior nursing staff in the department attended the clinical leader’s forum which was held quarterly and led by senior nurses at the trust. Senior registered nursing staff received information from the regular senior nurses meeting which described any nursing related matters. Registered nursing staff felt they had enough support and attended conferences to keep up to date on nursing.

Senior registered nursing staff held one to one meetings with all relevant staff.

Managers told us they were considering training for band three staff in cannulation. Managers told us there were training and learning opportunities available externally and staff were supported through leadership courses. There was a in house leadership course available to medical staff. Managers told us they had attended relevant conferences.

Team leaders in the CT department mentored new members of staff and there was an induction pack for new starters to complete. There was also a CT training pack available.

Staff in the main x-ray department told us they received emails detailing the courses and training available and that there were opportunities for staff to attend courses. Staff told us they completed annual continuing professional development and personal development reviews.

The radiology new innovations and quality improvement document provided by the trust highlighted the radiology department at the trust had a commitment to training in the region. The document also highlighted the service had appointed a consultant sonographer to help support ear, nose and throat and interventional services along with training and there was a senior sonographer who provided mentoring of radiology trainees.

The radiation protection supervisors provided basic good practice training to relevant registered nursing staff in the cardiac catheter laboratory. In the nuclear medicine department, managers told us registered nurses had radiation safety training as part of their induction course. Staff also told us they did informal learning on relevant areas such as ionising radiation medical exposure regulations (IR(ME)R) and ionising radiation regulations (IRR).

In DEXA at the Freeman hospital, managers told us the radiographers had access to the nuclear medicine diploma to increase competency and knowledge. Staff we spoke with in CT told us they had done in-house training on CT and the radiation protection supervisor course was provided by the medical physics department and team leads had to attend a short course. Staff told us that when they do cardiac reporting there was in house training including three half days and they had 250 cases assessed and required 95% accuracy.

In the MRI unit there was in-house training for radiographers and templates available to staff such as a basic MR training log covering the MR department and an equipment competency template.

Staff told us there were opportunities to professionally develop in their roles. There were opportunities to complete appraisal training for staff who completed appraisals with staff. Managers in echocardiogram could describe the training that was completed.
**Multidisciplinary working**

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

There was multidisciplinary team (MDT) working across the departments and staff attended various MDT meetings across the trust. Various staff groups such as radiographers, medical staff, nursing staff, clinical assistants and administrative staff worked together to provide care to patients. The neuroradiology department had MDT meetings as required to discuss patient care and treatment. Staff told us they would assist in co-ordinating to other services in the trust as required.

The ultrasound team attended regional team meetings as required.

There was multidisciplinary team working in the mammography unit with medical staff, specialist registered nurses and mammography staff working together to provide care and treatment to patients. Staff told us patients who had a biopsy would also have a specialist nurse and would be discussed at a multidisciplinary team meeting which included consultant medical staff, clinical nurse specialists, MDT co-ordinators and advanced practitioners.

The cardiac x-ray team at the Freeman hospital attended the audit meetings in the cardiothoracic department. Staff told us the cardiologists were going to further link with the MRI and ultrasound departments going forward.

**Seven-day services**

The service operated 24 hours, seven days a week and staff worked on a shift pattern to ensure the department was staffed as required. There was also 24 hours a day, seven days a week access to the emergency and trauma imaging which included rapid access to CT scanning.

The cardiac x-ray department opened between 8:30am and 4:30pm and the main x-ray department provided cardiac x-ray after the department was closed.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

**Mental Capacity Act and Deprivation of Liberty training completion**

For the period April to September 2018 the completion rates for training on Mental Capacity Act and Mental Health Act for staff in the diagnostic imaging service are detailed below:

**Trust level**

A breakdown of compliance for MCA training courses as of September 2018 at trust level for staff in diagnostic imaging care is shown below:

**Nursing and midwifery staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible</th>
<th>Number of staff</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>

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The trust set a target of 95% for completion of mental capacity act training. Managers told us mental capacity act training was mandatory. Staff we spoke with could describe mental capacity and what they would do if a patient lacked capacity. Staff in interventional radiology also described best interest decisions. Staff we spoke with could describe how they seek consent and were confident in the action to take if they suspected a patient lacked mental capacity.

Staff in the department used verbal consent and written consent. Written consent was used for invasive procedures. Staff told us they would communicate with the referring clinician if required regarding consent. The consent forms seen for intravenous contrast in the MRI unit were in date.

Staff told us they received online consent training and there was a half day course staff attended on consent. Staff in mammography told us that if a person potentially lacked mental capacity, they would seek assistance from the medical staff and if required discuss at a multidisciplinary team meeting.

### Is the service caring?

#### Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

The main waiting area had a sign at reception asking patients and visitors to wait to be called to reception to maintain privacy in the department and mitigate the risk of patients being overheard whilst speaking with reception staff.

Staff responded to patients where they may be anxious or claustrophobic and could offer visits to the department before appointments to address patient concerns or claustrophobic patients.
There was a chaperone policy in place in mammography which staff adhered to based on best practice guidance. Staff could describe the chaperone policy and the care provided to patients with a disability attending the service. Chaperones were available in the main x-ray department and staff told us chaperones were always available if required.

Patient privacy and dignity was maintained in most areas visited, however there were occasions during the inspection where patients were waiting to be seen on beds in the corridors on the main x-ray department which did not support a patient’s privacy and dignity whilst in the department.

At the Freeman hospital, the MRI unit had a private room available where staff could go through the safety questionnaire with patients to ensure privacy and dignity was maintained. The cardiac x-ray department had a changing room which was connected to the scanning room which provided additional privacy to patients. Dementia training was provided to reception staff in the cardiac x-ray department.

We spoke with thirteen patients at the RVI during the inspection and overall feedback was positive regarding the services and care provided. Patients we spoke with felt they had been treated with kindness and compassion. Patients felt their privacy and dignity had been respected during their visit to the diagnostic imaging department and felt staff had been respectful.

The trust provided a patient satisfaction survey for 2018 for radiology. Results for the CT department at the Freeman hospital showed 99% of respondents said the receptionist checked their details when they gave them the request card and there was no response in 1% of respondents. 76.2% of respondents strongly agreed that staff were polite and very welcoming, 20.8% agreed staff were polite and very welcoming, 2% neither agreed or disagreed and 1% of respondents disagreed with staff being polite and very welcoming. There were 101 returned questionnaires.

The survey showed 67.3% of respondents said the radiographers and assistants were very welcoming and polite, 19.5% of respondents agreed that radiographers and assistants were very welcoming and polite, 5.9% of respondents neither agreed or disagreed, 1% of respondents disagreed and there was no response for 5.9% of respondents. There were 101 returned questionnaires.

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

Patients we spoke with told us they had felt involved in the decision-making process of their care where applicable and staff communicated with patients during their visit to the department and during the care being provided.

A quiet room was available in the department which could be used by patients and visitors if required to enhance privacy and dignity.

Overall, patients we spoke with also felt they had been offered adequate psychological and emotional support where relevant in the department. The service had access to a mental health first aider to provide further advice and support as required.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.
The neuroradiology department had three play therapists and specialists who had assisted in training staff in disruption techniques for relevant patients attending the service. Staff told us managers had been supportive in implementing this role in the department. Staff had also done work with claustrophobic patients attending the department. For example, patients could attend to have a look around the department before appointments and staff told us there was information that the patient may be claustrophobic on the referral form and they would contact them as required.

Patient feedback during the inspection regarding staff introducing themselves was varied. Overall, patients we spoke with also felt they would know who to contact if they were worried about anything from the visit to the department.

Reports were sent back the general practitioners from the x-ray department between seven and ten days after the scan and hospital reports were available on the trust information system immediately after the scan. Appointment letters were sent to patients prior to appointments.

There were safeguarding posters on display in the department areas we visited during the inspection.

The trust provided friends and family test data between January 2018 and November 2018 and this showed there were six respondents who were extremely unlikely, unlikely, don’t know or neither likely or unlikely and there were 48 respondents who were extremely likely or likely to recommend the service. There were 54 respondents.

The trust provided a patient satisfaction survey for 2018 for radiology. Results for the CT department at the Freeman Hospital showed 50.5% of respondents were told how and when they would receive their results, 34.7% were not told how and when they would receive their results and there was no response in 14.9% of respondents. 70.3% of respondents said they were attended to on time if they had an appointment, 13.9% of respondents said within 15 minutes, 9.9% were attended to between 15 minutes and 30 minutes, 4% of respondents said between 30 minutes and 60 minutes and 2% did not respond.

During the inspection there was limited evidence staff had access to communication aids to enhance communication with people with additional needs where required.

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**Is the service responsive?**

**Service delivery to meet the needs of local people**

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

Managers told us the directorate fed into the trust capacity and demand planning. Included in this planning was the departments equipment imaging plan which was provided to capital planning at the trust. Managers told us about business planning and that the service had gone through a strategic planning review where each of the directorates had to present their initiative.

Demand and capacity was managed by the leadership team and managers we spoke with were aware of challenges around reporting times and worked with other departments such as finance and human resources regarding capacity and demand.

The department had signage to direct patients to the relevant areas within the department.

The lung function service and the sleep service at the trust were co-managed so resources were shared between the two departments.
The interventional radiology team worked across the two hospital sites at the trust increasing the flexibility of the service.

The neuroradiology department developed business cases based on the managers plans and needs assessment of the service.

There were three radiographers working in the CT department and they separated their responsibilities to provide care and treatment to patients and ensure the pathway worked as required. For example, one radiographer would do cannulation if required, one radiographer would scan the patient and one radiographer would assist in scanning and check the required records.

The echocardiogram service was expanding and the service were planning to establish a seven-day service. The service had recruited an additional three whole time equivalent staff members. The echocardiogram department were managed by the cardiology directorate.

The cardio x-ray department offered imaging to GP patients, patients attending for appointments in the northern centre for cancer care and inpatients at the trust.

The lung function service and the sleep service at the trust were co-managed so resources were shared between the two departments.

The interventional radiology team worked across the two hospital sites at the trust increasing the flexibility of the service.

Meeting people’s individual needs

The service took account of patients’ individual needs.

The services could add alerts to the electronic system used if a patient with additional needs did attend the department.

Staff told us patient information leaflets were available for patients in the different specialities. Interpreters and British Sign Language support was available and accessible across the department at the trust.

There were patient information leaflets available for MRI scans, CT scans and ultrasound scans on display in the waiting areas.

The nuclear medicine department had a registered nurse who was also a dementia lead within the department to provide advice and support as needed. Staff I dual energy x-ray absorptiometry (DEXA) told us information leaflets were sent out with appointments.

The mammography unit offered a one stop service for people with potential cancer diagnosis. Patients would attend outpatients where they could be referred through to ultrasound if required. Staff told us they could show patients the equipment used if required and could bring patients back for an appointment with additional time allocated. Staff could offer more time for appointments if required.

Staff could describe an example of the equipment used to adjust for the care provided to patients, for example the access to a scoliosis chair in the department. The main x-ray department were working on a new wheelchair for patients to address patient’s individual needs.

The radiology new innovations and quality improvement document highlighted the trust had implemented a combined ear, nose and throat and ultrasound neck lump clinic.

At the Freeman hospital, patient feedback was mixed regarding receiving patient information leaflets during their treatment or procedure.
The cardiac x-ray department had dementia leaflets available on the staff boards providing information to staff in the department on dementia.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

**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 similar to the England average, but has tended to drop during 2018 whereas the England average has risen. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows 6+ weeks percentages over time.

(Source: NHS England – Diagnostic Waits)

The trust provided information highlighting that in March 2018 GA MRI waiting times were at 14 months and this had reduced to six weeks in December 2018. Staff told us the MRI waiting lists had reduced due to increasing the scanning lists until 8pm and the service had Sunday waiting lists to address the waiting times.

**Reporting**

Chest x-rays from the general practitioners between June 2018 and August 2018 was 98% within the local standard reporting period. The standard was 100% compliance within three working days. The CT chest x-ray from general practitioners between June 2018 and August 2018 was 99% within the local standard reporting period. The local standard was 100% within two weeks.

Between June 2018 and August 2018 in accident and emergency x-ray the service was at 77% against the standard. The standard was 100% within three working days.

Between June 2018 and August 2018 in CT outpatients the service was at 81% against the standard. The standard was 100% within two weeks.

Between June 2018 and August 2018 in the CT colon service the service was at 52% against the standard. The standard was 100% within one week.
Between June 2018 and August 2018 in CT accident and emergency the service was at 49% against the standard. The standard was 100% within two hours.

Between June 2018 and August 2018 in MRI outpatients the service was at 62% against the standard. The standard was 100% within two weeks.

Between June 2018 and August 2018 in the MRI knee service the service was at 67% against the standard. The standard was 100% within two weeks.

Between June 2018 and August 2018 in the MRI prostate service the service was at 61% against the standard. The standard was 100% within one week.

**Urgent referrals and waiting times**

Staff in CT told us cardiac reporting was carried out by the radiographers and this would be done within 24 hours.

The service provided information showing there were appointments waiting longer than two weeks for urgent and priority appointments.

The waiting times for urgent cancer appointments showed the longest waits were in CT, followed by MRI, ultrasound and then plain film imaging. For example, CT had between 1000 and 1200 appointment episodes on the combined cancer waiting list with around 600 appointments being less than one week, the second highest number of appointments being one to two weeks and the other appointments being between two weeks and six plus weeks. This information stated there were pressures in waits for specialist imaging such as CT and MR cardiac and some complex abdominal imaging.

The information provided by the trust showed the length of time in weeks for waits for combined priority urgent appointments in 2018. This information showed the longest waits were in CT, followed by ultrasound, MRI and then plain film.

The service had recently started to outsource some elective CT and MRI imaging. The service also had an external provider attend the trust to assist in reporting some plain film x-ray.

The main x-ray department provided 24 hours a day, seven days a week emergency and trauma imaging which included rapid access to CT scanning. The department offered a range of services including MRI, CT, ultrasound, Barium studies, Fluoroscopy, computed radiography (CR) and digital radiography (DR) imaging. Imaging could be accessed immediately on the x-ray system across the hospital and in the emergency department. Referrals to the radiology department came in various ways. Inpatients could be referred electronically and outpatients were referred on paper requests but managers told us they were considering moving it all to electronic referrals. Referrals were also received from general practitioners (GP) and there was minimal independent health work carried out.

The bookings team at the service managed ‘did not attend’ rates for the service. Where there were ‘did not attend’ appointments staff would contact the patient to make another appointment. Managers told us the trust were considering text reminder services to address ‘did not attend’ appointments and they would book other patients into ‘did not attend’ appointments.

The trust provided information on the ultrasound key performance indicators and this showed the RVI had an ultrasound DNA rate of around 10% between October 2017 and March 2018. The rate of DNA for MRI between October 2017 and March 2018 was around 10%. The rate of DNA for CT between October 2017 and March 2018 was also around 10% These were for both hospital sites.

The radiology department had a bookings team which facilitated non – urgent and urgent bookings to the department. Appointments were allocated and sent to patients, although staff told us they
could facilitate appointment choices and different times for appointments if the patients contacted the bookings team. There was walk in appointments available for main x-ray and staff told us they could facilitate urgent MRI appointments as necessary. Staff told us general practitioners could use an appointment system to book patient appointments directly.

Staff told us prioritisation of bookings was done using a priority status on the bookings cards. For example, ultrasound referral cards would have a priority status of routine or urgent which highlighted the priority of the referral and once these were on the electronic systems they would go to the sonographer who would check what preparation was required. Inpatient referrals went directly to the sonographer.

Staff in the CT department told us they could always facilitate urgent patients and would discuss this with the radiologist and the superintendent radiographer and that team leads and the superintendent would vet the requests. There was a procedure for the practice of radiographers protocolling CT requests.

The departments visited in diagnostic imaging did not have boards highlighting waiting times in clinic, although the mammography unit did have an information board which was updated and included updates such as time delays.

The service had recently started to outsource some elective CT and MRI imaging. Service also had an external provider attend the trust to assist in reporting some plain film x-ray.

Staff told us next day appointments were available in the different specialities in radiology if required.

Staff told us that in the x-ray department GP reports would go back to the doctor between seven to ten days after the scan and that priority patients such as patients with fractures would be directed to the minor injuries unit for immediate treatment.

Inpatient electrocardiogram (ECG) records would be added to patient records and outpatient ECG records were sent to the general practitioner. Requests for inpatient ECG were received into the ECG department on a written request form and staff would either attend the ward to complete the ECG or patients would attend the department.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Summary of complaints

From September 2017 to August 2018 there were eight complaints about diagnostics: four at Freeman Hospital and four at Royal Victoria Infirmary.
(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From April 2017 to March 2018 there were 184 compliments within diagnostics.
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Managers told us complaints could be received into the department in various ways and that when a formal complaint was received this would go to the directorate manager for radiology and then investigated by the relevant person.

Managers told us learning from complaints and feedback to staff was completed individually and
generic feedback from learning from complaints was done through the three-monthly newsletter. The directorate manager had oversight of complaints in the department. Overall, there were no themes or trends in the complaint information provided by the trust, although two of the complaints were regarding delays to treatment. The trust provided information highlighting they had submitted a business case in the neurosciences department for extra capacity for pre-assessment to avoid ad-hoc sessions as changes made from complaints.

The notice board included a patient advice and liaison service sign displayed which provided information to patients and visitors on the trust patient advice and liaison service.

**Is the service well-led?**

**Leadership**

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

There was a clear leadership structure in place in the areas visited and diagnostic imaging was part of the radiology directorate. The service was managed by a leadership team including a directorate manager, clinical director, radiology services manager and a deputy radiology services manager. Each speciality within diagnostic imaging had a superintendent radiographer.

Leaders worked across both sites of the trust which increased the visibility of the leadership team across the specialties. Staff were positive about leaders in the various specialities and leaders being approachable and told us there was support as required from leaders.

Leaders we spoke with during the inspection understood and could describe the challenges the service had and described the actions taken to address challenges.

Leaders held regular meetings to manage and provide the services and ensure there was oversight of the various specialities provided.

The neuroradiology service was part of the neurosciences department, although staff in the services worked closely with radiology and completed joint recruitment and discussed resources as required.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

The leadership team could describe the vision and strategy for the department which was to ensure reporting times were addressed and met as required. The trust had a vision and values document which was on display in the various departments visited. Staff could describe working to the trust operational agenda. Leaders told us they were proud of going above and beyond for patients.

The trust provided a radiology strategy presentation for 2018/23 which detailed information of radiology activity, strengths, challenges, top priorities, patient experience, strategic options and the top three areas for transformation. The top three areas for transformation were vulnerable services, performance and reporting.

Managers told us they would submit information to the quality performance review and would meet with finance for example to discuss where they were and where they would like to be and consider their strategy along with the broader strategy. There was no documented formal strategy for the
department, although managers told us they would respond to changes as required and they had developed an action plan with senior trust managers on what they could try to do.

There were challenges described with regards to staffing in the department and the leadership team could describe the action they were taking to improve staffing levels. The leadership team told us they were continuing to recruit as needed, completed international recruitment, extending and offering a wide variety of roles to current staff and training staff in areas where there were shortages. The department had also been given permission to overrecruit which had assisted in additional staff to the department.

There were managed equipment services in place for scanning equipment.

**Culture**

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

Overall, morale was good and staff told us there was good teamwork, openness and honesty in teams and teams were supportive. Staff we spoke with were proud to work for the organisation and felt respected and valued by the organisation. Staff and the leadership teams we spoke with were aware of and could describe the duty of candour.

There was opportunity for staff to progress in diagnostic imaging and staff had access to development courses.

Managers told us they assessed morale in the department by being in attendance in the department and the service had an annual staff survey. Managers told us there were no staff survey concerns and there was a low turnover and low sickness rate of staff in the department.

Managers told us some of the service had moved to protected reporting time and were considering home reporting for staff.

The diagnostic imaging department had monthly staff meetings. Each month the staff meeting would alternate between being opened by the managers and the next meeting would be opened by the staff. This had been changed based on feedback from staff in the department.

The radiology department produced a newsletter which had information shared from the various specialties in the department for staff to read. The trust provided the December 2018 newsletter and this included information such as recruitment, compliments and lessons to be learnt.

The radiographer meetings were used to discuss items such as the environment, infection control and staffing issues. Staff could describe where an issue had been discussed and the outcome from the discussion was a new checklist had been created.

The mammography unit staff attended the radiology management executive and could provide feedback at this meeting and the lead for the department also attended the radiology operational meeting.

A manager in the department had recently took on the role as the department health and wellbeing lead.

The departments had introduced an initiative to highlight the positive work staff did and was used to provide positive feedback to staff. Patients or staff could nominate staff for this initiative.

**Governance**
The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

Managers described the governance arrangements in the service. The service had a monthly executive meeting where governance was included and discussed and the governance committee was part of this meeting. There was also a department operational meeting which superintendent radiographers would attend and governance could be raised at that meeting. There was a consultant meeting at each hospital site.

The trust provided radiology management executive meeting minutes for December 2018. This included agenda items such as quality improvement, quality strategy, never events, audit of the WHO checklist, finance, systems and support, complaints, compliments and radiation safety.

The service had discrepancy learning meetings six to eight times a year where the teams would discuss why a discrepancy had occurred and share the learning from it.

The directorate manager attended the trusts weekly morning huddle and the radiology department attend the clinical risk group.

The service was starting to outsource some reporting to an external provider. Managers told us there would be initial double reporting and the service would feedback discrepancies to the outsourcing provider as required and there was a service level agreement in place and that the service would have meetings with the outsource provider.

Managers told us the RVI had an emergency power supply, although this was only in one part of the building and there was no emergency power supply in ultrasound or main x-ray. The trust did have a backup generator for the department.

There were three monthly radiation meetings in the department involving radiation protection supervisors and radiation protection advisors and considered topics regarding radiation in the various specialties. The nuclear medicine department had an operational monthly meeting to discuss operational issues and there were team meetings weekly. Manager’s in nuclear medicine told us they had standardised protocols across the two hospital sites and there was the same management and procedures across both sites.

Staff in nuclear medicine told us there was three monthly radiation protection committee meetings and there was a IR(ME)R governance group quarterly which radiologists attended and these fed into the radiation protection committee meetings. The directorate manager attended these also. Nuclear medicine was formalising the meetings with the radiation protection advisors and the radiation protection supervisors. The radiation protection advisors would try and attend the operational meetings where they could. Staff told us the medical physics experts would get information on radiation incidents if they occurred.

The annual IR(ME)R report from December 2017 had two recommendations for the service. The service had onsite medical physics experts and radiation protection advisors.

The service had reports available to review reporting and waiting times.

The trust provided information showing they had service level agreements in place for third party services.

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 radiology department had a risk register which was reviewed monthly at the executive meeting. The directorate manager and risk and safety manager would also review the risk register monthly. The neuroradiology department had a risk register which was reviewed monthly.

Managers described the top three risks to the service and these were paediatric radiologist staffing, delayed outpatients reporting and delivery of the breast service. The trust was trying to mitigate the paediatric radiologist staffing level risk by putting more sonographers and radiographers into the service, considering adding an additional two advanced practitioners into the service and the manager told us adult radiologists were assisting in the paediatric service within their scope and practice. Managers told us they had good links with the paediatric directorate and had regular meetings with directorate.

Managers told us the service were mitigating the delayed outpatient reporting risk by outsourcing, providing protected reporting time and additional recruitment. Managers told us they were mitigating the risk regarding the delivery of the breast service in training consultant mammographers and had successfully recruited more staff.

The services had access to the required performance reports and managers told us key performance indicators were discussed at the management executive meeting. The department had appointed a safety and risk lead radiologist who attended the trust clinical risk group and would feed back to the relevant department management meetings. The safety and risk lead role also supported incident investigations as needed.

Managers in the nuclear medicine department described the relevant site licenses the trust had in place and the licenses which some medical staff had as required by nuclear medicine. The DEXA team attended regional meetings once a year.

Managers in echocardiogram told us the reporting system used in the department was on the risk register and required replacing which was progressing, although the pace of this work had been slow.

The Freeman did not have an emergency power supply except for two interventional radiology rooms which had an uninterrupted power supply. Managers told us they had raised this and as the trust were replacing equipment they were getting more uninterrupted power supplies installed. There was a trust backup generator.

Information management

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

Staff had access to the required information systems. Staff could access the trust intranet for information and news about the trust. Nuclear medicine had systems which staff could access policies, procedures and risk assessments. In other departments such as x-ray staff could access policies and procedures on the computers in the department. Systems used by staff were password protected.

Diagnostic images were reported on the information system used and could be access in the hospital including the emergency department after the scan was completed. The radiology systems were available in the main x-ray rooms allowing staff to check previous x-rays.

Managers described the challenges they had with some of their information systems and were trying to develop safety systems for unreported work. Managers told us they had upgrades and were meeting with external providers to address the challenges.
Managers told us the service was involved in a regional team with regards to information systems. Staff had access to an internal information technology team for support as required.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The ECG department was in the cardiology department. The department had ‘how are we doing’ information board and there was a family and friends test self-service questionnaire where patients could complete surveys electronically, although this was used mainly for outpatients. There was limited patient feedback on display for ECG or other cardiology testing departments.

The mammography unit gathered feedback in three ways. The service used the ‘take 2 minutes’ system where patients could provide feedback, there was patient experience cards available and the friends and family test was used across the service, although this was used for staff to provide feedback also. However, the department did not have any patient feedback on display during the inspection.

The trust had completed a 2017 staff survey. This was used to provide feedback to the service from staff.

The trust completed a 2018 patient satisfaction survey for the radiology departments which detailed information such as positive comments and areas for improvement and feedback was provided on the environment, staff, location and waiting times. The document also included an action plan, although the action plan did not highlight whether the actions had been completed.

The x-ray department had information displayed on the notice board on the patient advice and liaison service, radiation and diagnostic reference levels. The cardiac x-ray department had participated in a radiography day and had held a stall at the trust which provided information to the public on what the service did. The department completed annual patient experience feedback to gather feedback and improve the service.

During the inspection there was no friends and family feedback forms on display in the echocardiogram department at the Freeman Hospital.

**Learning, continuous improvement and innovation**

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

There were various innovative pieces of work ongoing in different areas of the diagnostic imaging departments. The trust provided information highlighting the neuroradiology department had collaborated previously with a local university in different research. Managers told us that various departments were involved in research.

The hospital had worked jointly with other external partners on a ‘virtual radiology’ room which had computers available for staff and students to use to learn about diagnostic imaging and reporting and this room could also be used for teaching radiology to students.

The sleep service had recently won a national award for innovation. The lung function service had links to the research going on across the trust.
The department had the 2018 ‘radiographer of the year’ and the 2016 ‘team of the year’. The diagnostic imaging department also had two consultant radiographers to provide further advice and knowledge in the services.

The diagnostic imaging service had been considering a pilot for working from home reporting to increase the appeal to staff working at the trust and add increased flexibility to staff working.

The Freeman Hospital had implemented low dose CT scanning which lowered the level of radiation received by patients.

The trust provided a radiology new innovations and quality improvement document. This highlighted some of the innovation and improvement the service was doing. This document highlighted the iodine seeds use in the breast clinic and highlighted that the service supported training of other centres to learn the technique. The document highlighted the rapid access to highly specialist ultrasound examinations in the pregnancy and crohn’s service.

The document highlighted that trust staff were involved in projects to assist in diagnosis and improve the patient pathway relating to artificial intelligence.

Staff told us they had improved compliance with dosimetry and use of protection glasses in the cardio x-ray department using audit and providing good practice days to staff at the Freeman hospital. Staff in cardiac x-ray had participated in stalls providing information on what the service did to the public.

Managers in nuclear medicine could describe innovation the department had done such as keeping two slots a day available to provide patients with a next day appointments.

Staff in the cardiac x-ray department could describe changes they had made from audit’s and feedback to improve the services and care provided. For example, staff had changed the document used for checking the trolley which had increased compliance with resuscitation trolley checks in the department. Staff had also identified a challenge with general practitioner patients waiting for appointments to the chest x-ray department and the service had increased appointments in the afternoon to address this challenge.

Informal feedback regarding privacy and dignity in the cardiac x-ray department had led to changes to improve privacy and dignity. The service had designed the new layout of the department so the changing room was connected to the scanning room to improve privacy and dignity.

The cardiac x-ray department had changed the radiology request from feedback regarding falls risks. The service had added a tick box to the form for falls risks to address this feedback. The quality improvement document the cardiac x-ray department created had come from patient feedback, staff feedback and informal feedback.

Staff told us the echocardiogram were trying to achieve departmental accreditation.

The ‘how are we doing’ board in the interventional radiology department had a section for ‘you said, we did’ and this highlighted changes such as a water fountain and an action in progress was having music as a distraction.
Facts and data about this service

The Great North Trauma and Emergency Centre for Newcastle is located at the Royal Victoria Infirmary (RVI). It is a purpose built facility. The Great North Trauma and Emergency Centre provides 24/7 resident emergency medicine consultant cover. Patients are received from as far afield as Cumbria to the Scottish borders; the helipad also enables rapid access for these patients. At times when the helicopter is unable to fly, medical staff attend in specially equipped Merit cars and accompany patients to the department by land ambulance. There is a separate access within the emergency department for children who also have access to this high level of clinical care.

There is a minor injuries unit and a GP led service within the same department. Elsewhere in the City the trust has three walk in centres, Molineux Street in Byker, Lemington walk in centre, Lemington and Westgate walk in centre on the CAV site (Centre for Ageing and Vitality). At the Royal Victoria Infirmary, in close proximity to the Great North Trauma and Emergency Centre is both the assessment suite and ambulatory care unit. The assessment suite is a 50-bedded unit with medicine consultant cover 8am-10pm seven days a week. As well as taking emergency patients from ED, GPs can refer patients who need admitting directly to the suite therefore bypassing ED.

The ambulatory care unit provides care for patients who can have investigations and treatments completed and be discharged within the same day. Again this is available to GPs for direct referrals into the service. The trust has a number of representatives at the Newcastle System Resilience Group where they play an active part in developing services that support the urgent and emergency care pathways.

(Source: 20180718 RPIR Acute Queen Victoria NHS Foundation Trust RPC Final (5) – Context)

Details of emergency departments and other urgent and emergency care services

The trust has a full ED at the Great North Trauma and Emergency Centre for Newcastle, located at Royal Victoria Infirmary. It also has three walk-in centres and an emergency admissions suite at Freeman Hospital that is specifically for patients presenting as an emergency requiring surgical review.

(Source: Trust Routine Provider Request, acute context)

Activity and patient throughout

Total number of urgent and emergency care attendances at The Newcastle upon Tyne Hospitals NHS Foundation Trust compared to all acute trusts in England, July 2017 to June 2018
From July 2017 to June 2018 there were 202,092 attendances at the trust’s urgent and emergency care services as indicated in the chart above. (Source: Hospital Episode Statistics)

**Urgent and emergency care attendances resulting in an admission**

The percentage of A&E attendances at this trust that resulted in an admission remained similar 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**

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>2016/17</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>28,435</td>
<td></td>
</tr>
<tr>
<td>Discharged*</td>
<td></td>
<td>142,356</td>
</tr>
<tr>
<td>Referred*</td>
<td>21,578</td>
<td></td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>3,472</td>
<td></td>
</tr>
<tr>
<td>Died in department</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Left department#</td>
<td>3,290</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2,806</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>75</td>
<td></td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
Mandatory training

Mandatory training completion rates

The trust set a challenging target of 95% for completion of mandatory training. The information provided to us by the trust showed the year to date information and not the information for the full year.

Trust level

A breakdown of compliance for mandatory training courses as of September 2018 at trust level for staff in urgent and emergency care is shown below:

### Nursing and midwifery staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of Patient Falls</td>
<td>101</td>
<td>99</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>101</td>
<td>99</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>101</td>
<td>92</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>101</td>
<td>92</td>
<td>91%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>101</td>
<td>87</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>101</td>
<td>74</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>101</td>
<td>72</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>101</td>
<td>71</td>
<td>70%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>101</td>
<td>67</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>101</td>
<td>66</td>
<td>65%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>101</td>
<td>65</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Basic Life Support</td>
<td>92</td>
<td>47</td>
<td>51%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>101</td>
<td>48</td>
<td>48%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Local Induction</td>
<td>5</td>
<td>2</td>
<td>40%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff failed to meet the 95% completion target for 12 out of 14 mandatory training modules. The lowest scoring module was local induction with 40% however only five staff were required to complete this module.

For the last financial year (April 2017 to March 2018) nursing staff did not meet the 95% target with an overall training completion rate of 74%.

We spoke with staff about mandatory training and they all told us they were booked to attend training to ensure they met the targets before 31st March 2019.
Medical and dental staff

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>45</td>
<td>35</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>45</td>
<td>35</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>45</td>
<td>33</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>45</td>
<td>33</td>
<td>73%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>45</td>
<td>30</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>45</td>
<td>29</td>
<td>64%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>45</td>
<td>25</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>45</td>
<td>24</td>
<td>53%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>45</td>
<td>23</td>
<td>51%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>45</td>
<td>23</td>
<td>51%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>46</td>
<td>16</td>
<td>35%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Basic Life Support</td>
<td>35</td>
<td>12</td>
<td>34%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Local Induction</td>
<td>12</td>
<td>1</td>
<td>8%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff failed to meet the trusts 95% completion target for all 13 mandatory training modules; the lowest scoring module was local induction with 8% of which 12 staff were eligible for this module.

For the last financial year (April 2017 to March 2018) the medical and detail staff did not meet the 95% target with an overall training completion rate of 65%.

We spoke with staff who told us their mandatory training had been booked and there were plans in place to make sure they completed all of their mandatory training before 31st March 2019.

The trust provided training data for only one site, Royal Victoria Infirmary which is shown above). *(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

Staff told us they were supported to attend mandatory training and were allocated specific training days on their rota. The department aimed for staff to be able to complete all mandatory training in one day however this was not always possible.

Staff told us they very rarely had problems accessing training, or missing training because the department was too busy for them to leave. This was because they were not included in staffing numbers for the days they were due to attend training. Senior nurses and the management team confirmed this.

We spoke with medical staff about their training within the department. Junior medical staff told us they were very happy with the clinical training they received whilst in the ED. They told us senior staff were very supportive and knowledgeable. They also told us staff challenged them in a positive way to make them think and learn.

We observed senior clinical staff delivering informal training to trainees during our inspection for example by discussing unusual presentations of conditions.

We looked at the General Medical Council (GMC) survey of trainee medical staff receiving training in emergency medicine in the region. This showed the ED achieved excellent scores and had the highest overall satisfaction rate of all EDs in the region. It was also noted as a positive outlier in 10 of 18 areas covered by the survey. None of the areas were negative outliers.
Safeguarding

The trust set a target of 95% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses as of September 2018 at trust level for staff in urgent and emergency care is shown below:

**Nursing and midwifery staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>9</td>
<td>8</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>101</td>
<td>83</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>101</td>
<td>68</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The information above shows the completion rate from April to September 2018 however the trust measured compliance over a 12m period from April to March. Although not fully compliant at the six month stage, the trust had training booked for staff and plans in place to ensure compliance with the 95% standard within the 12m period.

Information sent to us by the trust showed the compliance for year to date (September 2018) and there were plans in place to ensure all staff had completed their level 1 and level 2 training by the end of March 2019.

Nursing and midwifery failed to meet the trusts 95% completion target for all three safeguarding training modules for the last financial year (April 2017 to March 2018) however, the nursing staff had an overall training completion rate of 91%.

**Medical and dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>45</td>
<td>30</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>45</td>
<td>23</td>
<td>51%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

The information above shows the completion rate from April to September 2018 however the trust measured compliance over a 12m period from April to March. Although not fully compliant at the six month stage, the trust had training booked for staff and plans in place to ensure compliance with the 95% standard within the 12m period.

Medical and dental staff failed to meet the trusts 95% completion target for both safeguarding training modules. For the last financial year (April 2017 to March 2018) the medical and dental staff did not meet the 95% target with an overall training completion rate of 67%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We asked the department to send us a breakdown of safeguarding training between adults ED and children’s ED. This showed children’s ED staff were 49% compliant for safeguarding level 3 training. Adults ED staff were 48% compliant for safeguarding level 3 training as of December 2018. Staff assured us they had training planned and booked to ensure they met the target by
31\textsuperscript{st} March 2019.

We spoke with staff about safeguarding vulnerable adults and children. All staff we spoke with were able to describe the different types of abuse and potential signs of abuse. Staff spoke about some of the risks in the local area and we saw evidence of children and adults being referred to the appropriate agencies to manage their safety.

Staff could tell us about female genital mutilation (FGM) and child sexual exploitation (CSE) and clearly articulated the actions they would take if they identified a person at risk.

We found there were robust processes in place to identify people at risk of abuse and systems in place to identify any patients or family members who might slip through the net at initial encounter in the department. Experienced staff audited patient records to identify any patients they believed should have been referred but had not. If a patient had been missed, the staff involved in the patient’s care were involved in discussions about the case to identify why a referral had not been made.

The department had access to a health visitor liaison service who could contact families to offer them additional support if they had been identified as a family in need by staff within the department.

Staff in the paediatric department used a recognised tool when assessing children. This made sure staff asked the most appropriate, professionally curious questions when children and young people attended with injuries.

**Cleanliness, infection control and hygiene**

There were cleaning schedules in place and we saw completed paperwork confirming cleaning had been carried out. We saw staff completing the required tasks in line with schedules.

When we visited the department, we found it to be visibly very clean. Patient rooms were cleaned between patients and waiting area floors and seating were in excellent order. Patient toilets were clean. We found the environment was compliant with infection prevention and control guidelines and there was no dust below, or on top of surfaces. The cleaning staff were very thorough.

Staff could call cleaners to the department ‘out of hours’ if required. Health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.

There was sufficient personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this, latex gloves and other equipment and disposing of it correctly during our inspection.

The department had decontamination rooms and facilities to manage patients who attended with infectious diseases such as Ebola or chemical, biological, radiological or nuclear contamination.

We noted all staff were bare below the elbow in line with infection prevention and control policies.

In the paediatric waiting area, toys met infection control standards and had been cleaned regularly. The cubicles in the paediatric area were well stocked, tidy and uncluttered.

Staff training for infection prevention and control for the year to September 2018 was 71\% for nursing staff and 53\% for medical staff however, there were still a further six months for the remaining staff to complete their training and we were informed about training days organised to make sure this happened.
The adults’ and children’s’ departments had solid walled cubicles for patients who required isolation for the prevention and management of actual or potential infection.

During the inspection we saw one patient being barrier nursed. Staff used the correct PPE when entering the room however, the patient had not been provided with a commode should they need to go to the toilet. We identified this with the matron who took immediate action.

We looked at the areas where equipment was cleaned and these were visibly clean and there were cleaning schedules in place for all equipment. The equipment in this area was clean.

Mattresses we checked were in good condition and met infection prevention and control standards.

Environment and equipment

Consulting and treatment cubicles were a generous size and contained the necessary patient equipment. All cubicles had solid walls and solid doors to maintain privacy. There were monitoring bays in the majors area which had curtains.

The department had a room that could be used in the event of chemical, biological, radiation or nuclear (CBRN) contamination. This area was ready for use if required and when we checked hazardous material suits used to protect staff, these were all in date, easily accessible and ready for use.

We found that equipment in the department had been safety checked. All of the electrical equipment we checked had up to date tests.

Equipment was serviced and maintained in line with manufacturer’s guidelines, as there were maintenance contracts in place. To ensure accuracy, equipment was regularly calibrated.

We saw there were sufficient supplies of all equipment. This meant that if one suffered a mechanical breakdown, a spare machine was available.

The department had a plentiful supply of ultrasound machines quickly and easily accessible to staff who had received additional training to use them.

We checked some of the stock held in the store rooms. All the items we checked were within their expiry date.

During our time in the department we found cupboard doors locked and hazardous materials safely kept away from patients.

We checked resuscitation trolleys and found these were regularly checked by staff. All equipment was present and in date.

The waiting areas used by patients in the adult’s area were spacious with sufficient seating for patients and relatives. They also had natural light making them a more pleasant environment for patients. We did however find the waiting area for children to be smaller and staff told us there were occasions when the children’s waiting area was very full.

Managers were aware of the restrictions on the size of the department, particularly the childrens’ area and were considering how to improve this.

There was a separate secure waiting area suitable for children and young people. Cubicles presented an interesting environment for children and young people because there were toys and a television to distract and occupy children waiting to be seen or treated.
The department had a specific room suitable for adult and paediatric patients with mental health conditions. The room was ligature point free and had heavy furniture that could not be used as a weapon.

**Assessing and responding to patient risk**

**Emergency Department Survey 2016**

The trust neither scored significantly better nor worse than other trusts for the five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>5.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>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?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The median time from arrival to initial assessment was worse than the overall England median in every month over the 12 month period from October 2017 to September 2018. However, when we observed initial assessment of ambulance patients we saw patients were assessed quickly by staff using a dedicated ambulance rapid assessment bay. As soon as patients arrived by ambulance, they were taken to the bay and handed over to staff by one crew member whilst the second crew member gave the booking staff the patient’s details.

We spoke with ambulance crews who regularly brought patients to the department. They told us handover was efficient and happened quickly.
Ambulance – Time to initial assessment from October 2017 to September 2018 at The Newcastle upon Tyne Hospitals NHS Foundation Trust

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

The trust’s time to initial assessment for ambulance arrivals is, reportedly, typically much higher than average: the England average is 7-8 minutes whereas the Newcastle figure varies between 30-60 minutes. However, this is likely to be an issue around interpretation/recording of the time of initial assessment as the overall time to treatment at Newcastle is consistently better than the England average. The England average is about 60 minutes whilst the Newcastle figure varies between 30-60 minutes. Both the reported time to initial assessment and time to treatment at Newcastle have also shown improvement since May 2018.

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Royal Victoria Infirmary

From September 2018 to September 2018 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Royal Victoria Infirmary. Turnaround time includes the time taken to handover a patient plus the time taken by the ambulance crew to prepare the ambulance for its next call.

Ambulance: Number of journeys with turnaround times over 30 minutes - RVI A&E
However, the information above is contradicted by the fact the trust reported no black breaches. Additionally, handover time includes the time after a patient is handed over to hospital staff for the ambulance to restock, be cleaned and be ready to take further emergency calls.

From our observations over five visits to the department, patients were handed over to hospital staff quickly and effectively and the evidence we gathered showed there were no delays in patients being seen for initial assessment within the 15 minute standard. In particular, ambulance patients were seen quickly by a consultant in the ambulance assessment bay.

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From October 2017 to September 2018 the trust reported no “black breaches”.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

The department used a system called streaming to make sure patients were seen in the correct department to meet their needs. Streaming was carried out by a registered nurse and was carried out before the patient registered. Patients with minor illnesses or injuries were directed either the GP in the department or the minor injuries area of the department. Once streamed and booked in, more serious conditions were triaged to establish the level of risk posed by their presenting concern.

There were also rapid assessment and ambulatory care pathways so patients who were told to attend by their GP could go straight to the appropriate department. These included Early Pregnancy, Gynaecology and ambulatory care.

We discussed streaming and triage with staff. They told us that more senior or experienced staff streamed and triaged; these were important roles in the department. Individuals had to undergo additional assessments and have a desire to triage.

There was emergency medical equipment in the department and staff were experienced at dealing with sick patients. There were senior staff on hand to support less experienced staff at all times either in the department or as resident on call. This meant consultants could be in the department very quickly if needed.

Two of the department’s consultants had been awarded international recognition for their point of care ultrasound testing.
The department had an adult sepsis pathway and a paediatric sepsis pathway. Patients identified as being potentially septic were started on the sepsis pathway. There was a department sepsis lead. The electronic record keeping system also had a trigger to remind staff to consider sepsis when entering information about patients.

We viewed the latest sepsis re-audit information provided by the trust so we could see how well they were performing against national screening criteria used in the RCEM audits. Information provided by the trust showed sepsis screening had improved over time and was clearly a priority in the department.

The department used the national early warning score (NEWS) for adults and the paediatric early warning score (PEWS) for children to assist in monitoring patients and identifying when a patient’s condition was deteriorating. Staff were aware of the action they should take if patients deteriorated and there was a process in place for staff to follow.

We looked at the records of patients in the department and found that NEWS or PEWS had been completed regularly. However, on one of our visits we identified four patients who had not undergone regular observation checks. We highlighted this to the nurse in charge at the time because we had concerns about one patient in particular.

The trust responded quickly to our observations and introduced some new processes to ensure the problem did not reoccur. For example, every patient who had a NEWS score of 5 or above was highlighted in red and staff reminded to carry out regular, hourly observations.

The department had also introduced a PONCHO round every four hours and allocated a specific person to carry out this check. PONCHO stands for Pressure, Observations, Nutrition, Continence, Hydration and Other. The introduction of a formal PONCHO round meant all patients had observations carried out at least every four hours. Sicker patients had more frequent observations carried out.

Staff told us the department was due to start using an electronic observations system in April 2019 which would alert staff when a patient’s repeat observations were due.

Deteriorating patients were managed within the department and transferred to other departments once stable. Staff told us there were occasional delays transferring patients to other departments due to bed capacity within the hospital. However, staff told us they had very good links with departments such as the intensive care unit who came to the department quickly if needed.

Staff were required to record known patient allergies in patient records. This was a mandatory field in the electronic record therefore this was recorded consistently.

The trust provided us with information about specific life support training for adults and children. All staff at all grades and disciplines within the department had undergone some life support training. Clinical staff had undergone life support training appropriate to their grades and responsibilities. We were assured that staff had undergone appropriate life support, paediatric life support and trauma life support as per Royal College of Emergency Medicine (RCEM) guidance.

To assist the department in managing patients with respiratory conditions, the respiratory registrar visited the department on a daily basis. This supported the department and also made sure such patients were seen quickly by a specialist.

**Nurse staffing**

The fill rate for both reporting periods was above 95%. The trust provided us with data for the last financial year April 2017 to March 2018 and for April to September 2018. The file rate at
September 2018 was 99%.

<table>
<thead>
<tr>
<th>Planned staff WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE LFY</th>
<th>Planned staff YTD (Apr- Sep-18)</th>
<th>Actual Staff WTE YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>92.3</td>
<td>90.3</td>
<td>92.3</td>
<td>92.3</td>
<td>97.8%</td>
<td>99%</td>
</tr>
</tbody>
</table>

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

Vacancy rates

From October 2017 to September 2018 nursing staff in urgent and emergency services had a 1% vacancy rate compared to the trust average of 7% there was no target set by the trust for vacancy rates.

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

Staff we spoke with told us the adult and children’s departments were fully staffed. They expressed no concerns about staffing level however the consensus was that more staff would always be welcome.

The paediatric department was solely staffed by registered sick children’s nurses (RSCNs) and there was RSCN cover 24 hours a day, seven days a week.

Nurse staffing was regularly reviewed to ensure peaks of activity in the department were appropriately staffed.

Turnover rates

From October 2017 to September 2018 nursing staff in urgent and emergency services had a 4% turnover rate compared to the trust target of 8%.

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

Sickness rates

From October 2017 to September 2018 nursing staff in urgent and emergency services had a 3% sickness rate which met the trust target of 3%.

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

Bank and agency staff usage

From October 2017 to September 2018 substantive nursing staff covered 98% of hours available for this core service, 1% was covered by bank and 1% were unfilled. The department did not use agency staff.

Bank staff cover was usually provided by staff from the department thus ensuring staff could easily navigate the department.

<table>
<thead>
<tr>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Qualified nursing staff for urgent and emergency care</td>
<td>180,539</td>
<td>1,022</td>
<td>1%</td>
</tr>
<tr>
<td>Trust total - Qualified</td>
<td>6,530,050</td>
<td>139,878</td>
<td>2%</td>
</tr>
</tbody>
</table>

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

Medical staffing

The fill rate for both reporting periods was below 90%. The trust provided us with data for the last financial year April 2017 to March 2018 and for April to September 2018. The fill rate at September 2018 was 88.9%.
Doctors staffed the department 24 hours per day seven days a week. There was consultant cover from 8am to midnight with a resident consultant on call 24 hours every day. This met the Royal College of Emergency Medicine standard of consultant cover 16 hours each day. Doctors of all grades told us that consultants stayed as long as needed and staff told us consultants frequently worked beyond midnight depending upon the acuity of patients and how busy the department was. Consultants were present in the department for major traumas.

Consultants were flexible and when the department was busy or had very seriously ill patients, consultants often worked beyond their designated hours to support patients and staff even when they were not on call.

The paediatric ED had sub-specialty consultants and trainee doctors trained in paediatric emergency medicine. This meant staff in the paediatric ED were supported by paediatric trained doctors.

We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process. It was efficient and effective.

The trust reported to us that medical staff were fully up to date with revalidation requirements.

**Vacancy rates**

From October 2017 to September 2018 medical and dental staff in urgent and emergency services had a 16% vacancy rate, there was no target set by the trust for vacancy rates. The management team were aware of the vacancies and has introduced a number of initiatives to encourage new staff such as introducing research posts and CESR (certificate of eligibility for specialist registration).

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

**Turnover rates**

From October 2017 to September 2018 medical and dental staff in urgent and emergency services had a 10% turnover rate compared to the trust target of 8%. This included junior doctors rotating to new specialties.

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

**Sickness rates**

From October 2017 to September 2018 medical and dental staff in urgent and emergency services had a 1% sickness rate compared to the trust average of 3%.

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

**Bank and locum staff usage**

From October 2017 to September 2018 substantive medical staff covered 98% of hours available for this core service, 2% was covered by bank staff when needed.
Staffing skill mix

From July 2018 to 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 44 whole time equivalent staff working in urgent and emergency care at The Newcastle upon Tyne Hospitals NHS Foundation Trust.

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>7%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group</td>
<td>36%</td>
<td>32%</td>
</tr>
<tr>
<td>Junior</td>
<td>20%</td>
<td>24%</td>
</tr>
</tbody>
</table>

^ 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 department used a combination of paper and electronic records. Information recorded on paper records was scanned on to the system and added to the patient’s record. Scanned records could be accessed easily through the system.

We looked at 28 records, 16 for adults and 12 for children. Records contained sufficient information to ensure patients received care and treatment that met their needs.

The department was preparing to move to fully electronic records including electronic observations. Once implemented this would deliver a robust system for ensuring patients have observations carried out in a timely way.

We had no concerns about the standard of patient records. Records contained information such as risk assessments a number of mandatory fields for staff to complete. This made sure vital information was always captured.

Most records contained information about comfort rounds (regular checks with patients to ask if they need assistance to the toilet, provide them with a drink or snack or make sure they are generally comfortable, not in pain or in need of assistance). The department called these PONCHO rounds. We saw staff regularly carry out these checks during our inspection.
The electronic system also had other functions such as when patients had been referred for diagnostic tests or when the results had been returned. The named nurse and treating doctor were also easily identifiable from the patient record.

We looked at the standard of other records kept in the department such as cleaning logs, medication fridge checks and resuscitation trolley checks. We found that these were consistently completed.

**Medicines**

Within the adults ED, medicines were secured safely and only authorised staff could gain access.

Controlled drugs were stored securely and administration was appropriately recorded. We saw evidence of stock checks taking place as per the trust’s medicine policy.

Medicines requiring refrigeration where stored appropriately and there was evidence of action taken when the recommended temperature had been exceeded.

The department kept a stock of blank FP10 prescriptions (a prescription issued whilst in hospital which enables the patient to obtain medicines from an outside pharmacy). Records were kept each time a prescription was issued however the necessary information was not always fully recorded and therefore was not always in line with trust policy. We also found there was no evidence of oversight or audit around the issuing of these prescriptions.

Medicines were secured safely in the paediatric ED and only authorised staff could gain access.

Controlled drugs in the paediatric ED were stored securely and administration was appropriately recorded. We saw evidence of stock checks taking place as per the trust’s medicine policy.

Medicines requiring cold storage were stored in fridges however we found staff did not always follow the trust’s medicine policy in relation to the checking of fridge temperatures.

Within both paediatric and adult EDs, lists of appropriate individuals authorised to administer via patient group directions (legal framework which allows registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients without them having to see a prescriber) could not be provided on the day of inspection however evidence was provided post inspection to confirm staff authorisation.

Some nursing staff were independent nurse prescribers. This meant they had been assessed as competent to prescribe medication to individual patients outside of the PGDs.

Medical gasses were stored safely.

**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 November 2017 to October 2018, the trust had one incident classified as never events for urgent and emergency care. The trust provided us with a copy of the root cause analysis (RCA) carried out after the incident. It was clear the department had acted very quickly and
implemented urgent actions to ensure there was no opportunity for the incident to happen again. Additionally, when another hospital had a similar incident, the department shared their lessons learned to support learning at that hospital too.

Because of the never event, staff were involved in discussions about how to ensure the same error did not reoccur and the clinical director and matron held open door reflection sessions staff could attend if they wished to.

The trust had undergone a peer review of all Never Events, as a way of highlighting areas of practice than needed to be changed and had changed processes to mitigate against human errors such as changing stoppers on bottles of medication to make sure the medication could not be administered via the wrong route.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS

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

- Treatment delay meeting SI criteria – two incidents
- Apparent/actual/suspected self-inflicted harm meeting SI criteria – one incident
- Sub-optimal care of deteriorating patient meeting SI criteria – one incident

(Source: NHS Improvement - STEIS)

The department produced a lessons learned booklet for new staff joining the department to help them learn from past errors and ensure they did not make similar mistakes. This meant new staff also had awareness of previous incidents and showed the department had a proactive approach to managing incidents.

Staff told us they were encouraged to report incidents and near misses to ensure all staff learned from events and future patients were protected from the risk of harm.

Staff told us patient safety was at the forefront of the way the department operated and staff told us reporting of incidents and near misses was seen as a positive approach to ensuring patient safety was paramount in the department.

The department sent us information about the number, type and seriousness of incidents reported in the department. There were three incidents classified as major harm, six classified as moderate harm, 126 classified as minor harm and 584 classified as no harm/near miss. Of the total incidents, 487 related to pressure damage, pressure ulcers or moisture lesions noted on patients at the time of admission. After pressure damage, the most common type of incidents reported related to Access, admission and transfer and Clinical Assessment.

All the staff we spoke with, medical, nursing and administrative told us reporting incidents was encouraged and that incidents and near misses were used in a very positive way. All staff felt that there was a learning culture in the department, not a blame culture. This made staff feel safe to report incidents without fear of unfair repercussions.

Incidents were regularly discussed with staff at team meetings and handovers to make sure staff were presented with learning opportunities as quickly as possible.

From what we saw and staff told us, patient safety was the priority in the department and all staff were encouraged and supported to actively improve patient safety whenever there was an opportunity to do so.
When we asked staff if they could tell us about a serious incident in the department, they all gave us examples and described the processes that took place after the event.

All the staff we spoke with could describe to us what Duty of Candour meant and could give us an example of when this had been used.

### Is the service effective?

**Evidence-based care and treatment**

There was a wide range of departmental policies and guidelines for the treatment of both children and adults. We randomly checked policies to ensure they were in date and contained the most up to date best practice guidance.

Departmental policies were based upon the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. We looked at a reference tool available to staff and found that guidelines reflected recent updates to NICE guidance.

The trust had a process in place to review, assess and implement new guidance, publish it in a timely manner and then carry out clinical audit to review implementation. This process was supported by a trust wide team and led within the department by a clinical lead.

We saw there were pathways in place that followed NICE guidance for a number of conditions such as sepsis, head injury, fractured neck of femur (hip) and stroke. Where patients presented to the emergency department with these conditions, pathways were commenced.

The department had a CQUIN (Commissioning for quality and innovation) relating to sepsis. This showed the department was meeting the target for patients receiving antibiotics within one hour and meeting the target for sepsis screening within ED. Sepsis screening had been included in the electronic record.

Care was provided in line with ‘Clinical Standards for Emergency Departments’ guidelines and there were audits in place to ensure compliance.

Local audit activity demonstrated that audit and re-audit took place in the department, and there was evidence of changes implemented as a result. These included changes to documentation and to systems to support staff to follow guidance and best practice.

**Nutrition and hydration**

**Emergency Department Survey 2016**

CQC’s national A&E survey 2014 showed that the trust performed ‘about the same’ as other similar trusts for the ability of patients to access food and drinks whilst in the ED Department. In the CQC Emergency Department Survey 2016, the trust scored 7.9 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was better than other trusts and an improvement on the result from the previous survey in 2014.

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

Staff told us that sandwiches, hot meals and beverages were available to patients. We overheard staff asking patients if they wanted drinks or snacks and we saw patients being offered drinks and
being brought hot and cold meals. The housekeeper circulated the department periodically to offer patients drinks and snacks.

We saw relatives being offered drinks and there were vending machines present in the department that relatives and carers could access and the hospital had a number of shops, cafes and places to eat.

Patients who were receiving intravenous fluids had fluid balance charts in place. These were monitored and input and output were recorded correctly.

**Pain relief**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6 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 7.7 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.

Although not directly comparable because the questions were worded differently, the results above showed an improvement on the results in the 2014 survey related to pain relief where the department scored worse than the national average for the length of time patients waited for pain relief.

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

We looked at the records of 28 patients, 16 adults and 12 children. All of the children’s records showed a recorded pain score and 15 of 16 adult records had a pain score recorded.

When pain medication was needed, the records showed this was given to all patients.

There was a flow chart of pain management for staff to refer to, to help them manage a patient’s pain levels.

Patient pain levels were discussed at the handover and board rounds attended by both medical and nursing staff.

When patients were on a treatment pathway, such as for a fractured neck of femur or were receiving sedation, pain was regularly monitored and documented.

Patients we spoke with during our inspection told us staff asked them if they needed pain relief and checked later to make sure their need hadn’t changed. All patients told us they had received pain medication if required in a timely manner.

There were patient group directions (PGDs) in place so nursing staff could give specific pain medication to patients without the need of a doctor of nurse prescriber to write a prescription.

Both the streaming nurse at reception and the triage nurse could administer pain relief to patients and we observed staff doing this during our inspection.

**Patient outcomes**
In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Royal Victoria Infirmary emergency department failed to meet all of the national standards.

The department was in the lower UK quartile for three standards:
• Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 47.9%; UK: 77%.
• Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
    o Standard 5a (fundamental): within 60 minutes of arrival (acute severe). This department: 4.6%; UK: 19%.
    o Standard 5b (fundamental): within 4 hours (moderate). This department: 7.6%; UK: 28%.

The department was in the middle 50% for four standards:
• Standard 1a (fundamental): O₂ should be given on arrival to maintain sats 94-98%. This department: 17.8%; UK: 19%.
• Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 28.7%; UK: 26%.
• Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 22.8%; UK: 25%.
• Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

This department: 47.6%; UK: 52%.
(Source: Royal College of Emergency Medicine)

In the 2016/17 Consultant sign-off audit, Royal Victoria Infirmary emergency department failed to meet all the national standards.

The department’s results for one standard which was in the upper UK quartiles.

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 20.8%; England: 11%.

The department’s results for two standards which were between the upper and lower UK quartiles.

  This department: 16%; UK: 8%.

- 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: 16%; UK: 12%.

The department’s results for standard which was in the lower UK quartiles.

- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 4%; UK: 10%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 Severe sepsis and septic shock audit, Royal Victoria Infirmary emergency department met five out of eight national standards.

The department’s results for one standard which was in the lower UK quartile.

- Standard 1: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 40%; UK: 69.1%.

The department’s results for six standards between the upper and lower UK quartiles.

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 70%; UK: 64.6%.

- Standard 3: O₂ was initiated to maintain SaO₂>94% (unless there is a documented reason not to) within one hour of arrival. This department: 33.7%; UK: 30.4%.

- Standard 4: Serum lactate measured within one hour of arrival. This department: 48%; UK: 60%

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 51%; UK: 44.9%.

- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 39.8%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 33%; UK: 44.4%.

The department’s results for one standard which was in the upper UK quartile.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 56.6%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

We discussed the RCEM audit results with the clinical lead for clinical audit within the
department. They could provide us with detailed information about how the department had addressed the RCEM results such as by implementing new record keeping systems to ensure all information was accurately captured, delivering training and support to staff and ensuring systems supported staff to be able to deliver treatment in line with RCEM standards. They were also able to detail the plans they had to amend systems such as the electronic record to ensure staff could enter important information and prompted to do so.

The department had undertaken re-audit to measure compliance against the RCEM standards and provided us with evidence that compliance had improved in each of the RCEM audits detailed above. Continual re-audit was scheduled to ensure the clinical audit cycle continued to provide evidence and assurance of compliance against RCEM standards.

We looked at the re-audit of the RCEM audit for Moderate and acute severe asthma. The department’s results had improved significantly and were better than the national average in all but three indicators. They had also improved significantly against their results of 2016/17 in all but one indicator. Where the department was worse than the national average, the responsible auditing clinician had examined the indicator and patient records to find our why this was the case.

The department sent us the results of their re-audit of Consultant sign off. There had been two re-audits, one in 2018 and one in January 2019. The department was performing better than the national average for all but one indicator where a nil return was recorded due to very low sample numbers. The re-audit showed a continued improvement in compliance.

The department demonstrated continued use of the clinical audit cycle to promote improved compliance to national guidance and provide evidence that patients received evidence based care that reflected national guidelines.

The department had increased clinical audit activity over the past two years and had a comprehensive programme of clinical audit in place to monitor compliance against evidence based care.

The department produced a dashboard of performance against Trauma Audit and Research Network (TARN) standards that benchmarked the department nationally against other major trauma centres. The dashboard showed the department performed better than the national average in eight of the 12 measures and only slightly worse in four of the measures. The department had also been identified as one of only five major trauma centres to have a higher number of survivors than the England average.

Unplanned re-attendance rate within seven days

From October 2017 to September 2018 the trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average. In the latest month September 2018, trust performance was 11% compared to an England average of 8.5%.

Unplanned re-attendance rate within seven days - The Newcastle upon Tyne Hospitals NHS Foundation Trust

![Graph showing comparison of This Trust, England Avg., and Standard](image-url)
We discussed unplanned reattendances with senior staff within the department. The department had many initiatives in place to try to identify why patients reattended within seven days. The department had identified groups of patients who regularly reattended the department such as substance misuse and overdose patients.

The department had a CQUIN (Commissioning for Quality and Innovation) in place to reduce the frequency of attendance of patients with a mental health illness. A group of patients who attended frequently (more than 10 times a year) was identified. The department worked with the local ambulance trust, mental health trust, social care providers and patients to prepare care plans and put support in place to reduce the number of times the cohort of patients attended. Results from the first 12 months showed a reduction of almost 80% for the cohort of patients. Due to the success of the initiative, it has been continued for a further year with an additional cohort of patients. Results so far have shown an equal degree of success this year.

**Competent staff**

All new staff were allocated a buddy. The department had decided not to employ newly qualified nurses. Therefore, nurses who joined the department had to have been registered for at least 12 months.

Nurses new to the department had a four week supernumerary period where they shadowed an experienced member of staff and became orientated to the department.

When new staff joined the department they received a comprehensive induction. The induction programme included checking of competencies, such as, for airways, breathing, ventilation and oxygenation and familiarisation and competencies of new equipment. Staff reported the induction to the department was useful because there were items of equipment that they would otherwise have been unfamiliar with.

The department had clinical educators and hosted monthly teaching sessions where specific topics such as equipment, medical conditions or treatments were discussed. This ensured staff from all disciplines were up to date with new developments or techniques. All staff held medical device competency booklets and we saw these during our inspection. This provided demonstrable evidence that staff were competent to use equipment.

The department carried out simulation training for staff to ensure they could work confidently in unknown scenarios. This was a learning exercise but also gave staff confidence in real life
situations. We observed the impact these simulations had when we observed a major trauma brought in to the department.

Staff in the department spoke about additional competency training they had done over and above their mandatory training such as by attending clinical skills courses, or by undertaking paediatric immediate life support training. Other staff had taken on additional roles, such as training to become nurse practitioners.

Staff were competent in identifying vulnerable patients and referring them for specialist advice, such as from the psychiatric liaison team.

Staff received clinical supervision, and this was recorded in their individual clinical competencies books. We saw evidence of this during the inspection.

Senior staff told us that informal monitoring of the competency of staff was undertaken within the department and any concerns were addressed quickly with the staff involved.

### Appraisal rates

The trust provided us with appraisal rates for urgent and emergency care for the April to September 2018, two staffing groups met the 90% target set for the period covering up to March 2019.

We discussed this with staff in the department and managers told us there were plans in place to ensure all staff had undergone appraisal before the end of March 2019.

Whereas the appraisal target for March 2018 was 80% this core service narrowly missed the target with a completion rate of 78%.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Staff Required Year to Date</th>
<th>Staff Received An Appraisal - Year to Date</th>
<th>% Of Staff Received An Appraisal YTD</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>90</td>
<td>82</td>
<td>91%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>50</td>
<td>45</td>
<td>90%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>19</td>
<td>13</td>
<td>68%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>4</td>
<td>1</td>
<td>25%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>1</td>
<td>0%</td>
<td>90%</td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The department had a digital messaging service where staff could post when they wanted to update their competencies to ask colleagues to included them in any treatment which would support their competencies.

Medical staff received a comprehensive induction to the department. Prior to starting in their role, they received an induction pack including a booklet detailing competencies, a department handbook containing information about patient pathways and a patient safety document that contained information about previous patient safety incidents and advice about how to avoid making similar errors. Medical staff we spoke with told us this supported them to join the department and feel more competent in their role even after they had just started.
The lead consultant in the department took responsibility for monitoring the competencies and training needs of junior and trainee staff and made sure each member of staff received competency training to meet their needs. All medical staff were encouraged to hold their own portfolio and identify any additional training they needed for them to feel confident as well as competent in their role.

Junior staff we spoke with told us they were never asked to deal with anything they did not feel competent to do, unsupported. They told us there were always helpful more senior staff to refer to for advice and support.

Security staff raised some concerns to us about their role. They told us that sometimes they did not feel confident dealing with patients with a mental health condition or skilled enough to protect patients from harm. We spoke with the management team about this. They told us the hospital was already working with the local Mental Health Trust to design a training package for security staff to assist them in supporting patients living with mental health conditions. The trust also provided us with information about the training security staff had to undertake to work in the department. This included restraint, bribery and corruption, falls prevention, equality and diversity, conflict resolution, dementia, harassment and bullying and safeguarding vulnerable adults and children.

**Multidisciplinary working**

During our inspection we observed the management of a major trauma brought in to the department. We observed the handover from the medical team who accompanied the patient and saw this was succinct, precise and effective. We also observed teams from other departments such as anaesthetics and surgery attend the department in preparation for the arrival of the patient. Each member of staff from the different departments knew exactly their role in the patient’s immediate assessment, care and treatment. The operating theatres and scanning departments were ready to receive the patient as soon as they could go to the departments. The process was seamless and well-rehearsed to ensure the patient received the quickest, most efficient and effective handover possible.

As part of the incident, we also saw staff working with the patient’s family and other emergency services to ensure the wellbeing of all concerned. Staff cooperated with emergency services and demonstrated good interorganisational working.

We found emergency department teams worked effectively with other specialty teams such as orthopaedics, medicine and surgery within the trust and discussed patients and sought advice before making joint decisions about whether and where patients should be admitted.

There were close links with the ambulatory care department and the assessment suite and there were regular meeting throughout the day to discuss patients, demand and capacity.

There was quick access to mental health clinicians with 24-hour cover. The psychiatric liaison team were based within the department available to support staff as required.

There was a substance and alcohol misuse liaison team available by telephone to support patients’ families and staff treating them.

Staff worked closely with allied health professionals such as radiographers, occupational therapists and physiotherapists. The frailty team visited the department regularly to see patients who needed assessment and therapy input to assist their discharge. When patients needed support at home, the department liaised with other agencies to facilitate this.
The department had good links with the local authority and worked closely with social workers, mental health teams, GPs and emergency services to support patients who attended the department regularly to ensure they were receiving the most appropriate support in the community to help them avoid needing to attend the ED.

During our inspection, we saw a community nurse attend the department to liaise with staff about patients and ensure community support was in place for patients after discharge.

We saw medical and nursing staff work well together and communicate clearly and effectively about patients to ensure patients received the care and treatment they needed in a timely manner.

**Health promotion**

The drug and alcohol dependency team regularly visited the department to support patients who had attended and who might benefit from their services so supporting better health by helping people to stop using drugs and alcohol.

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.

We saw posters displayed in the department around health promotion, so patients were supported and encouraged to manage their own health. For example, there were posters around smoking cessation, weight loss and leading a healthier life which advertised guided parent/child sessions which patients could sign up to.

Staff identified both patients and their families who could benefit from additional support and promoted good mental health for relatives and carers.

When staff identified patients with particular problems such alcohol or drug abuse, they could refer a patient directly to a specialist service provided in Newcastle by the local mental health trust.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 95% for completion of mental capacity act training.

**Trust level**

A breakdown of compliance for MCA training courses as of September 2018 at trust level for staff in urgent and emergency care is shown below:

**Nursing and midwifery staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>101</td>
<td>98</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>101</td>
<td>98</td>
<td>97%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing and midwifery staff exceeded the trusts 95% completion target for both safeguarding modules.

**Medical and dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>45</td>
<td>37</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>45</td>
<td>37</td>
<td>82%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Medical and dental staff failed to meet the trusts 95% completion target for both safeguarding modules. For the last financial year (April 2017 to March 2018) the medical and dental staff did not meet the 95% target with an overall training completion rate of 88%. Compliance to training had improved significantly since our previous inspection when only 13% of medical staff and 53% of nursing staff had completed mental capacity act training.

We spoke with management staff about mandatory training and they told us there was a programme of training in place to ensure all staff completed their training by 31st March 2019.

(Source: Routine Provider Information Request (RPIR) P38 - Training)

All the staff we spoke with were aware of the principles of capacity and described to us the action they would take if they had concerns about the capacity of a patient. All staff were clear that all patients are assumed to have capacity unless they display behaviour to suggest the contrary.

Nursing staff told us they would highlight any concerns about capacity to the medical staff who took a lead in capacity assessments.

Medical staff described how they assessed a patient’s capacity to make decision using a two-stage process.

Staff we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us that they implied consent when the patient agreed to a procedure and we saw evidence of staff explaining procedures to patients and patients agreeing to them.

We saw staff use their knowledge about the Mental Health Act and actions to take if patients needed to be detained under the Act.

Staff in the paediatric department were clear about their responsibilities relating to children and young people and could explain their understanding of Fraser guidelines and Gillick principles in relation to consent and parental involvement.

Patients were offered chaperones for examinations to help them feel less vulnerable.

**Is the service caring?**

**Compassionate care**

**Friends and Family test performance**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently better than the England average from September 2017 to August 2018.

**A&E Friends and Family Test performance - The Newcastle upon Tyne Hospitals NHS Foundation Trust**
During the inspection we spoke with 32 patients and their relatives and carers and we observed the way staff and patients interacted within the department.

Patient and relatives consistently told us staff were kind and compassionate. None of the people we spoke with had anything negative to say about staff care and compassion.

We observed staff smiling and making eye contact with patient during our inspection. Patients and relatives who had visited the department previously told us staff always smiled and made eye contact.

Staff respected people’s dignity and cubicle doors were closed when care and treatment was being given. Patients described to us how staff treated them with respect and our observations corroborated this.

When we discussed care of patients with staff, there was a consistent message that staff wanted the patients to feel safe and cared for. Staff in both adult and paediatric ED were dedicated to looking after patients throughout their ED journey.

Staff took in to consideration people’s emotional needs as well as their physical needs even when patients attended with a physical problem. Staff had a holistic approach to caring for patients and their families.

In the patient led assessment of the care environment survey undertaken in April 2018, the trust scored 89% for privacy, dignity and wellbeing. There were no figures specifically for the emergency department at the Royal Victoria Infirmary (RVI).

During our time in the department, we saw patients being treated with dignity and respect. Staff were conscious of the religious and cultural needs of patients and made sure they were respected whilst delivering their medical care. When patients expressed a preference for a particular gender of nurse of doctor, this was accommodated whenever possible.
The department kept a stock of clothes which those in need, such as the homeless were offered. If patients came to the department in soiled clothes, staff offered the patient alternative clothing rather than just a hospital gown. This helped people to maintain their dignity and feel less self-conscious.

Staff were busy however they took the time to deliver care that was compassionate, and we saw patients being treated with patience and kindness at all times from all members of staff at all levels.

The department received consistently good feedback. We saw ‘Thank You’ cards from relatives of patients who had died in the department. Staff were thanked for the care and compassion they had demonstrated towards the patients and the families.

The organisation used a system called greatix to record positive feedback between colleagues. We saw evidence of greatix nominations for ED staff from other departments, commending them for their professional and compassionate behaviours toward both staff and patients.

The trust also had personal touch awards for staff nominated by members of the public. We saw examples of staff from the ED being nominated for personal touch awards by members of the public.

The department had received more than double the number of compliments than complaints and provided us with evidence of these compliments during the inspection.

**Emotional support**

Staff told us about how they would support patients who were distressed, by spending time with them to try and distract them until family members attended. We saw examples of this during our inspection with patients who were confused or frightened. Staff reassured them, spent time with them and stayed with them until they felt reassured.

Staff told us when the department was busy it was more difficult to spend time with patients however we visited the department during a busy time and saw staff going out of their way to make sure that no matter how busy the department was, patients and families received the emotional support they needed. We saw this in action when the relative of a major trauma patient was comforted and supported by staff who explained exactly what was happening to their loved one.

We observed all staff talking with patients and relatives in a calm way and offering reassurance to both concerned patients and their family members.

Staff offered support and gave information about support services available to both patients and families if this was required.

We saw staff offering emotional support to patient families and staff told us they always considered the family and carers’ support needs. We witnessed an example of this as staff referred a close relative to counselling services, offered them advice about how best to support their relative and signposted them to services who could support them as a carer as well as their loved one.

Staff told us they always considered family and carer needs and could identify when people needed support themselves to be able to be a carer for a patient. Staff gave us examples such as families of patients with drug and alcohol dependencies, living with dementia and mental health needs. Staff recognised that the wellbeing of carers impacted on the wellbeing of patients.
Staff told us, some patients who left pets alone at home often became anxious about their pets, particularly if they lived alone. In some circumstances, the staff could contact the chaplaincy who could organise care for pets.

Staff had undergone training about organ donation and having difficult conversations with patients and relatives at end of life so could offer support in difficult situations.

There was pastoral support available for patients of any or no religious belief.

Understanding and involvement of patients and those close to them

Emergency Department Survey 2016

The trust scored about the same for 23 out of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored better than other trusts for one question.

Q10. Were you told how long you would have to wait to be examined? Score: 4.7

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

We saw patients being given information and supported to make decisions about the treatment they would like to receive.

Parents told us that both they and their children were involved in discussions about treatment options particularly when the children had injuries.

During our inspection, we witnessed excellent interactions with patients. Staff took time to reassure patients and explain to them why they were waiting or what the next stage of their treatment or care was. This supported patients to make decisions about their treatment. Patients’ and relatives’ emotional and social needs were considered by staff. When we spoke with patients and relatives, they confirmed this.

Staff recognised when relatives and carers also needed support and signposted them to support services such as counselling services, support groups and social services.

Staff made sure information they gave was in language the patient and their family could understand without complicated medical terminology. Staff gave patients and relatives the chance to ask questions and time to think before making any decisions. Patients and relatives were very positive about how information was presented to them.

Overall, patients told us staff responded compassionately when people needed help and supported them to meet their personal needs as and when required.

Staff helped people and those close to them to cope emotionally with their care and treatment.

Relatives we spoke with told us they felt included in the care of their loved one. Patients also told us their relatives were included in their care and treatment process as much as they wanted them to be.

Is the service responsive?

Service delivery to meet the needs of local people
Patients who attended the RVI were briefly assessed and directed to the most appropriate area to deal with their condition. There were pathways in place so patients with certain conditions or letters from GPs could access services quickly.

This configuration of services took place with the support of the local Clinical Commissioning Groups and local stakeholders.

The RVI ED was a major trauma centre. The department was staffed by consultants between 24 hours every day. The department was exceeding the RCEM ‘rule of thumb’ recommendations for consultant cover of 16 hours each day.

All staff told us that consultants often worked beyond their contracted hours when the department was busy. Additionally, the department always had experienced staff present on site overnight should they be needed.

At the time of the inspection, the RVI accepted a wide range of patients including those suffering stroke, trauma, cardiac arrest, surgical emergencies and obstetrics and gynaecology emergencies. The department had the facilities and expertise to see all types of patient brought in either by land, or air ambulance.

The department had acknowledged the mental health needs of the local population. Patients had access to mental health support services on site via the psychiatric liaison team and the children and adolescent mental health services (CAMHS) team, provided in partnership with the local mental health trust.

The hospital had a team of staff dedicated to supporting patients who had additional care needs, to ensure patients were only admitted to hospital if their health required so and to assist patients in accessing equipment and social care.

There was a large co-located paediatric ED therefore the hospital accepted babies, children and young people. The department worked very closely with the children’s wards and the paediatrics team to look after children who were unwell. In the case of a child needing to be in the resuscitation department, the department had a dedicated paediatric resuscitation bay within the main resuscitation department.

The paediatric unit was adjoining the paediatric assessment unit of the Great North Children’s’ Hospital and therefore any children who needed additional support could access the unit quickly and easily. Some children had paediatric passports and could bypass ED and directly access the children’s wards.

All staff were aware of the type of patients who attended the department and the potential incidents that could occur locally. Managers ensured that the department had the necessary equipment and trained staff to manage such situations.

There were robust plans in place to manage major incidents and the department was equipped to receive patients with suspected highly contagious conditions such as Ebola. It was one of only two in England equipped and designated to do so.

The department took note of local events such as football matches and events at the local racecourse and made sure there were sufficient experienced staff in the department to manage patients who arise from such events.

Meeting people’s individual needs
Emergency Department Survey 2016
The trust scored about the same as other trusts for the three questions in the emergency department survey relating to the caring domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

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

The waiting rooms for adults and children could accommodate wheelchairs and mobility aids and there were dedicated disabled toilets available in both areas.

There were facilities, such as chairs and wheelchairs, for bariatric patients and some trolleys were designed for larger patients. Specialist bariatric equipment such as hospital beds were stored as part of the trust’s equipment library and could be requested when needed. Staff told us they had no problems accessing specialist equipment.

There were vending machines present in the department that relatives and carers could access, and the hospital had many shops and places to purchase food close by.

There were private breast-feeding facilities available to allow privacy if mother preferred although they were also supported by staff should they choose to breastfeed their baby in public areas within the department.

The trust had access to interpreting services for people whose first language was not English. Staff we spoke with told us interpreting services were available if required via telephone. Staff were aware of how to access telephone interpreters.

The department had produced many leaflets associated with patient pathways such as head injuries. We noted leaflets were in English however when we asked staff if they were available in other languages or formats such as large print or Braille, all staff told us they were. They also said they would go through any leaflets with the patient to make sure they fully understood about aftercare and what to do if they started to deteriorate before the patient left the department.

The department had access to sign language interpreters and video interpreting for people living with hearing impairment. The department had hearing aid loops in place too.

There were private and quiet areas for relatives to wait whilst patients were being treated and there were relatives’ rooms within the department. These were functional however, did feel clinical and cold.

When a patient passed away, they were moved to a viewing room so that family could have privacy to visit. The relatives’ room was next door to the viewing room and relatives could spend as much uninterrupted time with their loved one as they wished.

The department had bereavement boxes for adults and children and a special pack for children who had lost a parent or sibling. There was information, advice, keepsakes and handprint and footprint kits for children.

Staff were aware of the cultural and religious differences within the community and when patients passed away. They were sensitive to the needs of the family and the community in those
circumstances and understood what was required. There was access to chaplaincy services for patients and relatives of different faiths or none.

The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals and would try to involve family and carers in discussions about care needs.

The department had a dementia friendly room decorated with bright colours and easy to read clock. There were distraction items available and a music player to soothe patients.

Staff we spoke with told us that whenever possible, people living with dementia or a learning disability were seen as quickly as possible to minimise distress for the patient.

Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.

Patients with purely mental health needs waited in the mental health rooms or a quiet area. These rooms had been risk assessed and met specific required criteria such as no ligature points, two exits and furniture heavy enough not to be used as a weapon. Each patient was risk assessed to make sure they were placed in a room that met their needs and reduced the risk of them harming themselves.

Staff in the department had access to 24/7 psychiatric liaison support or child and adolescent mental health services (CAHMS) with a quick response time. Any patients who presented with a mental health condition were referred to one of these teams.

Staff told us that they had been trained to deal with violence and aggression. Security staff were based in the department and were a visual deterrent as well as a physical resource to support staff if patients became violent, aggressive or unsettled.

The department had a specific team who carried out a comprehensive assessment of frail or elderly patients present in the department with a view to carrying out a holistic assessment of their physical, mental and social needs and arranged safe discharge for them. The also carried out post discharge phone calls to vulnerable of frail patients to check in if they had any new assistance needs.

Access and flow

At the time of our inspection, we spoke with senior staff about waiting times. They had introduced a number of measures in an attempt to improve patient waits. This included using streaming to direct patients to the most appropriate care setting, direct access to the emergency ambulatory care unit, direct admission for patients referred by GPs, pathways for Urology, Gynaecology and ENT and chest pain rapid assessment unit. Each of these received different types of patients with the aim of reducing the burden on the department, enabling them to see patients quickly and efficiently in the right place at the right time.

Nursing staff directed patients to the most appropriate area of the department such as the minor injuries unit or the GP. This meant patients saw the most appropriate clinician for their condition and avoided unnecessarily long waits for patients.

When the department was busy, a process called RAT (rapid assessment and treatment) was used. This involved an experienced doctor usually a consultant, a nurse and a health care assistant (HCA) seeing patients and quickly requesting tests and initiating treatment. Although labour intensive, it meant patients did not have long waits for a diagnosis.
The department had a flow coordinator. Their role was extensive and included chasing blood test and x-ray results, informing wards of bed needs, supporting clinical staff by informing them when test results had been received and preparing all documentation for patients who needed to be transferred to another department. Staff told us this role was crucial to helping the flow in the department because it meant they could focus on treating patients and not worrying about the administrative side.

The department was located next to the radiology suite with x-ray and CT facilities. ED urgent and emergency patients were given priority over routine patients attending the department. This meant patients could be x-rayed or scanned quickly. This was particularly important for patients with time critical diagnoses such as stroke as it meant they could be started on treatment quickly thus helping to minimising the impact of their condition.

From our observations and discussions with patients and staff, patients were triaged and assessed quickly. Staff told us patient waits to be seen by specialist staff such as surgeons or from other disciplines and departments were usually short. Staff also told us the department had good links with the intensive care unit and anaesthetists and intensivists came to the department promptly if needed.

The trust held bed capacity meetings at least twice each day. This meant the entire trust was aware of the needs of ED and could prepare for potential admissions. The impact of this was that patients did not have long waits in the ED before being moved to a ward.

The director of nursing spoke with the matron to discuss performance, bed availability and flow every day. This was to identify any blockages in the system and work towards removing them. Minutes from the monthly operational meeting showed access and flow through the ED were a high priority for the executive management team at the trust.

During our inspection we did not witness any patients waiting long periods of time in the department to be moved to a bed on a ward.

The department was working hard to reduce the risks for patients who had long waits such as by moving patients from trolleys to hospital beds and using pressure relieving equipment for patients who were a high risk of developing pressure ulcers. The fact that no patients had waited more than 12 hours for a bed also assisted this.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour.

Although the trust performance followed the national trend, the median time to treatment was better than the England average and standard from October 2017 to September 2018. In the latest month September 2018, the median time to treatment was 38 minutes compared to the England average of 61 minutes.

Patients waited less time in the department for treatment to commence than the England average, consistently from October 2017 to September 2018.

**Median time from arrival to treatment from October 2017 to September 2018 at The Newcastle upon Tyne Hospitals NHS Foundation Trust**
Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From October 2017 to September 2018 the trust performance was similar to the standard and performed better than the England average. This meant patients attending this department were generally seen and discharged more quickly than patients attending other EDs across England.

Four hour target performance - The Newcastle upon Tyne Hospitals NHS Foundation Trust

Percentage of patients waiting more than four hours from the decision to admit until being admitted

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. This meant once a decision had been made by the hospital to admit a patient, a maximum of 9% of patients waited in January 2018 and less than 2% of patients in September 2018 waited more than four hours before being moved to a ward. This was an indicator that flow through the hospital worked efficiently and could respond to demand for beds created by admissions via ED.
Percentage of patients waiting more than four hours from the decision to admit until being admitted - The Newcastle upon Tyne Hospitals NHS Foundation Trust

![Graph](attachment:image)

(Source: NHS England - A&E SitReps).

**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from October 2017 to September 2018, no patients waited more than 12 hours from the decision to admit until being admitted.  

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

This is an indicator that flow throughout the hospital was well managed and could adapt and respond to patient admissions via the ED.

Moving patients to a ward quickly after a decision to admit has been made denotes a better experience for patients than waiting in an ED.

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

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.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen** - The Newcastle upon Tyne Hospitals NHS Foundation Trust
Performance against this metric showed an improvement from October 2017 to December 2017 and then remained steady at less than 1%.

The department performed better than the England average consistently from November 2017 to August 2018.

**Median total time in A&E per patient (all patients)**

From October 2017 to September 2018 the trust’s monthly median total time in A&E for all patients was better than the England average. In the latest month September 2018, the trust’s monthly median total time in A&E for all patients was 100 minutes compared to the England average of 154 minutes.

This meant generally, patients were triaged, treated and discharged more quickly in this department than the England average. Patients’ clinical needs were responded to quickly and patients received the right care at the right time by the right people.

**Median total time in A&E per patient - The Newcastle upon Tyne Hospitals NHS Foundation Trust**

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

**Learning from complaints and concerns**

**Summary of complaints**

Between September 2017 to October 2018 there were 20 complaints about the ED at the RVI. Of these complaints, two were upheld, 14 were not upheld and six were partially upheld. None were
referred to the ombudsman.

The most common themes of complaint were Clinical treatment (15) then attitude of staff (2).

The trust took an average of 69 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed in 20-60 days (up to 60 days for more complex complaints). It was unclear from the information sent to us how many of the complaints had been classified as complex.

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

The department had a robust process to address complaints. Verbal complaints raised in the department were initially managed by staff and escalated to matron as appropriate. The department tried to manage complaints locally and placed an emphasis on local resolution at the agreement of patients.

All written complaints received by the complaints department were shared with the matron and clinical director. All complaints had senior clinician involvement and oversight from ED staff. All written complaints were investigated and reported to the complaints department for formal reply.

The trust preferred to meet with complainants face to face to discuss the outcome of a complaint, as long as this was acceptable to those who had complained. The management team explained to us how this was preferable to sending lots of letters because it gave people the chance to ask supplementary questions. It also made the process more ‘user friendly’ and meant staff could offer support to complainants and explain complicated matters more easily. If, however, complainants preferred not to meet face to face, they were offered a telephone call. Even when there had been a face to face meeting, complainants still received written information for their reference.

Information about complaints and incidents was regularly sent to staff as part of a newsletter produced about lessons learned. The department was proactive in its approach to addressing complaints.

Patients and relatives, we spoke with were aware of how to make a complaint to the trust although none of the people we spoke with had made a complaint about the department.

There was information about how to raise concerns about the department or the trust on display in the department and there were leaflets available for patients to take away with them.

Staff were able to describe to us the action they would take if a patient or relative complained to them.

Staff and managers told us that feedback was given to staff when they were part of a complaint. Additional training was offered as a way of supporting staff when the issue related to clinical care. Staff were encouraged and sometimes required to write a reflective piece about complaints they had been involved in as a way of learning. This was evidenced in the information sent to us by the trust.

Number of compliments made to the trust

The trust sent us a file of information about compliments received by the department. This contained evidence about compliments received from patients, their relatives and staff from other departments.

The trust operated a scheme that allowed colleagues to nominate each other when they witnessed excellent care that went above and beyond.
The file we saw had thank you cards from patients, carers and relatives to staff in the department who had given support through times of grief, distress and anxiety. There were cards from relatives whose loved one had passed away in the department thanking staff for their compassion and from patients who were grateful for the care and treatment they had received.

**Is the service well-led?**

**Leadership**

The adult ED was overseen by a clinical director, matron and operational manager. The paediatric ED shared medical leadership however a separate matron managed the nursing staff. The paediatric matron was aligned to the Great North Children’s Hospital.

We spoke with both matrons. They told us they worked closely together to make sure the department as a whole ran smoothly.

When we spoke with medical staff, they told us the clinical lead had excellent oversight of both the adult and paediatric departments.

The adult ED and paediatric ED both had senior nurses in post to oversee the daily management and requirements of the department. We met with these staff and found them to fully understand the challenges of the department in relation to performance, demand, staffing and risks. They presented a cohesive team committed to the ED and its staff.

Nursing staff we spoke with during the inspection told us that they felt very well-led at all levels and had no concerns with their line managers or senior managers. They told us the management team was visible, approachable and supportive.

Similarly, medical staff told us their leadership was inclusive and provided good direction within the department and strong representation for the department within the wider trust. Leaders were supportive and committed to teaching. Leaders were approachable and visible to all staff and inclusive in their approach to management and leadership.

Staff told us they felt empowered to suggest new ways of working and try new things to improve patient experience or the efficiency of the department. All staff were encouraged and supported to undertake quality improvement projects in the department.

Staff we spoke with told us that senior executives from across the trust visited the department. Staff knew who the chief executive was and could name the director of nursing and medical director. They said they would recognise them if they came to the department.

**Vision and strategy**

The management team had a strong and clear vision for the service and was working with other departments within the hospital as well as local providers and commissioners to ensure that services met the needs of the local populations.

The management team had carried out analysis of the volume and type of patients attending the department and had devised a strategy to ensure patients were seen in the most appropriate area of the department. The strategy included having a GP employed in the department 15 hours each day.
The strategy assessed the strengths and weaknesses in the department and identified actions to move forward and address such weaknesses.

The strategy used a PESTEL (political, economic, social, technological, environmental and legal) approach to assess risks and SWOT (strengths, weaknesses, opportunities and threats) approach to look at solutions.

Through the strategy analysis, managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to manage demand. The management team worked flexibly to look at new and innovative ways of delivering patient care. This was a continued approach demonstrated when we spoke with staff and the management team and from details in the department strategy.

The trust had consulted with local commissioners, stakeholders, staff and patients as well as looking at how other departments delivered their services to develop a model of care suitable for the population of patients who accessed services at RVI ED.

Urgent and emergency care services had been configured to include new models of working with other specialties to manage patients who attended as a major trauma and ensure they received the aftercare they needed on a dedicated trauma ward.

The management team were working closely to ensure the service was sustainable for the future. This included developing new roles such as nurse practitioners who, in the future would be able to work within the junior doctor rota.

**Culture**

There was a culture of delivering safe care in the department and staff were encouraged and supported to report incidents. Incident reporting was embedded in the culture of the department.

Staff we spoke with told us they could report concerns and incidents without fear of reprisals and were confident that when issues were raised, they were dealt with appropriately. Staff felt supported both when they reported incidents and throughout the investigation period of incidents.

If staff made errors, they could report them and were confident they would be supported and managed fairly. Managers told us there was a strong culture of self-reporting within the department and staff we spoke with confirmed this.

We spoke with a number of staff from different disciplines about the culture of the department. All staff described the department as friendly and ‘like a family’. The wider team worked and socialised together and there were very good working relationships.

Health care assistants, junior doctors, and nurses told us senior clinicians were keen to educate colleagues and we saw evidence of this during the inspection. Staff thought there was a very good learning culture and were very comfortable to ask questions to broaden their knowledge.

The atmosphere in the department showed that staff focus was on treating patients in an efficient way however staff also took time to support each other through difficult and stressful times.

The way we saw staff interact with each other demonstrated that there was professional communication between staff from different disciplines. Staff worked together to ensure patients received the best coordinated care they could.

Staff were very committed to the care of patients and we were told of examples when staff had worked extra hours or stayed late to be with a patient.
Staff felt that their hard work was recognised, and they felt appreciated by their colleagues and line managers. One staff member also gave an example of receiving a letter of thanks from the chief executive after dealing with a particularly challenging case.

**Governance**

Nursing and medical staff both had patient safety roles in the department. They were given time away from clinical duties to carry out this work.

The department had governance leads who attended clinical governance, patient safety and mortality and morbidity meetings where information about complaints and incidents was shared. We saw minutes of these meetings and spoke with staff about them. Junior staff were also invited and given the opportunity to present unusual cases to the group for discussion and learning purposes.

Information from committees such as complaints, learning from deaths and learning from incidents was regularly discussed with staff at huddles.

The clinical governance lead produced a regular newsletter for staff to brief them about the latest complaints and incidents and this information was incorporated in to a booklet given to all staff new to the department.

Additional training was arranged for staff when this was identified as an outcome from complaints or incidents.

We were given examples of when this had happened for example in response to the department’s never event.

There was a process in place to ensure all relevant NICE guidance, patient safety and drug alerts were assessed and implemented, and that staff were aware of any changes. A member of clinical staff took the lead however we saw other staff of different disciplines contributing to the knowledge resources such as patient pathways and care bundles.

The introduction of an online library of policies, procedures and guidelines meant staff could access up to date information about care and treatment. There was detailed information about treatment pathways and medicines as well as links to the original guidance source.

There was a process in place for ensuring the results of radiology investigations were followed up to ensure any “missed abnormality” was followed up in a timely manner. This was overseen by a consultant in the department who reviewed all x-rays. Where abnormalities had been missed, staff involved were informed and offered additional support and training.

**Management of risk, issues and performance**

We looked at the minutes of the monthly operational meetings for the last five months. These clearly articulated the risks the department faced and detailed how these would be addressed and who was responsible for actions. This demonstrated how the management team addressed current risks, but also looked to the future to try to pre-empt and new risks the department may face. The management team were proactive in their approach to risk management.

The department also had a risk register. We reviewed the register and found it to be comprehensive with actions clearly allocated to staff. Mitigating factors were detailed and there was a current risk rating and an aspirational risk rating. The register was under regular review to ensure that the content of the register was reflective of the real-time risks within the department.
The risk register was updated regularly and there were details about mitigating actions in place. The staff we spoke with were clear about the risks the department faced and told us they could highlight any risks they identified to their line managers and the senior team.

When we spoke with the management team, they could clearly tell us about the risks posed to the department and how these were being addressed. They were realistic about the challenges in the department but had robust plans in place to address these challenges. Many of these were detailed within the department strategy.

Managers discussed waiting time breaches regularly and carried out daily analysis of information to identify any themes take actions to address issues, such as bed shortages across the hospital. Senior managers throughout the hospital were involved in discussions about patient flow and the executive team placed a high priority on the ED meeting waiting time targets and ensuring patients had the most appropriate treatment as quickly as possible.

The department had a robust process in place to escalate the status of the department if it was under pressure. When the department was under pressure extra support from senior managers and other departments around the hospital was made available.

**Information management**

The department collected information used to monitor and manage performance. There were robust measures in place to monitor and manage the performance of the department against local and national indicators. These were closely observed by the management team and communicate to staff when appropriate.

The department used a number of IT systems to collect and share information such as laboratory tests and x-ray results, admission and discharge times and ambulance handover times as well as patient records. The department was almost paper free and had plans in place to continue the roll out of the electronic patients record. All clinical information was saved on the electronic patient record system used in the department. This included medical and nursing records and patient observations.

Staff could access patient information using an electronic system. This included information such as previous clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. This meant that staff had information about the most up to date medications, health conditions and symptoms to enable them to make a better diagnosis and treatment plan. Ambulance staff could also share patient test results with the staff whilst enroute to the department.

Some information such as test results and discharge letters were shared with GPs with consent and agreement from patients.

Patients transferred to other services or sites took photocopies of their medical records with them. The privacy of patients in the department was protected as screens showing patient information were not visible.

The trust had information governance policies and procedures in place to ensure that information was stored securely and protected patients’ privacy and security.

Staff were aware of their responsibilities in relation to data protection and making sure that information was accurate and managed securely.

Data protection principles were followed.
Information governance including data protection and confidentiality was monitored and any incidents reported appropriately.

During the inspection, we saw that TV screens were present to display public health messages and local news.

**Engagement**

Staff told us they were kept informed about opportunities to progress such as training and promotion opportunities at daily handovers, via emails and through huddles.

The department participated in the friends and family test and CQC surveys and worked with local communities to assess services. For example, a local learning disability group came to the department and described how the department made them feel. The spoke with staff about their experiences. Staff also told us about former patients attending the department to talk about their experiences and the impact their visit to the department had had on them.

Staff told us hearing patients’ stories was powerful and helped them to ensure they continued to deliver care that was compassionate.

Staff from the department had taken part in trust wide engagement exercises such as online surveys. However, there had been no specific engagement work carried out with the department.

Senior staff had an open door policy and encouraged staff to see them if they had any concerns.

**Learning, continuous improvement and innovation**

We asked the trust to tell us about any innovative work they were doing in the department, any learning and any continuous improvement. The trust provided us with examples of the innovative work being carried out by the ED.

The department had introduced a post discharge call system for elderly patients. The service called patients post discharge to find out if they required any further support such as from social care, mental health or community rehabilitation services. The aim was to ensure continued patient safety and also reduce hospital reattendances. The service was part of the overall trust frailty strategy aimed at improving the care of frail elderly patients.

Work was underway in the department to reduce ambulance hand over times. The aim of the project was to ensure patients received a quick handover and could commence assessment and treatment quickly and also ensure ambulance crews were released quickly to they could get back in to service and respond to other patient emergencies.

The department also introduced a new clinical space to carry out rapid assessment of patients brought to the department by ambulance. The area is managed and overseen by one of the consultants in the department and is staffed by nurses and health care assistants. Patients are quickly handed over to the department allowing ambulance crews to be released to attend other emergencies. Patients are quickly assessed and able to commence their treatment journey.

Nursing staff underwent additional training about managing patients with respiratory conditions. Staff from respiratory medicine delivered a training day for ED staff to attend. This training enhanced the skills of nurses in ED and enabled them to deliver better care for patients attending with a respiratory condition.
There were a number of pathways in place for patients to access wards quickly via ED. These included rapid access to ENT, gynaecology, urology and the local, linked urgent care centre. Additionally, there was an emergency ambulatory care assessment area staffed by the ED team where patients with an extensive specified list of conditions were treated.

New and enhanced clinical pathways were in the process of being developed to enable patients to access the ambulatory care unit rather than ED to ensure patients accessed care and treatment quickly and reduce the impact of attendances on the ED.

The department had developed a hotline GP’s could use to call and ask for advice about their patients. This meant patients were not sent to the department inappropriately by GPs.

Every Friday and Saturday night, the department had an IDVA (independent domestic violence advocate) present. They were contracted by the trust and able to support victims of abuse and signpost patients to further support available.

Patients living with dementia were well supported in the department and there was a dementia friendly room that contained distraction tools such as games, and twiddle muffs.

We also saw evidence that the department encouraged clinical research and was involved in a number of research projects.

The department scored highly for medical training and was identified as one of the best places for medical students and junior doctors to study by Health Education England North East.
End of life care

Facts and data about this service

End of life care at this trust was delivered by all clinical staff supported by the senior nurse for specialist palliative care, end of life care, lead clinician and teams of specialist palliative care nurses, consultants, health care assistants and administrative staff. These roles supported all staff to deliver end of life care across the trust (community and acute settings) through education, training, audit, research, documentation, and clinical availability. A core function of this service was monitoring, and reporting on standards of care, and compliance against local, regional, and national guidance. The service actively sought user experience feedback in order to improve care. The trust did not have any inpatient palliative care, or specialist palliative care beds. End of life care was delivered in all acute clinical areas.

The specialist palliative care service offered advice and holistic assessment of patients with complex specialist needs. It consisted of four clinical teams, three in the acute setting based at Freeman Hospital main site, Northern centre for cancer care, Royal Victoria Infirmary (RVI) and a Newcastle community based team. All teams were supported by a Senior Nurse for palliative and end of life care and lead clinician. Each team consisted of nurse specialists, consultants in palliative medicine, Macmillan end of life healthcare assistants and administrative/clerical support staff.

(Source: Acute Provider Information Request – Acute context tab)

The trust had 1,800 deaths from July 2017 to June 2018.

(Source: Hospital Episode Statistics)

This report predominantly focuses on the inspection of services provided by the specialist palliative care medical, nursing and administration team, the mortuary staff and the chaplaincy and bereavement teams.

We inspected the whole core service and looked at all five key questions. In order to make our judgements, we spoke with a total of five patients and 45 staff from different disciplines. We observed daily practice and viewed six sets of records of patients at this hospital. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Is the service safe?

Mandatory training

At our previous inspection in 2016, the Specialist Palliative End of Life Care (SPEoLC) service was meeting the trust target of 95% compliance with mandatory training, with the exception of the chaplaincy team.

At this inspection, information provided by the trust showed compliance for this site had deteriorated, with nursing staff meeting the 95% target in eight of 13 training courses. Staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.

All staff received an introduction to palliative and end of life care at the trust induction session, which included information about the team, how they could be contacted, the five priorities of patient care, and the care of the dying document.
We discussed manual handling training with the mortuary staff. This was done as part of their mandatory training. There were three manual handling facilitators working within the mortuary department who received regular training updates and disseminated information to staff.

**Mandatory training completion rates**

The trust set a target of 95% for completion of mandatory training.

The trust did not provide medical staffing data against this core service.

A breakdown of compliance for mandatory training courses from April 2018 to September 2018 at the trust for qualified nursing & midwifery staff and health visiting staff in end of life services is shown below:

**Trust wide**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Patient Falls</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>19</td>
<td>17</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>19</td>
<td>15</td>
<td>79%</td>
<td>95%</td>
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</tr>
<tr>
<td>Information Governance</td>
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<td>15</td>
<td>79%</td>
<td>95%</td>
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<tr>
<td>Local Induction</td>
<td>4</td>
<td>2</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff failed to meet the trusts 95% completion target for nine out of 13 mandatory training modules; four modules met the 95% target and the lowest scoring module was local induction with 50%.

For the last financial year period of April 2017 to March 2018 nursing staff within end of life services achieved a 98% completion rate for mandatory training against a trust target of 95%.

**Royal Victoria Infirmary**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Patient Falls</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
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<td>2</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>3</td>
<td>2</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>3</td>
<td>1</td>
<td>33%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff at the RVI Hospital achieved 100% completion for eight out of 13 mandatory training modules; the lowest scoring module was infection prevention control was 33%.

For the last financial year period of April 2017 to March 2018 nursing staff within end of life services at the RVI Hospital achieved a 98% completion rate for mandatory training against a trust target of 95%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Bereavement, chaplaincy and mortuary staff were meeting the trust’s 95% completion target in three of 13 modules. This data was not available by site as all staff worked across both sites.

**Safeguarding**

We spoke with specialist palliative care nurses who were able to clearly explain their responsibilities in relation to safeguarding patients. They were able to share examples of when they had needed to submit safeguarding concerns for patients in their care. They told us that they had not experienced any difficulties in obtaining advice, and that this was available 24 hours a day.

Monthly SPEoLC multidisciplinary meetings were attended by safeguarding team members.

We discussed safeguarding with ward staff caring for patients approaching the end of their life, and they could outline their responsibilities in relation to safeguarding patients and gave examples of recent practice. We saw contact details for safeguarding teams clearly displayed in ward areas.

The trust set a target of 95% for completion of safeguarding training.

The trust did not provide medical staffing data against this core service.

A breakdown of compliance for safeguarding training courses from April 2018 to September 2018 at the trust for qualified nursing & midwifery staff and health visiting staff in end of life services is shown below:

**Trust wide**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>19</td>
<td>18</td>
<td>95%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>19</td>
<td>16</td>
<td>84%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff failed to meet the trusts 95% completion target for two out of three safeguarding training modules; the lowest scoring module was safeguarding adults level 2 with 84%.

From April 2017 to March 2018 nursing staff within end of life services achieved a 96% completion rate for safeguarding training against a trust target of 95%.
Royal Victoria Infirmary

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>16</td>
<td>15</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff at the RVI Hospital failed to meet the trusts 95% completion target for all three safeguarding modules.

From April 2017 to March 2018 nursing staff within end of life services at the RVI Hospital met the trust target of 95%.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

We visited several areas in which palliative and end of life care were provided, including hospital wards, the mortuary and bereavement offices. All areas appeared clean, tidy and well maintained. We saw that personal protective equipment, including gloves and aprons, was readily available, and there were appropriate handwashing and hand decontamination facilities in all areas.

In the mortuary there was a separate autopsy theatre which would be used in the case of infection. If a patient with an infection was transferred to the mortuary, the mortuary team would be informed by ward staff and the patient flagged on the computer system. ID tape would be used, and an IPC notification completed by ward staff. The mortuary areas were well maintained, and the examination areas had downdraught ventilation.

Mortuary staff told us that there was a robust handover for patients brought to the mortuary by porting staff. We saw that this was completed at all times, and porting staff we spoke to could tell us what they needed to do.

The mortuary was very clean and odour free. Staff spoke passionately about their infection control measures and standards of cleanliness. There was a separate fridge to store the remains of pre-term babies and we saw that fridges were cleaned, and temperatures monitored daily. All other mortuary fridges had an electronic temperature monitoring system that automatically alerted the estates team if temperatures were out of range.

The trust conducted bimonthly environmental cleanliness audits, comprising a matron’s monthly check, hand hygiene checks and infection prevention and control practice. For the previous year, Surgery, Medicine and Urology, all areas where patients receiving end of life care had been cared for, averaged over 95% compliance.
(Source: data request DR049, DR050 EoL IPC audits)

Environment and equipment

There were no specific end of life beds for patients at this hospital. We visited Urology, Surgery and Medical wards where end of life patients were being cared for. We found all wards to be clean and tidy, uncluttered and in good decorative order.
The mortuary had a ritual washing room and three separate viewing rooms for adults, children and babies. The viewing rooms were sensitively decorated and furnished and could be adapted to the needs of families. The main autopsy suite was modern and spacious, and there was a separate area utilised for babies under 24-weeks’ gestation from across the region. Ceiling hoists and lifts were available to access the refrigerators.

The trust used two types of syringe drivers to deliver drugs to patients receiving end of life care. One type was used for inpatients, and these were stored centrally in an equipment library. We heard from several staff that they did not have any problems accessing these and they were always available when needed. Staff using these devices had their competency assessed and centrally recorded.

When patients were discharged, they were transferred onto a second, smaller device, a stock of which was held by the end of life team. Specialist nurses fitted these in the hospital, and care of the device was then picked up by the district nursing team who would visit the patient shortly after their arrival home. This meant that patients’ pain was controlled well, and we found no evidence of patients who had been using a syringe driver being transferred without one in place. We saw that all eligible specialist nurses were compliant with their training and their competency sheets were up to date.

Monthly compliance reports were automatically generated; these identified staff within the Directorate recorded on the electronic database, and the devices each individual was registered to use. This report was routinely shared with Directorate Managers and ward level reports have also been produced on request.

Plans had been submitted and funding was in place for the building of the Oasis Suite, which would be a self-contained apartment style space for relatives of patients who were dying. Plans included a space for washing, cooking and taking time out on comfy seating.

The mortuary had capacity for 105 patients. Two fridges were designed for bariatric patients, and five were deep freezers suitable for longer term storage of bodies. Staff could use extra capacity (including accessing additional bariatric fridges) at the Freeman Hospital and would divert coroners cases there if needed.

Assessing and responding to patient risk

Patient referrals to the SPEoLC were received by the team secretary and passed to the team coordinator for triage. Follow up and assessment was then arranged, or advice given. New referrals were also discussed and triaged at the daily morning team meeting, where the team’s workload and current patients were discussed and reprioritised. The team aimed to see the same patients where possible to provide continuity of care and reduce risk. The team’s comprehensive education on general wards meant that ward staff were clear when to make a referral to the team.

We were told that an end of life pathway would be initiated following discussion with the patient, their family, and the multi-disciplinary team involved in their care. A plan of care for the dying person was introduced, based on the five priorities of care, which was an individualised care plan and communication record.

Warning notices were in use in the mortuaries attached to fridges, for example for patients with similar names and for those with pacemakers or implantable defibrillators.

Each directorate had a directorate liaison offer whose role was to ensure that arrangements were in place for the timely dissemination, action and review of national and local alerts. The trust
monitored centrally the response of each directorate to each alert and followed this up where this had not been timely. We were therefore assured that alerts would reach the right people and be followed up in a timely way.

Nurse staffing

The SPEoLC teams consisted of band six and band seven nurses. We were told that staff recruitment was not usually an issue, and turnover and sickness rates were low.

The trust provided us with data for the last financial year (April 2017 to March 2018) and then for April to September 2018, the fill rate has declined at both sites for nursing staff and as of September 2018 the fill rate is 50% for this core service.

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned staff WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE LFY</th>
<th>Planned Staff YTD (Apr-Sep-18)</th>
<th>Actual Staff YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary</td>
<td>2.2</td>
<td>2.2</td>
<td>19.2</td>
<td>2.2</td>
<td>100%</td>
<td>11%</td>
</tr>
</tbody>
</table>

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

Vacancy rates

From October 2017 to September 2018 nursing staff in end of life had a 9% vacancy rate compared to the trust average of 12% there was no target set by the trust for vacancy rates.

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

Turnover rates

From October 2017 to September 2018 nursing staff in end of life had a 36% turnover rate compared to the trust average of 5% there was an 8% target.

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

Sickness rates

From October 2017 to September 2018 nursing staff in end of life had a 1% sickness rate compared to the trust average of 4% there was an 3% target set by the trust for sickness.

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

Bank and agency staff usage

From October 2017 to September 2018 substantive nursing staff covered 95% of hours available for this core service, 5% was covered by bank staff when needed.

<table>
<thead>
<tr>
<th></th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>End of life core service total</td>
<td>29,154</td>
<td>1,333</td>
<td>5%</td>
<td>0</td>
</tr>
<tr>
<td>Trust total (Qualified nurses)</td>
<td>6,530,050</td>
<td>139,878</td>
<td>2%</td>
<td>9,662</td>
</tr>
</tbody>
</table>

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

Consultants worked across both hospital sites and community. They also provided an out of hours on-call telephone advice service. Trainee doctors worked with the team and were fully involved with patient care. Undergraduate training was provided to junior doctors at induction.

The trust’s medical staffing met commissioning guidance for specialist palliative care.

We spoke with a member of the medical team who told us that they worked part time across both sites, and also provided advice remotely through the on call telephone advice system. They had a middle grade doctor with them who they were training and mentoring. They explained that the team always had a junior doctor trainee with them, and also supported palliative care specialist trainees. They felt that the service was busier, but safe, and put this down to greater awareness of their role.

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

Vacancy rates

There were no vacancies for this core service for the period from October 2017 to September 2018.

Turnover rates

The trust reported one member of the medical team leaving in the 12 months prior to December 2018.

Sickness rates

The trust reported a sickness rate of 1.86% for the 12 months to December 2018.

Bank and locum staff usage

From October 2017 to September 2018 medical staff in end of life had a 1% bank usage rate.

<table>
<thead>
<tr>
<th></th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of life total</td>
<td>11,627</td>
<td>127</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trust total (medical staff)</td>
<td>1,746,066</td>
<td>45,659</td>
<td>1,629</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical agency locum)

The trust’s chaplaincy, mortuary and bereavement services teams had low sickness rates, low turnover and low vacancy rates for the previous 12 months.

Records

We looked at six sets of medical records for end of life patients at this hospital. All were stored securely. The team used an electronic healthcare record system, which linked with the community and local hospices. All patients were registered on this system and documentation was completed electronically, then printed for inclusion in hospital notes. We viewed several printed versions of notes completed by the team and all were written clearly with attention to detail and comprehensive treatment plans.

We saw that information in patient’s notes included medication history, pain management, microbiology information, documentation of discussions with the patient about their physical and
emotional wellbeing, ongoing place of care, and discharge planning. Ward staff told us that the notes provided by the SPEoLC team were always clear and helpful.

The trust’s used the regionally adopted ‘Care of the Dying Patient’ booklet. Staff explained that although this was the trust’s preferred documentation, it would not be implemented if this was against the patient’s wishes. For example, if a person did not believe or did not want to think that they were dying, the booklet would not be used to avoid further distress. Medical staff told us that introduction of the booklet could be challenging as there were some longstanding taboos surrounding the discussion of death. Work was ongoing to produce the booklet electronically, which would provide an increased focus on the five priorities of care and would prompt staff to record a patient’s preferred place of death at the earliest appropriate opportunity.

We spoke with staff who regularly used the end of life pathway documentation and they told us that, although it was a large document, they found it straightforward to complete and thought it took patients’ needs and wishes into account.

The team regularly audited use of the care of the dying patient booklet. Their most recent audit showed it was being used in 20 of 25 cases. In those cases it was not being used, all of the information was available elsewhere in the patient’s notes. The team’s previous audit showed the document was being used in 65% of cases, and in 69% of eligible patients in the assessment suite.

**Medicines**

Prescribers on wards used pre-defined order sets for end of life prescribing of anticipatory medicines. These order sets contained a predetermined selection of medicines in line with trust policy. When these order sets were accessed by ward staff, an automatic email alert was sent to the end of life / palliative care teams and chaplaincy staff to alert them to this. We did not see any completed prescription charts at this site as anticipatory medicines removed the need for these.

We looked at medicines records for one patient receiving end of life care. Medicines for this person were in a syringe driver (small infusion pump used to gradually administer medicines continuously over a set period of time). The reasons for the use of this infusion were clearly documented in the person’s notes. However, we found that staff were not adhering to trust policy as they had not recorded that they had checked the infusion as regularly as suggested.

The end of life care team audited prescribing at the time of death. A member of medical staff was in the process of reviewing 52 sets of prescription charts and notes to check whether what was prescribed was appropriate with actions and learning to follow. A January 2018 review of prescribing at end of life found that the recent addition of oral replacement gel to anticipatory drug order sets was still to be fully embedded, but that standards of prescribing remained high.

At our last inspection we saw that syringe drivers were disconnected when patients were being discharged from hospital to the community, and different devices reconnected when the patient arrived at home. We were concerned this posed a risk of patients experiencing breakthrough pain. At this inspection, we found that patients’ syringe drivers were changed to different devices prior to discharge rather than being disconnected. This was done by SPEoLC nurses, and we were told that nurses from the local hospices provided out of hours support if necessary. We saw no reported incidents in relation to the transfer of patients with syringe drivers.
Incidents

Staff understood their responsibilities to raise concerns, to record safety incidents and near misses and knew how to report them appropriately. They were aware of the incident reporting procedure. Learning from incidents was used as an education opportunity for all staff and we saw discussion around recent incidents taking place at the team meeting. Feedback was given to staff involved.

Incidents were reported using an electronic system and those relating to the end of life team came direct to the team leader for review. These were then discussed and formed a standing agenda item at each team meeting. We reviewed a set of incidents with a common theme and found that these were well documented with clear actions taken and lessons learned.

Nursing staff gave an example of an incident that had occurred in A&E, where the team had provided telephone advice but the outcome for the patient could have been better. As a result, the team strengthened their links with A&E and have since provided education directly to that team including specific information about how such a scenario could be more effectively managed in future.

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 within end of life 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 no serious incident (SIs) in end of life care which met the reporting criteria set by NHS England from October 2017 to September 2018.
(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

Policies used by the service were available for staff to access on the trust intranet. These included a range of pathways and guidance which reflected national evidence based best practice and guidelines. The trust had an implementation policy for National Institute of Health and Clinical Excellence guidelines and a sub-committee of the trust board was responsible for monitoring compliance. Non-compliance was escalated to the trust board.

Specialist nursing staff told us they were well equipped to treat patients with a mental health condition and liaised with the psychiatry team daily in such cases. Staff knew how to refer to the drug and alcohol service, should they need to do so.

We asked how staff would manage patients with challenging behaviour. They told us that effective use of communication skills was at the centre of all patient interactions. They would talk to the patient and allow them the opportunity to discuss any issues or anxieties. They gave us examples of patients with mental health problems who had required referral to the psychiatric liaison team;
joint care plans had been developed, reviewed and modified as necessary. Security staff had been commended for the compassionate way in which they supported a patient experiencing acute mental health symptoms and for the relationship they built with the patient. We were told that if patients needed monitoring on a one to one basis, this could be quickly arranged.

The team worked closely with end of life link nurses on wards, who met regularly with nurse specialists from the team. They were working on discharge, including practical examples where a link nurse would be given a case study and asked to assess and grade the person’s discharge. Link nurses were given a clear role description, purpose and key activities.

The team were part of the pilot to develop a Public Health England dataset for palliative care in 2015. They have rolled out and continued with the use of this dataset and this was observed to be in use at daily team discussions.

The most recent visit to mortuary services by the Human Tissue Authority (HTA) concluded that despite some minor shortfalls, several strengths were identified. The associated action plan to rectify the three minor shortfalls provided by the trust was appropriate and set reasonable targets for completion. All three were reassessed and found by the HTA to have addressed the issues identified.

**Nutrition and hydration**

We checked 13 sets of patient notes across both sites. In all cases, a nutritional assessment had been included in the notes. Where appropriate, fluid balance charts were also present.

The trust audited nutrition and hydration as part of their ongoing real time end of life care audits. In 85% of cases in the most recently published audit, an assessment was made regarding the patient’s ability to eat and drink. 59% of patients were documented to have an impaired or unsafe swallow.

There was evidence in patients’ notes that a discussion regarding hydration and nutritional requirements had taken place with the patient in 27% of cases and in 100% of cases where the patient was capable.

In 100% of cases there was a documented discussion with relatives/carers regarding hydration and in 86% of cases there was a documented discussion with relatives/carers regarding nutrition.

**Pain relief**

The team told us that following national recent media interest in incorrect doses of medication for pain relief, they conducted a gap analysis, supplemented with regular medication audits. They also attended as many morbidity and mortality meetings as they could in other areas such as critical care.

The team were using a specially designed pain scale for patients who cannot clearly articulate their needs as part of the care of the dying patient booklet. We saw in patients’ notes that this had been appropriately used and completed. Where pain was not being controlled, we saw an increase in painkilling medication had been given, and the reason for this was documented in the patient’s notes. As part of their ongoing audit programme, the team had identified that use of the bespoke pain scale was an area that could be improved in terms of more widespread use on wards. They were planning education programmes with the aim of further improving this position.
Patients we spoke to told us their pain had been well controlled. One person told us that they always got painkillers straight away and they “got told off” for not asking for them.

**Patient outcomes**

The SPEoLC teams had contributed to the Public Health England national palliative care dataset pilot which measured, analysed and compared some of the key outcomes that mattered most to people who received specialist palliative care.

The trust did not participate in the Gold Standard Framework (GSF) scheme. There had been a similar local scheme, funded by the local clinical commissioning group, but funding for this had now ceased.

**End of Life Care Audit: Dying in Hospital 2016**

The trust participated in the End of Life Care Audit: Dying in Hospital 2016 and performed better than the England average for all five clinical indicators. The trust answered yes to seven of the eight organisational indicators, answering no to the question “Was there face-to-face access to specialist palliative care for at least 9am to 5pm, Monday to Sunday?”

*(Source: EoLCA – End of Life Care Audit – Dying in Hospital)*

**Competent staff**

The SPEoLC nursing and medical teams showed evidence of continuous postgraduate training and learning, covering topics such as dementia, medical ethics and law, advanced communication skills and practice development. This included studying to degree or masters level in palliative care.

The medical team provided input into third year and final year training for medical students to make sure all had at least a basic understanding of palliative care during which time they covered the five priorities of care. They also provided 20 minute ad-hoc education to medical staff working in the assessment suite. The medical team also jointly delivered education with the heart failure team.

End of life nurses had visited wards or areas to deliver training on the use of the Care of the Dying Patient booklet. A total of 274 staff took part in the training over five days. Staff told us that there was more of a recognition following this training about the importance of discussing a patient’s preferred place of death as early as possible.

One nurse on a medical ward told us that they and some of their other nursing colleagues had been too busy to attend on the day that the end of life team came to the ward. They asked the specialist nurse if she would return again as they really wanted to receive the update, and the specialist nurse came back the following week to ensure everyone who wanted training received it.

The wards we visited all had link nurses for palliative and end of life care. We spoke with a link nurse who regularly attended meetings and ensured relevant information was disseminated to staff. Staff told us that they felt there was more exposure to palliative and end of life care for doctors and nurses in training, which had helped to raise awareness and improve communications with patients and relatives. It was felt by staff of all levels that the education and support provided by the SPEoLC team was invaluable, and information or guidance was always available, either from the team directly or from their dedicated intranet page.
There was no specific clinical educator role within the team, however other members of the team were providing a wealth of adhoc, formal and informal training opportunities, supported by good links with the trust’s central clinical educator team. Nurse specialists invited the trust education team to attend their quarterly subgroup meetings.

Nurse specialists entering the end of life team were supernumerary for the first six months in post. They did see patients but were also offered a wealth of other shadowing and development opportunities, such as spending time with local hospices, the transplant team and identifying their own opportunities.

The team provided two five day courses a year for qualified staff providing comprehensive training on end of life care. This included a whole day on communication, and another on advanced care planning. Some places were ringfenced for staff attending from the community or from local care homes. This course was advertised internally and externally and was regularly oversubscribed.

The team also provided a one day shorter course twice a year for qualified staff giving more of an overview of the topics covered in the longer course.

The team provided a one hour slot of training as part of the HCA Academy programme for aspiring healthcare assistants, and also fed into the trust’s preceptorship programme. They were looking to build a bespoke training session for healthcare assistants already in post as they recognised this was a gap in the current offer. We discussed training with two ward-based healthcare assistants and they both told us they had received education and support from the SPEoLC team and from ward colleagues, and that they always felt comfortable asking for help and advice.

The team was also involved in teaching provided by the trusts healthcare academy, in induction and preceptorship programmes, and in provision of communications training such as the ‘sage and thyme’ course: a workshop which focused specifically on communicating with people who were worried or emotionally distressed. The palliative care team leader was a ‘sage and thyme’ facilitator and had run five pilot sessions of this training in 2018 which had been very successful; training was to be continued in 2019.

The chaplaincy team were all appropriately and substantially qualified in their field, including specialist knowledge in areas such as child death and child bereavement, issues around faith and organ transplantation, and wider ethical issues. They also provided training to staff and external organisations including ethics and bereavement sessions, student nurse sessions, and attended trust inductions.

Appraisal rates

The trust provided us with appraisal rates for end of life for the April to September 2018, only one staffing group met the 90% target set for the period covering up to March 2019.

Whereas the appraisal target for March 2018 was 80% this core service missed the target with a completion rate of 65%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff Required Year to Date</th>
<th>Staff Received An Appraisal - Year to Date</th>
<th>% Of Staff Received An Appraisal YTD</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Qualified nursing & health visiting staff (Qualified nurses) | 13 | 10 | 77% | 90% | No
Support to doctors and nursing staff | 4 | 2 | 50% | 90% | No
Support to ST&T staff | 6 | 3 | 50% | 90% | No
(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Medical staff appraisal rates were 62.5% at the time of our inspection.

**Multidisciplinary working**

We observed a consultant led multidisciplinary team meeting. The team discussed patients and their current needs using the recently developed national palliative care indicators set. The team used a ‘phase of illness allocation in accordance with phase definition’ flow chart which determined the level of anticipated intervention in terms of changes to the care plan. Any learning points for action were logged and themes were scheduled for discussion at the monthly clinical governance meeting.

We saw examples of effective multidisciplinary working on wards: ward staff told us that, whenever possible, the process of referring patients to the SPEoLC team would involve the whole of the ward team involved in a patient’s care. They also worked alongside specialist nurses and doctors for support with specific conditions. Staff told us they felt discussions and treatment planning was much more open, and they felt much more empowered when caring for people at the end of life, particularly due to the support they received from the SPEoLC team.

Two specialist Macmillan nurses based within the local ambulance trust attended the end of life team’s meetings for shared learning opportunities and to improve links.

We saw that SPEoLC meetings involved staff from other areas, such as from safeguarding and learning disabilities teams. We heard examples of when legal advice had been required, and the trust’s legal team had provided timely and helpful support. The team also had good working relationships with pharmacy services and specialty teams within the hospital.

A member of the team worked closely with heart and lung transplant teams to change the perception of palliative care in order to offer this service more proactively to this group of patients, who historically did not receive it. They had been awarded the Dundas Medal (a national palliative care award) in 2018 for this work.

**Seven-day services**

The team provided a seven day service to patients and their families. During weekdays, consultants, doctors and nurse specialists reviewed patients daily. At weekends, reviews were conducted by nurse specialists. They were supported by an on call hospice advice line with direct access to consultant advice.

Mortuary staff did not work at evenings or weekends but were on call to come in if a body needed to be released during these periods. They told us they did not have any problems releasing a body in a timely manner if all paperwork was complete and were therefore able to meet the needs of those faiths requiring prompt burial.
Bereavement services staff did not work at weekends or during the evenings, however they managed skilled reception staff who had been given additional training to be able to provide an interim bereavement service out of hours.

The chaplaincy service provided 24-hour cover and, out of hours, aimed to respond within one hour.

Radiology and pharmacy services were available out of hours, either directly or on an on-call basis, and allied health professionals such as physiotherapists were available at the weekend.

**Health promotion**

The service promoted the national Dying Matters weeks once a year. The team told us that last year they held stalls at both sites, encouraging both patients and staff to discuss death and dying, and also highlighting the work of other services such as local hospices. They talked about plans for a death café for the coming year.

We saw Macmillan support leaflets were readily available in many areas and provided guidance for patients and their relatives in a range of subjects, including emotional, financial and therapy information.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.

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

We looked at the trust's policies for consent and mental capacity act, including DoLs. We found that these were in date and contained appropriate references to legislation such as the mental capacity act, equality and diversity and the human rights act.

Specialist end of life care nurses told us that they accessed mental capacity act and deprivation of liberty safeguards training on a rolling programme, available online.

The team had been involved in the development of the regional 'deciding right' app and associated resources, aimed at emphasising the partnership between the individual, carer or parent and the clinician and placing the Mental Capacity Act (MCA) at the centre of shared decision-making. The resources and app were accompanied by training for professionals and the team was in the process of cascading this to GPs and clinical educators.

To illustrate the importance of the programme and the effect it could have on patients and their families, a patient representative was attending trust board to share their experience.

We checked seven 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms at this site. In one case, there was not sufficient information recorded on the form to assure us that the form had been appropriately discussed with the patient. However, this form had been completed at another trust. All other forms were well completed, with good documentation, and detailed notes. These were all countersigned by a consultant, dated, and stored in the front of the patient's paper
notes.
The trust provided a copy of their most recent audit of DNACPR documentation (August 2018) which confirmed our findings that forms were almost always being completed appropriately and that this was an improving picture. Actions were in place to address any measures that had deteriorated since the previous audit.

**Mental Capacity Act and Deprivation of Liberty training completion**
The trust set a target of 95% for completion of safeguarding training.

A breakdown of compliance for mental capacity training courses from April 2018 to September 2018 at the trust for qualified nursing & midwifery staff and health visiting staff in end of life services is shown below:

<table>
<thead>
<tr>
<th>Trust wide</th>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>19</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Mental Health Act</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff achieved 100% completion for both mental capacity training modules.

From April 2017 to March 2018 nursing staff within end of life services achieved a 100% completion rate for mental capacity training against a trust target of 95%.

**Royal Victoria Infirmary**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
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<td>Mental Health Act</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
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</tbody>
</table>

Nursing staff at the RVI Hospital achieved 100% completion for both mental capacity training modules.

From April 2017 to March 2018 nursing staff within end of life services achieved a 100% completion rate for mental capacity training against a trust target of 95%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

**Is the service caring?**

**Compassionate care**

We observed patients being treated with dignity and respect. We observed a number of interactions between staff, patients and relatives. Staff were polite and professional in their approach. We observed staff responding compassionately to patients’ pain, discomfort and emotional distress in a timely and appropriate way.

Confidentiality was respected in staff discussions with people and those close to them.
Staff spoke about patients with complex needs in a respectful way and demonstrated a non-judgemental attitude.

Patients we spoke to told us their care had been good. They knew what the plan was for their care and where appropriate, had spoken with staff about their preferred place of death.

Chaplaincy staff told us that if a person died without sufficient income or next of kin to provide a funeral, the trust would arrange this for them.

A member of the bereavement services team voluntarily arranged and provided flowers for the chapel of rest viewing areas and funerals for people with no next of kin.

The mortuary contained a ritual washing room so that families who wished to wash and prepare their loved one could do so. East was marked on the floor to aid orientation for prayer.

Mortuary staff told us that they always washed and returned a person’s clothes to their family where this had been requested and there were no infection control risks.

A member of the mortuary team exhibited great compassion when talking about their service. They told us “my area is just another ward. Just because my patients are different, they are still my patients and I treat them as such. With respect.”

We spoke to two members of porting staff. They told us that they had received training on how to sensitively transport a deceased patient to the mortuary. They knew how to use protective equipment, and how to book the patient in on arrival. They had also received general moving and handling training. One porter also commented that they always felt welcomed by mortuary staff on arrival. An end of life link nurse on a general medical ward told us that when contacting the porters to arrange collection, they would always find a quiet area off the ward to do so.

Bereavement services staff offered a comprehensive ‘one-stop-shop’ service to families, organising paperwork, visits to the chapel of rest, and discussions with doctors as required. Staff told us they were proud to be in this important role and that patients remained ‘our patients until they leave the hospital’. Practical advice would be given regarding the death certificate, funeral services, mortuary services and administration procedures. Patient’s property was returned through the bereavement services team when necessary, to avoid relatives having a potentially upsetting visit to the ward.

One of their most important tasks was arranging for doctors to meet with families who still had questions or concerns about the patient’s care in the last days of life. This played an important role in the grieving process and also prevented worries or niggles developing into complaints. Out of hours arrangements were made through hospital reception teams, and staff always ensured that paperwork and death certificates were available in a timely manner, for example if needed for religious reasons.

**Emotional support**

We saw staff of all grades going to extraordinary lengths to support and comfort dying patients and their relatives. Staff worked beyond the end of their shift and out of hours to provide extra support and care and made special arrangements for those nearing death.

Staff we spoke with had received training in breaking bad news. They told us that they had to be prepared for a range of emotions, needed to adjust their approach according to a person’s reaction, and ensure all interactions were conducted as sensitively as possible.
The mortuary had three viewing rooms where families and friends could spend time with someone who had recently died. One was for adults, and was homely, bright, and clean. The second was for older children and featured a child’s bed and bedding, a chest of drawers and appropriate artwork on the walls. It looked like a child’s bedroom and there were teddies and toys in the room. Parents were encouraged to bring their child’s own duvet cover and teddies if they wished. The last was a baby room, with a rocking crib, chest of drawers filled with baby clothes, mood light playing lullabies, and teddies. Each room had its own seating area; these were separated by partitions which could be opened should more space be required.

Staff told us that people could visit by appointment to view their loved ones in these rooms. Chaplaincy staff explained that they contacted families in advance and were open and honest with them if the patient’s appearance had changed due to natural processes since their last visit.

Chaplaincy and mortuary staff told us that they had supported one family of a teenager who had passed away just prior to their birthday, to hold a small celebration of their life, in the viewing room on their birthday. They also supported the family of a baby who died just prior to Christmas to spend time with their baby on Christmas day. Staff decorated the crib with fairy lights and also brought in a Christmas tree and decorated it for the occasion.

Mortuary staff provided hand and footprints of babies if the families would like them, and locks of hair from any patient could be sealed in a variety of shaped lockets for families to keep. Staff had recently introduced matching bracelets available in a wide variety of colours and sizes, one each for both parents, and one for baby. Feedback was very positive. We also saw on a ward that a young child and parent who was nearing the end of their life had been given matching bracelets by staff.

As part of their ongoing work to improve experience for patients and their families, staff walked the route patients would take from wards to the mortuary to see how they could make this less challenging for families of patients.

The team had a newly developed psychological wellbeing practitioner role, which could increase access to brief, low intensity CBT interventions for patients with mild to moderate psychological difficulties.

Chaplaincy staff provided emotional, practical and spiritual support to both staff and patients. This included sitting with patients when a visit had been requested and offering their services to all patients identified as nearing the end of their life. In the previous 12 months, chaplains provided 671 care of the dying patient visits across the trust.

The chaplaincy team also provided memory boxes and individually selected resources for the families they supported. They had received dozens of Greatix thanks and acknowledgments for their work with end of life patients and the support they offered to staff caring for these patients.

The chaplaincy and mortuary teams supported the parent of a person who had passed away in difficult circumstances. The parent was initially reticent to visit their loved one but described being ‘struck’ by the way the team talked about their child as a person and how it was a privilege to care for them. They felt the viewing was ‘much less of an ordeal’ than they feared due to the caring way they and their child had been treated. They described how staff were not just professional, but actively wanted to look after their child, and that they really cared for both the person who had died and their family.
Understanding and involvement of patients and those close to them

We spoke with two patients who were being cared for on a general ward with oversight from the palliative care team. We were told that the team and the ward staff had been very caring and had involved the patient’s family at every opportunity. Family members had been encouraged to visit whenever they wished and to help with the patient’s care. One told us that they had been very well looked after and felt that staff had always involved them and their family; we saw from the patient’s notes that the patient’s family had been consulted and informed at all times, at the patient’s request, and that all interactions were clearly documented.

The team were using patient diaries with people and their families. These could transfer from the community into hospital and vice versa. They were a simple means of patients recording anything that was important to them, or for someone like a healthcare assistant to record for the family what they had discussed or done together, such as having read a book to the patient. They were in no way meant to replace any discussions with nursing staff but were more of a communication aid for families and the patient.

The trust’s regular bereavement survey showed a range of overwhelmingly positive responses with the majority of patients’ families feeling that they had been involved in their loved ones’ care and treatment. Their questions were fully answered and on the whole care had been appropriate. Although the survey made recommendations there was no associated action plan for improvement.

The team’s most recent patient experience audit was positive. Having switched to using interviews with patients and their families rather than questionnaires, they found their responses were more thorough and more constructive feedback on how they could improve was received.

Patients spoke about the team as being very supportive and answering their concerns thoroughly. Some of the recurring issues were to do with environment, specifically when it had not been possible to accommodate a patient reaching the end of their life in a side room. Patients said they had changed their perceptions about palliative care as a result of meeting the team and that they valued the time to chat and explore their condition.

Is the service responsive?

Service delivery to meet the needs of local people

End of life services were planned to meet the needs of the local population, to ensure patients received coordinated care that was accessible and responsive to people’s needs. We saw good partnership working between the hospital and community teams, local hospices, primary care providers and the ambulance service.

The Trust contributed to the Northern Palliative Care Partnership and was driving forward improvements in care and experience across the patch including the implementation of the care of the dying patient document and leading on training and dissemination of information for the Deciding Right initiative. The team was working to embed the six strategy headings into the work of the locality Northern Palliative Care Partnership.

The trust had audited its recording of patients’ preferred place of death following our previous inspection and found an improving picture comparable to national figures. The SPEoLC team were continuing to promote the importance of discussing this with patients and refining the ways in which they captured this data to improve future audits.
Health care assistants put together comfort packs for families staying with patients nearing the end of their life. These contain a number of items such as travel pillows, toiletries, and a pen and pencil. Families in receipt of these would be able to stay with their loved one rather than having to leave them to go home to fetch such items and we heard that this had a big impact and the packs were well received. A health care assistant told us they had come in as a volunteer over the Christmas period to make sure no families missed out.

Three members of nursing teams on separate medical wards told us that they found it easy to refer a patient to the end of life team who usually visited new patients the same day. Audit showed that 87% of hospital patients were visited the same day, rising to 97% of patients who were visited either the same day or following day.

A nurse told us they would check with the sister in charge if they needed to clarify if a referral was needed. They explained that if they needed any informal specialist advice, a member of the team was always available at the other end of the phone.

We checked the quality of the team’s initial assessment of a patient. They covered not only physical issues such as the patient’s pain relief, nausea and mobility, but also their reaction to the deterioration of their condition, where they might prefer to die and how they were coming to terms with their prognosis. This initial assessment demonstrated a full holistic assessment of the patient’s needs and wishes.

We discussed gaps in paediatric and transition palliative care services with senior staff: we were told that, although there was no specific service, there was a multidisciplinary team for children, teenagers and young adults with cancer and non-cancer diagnoses. The team worked alongside paediatric doctors to carry out joint reviews; it was felt that progress had been made, but the trust was working with specialist commissioners to drive further improvements.

We saw that the minutes of the Palliative and End of Life Care Strategy Group included evidence of planning services with the local community in mind. Representation from other areas of the hospital helped the team to keep a close eye on potential increases in demand and other local changes.

We saw an audit of usage of the palliative care advice line, which provided most of its advice out of hours, to doctors and nurses. This service had seen a decrease in use in the previous year, particularly by hospital out of hours staff. All calls requiring a call back by a consultant were returned promptly, and a third of calls required at least one follow on call.

**Meeting people’s individual needs**

Staff told us that they would move dying patients from a bay in to a single room if possible so that they could ensure patients privacy and dignity was maintained and so relatives could stay with the patient overnight and have more room.

The team had an equalities sub group working on gathering views from patients whose views could be harder to hear. They had implemented the ‘when someone is dying’ leaflet in Czech, Arabic and Polish as well as large print. Training for staff on issues relevant to the LGBTQ community around end of life was planned and would be led by a trans person from the local community.

We also saw that this group was planning work around prisoners and the detained community, refugees, transition patients, people with a mental health or neurological condition and others. The
group had an action plan for each piece of work and monitored equity of access to ensure they were doing the right things for the right people.

One of the team’s consultants was working with a homeless, drug and alcohol charity to identify people who were potentially nearing the end of their life earlier so appropriate support could be found. This included training the charity’s workers in basic triage skills, as this group of patients could be wary of medical professionals and working with a local hostel to provide a suitable environment for someone who was nearing the end of life but without permanent accommodation to go to.

We spoke to a member of the chaplaincy team who told us they had visited four patients that day having been alerted by the electronic system. During visits, the team spoke to patients and their families about the support they offered, left them a small slip with their contact details and placed a sticker in the patient’s notes to show they have visited. Chaplaincy staff supported people’s spiritual needs regardless of faith, including the needs of staff.

All of the chaplaincy team were Church of England chaplains; however they had a close network of honorary chaplains from a variety of faiths. Chaplains and honorary chaplains aimed to respond to a request for a visit within one hour if possible, 24 hours a day, seven days a week.

The main chapel had been closed for the previous nine years as nearby building work had restricted access. Services were held every Sunday in the spacious Meditheatre which was non-denominational, accessible and close to the main entrance. Muslim prayer sessions took place every Friday. Once a month, chaplains provided a service for people who had experienced perinatal bereavement.

The site had two quiet rooms, located at opposite ends of the hospital, for people to pray or have some quiet, contemplative time. We saw both rooms and found them to be well decorated and suitable for a variety of uses. Both contained torahs, prayer mats and other items suitable for a variety of faiths.

Ward staff told us there was a learning disabilities team who were available for support and guidance, and who would work alongside patients and relatives, for example to support with communication needs. Members of the learning disabilities team attended the SPEoLC monthly multidisciplinary team meetings.

Bereavement services staff provided booklets in a range of other languages and that they accessed telephone or face to face translation services if needed. Tablets were available to them to provide an internet linked BSL signing service and they had not experienced any problems with availability of this or any other translation services.

Staff were able to access community health care funding for patients whose preferred place of death was in the community, but they would need extra carer support in their preferred setting. They gave an example of a patient who wished to die in their local hospice but needed a health care assistant to support them. This was funded for them and the person was able to die in their preferred place of death.

We spoke to one of three end of life healthcare assistants providing specialist support to patients and their families. Their role was to spend time with families, check what conversations had taken place and what could still be done to better improve the experience of patients and their families. We observed another healthcare assistant bringing trays of tea to assembled family members around a dying patient’s bedside. They sat with the family and discussed their concerns.

We heard how healthcare assistants also arranged reduced car parking costs for visiting families and handed out comfort packs so that people could stay with the patient for longer.
It came to the attention of a local utility company that there were delays in the discharge of people going home to die, because they had a gas fire in the room where their bed would be, and it did not have a gas safety certificate. Obtaining a certificate was often expensive and time consuming. The gas company had agreed to provide this service, free of charge, either on the day of referral or the next morning, depending on the time they were contacted.

Chaplaincy staff ran a clothing bank for patients, provided food bank vouchers, covered some travel costs for visiting relatives, provided phone chargers, books, CDs and wash kits for families in need, and worked with a local charity to request emergency shelter for pets of people living on the streets when they were admitted to hospital.

**Access and flow**

Referral of patients for palliative or end of life care was done, following a multidisciplinary discussion involving those involved in a patient’s care on the ward, either by telephone or using the trust’s intranet referral system. The referral was received by the SPEoLC team and triaged to determine who should assess the patient and what level of support was required. Specialist palliative care nurses reviewed and triaged all referrals in to the team. Where necessary patients could be referred for a further review by a palliative care consultant.

The team told us they had seen an increase in referrals from all areas of the hospital, as awareness of the need for high quality palliative and end of life care had been raised. Staff were more proactive in determining the priorities of the patient, planning support and arranging discharge.

We saw evidence in a patient’s notes that they were reviewed by the palliative care team the same day as the referral was received. A specialist nurse reviewed the patient’s pain relief and began to make arrangements for the patient’s discharge.

We observed a morning team board round. Specialist nursing staff, HCAs and doctors were present. The team discussed every end of life patient, including new referrals, and whether each individual would need their input that day. All new referrals were scheduled for a visit the same day. People’s medical needs including pain control and nausea were considered, and also wider family needs such as car parking discounts. Patients who had not yet expressed a preferred place of death were highlighted and a doctor was allocated to visit one of these patients to see if they would be willing to discuss this.

The end of life team had implemented a traffic light rating system to help plan for a patient’s discharge. Red discharges were urgent and priority, amber less so, and green applied to a patient who could wait a little longer. A discharge checklist was printed and attached to the front of the patient’s notes, and both ward staff and the end of life team could contribute to putting things in place to facilitate discharge. Specialist nurses explained that red discharges would normally be overseen within the team, with amber and green discharges being ward led. A recent audit of red discharges showed that on the whole, people were going home in a timely way. The team’s discharge sub-group, having completed this audit, had begun to work on a review of electronic incidents relating to discharges to see what further improvements could be made.

We heard of an example where the team managed to send a patient requiring a red discharge home to Northallerton, 60 miles away, within four hours.

Nursing and medical team members told us that they felt these were being more widely used on wards and recognised as the useful prompt they had designed them to be. Staff told us that physiotherapists and ward staff actively moved discharge along at weekends and this had...
improved dramatically over the last eight years, providing something that felt much more like a seven day service.

A member of nursing staff on a specialist medical ward told us that they had received good support from the end of life team when arranging an amber discharge. We saw in this patient’s notes that members of the end of life nursing team had provided weekend support to the ward to ensure plans for the patient’s discharge were progressing.

Specialist nurses told us that since the end of life team had had access to a specific end of life ambulance service provided by the local ambulance trust, there had been far fewer issues with timeliness or appropriate support during discharge.

We saw the mortuary team worked hard to facilitate the release of patients in a timely manner, and staff provided an on-call service enabling patients to be released out of hours if necessary. For any patients who were unidentified or needed to remain in the mortuary for extended periods due to legal or funding reasons, permission from the coroner or patient’s family was requested, for deep freezing or embalming purposes.

We saw evidence that discussions about the patient’s preferred place of death took place as soon as was deemed appropriate, and that this was documented in the patient’s notes. The trust’s May/June 2017 audit of end of life care documentation showed that people’s preferred place of death was articulated in 85% of cases. 100% of these were fulfilled.

**Learning from complaints and concerns**

We discussed the handling of complaints with senior staff. The palliative care team leader was a facilitator on the ‘sage and thyme’ communications course, and effective communication was at the centre of the complaints process. We were told that staff felt it was important to recognise and acknowledge the distress and worries of those involved; allow them to express their concerns and let them know they were being heard; provide a helpful response; involve them; and work together to plan a solution.

Specialist nursing staff told us that they received few complaints, but that these would come through their executive lead and then be fed back to them. They worked hard to address concerns informally before they developed into complaints and this was evidenced by the low number of complaints. As the service relied on general wards or units to provide information in a timely way, it was not always within their power to close complaints within the trust 60 day deadline for complex complaints.

Complaints were a standing agenda item on team meetings and we saw from team minutes that these were regularly discussed.

**Summary of complaints**

Between September 2017 to October 2018 there were 11 complaints for end of life services, the trust took an average of 68 days to close complaints which is not in line with their complaints policy which states complaints should be closed within 20-60 days (up to 60 days for more complex complaints).

- RVI – three complaints

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run a service providing high quality sustainable care. There was a clear management structure at directorate and departmental levels. Leaders knew about the quality issues, priorities and challenges in the department.

The nursing and medical teams were established, with experienced staff that provided clinical and professional leadership. Staff told us that they were well supported in their roles and had a clear understanding of their responsibilities. They said leaders were visible and approachable. Ward staff told us that the SPEoLC team were well known to them and easily accessible.

The NuTH Specialist Palliative Care and End of Life teams were divided into 2 directorates. The Medical Staff were in the Cancer Services Directorate and the rest of the staff were in Patient Services Directorate. For clinical governance purposes the medical staff were within a directorate with a Medical Clinical Director. The service reported to the Deputy Director of Nursing and Patient Services and had a direct link into Trust Board. The Trust Board received an update paper twice a year.

There was a dedicated non-executive and executive director aligned to the team. While the current non-executive director was quite new in post, the team had made contact with them and invited them to team meetings. The team spoke positively about the change brought about by the previous non-executive director who obtained funding to bring about the move to seven day services.

There was no operational manager post within the team, which was jointly consultant and nurse led. The team recognised that this role would further strengthen their leadership, and conversations had taken place at an executive level with a view to implementing this.

The team’s meeting minutes included sections considering wider corporate priorities as well as those of the directorate, meaning that locally, leadership was well positioned to be actively contributing to these.

Vision and strategy

The new team strategy (2018-2021) had been developed with careful consideration for the local population’s needs, and current best practice. Six strategic aims had been developed as follows; each person is seen as an individual, each person gets fair access to care, maximising comfort and wellbeing, care is coordinated, all staff are prepared to care, and each community is prepared to help.

The team were committed to achieving these aims which were discussed regularly at team meetings. A quarterly strategy group meeting with representatives from other directorates provided the team with a further sense check on progress. Leaders spoke positively about the distance already travelled in achieving these.

We saw that the trust’s core values were clearly displayed in ward areas and in the mortuary offices. These were: patients come first; people and partnerships are important; professionalism at all times; pioneering services, and pride in what we do. Also displayed were the core behaviours expected of all staff: enabling our vision; demonstrating our values; commitment to service delivery; and achieve results for patient care.
Culture

The trust promoted the ethos that care of the dying was everyone’s responsibility and provided the skills and tools to enable staff to consistently and compassionately undertake this. We spoke to staff on general wards where end of life care patients were being nursed. They echoed the sentiment that end of life care was everyone’s responsibility and the hospital support palliative care team were accessible, effective and worked collaboratively with staff on the wards, whether in person or remotely. We found that staff on general wards had been supported to provide high quality palliative care to patients on their ward, which demonstrated the ‘upskilling’ culture of the SPEoLC team.

Staff told us they felt respected and valued. Staff felt supported in their work and there were opportunities to develop their skills and competencies, which was encouraged by senior staff. The team held twice yearly away days to strengthen teamwork, attended by the head of nursing, plus twice yearly the team held joint meetings with their community colleagues.

Staff working in the mortuary had a very positive culture and spoke with purpose and at length about their pride in their colleagues and the service they provided. We were told by mortuary staff that they did feel valued for their work and had very positive relationships with other members of staff and families of patients.

We observed a monthly team meeting, held at the Freeman Hospital, although the venue alternated. There were 23 people present, including doctors, nurses, healthcare assistants, administrative staff and allied health professionals. Discussion was very open and honest and every person attending contributed in some way to the discussion. The team were supportive of each other’s actions and opinions and recognised outstanding practice amongst their members. They were collaborative, respectful and offered appropriate challenge. The team also discussed and suggested next steps and the dissemination of learning.

The trust had developed ‘greatix’ awards, which recognised the achievements of staff and enabled the sharing and celebration of successes. We were given examples of a nurse successfully managing a complex discharge under pressure and security staff who had been involved with a patient, who were commended for their compassion and effective relationship building.

Governance

The end of life team had a comprehensive programme of audits offering good oversight of their progress and position against strategy and targets. Audits of prescribing, use of the care of the dying patient document, recording of patients’ preferred place of death, efficacy of rapid response discharge planning were all regularly completed.

We saw that implementation and use of the care of the dying patient document was discussed at the team’s January team meeting. Although the document was not being used in 5 of 25 cases, the team could see that the information that should be held there was present elsewhere in the patient’s records in 100% of cases. Where the document was not being used, explanations were given as to why it was not appropriate.

The Palliative and End of Life Care Strategy Group was chaired by the medical lead with representation from a variety of staff including different departments within the trust. The governance system supported the strategy and provided assurance to the board.
Management of risk, issues and performance

The team did not hold its own separate risk register, and risks were held on the wider patient services register. However, there were only three risks for the team, and they were able to articulate these.

We were told the biggest risk at the time of our inspection related to the potential loss of the enhanced supportive care (ESC) team if further funding could not be secured. The team was currently funded to operate until June 2019; discussions around the future of the team were ongoing. The wider register was searchable, and we saw it was straightforward to view just the team’s risks.

A monthly Clinical Assurance Tool (CAT) provided an overview of ward level performance against a wide range of clinical and environmental measures for each ward and Directorate to the Trust Board. The CAT measured and demonstrated compliance with published documents and national drivers.

Senior staff told us another potential risk was related the on-call out of hours advice system. This was often provided by the hospital’s consultants and was not commissioned, so was recognised as being a vulnerable service. Regular joint meetings took place with local hospices to discuss possible changes and improvements to this service. Use of this service was regularly audited.

The trust’s mortuary contingency plan included robust procedures covering lack of capacity at one or both sites. Experienced mortuary staff told us they had never had to implement these procedures due to both mortuaries being full, but they knew what to do should this occur.

A major incident plan was in place, and this site had its own directorate summary, available on a single side of A4 for quick and easy reference.

Information management

There was a comprehensive end of life resource and information section on the trust’s intranet site, and we saw that policies and guidelines were available to staff on here. We observed the updating and reviewing of policies being discussed at the hospital SPEoLC team meeting.

The SPEoLC teams had a social media page which they used to share projects, strategies and information across the trust.

We saw that computers used in ward areas and both mortuaries were password protected when not in use. Mortuary staff told us that any information they needed to send electronically was done from a secure email account.

In the mortuary there was a comprehensive patient identification and registration system in place, which was explained to us in detail by the mortuary staff. We saw that alerts were in use in the mortuary, for example for patients with the same or similar names.

The current records and information management system used by the trust was a local system; senior staff told us the possibility of a regional system was being explored. A local GP was leading a project to introduce new software which would enable local systems to link together.

The SPEoLC team recognised that access to care after death education and information needed to be improved upon, following feedback from staff and link nurses. They were working with chaplaincy, mortuary and bereavement services staff to facilitate this, and to support staff to learn about other areas and processes.
Engagement

Ward staff told us there was much more awareness of palliative and end of life care, and they felt much more involved, due to the training and support they received from the SPEoLC team.

The trust conducted bereavement surveys twice yearly. It had been noted in the most recent survey that there was a need to improve completion rates of the care after death form. Staff had worked with the wider bereavement services team to agree that more comprehensive verbal prompts would be offered to encourage ward staff to complete this documentation.

During Dying Matters week in May 2018, specialist staff raised awareness with wider staff about their role. They gathered views on how their service could improve and also let staff know how they could access the comprehensive end of life care training on offer.

The end of life team conducted a patient experience audit twice yearly. Patients and their families were generally satisfied with the service. However, because patients were generally seen by a number of different services or people, they could struggle to recall exactly who the end of life team were and what their impact had been. The team were looking to review their methodology and revisit questions to refine this for the next audit.

Learning, continuous improvement and innovation

Since our last inspection there had been positive improvements in the management of patients with syringe drivers during discharge, following the purchase of new ambulatory devices. No incidents regarding these had been recorded.

Regarding preferred place of death, the recording process had improved, and teams were more aware of the data collected. Care available in the community had improved, engagement with the ambulance service was good, and staff were more aware of the importance of discussing preferred place of death with patients.

Care of the dying documentation had been relaunched to raise staff awareness and improve engagement. The end of life team leader had visited wards to provide staff with information and support, and also to gain staff feedback: 274 staff had been involved over five days.

Staff awareness and engagement in end of life and palliative care was also addressed using newsletters, flyers cascaded to staff groups, and through staff induction. We saw that good morale within the service had a positive impact on staff in other areas.

At each team meeting, a slot was scheduled for learning from specific issues. We observed a team member describing a complex case where it was not clear where, to who and when to release a patient’s personal effects. The team offered insight and suggestions and the team member was congratulated for their work in reaching a conclusion acceptable to all parties.

One of the palliative care consultants led the most recent Northern Regional Palliative Care Physicians Group meeting, focussing on patients on the pathway to heart transplantation.

Every four to five weeks, the end of life team attended group supervision with a clinical psychologist. This gave them the opportunity to discuss any cases that had been particularly difficult or troubling, and to offer peer support. Staff told us that these sessions were very open and honest, with no role demarcation, and all staff were happy to contribute. The sessions were protected time, enabling staff to prioritise their own wellbeing.
Mortuary staff had been nominated for the national NHS unsung heroes award in 2018. Although they were not successful, they felt pride in having raised awareness of their service which they told us was often overlooked.

The trust led nationally on a piece of work overseeing the withdrawal of ventilation in a home setting for patients with motor neurone disease and the team was part of a national committee informing best practice. The team have conducted more withdrawals of ventilation than anyone else in the country and their findings have been presented internationally.

The SPEoLC team had a funded research place with the northern palliative care partnership and had been looking at use of cannabinoids in treatment of cancer pain. Senior staff told us they aspired to be more active in research projects in the future.

The SPEoLC teams had contributed to the Public Health England national palliative care dataset pilot which measured, analysed and compared some of the key outcomes that mattered most to people who received specialist palliative care.

A member of the team had been awarded the Dundas Medal (a national palliative care award) in 2018 for their work with heart and lung transplant teams and their patients. This group of patients did not normally receive palliative care due to the perception that a transplant would offer hope and a new lease of life, however high mortality rates showed there was an unmet need. Prior to the intervention, less than 10 transplant patients received palliative care per year. In the first year of intervention, this rose to 45. The wider SPEoLC team supported patients through difficult times, either towards recovery or, if this was no longer an option, to facilitate transfer to a patient’s preferred place of death. Feedback from patients and staff was overwhelmingly positive and changed perceptions that palliative care was only for people who were expected to die.
Diagnostic imaging

Facts and data about this service

The imaging specialties at the RVI included computed tomography (CT), magnetic reasoning imaging (MRI), Ultrasound, Plain Film X-ray, Fluoroscopy, Gamma cameras and single photon emission computed tomography (SPECT) CT.

Interventional Radiology was provided at the Royal Victoria Infirmary (RVI) site and there was a nuclear medicine department at the RVI.

Diagnostic imaging provided services to adults and children across the department and had a dedicated x-ray area with a waiting room for children.

There were around 499,985 examinations provided across the trust for diagnostic imaging between April 2017 and March 2018. This included approximately 66,780 CT examinations, approximately 81,970 diagnostic ultrasonography, approximately 28,370 fluoroscopy examinations, 52,375 MRI examinations, Approximately 260,000 plain film x-rays and approximately 575 SPECT CT examinations.

The nuclear medicine department carried out approximately 12,000 procedures across the trust each year.

(Source: Acute provider information request – context)

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

The service had an ionising radiation medical exposure regulation (IR(ME)R) inspection from the Care Quality Commission (CQC) in July 2018. Following the IR(ME)R inspection an improvement notice was issued, and this was removed prior to this inspection following submission by the trust of a compliant action plan.

During the inspection we visited the main x-ray department, which included a children’s x-ray area, fluoroscopy, electroencephalogram (EEG), ultrasound, Magnetic Reasoning Imaging (MRI), Computed Tomography (CT) and the lung function department at the Royal Victoria Infirmary.

During the inspection we spoke with 28 staff, 14 patients and reviewed eleven records and safety forms.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Is the service safe?

Mandatory training

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

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training.

Royal Victoria Infirmary

A breakdown of compliance for mandatory training courses as of September 2018 at Royal Victoria Infirmary (RVI) for qualified nursing staff in diagnostic imaging is shown below:
In diagnostic imaging at the RVI, the 95% target was met for three of the 13 mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses as of September 2018 at Royal Victoria Infirmary (RVI) for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Patient Falls</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>18</td>
<td>16</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>18</td>
<td>16</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>18</td>
<td>16</td>
<td>89%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>18</td>
<td>15</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>18</td>
<td>15</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>18</td>
<td>15</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Basic Life Support</td>
<td>16</td>
<td>12</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>18</td>
<td>13</td>
<td>72%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>18</td>
<td>10</td>
<td>56%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Local Induction</td>
<td>2</td>
<td>0</td>
<td>0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging at the RVI, the 95% target was met for three of the 13 mandatory training modules for which qualified Allied Health Professionals (AHPs) in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Induction</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>24</td>
<td>23</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>24</td>
<td>23</td>
<td>96%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>24</td>
<td>22</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>24</td>
<td>22</td>
<td>92%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>24</td>
<td>20</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>24</td>
<td>15</td>
<td>63%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>24</td>
<td>14</td>
<td>58%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>24</td>
<td>13</td>
<td>54%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>24</td>
<td>12</td>
<td>50%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Basic Life Support</td>
<td>22</td>
<td>10</td>
<td>45%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>24</td>
<td>9</td>
<td>38%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>26</td>
<td>9</td>
<td>35%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging at the RVI, the 95% target was met for three of the 13 mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses as of September 2018 at Royal Victoria Infirmary (RVI) for qualified Allied Health Professionals (AHPs) in diagnostic imaging is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Induction</td>
<td>34</td>
<td>34</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>187</td>
<td>185</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevention of Staff Falls</td>
<td>187</td>
<td>185</td>
<td>99%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>187</td>
<td>160</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Anti-Bribery and Corruption</td>
<td>187</td>
<td>152</td>
<td>81%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>187</td>
<td>146</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>187</td>
<td>142</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>187</td>
<td>133</td>
<td>71%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 2</td>
<td>181</td>
<td>123</td>
<td>68%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and Handling Level 1</td>
<td>6</td>
<td>4</td>
<td>67%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Adult Basic Life Support</td>
<td>181</td>
<td>119</td>
<td>66%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>PREVENT</td>
<td>187</td>
<td>116</td>
<td>62%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Paediatric Basic Life Support</td>
<td>123</td>
<td>57</td>
<td>46%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was met for three of the 13 mandatory training modules for which qualified AHPs were eligible at RVI.

The overall completion rate for the period April – September 2018 was 81%, compared to 92% for 2017/18.
(Source: Routine Provider Information Request (RPIR) – Training tab)

Mandatory training was provided as a mixture of e-learning and face to face learning.

Staff completed mandatory training across the service. Where mandatory training was not up to date for staff, managers told us staff were booked on to training to ensure it was completed. Managers were also asking staff to complete the mandatory training as required. Staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.

The department manager’s maintained oversight of the mandatory training compliance and told us this was discussed at the executive team meeting. There was also trust oversight of mandatory training as it was part of the board papers, for example in December 2018.

The radiation protection supervisors completed a two-day course led by the regional medical physics team and there was a two-yearly refresher course available to staff. The radiation protection supervisors provided annual updates around good practice to staff as required.

Safeguarding

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

Safeguarding training completion rates

A breakdown of compliance for safeguarding training courses as of September 2018 at trust level for qualified nursing staff in diagnostic imaging is shown below:
<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>18</td>
<td>15</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>6</td>
<td>5</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>18</td>
<td>14</td>
<td>78%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as of September 2018 at trust level for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children Level 1</td>
<td>20</td>
<td>18</td>
<td>90%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>44</td>
<td>38</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>44</td>
<td>33</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as of September 2018 at trust level for qualified Allied Health Professionals in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>185</td>
<td>143</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>187</td>
<td>144</td>
<td>77%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>119</td>
<td>90</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which qualified AHPs were eligible.

**Royal Victoria Infirmary**

A breakdown of compliance for safeguarding training courses as of September 2018 at Freeman Hospital for qualified nursing staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>12</td>
<td>10</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>12</td>
<td>9</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as of September 2018 at Freeman Hospital for qualified Allied Health Professionals is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>12</td>
<td>10</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>12</td>
<td>9</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
Hospital for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>24</td>
<td>20</td>
<td>83%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>24</td>
<td>18</td>
<td>75%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as of September 2018 at Freeman Hospital for qualified Allied Health Professionals in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>66</td>
<td>57</td>
<td>86%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>68</td>
<td>52</td>
<td>76%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 95% target was not met for any of the safeguarding training modules for which qualified AHPs were eligible.

The overall completion rate for the period April – September 2018 was 79%, compared to 95% for 2017/18.

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

The trust had a trust wide safeguarding adult’s policy and guidelines with an expiry date of 28 November 2021. The trust had a child protection and safeguarding children policies and procedures document with an expiry date of 18 January 2020. The service had safeguarding radiology meetings and the trust provided a radiology directorate skeletal survey referral process August 2017 which had a review date of August 2019. The trust provided information highlighting the trust had a quarterly safeguarding committee and the trust safeguarding team provided guidance and support to staff.

Staff we spoke with during the inspection were aware of safeguarding and could describe how they would report a safeguarding concern, for example contacting the safeguarding team at the trust if they had concerns. During the inspection there were safeguarding posters on display in the departments.

Managers told us staff in the children’s x-ray area of the department were trained to level three children’s safeguarding and staff in other areas of diagnostic imaging were trained to level two children’s safeguarding. The trust provided information stating that staff who worked with children for more than 50% of their time required level three safeguarding training. Staff had access to a trust wide safeguarding team for additional advice as required.

Information provided by the trust highlighted there were three radiographers in the children’s x-ray area and 2.2 whole time equivalent radiologists and the information showed that two radiographers had level three children’s safeguarding and one member of staff was booked to attend the course. Information provided by the trust showed that two radiologists were compliant with level three children’s safeguarding training and one consultant was booked onto the safeguarding level three children’s training refresher course.
Staff we spoke with during the inspection could describe using the three-point identification check in the department to check identification of patients and could describe the ‘pause and checked’ checklist which was used. The three-point identification check included name, date of birth and address. The ‘paused and checked’ checklist was on display in departments during the inspection. The ‘paused and checked’ poster is a clinical imaging operator 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.

Cleanliness, infection control and hygiene
The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

Areas visited were visibly clean and tidy. During the inspection we saw staff adhering to ‘bare below the elbow’ guidance. Hand sanitiser was available for use in the department and there were hand washing sinks available in various areas visited. Staff told us departments received daily cleaning. There were hand washing guidance posters on display in departments. There was waste disposal for various types of waste available across the department.

Staff told us ultrasound probes were cleaned after each patient with cleaning wipes. Scanning beds were wiped down after each patient as needed and a new paper cover was put on the scanner bed. Staff in the lung function service described the various cleaning of equipment such as cleaning some equipment with cleaning wipes and that some equipment needed to go to the sterilisation unit for cleaning. Staff told us they would follow manufacturer’s cleaning requirements for equipment.

Staff told us patients who may have a communicable disease would be scanned at the end of the day or before lunchtime and the rooms would be cleaned as appropriate afterwards.

Hand hygiene audits were completed in the department. The main x-ray department had hand hygiene results on display which showed 100% compliance for recent results. There were cleaning sheets for the two main x-ray rooms at the RVI and sheets seen during the inspection were signed as required. There was a foot rest in the MRI department which did not have a paper cover to increase the infection control standards.

The trust provided environmental cleanliness reports for November 2018. Radiology was included in this report and 97.24% compliance for the monthly matrons check, 96% compliance for hand hygiene opportunity, 92% for hand hygiene technique, 100% compliance for infection, prevention and control practice and 96.82% for total environmental cleanliness. Although there was no action plan attached to these reports.

The trust had a radiology directorate and nuclear medicine procedure for the decontamination of the radioiodine suite. The trust had a radiology directorate and nuclear medicine IRR17 risk assessment for contamination in working areas.

Environment and equipment
The service had suitable premises and equipment and looked after them well.

The department had a main waiting area with reception and seating available. There were toilets available in the department. The service also had separate waiting areas in the children’s
radiology area and other specialities across the department. During the inspection areas of the department visited were tidy.

There was signage on display directing patients and visitors to the diagnostic imaging department and signage on display in the department for the various specialties.

The various departments within the diagnostic imaging unit had relevant warning signage on display to highlight restricted areas to staff, patients and visitors. The x-ray areas had lights warning of x-rays. Although during the inspection exposure charts and guidelines were not on display in the two main x-ray rooms at the RVI. The fluoroscopy rooms had warning signs such as ‘controlled area x-rays’ and ‘authorised persons only’. There were areas in the departments with swipe access to enhance security.

The department was wheelchair accessible along with wheelchair accessible rooms. A hoist was available in the department for use as required to assist with moving and handling. Patients waiting in the main waiting area of the department were visible to the reception staff, although some of the smaller waiting areas were outside clinic rooms.

The children’s x-ray waiting area had toys, books and a DVD player available and the service had implemented a small toy scanner with attachments which children could interact with. The children’s area also had a games station available for use and information on display regarding health promotion. The children’s corridor had separate waiting areas for different age groups, one waiting area for toddlers and one waiting area for teenage children. A quiet room was available in the children’s corridor to assist in providing additional privacy and dignity to patients and visitors.

There were reporting rooms with computers available for staff to use.

Managers told us equipment was logged onto a servicing and planned preventative maintenance schedule. Staff could report faults and issues with any equipment electronically. The trust provided a 2018 radiology equipment list which highlighted the different specialties in diagnostic imaging along with the location, quality assurance performed and quality assurance due dates for equipment used. This equipment list showed that equipment had a previous preventative maintenance date logged and the next preventative maintenance date was documented or documented where it was to be confirmed with the vendor.

The departments had four resuscitation trolleys. Although only two resuscitation trolleys had the daily and weekly checks consistently completed, the resuscitation trolley in the reception area of main x-ray had 26 separate dates where checks were not completed between 1 October 2018 and 15 January 2019. The resuscitation trolley in the ultrasound department had 20 separate dates where the checks had not been completed on weekday between 1 October 2018 and 15 January 2019. We raised this with managers during the inspection who told us they were going to address it.

The interventional resuscitation trolley had equipment for both adults and paediatric patients. This resuscitation trolley had the checks completed as required between 1 October 2018 and 15 January 2019. The neuroradiology resuscitation trolley had been completed as required between 2 January 2019 and 17 January 2019.

Risk assessments had been completed for various risks across the department. These were stored electronically on the trust systems. The main x-ray department had eight risk assessments on the electronic system.

The nuclear medicine department had completed risk assessments in the department and these were stored electronically on the trust systems, for example the risk assessment for ionising
radiation 1999. There were 57 risk assessments on the system and eight required review. Managers told us they were going to address this.

We visited the magnetic reasoning imaging unit (MRI) and found there were certain items which were not labelled as MR safe or MR conditional for example. We raised this with managers who told us they were going to address the concerns.

The MRI unit had warning signage on display to highlight the risks to staff and patients. Patients had to complete a safety questionnaire before they could enter the MRI unit with staff.

Staff had the required equipment available and accessible for use. Personal protective equipment was available for use in the department. Equipment such as lead aprons had annual audits to check for defects. Staff wore dosimeters where applicable to monitor exposure to radiation. The radiation protection supervisors participated in the annual radiation protection audit as needed.

The service had 24 hours, seven days a week access to information technology support as required and managers told us they had been working with an external provider to address the challenges around information systems used in the department.

The scanning rooms in MRI and CT had colourful pictures on the walls and electronic images on display.

There were changing rooms available and a breastfeeding room. There was seating available in the children’s waiting areas. The children’s x-ray department had various pictures on display in the various rooms.

The neuroradiology department patient environment had been redesigned around two years prior to the inspection in response to a business case.

During the inspection there was a suction machine which required servicing. This was raised with managers who told us they had replaced it during the inspection and the original one was being serviced.

The Royal Victoria Infirmary was based in Newcastle and there was car parking on site at the hospital.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

The department had access to an in-house medical physics expert, radiation protection expert and the department had radiation protection supervisors for advice. Staff told us they had access to a radiologist for advice as needed.

Where adults and children patients were clinically unwell or deteriorated in the department, staff would call the hospital resuscitation team and had access to a resuscitation trolley in the department. Staff in the CT and MRI department also told us they would call the radiologist. In the MRI department, the local rules included emergency procedures. The trust had a flow chart for an unwell patient in radiology CT at the RVI. The trust provided a standard operating procedure for the radiology directorate for the care of the deteriorating patient in the radiology department with an effective date of 6 February 2019 and an expiry date of 1 June 2021.

The service had local rules in place for staff to follow for their speciality area. There was also a trust wide MR safety group. The MR safety form used in the MRI department was signed by the
radiographers and the patient once complete. The MRI safety questionnaire was sent out with the appointment in the post.

Managers told us they were working on writing new standard operating procedures for the MRI unit. The department had a MRI safety procedure and an MRI safety file in the department. However, the MRI scanner competencies required updating as the previous entry was from 2015 and not all members of staff had signed the MRI evacuation process documents.

The World Health Organisation (WHO) checklist was used in interventional radiology. Staff told us this revised checklist incorporated the local safety standards for invasive procedures (LOCSIPP) as well as National Early Warning Scores (NEWS). Staff could describe the WHO checklist during the inspection and the local safety standards for invasive procedures (LOCSIPP). The service had recently started to audit the WHO checklist.

The trust provided information highlighting the process for sedated patients in the department. For example, staff told us that in the paediatric diagnostic imaging area, a paediatric nurse would be with the patient if they were sedated. The trust had a document for the guidelines for the practice of intravenous sedation in adults with an expiry date of 29 March 2020.

Staff in the department wore dosimeters and the radiation protection advisors would advise staff when they required changing which we were told was two monthly. These were worn to monitor the staff exposure to radiation in the department.

Staff told us patients receiving contrast in the CT department stayed in the department for around 20 minutes after the procedure for safety precautions. Staff completed basic life support training as part of mandatory training.

The CT department had the local and national diagnostic reference levels (DRL) displayed on the wall dated July 2018. Staff told us they would inform a radiologist if an abnormality or something unexpected was seen on a scan in CT.

Managers in nuclear medicine told us referrals were made in line with IR(ME)R guidelines.

The safety forms used in the MRI department included questions, for example regarding pregnancy.

Staff used the ‘paused and checked’ checklist in the department to check the correct patient was receiving the correct scan. Results from the 2018 patient satisfaction survey for the CT department at the RVI hospital showed 91% of respondents said the radiographer or assistant checked their details (Name, address and date of birth) before the scan, 3% of respondents said no and there was no response in 6% of respondents. There were 100 returned questionnaires.

Staffing

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

The diagnostic imaging department was open 24 hours a day, seven days a week and therefore there was a shift rota for staff working. This was managed by the departments resources team who managed annual leave and the staff rota to ensure the shifts were covered as required. The resources team was managed by a superintendent radiographer.

There were national challenges with staffing shortages in diagnostic imaging departments, however managers had done various pieces of work to address this challenge and recruit the staff required. The department had completed international recruitment to increase radiographer
staffing levels in the department. Managers told us they had been able to overrecruit to the service and there had been active support from the human resource department for recruitment.

Managers told us there were challenges with medical staffing in the children’s department and the action taken to address these challenges included continued recruitment and providing other staff groups additional training to assist in the department.

The trust provided a radiology strategy presentation for 2018/23 showing there were 424 staff and 39 consultants in the radiology service.

The radiology new innovations and quality improvement document provided by the trust highlighted there had been registrar on-call improvement and the services had increased the number of on-call trainees from one to two staff in the evening shifts at the RVI.

**Nurse staffing**

The trust has reported their qualified nurse staffing numbers for diagnostic imaging below for the period April to September 2018.

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned staff WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE LFY</th>
<th>Planned staff YTD (Apr-Sep-18)</th>
<th>Actual Staff WTE YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary</td>
<td>11.1</td>
<td>10.1</td>
<td>11.1</td>
<td>10.7</td>
<td>91%</td>
<td>96%</td>
</tr>
</tbody>
</table>

As of September 2018, the actual staffing level (WTE) for qualified nursing staff in the diagnostic imaging service was:

- 96% of the planned level at Royal Victoria Infirmary  
  *(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

**Vacancy rates**

The trust has offered no formal vacancy target, but from October 2017 to September 2018 the trust-wide vacancy rate averaged 6%.

In the diagnostic imaging service, the vacancy rate averaged 15%. Among qualified nursing staff the vacancy rate was 8%. Among qualified nursing staff in the diagnostic imaging service:

- Royal Victoria Infirmary was 12%  
  *(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

To address vacancies the service continued to recruit as required and had trained staff in additional roles to increase flexibility within the service.

**Turnover rates**

The trust has an 8% target for turnover. From October 2017 to September 2018 the trust-wide turnover rate averaged 9%.

In the diagnostic imaging service, the turnover rate averaged 7%. Among qualified nursing staff the turnover rate was zero.

- Royal Victoria Infirmary was 0%  
  *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*
Sickness rates

The trust has a 3% target for sickness absence. From October 2017 to September 2018 the trust-wide sickness rate averaged 4%.

In the diagnostic imaging service, the sickness rate averaged 3%. Among qualified nursing staff the sickness rate was 4%.

- Royal Victoria Infirmary sickness rate was 3%

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

Bank and agency staff usage

For qualified nursing staff, from October 2017 to September 2018 the diagnostic imaging service:

<table>
<thead>
<tr>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>diagnostic imaging total – Qualified</td>
<td>27,473</td>
<td>2,284</td>
<td>8%</td>
</tr>
<tr>
<td>Trust total – Qualified</td>
<td>6,530,050</td>
<td>139,878</td>
<td>2%</td>
</tr>
</tbody>
</table>

Qualified nursing was used at the RVI site, bank staff covered 8% of hours and no agency staff were used.

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

Medical staffing

As of September 2018, the actual staffing level (WTE) for medical staff in the diagnostic imaging service was:

<table>
<thead>
<tr>
<th>Site</th>
<th>Planned staff WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE</th>
<th>Planned staff YTD (Apr-Sep-18)</th>
<th>Actual Staff WTE YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary</td>
<td>27.0</td>
<td>24.9</td>
<td>26.0</td>
<td>24.3</td>
<td>92%</td>
<td>94%</td>
</tr>
</tbody>
</table>

- 94% of the planned level at Royal Victoria Infirmary

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

Vacancy rates

The trust has offered no formal vacancy target, but from October 2017 to September 2018 the trust-wide vacancy rate averaged 6%.

In the diagnostic imaging service, the vacancy rate averaged 15%. Among medical staff the vacancy rate was 6% by site:

- The vacancy rate at Royal Victoria Infirmary was 9%.

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

Turnover rates

The trust has an 8% target for turnover. From October 2017 to September 2018 the trust-wide turnover rate averaged 9%.

Among medical staff the turnover rate was 2%. Among medical staff in the diagnostic imaging
service:

- The turnover rate at Royal Victoria Infirmary was 4%.
  *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

The trust has a 3% target for sickness absence. From October 2017 to September 2018 the trust-wide sickness rate averaged 4%.

In the diagnostic imaging service, the sickness rate was 1%. Among medical staff in the diagnostic imaging service:

- The sickness absence rate at Royal Victoria Infirmary was 1%  
  *(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and locum staff usage**

For medical staff, from October 2017 to September 2018 the diagnostic imaging service:

<table>
<thead>
<tr>
<th></th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>155,981</td>
<td>809</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>total</td>
<td></td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Trust total</td>
<td>1,746,066</td>
<td>45,659</td>
<td>1,629</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Filled 1% of its shifts with bank staff and filled no shifts with agency staff and no shifts unfilled.

Managers told us the service did not use agency staff for medical staffing.  
*(Source: Routine Provider Information Request (RPIR) – Bank Agency Locum)*

Medical staff were available on site for advice and as needed.

The trust had three paediatric radiologists but had identified it was under resourced by around three paediatric radiologists. To address this the trust had supported the department in trying to recruit to these roles and there was a dedicated human resource officer to address these issues. The department stated they had repeated attempts to recruit staff and were working with the paediatric directorate regarding the resource to develop a vision for the service and the information provided stated they had support from senior trust staff to consider recruitment strategies. In the interim the information provided by the trust stated some paediatric scans and other procedures were reported and done by non-paediatric radiologists.

There were national challenges with recruiting radiologists. The service double reported scans where required, although the staffing challenges had made meeting reporting time targets a challenge.

**Qualified allied health professional staffing**

Managers in neuroradiology told us they had used radiographer locum staff but were continuing to recruit radiographers and during the inspection had two vacancies.

As of September 2018, the actual staffing level (WTE) for qualified AHP staff in the diagnostic imaging service was:
<table>
<thead>
<tr>
<th>Site</th>
<th>Planned staff WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE LFY</th>
<th>Planned staff YTD (Apr-Sep-18)</th>
<th>Actual Staff WTE YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Infirmary</td>
<td>59.9</td>
<td>58.4</td>
<td>59.0</td>
<td>57.8</td>
<td>97%</td>
<td>98%</td>
</tr>
</tbody>
</table>

- 98% of the planned level at Royal Victoria Infirmary
  *(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

**Vacancy rates**

The trust has offered no formal vacancy target, but from October 2017 to September 2018 the trust-wide vacancy rate averaged 6%.

Among qualified AHPs the vacancy rate was 10%.

- The vacancy rate at Royal Victoria Infirmary was -1% (indicating it is over staffed)
  *(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

The trust has an 8% target for turnover. From October 2017 to September 2018 the trust-wide turnover rate averaged 9%.

In the diagnostic imaging service, the turnover rate was 8%:

- The turnover rate at Royal Victoria Infirmary was 6%.
  *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

The trust has a 3% target for sickness absence. From October 2017 to September 2018 the trust-wide sickness rate averaged 4%.

In the diagnostic imaging service, the sickness rate was 2%:

- The sickness absence rate at Royal Victoria Infirmary was 3%
  *(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

The trust provided information stating the service was at full establishment for paediatric radiographers with one whole time equivalent team lead and two radiographers sharing one whole time equivalent position and that all other shift radiographers would rotate through the area. The service was considering a business case for additional radiographer staff.

Managers told us they had been successful in 2018 in recruiting eighteen more radiographer staff to the service.

**Records**

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

Records were kept electronically and scans were available electronically after the scan was complete. Records were password protected as required. There was electronic access to scans and results across the trust. The diagnostic imaging departments had access to the trust patient records systems and could access the radiology systems across the different specialties. Records from radiology systems were available across the hospital to medical teams as required.
We checked four patient MRI safety forms which were completed as required.

The service had a project registered for the audit of radiography patient dose data entered onto the radiology systems, although this had not yet started.

During the inspection we checked seven WHO checklists for patients where they had been uploaded to the radiology information system and found four checklists were fully completed, one checklist had not been uploaded to the system and two did not require the checklist to be completed.

The service scanned safety forms onto the systems once they were completed, although there were no regular audits of this.

The trust provided information highlighting they used electronic systems to communicate with general practitioners and reports could be sent to the general practitioners using these systems. The information stated that once a report was written it was sent to the system and this would take approximately 20 minutes.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines.

The services we visited kept medicines. Medicines in the main department were stored securely in locked cupboards and medicines seen were in date. During the day in the department some medicines such as contrast media would be kept in the scanning rooms for use and not locked away, however they were in a restricted environment with staff in attendance during the day.

We looked at patient group directives (legal framework which allows registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients without them having to see a prescriber) in the Radiology department at Royal Victoria Infirmary and found all to be in date and signed by the appropriate individuals.

We also saw evidence that competency assessments of staff working under these patient group directives had been completed in November 2018.

The nuclear medicine department had a pharmacy scientist working in the department available for advice as required. Managers in the nuclear medicine department could describe the relevant licenses which certain professionals held in the trust and had a folder detailing these licenses.

Registered nursing staff were responsible for ordering medicines from pharmacy each week. There were controlled drug weekly checks and when checked these were up to date with checks.

During the inspection there was a medicines refrigerator managed by the anaesthetic team and the room was unlocked and the refrigerator was unlocked. Staff took immediate action to rectify this situation at the time. Temperatures had been recorded, although the escalation process highlighted if the refrigerator temperature had been the same for two consecutive days it should be escalated. This had occurred and no action was documented.

**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.
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 linked to diagnostic imaging. (Source: Strategic Executive Information System (STEIS))

The radiology service managers told us incidents would be reported through the electronic reporting system and incidents would be investigated by senior staff in the diagnostic imaging speciality the incident occurred. Managers told us they had oversight of incidents as when they were reported they received information of the incident.

Staff we spoke with could describe how they would report incidents on the electronic reporting system.

Managers told us learning from incidents was done through a newsletter which the department created and shared with staff every three months. The department also had three monthly team meetings. Staff we spoke with could describe how they would report incidents in the department.

There had been a never event in the neuroradiology department in the previous 12 months. Staff told us the never event had been investigated and learning had been shared with the neuroradiology team and the diagnostic imaging team. Managers told us an action plan had been produced and was now closed. Managers told us they had looked at human factors and the action plan included changes to the local safety standards for invasive procedures (LOCSIPP) and the world health organisation (WHO) safety checklist.

Managers in nuclear medicine at the trust told us that incidents were reported through the electronic incident reporting system and that radiation errors or incidents would be discussed at the radiation protection committee which met every three months.

Staff we spoke with could describe the duty of candour. Duty of candour means the service must be open and honest with patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Managers told us there was a being open policy.

Breakdown of serious incidents reported to STEIS

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

Both were treatment delays and one was at the RVI:

- In May 2018, in the RVI Neuroradiology department, a CT scan was delayed for a patient.

These incidents were reported with specialties (“clinical area”) Medicine and Accident and Emergency, so are also counted under those core services. (Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
The radiology new innovations and quality improvement document provided by the trust highlighted the service had introduced multi parametric MRI with increased numbers to comply with NICE guidelines and pathway optimisation.

Staff could describe the evidence based care and treatment used across the specialities and how National Institute for Care and Excellence (NICE) guidance had led to changes in practice in diagnostic imaging. Information provided by the trust highlighted responsibility for monitoring compliance with the implementation policy for NICE guidelines was with the clinical effectiveness and audit committee which reported to the clinical governance and quality committee.

Diagnostic reference levels (DRL) were used in the department and these were on display in areas visited. These were audited annually by the medical physics department. The service had an annual IRMER report for diagnostic radiology for December 2017. The service also provided a radiation protection advisor (RPA) diagnostic radiology and radiotherapy report for the trust in December 2017.

The department completed audits in the specialties against their practice and had audits planned. The department contributed to local and national audits to enable benchmarking of their services.

The trust provided an annual clinical effectiveness report for radiology for October 2017 to October 2018. Audits detailed regarding national guidance and best practice included the royal college of radiologist’s national audit of seven-day care in radiology and highlighted the data was submitted to the national audit.

The trust provided a IR(ME)R clinical audit programme. For example, this programme included the scope of audits such as audit of completeness of CT patient safety questionnaires and the date scheduled for further audit was October 2019.

There were local rules documented for the diagnostic use of x-rays in the x-ray department which staff were required to follow. This had a review date of 30 July 2020. All 21 local rules on the electronic systems were within the review date of 2020. Managers in nuclear medicine told us the next radiation protection report and next medical physics expert report was due in December 2019. These were annual reports.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff could provide food and drinks to patients as required in the department or if patients had been waiting for a period of time in the department or required food and drink.

There was a display in the children’s waiting area detailing nutrition to provide information to patients and visitors in the department.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain.

The department kept a small amount of pain relief. The service did not use any specific tools to monitor pain.
Patient outcomes

Managers 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 and specialties within diagnostic imaging and nuclear medicine completed regular audits to enable review of their current practice. The service had discrepancy meetings called learning meetings to review previous reports and highlight any learning from these. These were monthly meetings. Reporting radiographers would attend the discrepancy meetings.

The trust participated in national audits such as the Royal College of Radiologists audits. For example, the radiology audit report detailed the Royal College of Radiologists national audit of compliance with UK guidelines for the prevention and detection of acute kidney injury in adult patients undergoing iodinated contrast media injections for CT and this radiology audit report provided by the trust stated they met the current guidelines.

The World Health Organisation (WHO) checklist was used in the interventional radiology department. The trust provided the WHO interventional radiology audit questionnaire which was used to audit the checklist, although the information provided did not detail the recent results from the audit.

The trust provided an annual clinical effectiveness report for radiology for October 2017 to October 2018. This report highlighted an audit for radiology patient satisfaction survey 2018 including radiation risk patient awareness. The main findings highlighted that 95% of patients were happy with the way they were treated and 73% had received information about the benefits and risks of the imaging examination.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Appraisal rates

The trust provided us with appraisal rates for diagnostic imaging care for the April to September 2018, no staffing groups met the 90% target set for the period covering up to March 2019.

Whereas the appraisal target for March 2018 was 80% this core service met the target with a completion rate of 84%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff Required Year to Date</th>
<th>Staff Received an Appraisal - Year to Date</th>
<th>% Of Staff Received an Appraisal YTD</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>40</td>
<td>35</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>16</td>
<td>14</td>
<td>88%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>22</td>
<td>19</td>
<td>86%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>30</td>
<td>23</td>
<td>77%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>52</td>
<td>36</td>
<td>69%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>71</td>
<td>49</td>
<td>69%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
The department had eight reporting radiographers who told us they completed a post graduate certificate to progress to reporting radiographers. There were also five reporting radiographers in training in the different specialties. Managers told us there was a consultant mammographer and two further staff in training. The radiology new innovations and quality improvement document provided by the trust highlighted there was a cardiac CT radiographer in the service.

There were two consultant radiographers providing further advice and knowledge to the department. There were assistant practitioners providing further support to patients and these staff worked under the supervision of qualified staff in the department. There was a standard operating procedure for assistant practitioners called assistant practitioners performing quality assurance (QA) in the main radiology department which had a review date of 29 March 2020. Staff could describe the competency based approach to their induction and spoke of supportive teams and colleagues and the structured approach to the induction programme where staff were able to spend time in each speciality area. Staff described the variety of work undertaken at the trust and the opportunities available and staff were supported in their professional development.

There was a weekly education meeting in the lung function service which included consultants and specialist nurses. The radiology department had a radiographer and student learning board which included information on clinical supervision.

Staff had annual appraisals and told us the human resources department would highlight appraisals required if they had not been completed and there were also prompts on the electronic system used by staff. Staff also had to meet the 95% mandatory training target as part of the appraisal. Superintendent radiographers and managers were responsible for completing staff appraisals. The appraisal year was from April 2018 to March 2019 and therefore was still in progress.

Senior nursing staff in the department attended the clinical leader’s forum which was held quarterly and led by senior nurses at the trust. Senior registered nursing staff received information from the regular senior nurses meeting which described any nursing related matters. Registered nursing staff attended conferences to keep up to date on nursing.

Senior registered nursing staff held one to one meetings with all relevant staff.

Managers told us they were considering training for band three staff in cannulation. Managers told us there were training and learning opportunities available externally and staff were supported through leadership courses. There was a in house leadership course available to medical staff. Managers told us they had attended relevant conferences.

Team leaders in the CT department mentored new members of staff and there was an induction pack for new starters to complete. There was also a CT training pack available.

Staff in the main x-ray department told us they received emails detailing the courses and training available and that there were opportunities for staff to attend courses. Staff told us they completed annual continuing professional development and personal development reviews.

The radiology new innovations and quality improvement document provided by the trust highlighted the radiology department at the trust had a commitment to training in the region. The document also highlighted the service had appointed a consultant sonographer to help support ear, nose and throat and interventional services along with training and there was a senior sonographer who provided mentoring of radiology trainees.
The radiation protection supervisors provided basic good practice training in radiation to relevant registered nursing staff in the cardiac catheter laboratory. In the nuclear medicine department, managers told us registered nurses had radiation safety training as part of their induction course. Staff also told us they did informal learning on relevant areas such as ionising radiation medical exposure regulations (IR(ME)R) and ionising radiation regulations (IRR).

Staff told us there had been discussions with the senior managers regarding LOCSIPPS and human factors training which during the inspection was not completed, although staff were working towards developing training in this area.

**Multidisciplinary working**

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

There was multidisciplinary team (MDT) working across the specialties and staff attended various MDT meetings across the trust. Various staff groups such as radiographers, medical staff, nursing staff, clinical assistants and administrative staff worked together to provide care to patients. The neuroradiology speciality had MDT meetings as required to discuss patient care and treatment. Staff told us they would assist in co-ordinating with other services in the trust as required.

The lung function service had a monthly multidisciplinary team meeting with the sleep service involving consultants and registered nurses. Staff described having clinical support from cardiology consultants and neurology consultants for advice and these staff were accessible. The ultrasound team attended regional team meetings as required.

There was multidisciplinary team working in the mammography unit with medical staff, specialist registered nurses and mammography staff working together to provide care and treatment to patients. Staff told us patients who had a biopsy would also have a specialist nurse and would be discussed at a multidisciplinary team meeting which included consultant medical staff, clinical nurse specialists, MDT co-ordinators and advanced practitioners.

The neuroradiology department was staffed by a multidisciplinary team including neuroradiographers, neuroradiologists and neuroradiology nurses. Staff told us there were regular MDT’s for reporting radiographers.

**Seven-day services**

The service operated 24 hours, seven days a week and staff worked on a shift pattern to ensure the department was staffed as required. There was also 24 hours a day, seven days a week access to the emergency and trauma imaging which included rapid access to CT scanning.

A superintendent radiographer and consultant radiologist were available until midnight at the RVI.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

**Mental Capacity Act and Deprivation of Liberty training completion**
For the period April to September 2018 the completion rates for training on Mental Capacity Act and Mental Health Act for staff in the diagnostic imaging service are detailed below:

**Trust level**

A breakdown of compliance for MCA training courses as of September 2018 at trust level for staff in diagnostic imaging service is shown below:

**Nursing and midwifery staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>18</td>
<td>18</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing and midwifery staff exceeded the trusts 95% completion target for both modules.

**Medical and dental staff**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>44</td>
<td>43</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>44</td>
<td>43</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical and dental staff met the trusts 95% completion target for both modules.

**Qualified Allied Health Professionals**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>187</td>
<td>184</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>187</td>
<td>184</td>
<td>98%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

AHPs also met the trusts 95% completion target for both modules

(Source: Routine Provider Information Request (RPIR) P38 - Training)

The trust set a target of 95% for completion of mental capacity act training. Managers told us mental capacity act training was mandatory. Staff we spoke with could describe mental capacity and what they would do if a patient lacked capacity. Staff in interventional radiology also described best interest decisions. Staff we spoke with could describe how they seek consent and were confident in the action to take if they suspected a patient lacked mental capacity.

Staff in the department used verbal consent and written consent. Written consent was used for invasive procedures. Staff told us they would communicate with the referring clinician if required regarding consent. The consent forms seen for intravenous contrast in the MRI unit were in date.

Staff told us they received online consent training and there was a half day course staff attended on consent. Staff in mammography told us that if a person potentially lacked mental capacity, they would seek assistance from the medical staff and if required discuss at a multidisciplinary team meeting.
Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

The main waiting area had a sign at reception asking patients and visitors to wait to be called to reception to maintain privacy in the department and mitigate the risk of patients being overheard whilst speaking with reception staff.

There was a chaperone policy in place in mammography which staff adhered to which was based on best practice guidance. Staff could describe the chaperone policy and the care provided to patients with a disability attending the service. Chaperones were available in the main x-ray department and staff told us chaperones were always available if required.

Patient privacy and dignity was maintained in most areas visited, however there were occasions during the inspection where patients were waiting to be seen on beds in the corridors in the main x-ray department which did not support patient’s privacy and dignity whilst in the department.

We spoke with twelve patients at the RVI during the inspection and overall feedback was positive regarding the services and care provided. Patients we spoke with felt they had been treated with kindness and compassion. Patients felt their privacy and dignity had been respected during their visit to the diagnostic imaging department and felt staff had been respectful.

The trust provided friends and family test data between January 2018 and November 2018 and this showed there were six respondents who were extremely unlikely, unlikely, don’t know or neither likely or unlikely to recommend the service and there were 48 respondents who were extremely likely or likely to recommend the service. There were 54 respondents.

The trust provided a patient satisfaction survey for 2018 for radiology. For example, results for the CT department at the RVI hospital showed 97% of respondents said the receptionist checked their details when they gave them the request card and there was no response in 3% of respondents. 64% of respondents strongly agreed that staff were polite and very welcoming, 32% agreed staff were polite and very welcoming, 4% neither agreed or disagreed. There were 100 returned questionnaires.

The survey showed 61% of respondents said the radiographers and assistants were very welcoming and polite, 31% of respondents agreed that radiographers and assistants were very welcoming and polite, 1% of respondents neither agreed or disagreed, 2% of respondents disagreed and there was no response for 5% of respondents. There were 100 returned questionnaires.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Patients we spoke with told us they had felt involved in the decision-making process of their care where applicable and staff communicated with patients during their visit to the department and during the care being provided. A quiet room was available in the department which could be used by patients and visitors if required to enhance privacy and dignity.

Overall, patients we spoke with also felt they had been offered adequate psychological and emotional support where relevant in the department. The service had access to a mental health first aider to provide further advice and support as required.
Staff responded to patients where they may be anxious or claustrophobic and could offer visits to the department before appointments to address patient concerns.

In the 2018 patient satisfaction survey at the RVI plain film x-ray, 74% of respondents stated they strongly agree that they were happy with the way they were treated in the department, 22% of respondents agreed, 1% neither agreed or disagreed and 3% did not respond. There were 100 respondents.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment.

The neuroradiology department had three play therapists and specialists who had assisted in training staff in disruption techniques for relevant patients attending the service. Staff told us managers had been supportive in implementing this role in the department. Staff had also done work with claustrophobic patients attending the department. For example, patients could attend to have a look around the department before appointments and staff told us there was information that the patient may be claustrophobic on the referral form and they would contact them as required.

Patient feedback during the inspection regarding staff introducing themselves was varied. Overall, patients we spoke with also felt they would know who to contact if they were worried about anything from the visit to the department.

Appointment letters were sent to patients prior to appointments.

In the 2018 patient satisfaction survey at the RVI for plain film x-ray, 83% of respondents were told how and when they would receive their results, 10% of respondents were not told and 7% did not respond. There were 100 respondents.

In the 2018 patient satisfaction survey at the RVI for MRI, 53.9% of respondents were told how and when they would receive their results, 34.3% of respondents were not told and 11.8% did not respond. There were 102 respondents. In the 2018 patient satisfaction survey at the RVI for ultrasound, 87% of respondents were told how and when they would receive their results, 4% of respondents were not told and 9% did not respond. There were 100 respondents.

Results for the CT department at the RVI hospital showed 40% of respondents were told how and when they would receive their results, 48% were not told how and when they would receive their results and there was no response in 12% of respondents. There were 100 respondents.

There were safeguarding posters on display in the department areas we visited during the inspection.

The trust provided a patient satisfaction survey for 2018 for radiology. The results for CT at the RVI for example showed 68% of respondents said they were attended to on time if they had an appointment, 11% of respondents said within 15 minutes, 8% were attended to between 15 minutes and 30 minutes, 4% of respondents said between 30 minutes and 60 minutes, 4% of respondents said over 60 minutes and 5% did not respond. There were 100 respondents.

The results for plain film x-ray at the RVI showed 52% of respondents were attended to on time, 20% of respondents within 15 minutes, 7% between 15 minutes and 30 minutes and 21% did not respond. There were 100 responses.

During the inspection there was limited evidence staff had access to communication aids to enhance communication with people with additional needs where required.
Is the service responsive?

**Service delivery to meet the needs of local people**

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

Managers told us the directorate fed into the trust capacity and demand planning. Included in this planning was the departments equipment imaging plan which was provided to capital planning at the trust. Managers told us about business planning and that the service had gone through a strategic planning review where each of the directorates had to present their initiative.

Demand and capacity was managed by the leadership team and managers we spoke with were aware of challenges around reporting times and worked with other departments such as finance and human resources regarding capacity and demand.

The department had signage to direct patients to the relevant areas within the department.

The lung function service and the sleep service at the trust were co-managed so resources were shared between the two departments.

The interventional radiology team worked across the two hospital sites at the trust increasing the flexibility of the service.

The neuroradiology department developed business cases based on the managers plans and needs assessment of the service.

**Meeting people’s individual needs**

The service took account of patients’ individual needs.

There were scanning machines which could facilitate scanning bariatric patients attending the service.

The mammography service could add alerts to the electronic system used if a patient with additional needs did attend the department.

Staff told us patient information leaflets were available for patients in the different specialities. Interpreters and British Sign Language support was available and accessible across the department at the trust.

The main x-ray department had two rooms and there was a changing room attached to the x-ray rooms. There were patient information leaflets available for MRI scans, CT scans and ultrasound scans on display in the waiting areas.

The nuclear medicine department had a registered nurse who was also a dementia lead within the department to provide advice and support as needed. The nuclear medicine department were also in the process of considering nursery nurses to assist with children at the RVI and this was to be trialled over the following weeks after the inspection. Staff in dual energy x-ray absorptiometry (DEXA) told us information leaflets were sent out with appointments.

The mammography unit offered a one stop service for people with potential cancer diagnosis. Patients would attend outpatients where they could be referred through to ultrasound if required.

Staff told us they could show patients the equipment used if required and could bring patients back for an appointment with additional time allocated.

Staff could offer more time for appointments if required.
Staff could describe an example of the equipment used to adjust for the care provided to patients, for example the access to a scoliosis chair in the department.

The main x-ray department were working on a new wheelchair for patients to address patient’s individual needs.

The radiology new innovations and quality improvement document highlighted the trust had implemented a combined ear, nose and throat and ultrasound neck lump clinic.

There were dementia champions available for advice as required in the department. The neuroradiology department had two dementia leads who could provide additional advice to staff.

A quiet room was available in the main x-ray department for patients and visitors use.

**Access and flow**

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

**Waiting times**

**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 similar to the England average, but has tended to drop during 2018 whereas the England average has risen. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England. The chart below shows 6+ weeks percentages over time.

(Source: NHS England – Diagnostic Waits)

The trust provided information highlighting that in March 2018 GA MRI waiting times were at 14 months and this had reduced to six weeks in December 2018. Staff told us the MRI waiting lists had reduced due to increasing the scanning lists until 8pm and the service had Sunday waiting lists to address the waiting times.
Reporting

Chest x-rays from the general practitioners between June 2018 and August 2018 was 98% within the local standard reporting period. The standard was 100% compliance within three working days. The CT chest x-ray from general practitioners between June 2018 and August 2018 was 99% within the local standard reporting period. The local standard was 100% within two weeks. Staff in CT told us cardiac reporting was carried out by the radiographers and this would be done within 24 hours.

Between June 2018 and August 2018 in accident and emergency x-ray the service was at 77% against the standard. The standard was 100% within three working days.

Between June 2018 and August 2018 in CT outpatients the service was at 81% against the standard. The standard was 100% within two weeks.

Between June 2018 and August 2018 in the CT colon service the service was at 52% against the standard. The standard was 100% within one week.

Between June 2018 and August 2018 in CT accident and emergency the service was at 49% against the standard. The standard was 100% within two hours.

Between June 2018 and August 2018 in MRI outpatients the service was at 62% against the standard. The standard was 100% within two weeks.

Between June 2018 and August 2018 in the MRI knee service the service was at 67% against the standard. The standard was 100% within two weeks.

Between June 2018 and August 2018 in the MRI prostate service the service was at 61% against the standard. The standard was 100% within one week.

Urgent referrals and waiting times

The service provided information showing there were appointments waiting longer than two weeks for urgent and priority appointments.

The waiting times for urgent cancer appointments showed the longest waits were in CT, followed by MRI, ultrasound and then plain film imaging. For example, CT had between 1000 and 1200 appointment episodes on the combined cancer waiting list with around 600 appointments being less than one week, the second highest number of appointments being one to two weeks and the other appointments being between two weeks and six plus weeks. This information stated there were pressures in waits for specialist imaging such as CT and MR cardiac and some complex abdominal imaging.

The information provided by the trust showed the length of time in weeks for waits for combined priority urgent appointments in 2018. This information showed the longest waits were in CT, followed by ultrasound, MRI and then plain film.

The service had recently started to outsource some elective CT and MRI imaging. The service also had an external provider attend the trust to assist in reporting some plain film x-ray.

The trust had a process for managing urgent cancer appointments and provided information on this which included date stamping referrals received in the department and entering these onto the electronic systems as urgent cancer appointments.

The main x-ray department provided 24 hours a day, seven days a week emergency and trauma imaging which included rapid access to CT scanning. The department offered a range of services including MRI, CT, ultrasound, Barium studies, Fluoroscopy, computed radiography (CR) and digital radiography (DR) imaging. Imaging could be accessed immediately on the x-ray system.
across the hospital and in the emergency department. Referrals to the radiology department came in various ways. Inpatients could be referred electronically, and outpatients were referred on paper requests, but managers told us they were considering moving it all to electronic referrals. Referrals were also received from general practitioners (GP) and there was minimal independent health work carried out.

The bookings team at the service managed ‘did not attend’ rates for the service. Where there were ‘did not attend’ appointments staff would contact the patient to make another appointment. Managers told us the trust were considering text reminder services to address ‘did not attend’ appointments and they would book other patients into ‘did not attend’ appointments.

The trust provided information on the ultrasound key performance indicators and this showed the RVI had an ultrasound DNA rate of around 10% between October 2017 and March 2018. The rate of DNA for MRI between October 2017 and March 2018 was around 10%. The rate of DNA for CT between October 2017 and March 2018 was also around 10% this date was for both hospital sites.

The radiology department had a bookings team which facilitated non – urgent and urgent bookings to the department. Appointments were allocated and sent to patients, although staff told us they could facilitate appointment choices and different times for appointments if the patients contacted the bookings team. There was walk in appointments available for main x-ray and staff told us they could facilitate urgent MRI appointments as necessary. Staff told us general practitioners could use an appointment system to book patient appointments directly.

Staff told us prioritisation of bookings was done using a priority status on the booking cards. For example, ultrasound referral cards would have a priority status of routine or urgent which highlighted the priority of the referral and once these were on the electronic systems they would go to the sonographer who would check what preparation was required. Inpatient referrals went directly to the sonographer.

Staff in the CT department told us they could always facilitate urgent patients and would discuss this with the radiologist and the superintendent radiographer and that team leads, and the superintendent would vet the requests. There was a procedure for the practice of radiographers protocolling CT requests.

The departments visited in diagnostic imaging did not have boards highlighting waiting times in clinic, although the mammography unit did have an information board which was updated and included updates such as time delays.

Staff told us next day appointments were available in the different specialities in radiology if required.

Staff told us that in the x-ray department GP reports would go back to the doctor between seven to ten days after the scan and that priority patients such as patients with fractures would be directed to the minor injuries’ unit for immediate treatment.

Learning from complaints and concerns
The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Summary of complaints
From September 2017 to August 2018 there were four complaints about diagnostics: four at Royal Victoria Infirmary.
(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From April 2017 to March 2018 there were 184 compliments within diagnostics.
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Managers told us complaints could be received into the department in various ways and that when a formal complaint was received this would go to the directorate manager for radiology and then investigated by the relevant person.

Managers told us learning from complaints and feedback to staff was completed individually and generic feedback from learning from complaints was done through the three-monthly newsletter. The directorate manager had oversight of complaints in the department. Overall, there were no themes or trends in the complaint information provided by the trust, although two of the complaints were regarding delays to treatment. The trust provided information highlighting they had submitted a business case in the neurosciences department for extra capacity for pre-assessment to avoid ad-hoc sessions as changes made from complaints.

The notice board included a patient advice and liaison service sign displayed which provided information to patients and visitors on the trust patient advice and liaison service.

Is the service well-led?

Leadership

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

There was a clear leadership structure in place in the areas visited and diagnostic imaging was part of the radiology directorate. The service was managed by a leadership team including a directorate manager, clinical director, radiology services manager and a deputy radiology services manager. Each speciality within diagnostic imaging had a superintendent radiographer.

Leaders worked across both sites of the trust which increased the visibility of the leadership team across the specialties. Staff were positive about leaders in the various specialities and leaders being approachable and told us there was support as required from leaders.

Leaders we spoke with during the inspection understood and could describe the challenges the service had and described the actions taken to address challenges.

Leaders held regular meetings to manage and provide the services and ensure there was oversight of the various specialities provided.

The neuroradiology service was part of the neurosciences department, although staff in the services worked closely with radiology and completed joint recruitment and discussed resources as required.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

The leadership team could describe the vision and strategy for the department which was to ensure reporting times were addressed and met as required. The trust had a vision and values document which was on display in the various departments visited. Staff could describe working to the trust operational agenda. Leaders told us they were proud of going above and beyond for patients.
The trust provided a radiology strategy presentation for 2018/23 which detailed information of radiology activity, strengths, challenges, top priorities, patient experience, strategic options and the top three areas for transformation. The top three areas for transformation were vulnerable services, performance and reporting.

Managers told us they would submit information to the quality performance review and would meet with finance for example to discuss where they were and where they would like to be and consider their strategy along with the broader strategy. There was no documented formal strategy for the department, although managers told us they would respond to changes as required and they had developed an action plan with senior trust managers on what they could try to do.

There were challenges described with regards to staffing in the department and the leadership team could describe the action they were taking to improve staffing levels. The leadership team told us they were continuing to recruit as needed, completed international recruitment, extending and offering a wide variety of roles to current staff and training staff in areas where there were shortages. The department had also been given permission to overrecruit which had assisted in additional staff to the department.

There were managed equipment services in place for scanning equipment.

**Culture**

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

Overall, morale was good, and staff told us there was good teamwork, openness and honesty in teams and teams were supportive. Staff we spoke with were proud to work for the organisation and felt respected and valued by the organisation. Staff and the leadership teams we spoke with were aware of and could describe the duty of candour.

There was opportunity for staff to progress in diagnostic imaging and staff had access to development courses.

Managers told us they assessed morale in the department by being in attendance in the department and the service had an annual staff survey. Managers told us there were no staff survey concerns and there was a low turnover and low sickness rate of staff in the department.

Managers told us some of the service had moved to protected reporting time and were considering home reporting for staff.

Although staff feedback was positive across the services, overall it was not as positive in the cardiology diagnostics department.

The diagnostic imaging department had monthly staff meetings. Each month the staff meeting would alternate between being opened by the managers and the next meeting would be opened by the staff. This had been changed based on from feedback from staff in the department.

The radiology department produced a newsletter which had information shared from the various specialties in the department for staff to read. The trust provided the December 2018 newsletter, and this included information such as recruitment, compliments and lessons to be learnt.

The radiographer meetings were used to discuss items such as the environment, infection control and staffing issues. Staff could describe where an issue had been discussed and the outcome from the discussion was a new checklist had been created.
The lung function team attended the directorate department meeting where teams discussed items such as clinical issues and the matrons overview and the team were invited to the senior nurse’s meetings, so they are aware of wider trust information.

The mammography unit staff attended the radiology management executive and could provide feedback at this meeting and the lead for the department also attended the radiology operational meeting.

A manager in the department had recently took on the role as the department health and wellbeing lead.

The departments had introduced an initiative to highlight the positive work staff did and was used to provide positive feedback to staff. Patients or staff could nominate staff for this initiative.

**Governance**

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

Managers described the governance arrangements in the service. The service had a monthly executive meeting where governance was included and discussed, and the governance committee was part of this meeting. There was also a department operational meeting which superintendent radiographers would attend, and governance could be raised at that meeting. There was a consultant meeting at each hospital site.

The trust provided radiology management executive meeting minutes for December 2018. This included agenda items such as quality improvement, quality strategy, never events, audit of the WHO checklist, finance, systems and support, complaints, compliments and radiation safety.

The service had discrepancy learning meetings six to eight times a year where the teams would discuss why a discrepancy had occurred and share the learning from it.

The directorate manager attended the trusts weekly morning huddle and staff from radiology the clinical risk group.

The service was starting to outsource some reporting to an external provider. Managers told us there would be initial double reporting and the service would feedback discrepancies to the outsourcing provider as required and there was a service level agreement in place and that the service would have meetings with the outsource provider.

There were three monthly radiation meetings in the department involving radiation protection supervisors and radiation protection advisors and considered topics regarding radiation in the various specialties. The nuclear medicine department had an operational monthly meeting to discuss operational issues and there were team meetings weekly. Manager’s in nuclear medicine told us they had standardised protocols across the two hospital sites and there was the same management and procedures across both sites.

Staff in nuclear medicine told us there was three monthly radiation protection committee meetings and there was an IR(ME)R governance group quarterly which radiologists attended and these fed into the radiation protection committee meetings. The directorate manager attended these.

Nuclear medicine was formalising the meetings with the radiation protection advisors and the radiation protection supervisors. The radiation protection advisors would try and attend the operational meetings where they could. Staff told us the medical physics experts would get information on radiation incidents if they occurred.
The annual IR(ME)R report from December 2017 had two recommendations for the service. The service had onsite medical physics experts and radiation protection advisors.

The service had reports available to review reporting and waiting times.

The trust provided information showing they had service level agreements in place for third party services.

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 radiology department had a risk register which was reviewed monthly at the executive meeting. The directorate manager and risk and safety manager would also review the risk register monthly. The neuroradiology department had a risk register which was reviewed monthly.

Managers described the top three risks to the service and these were paediatric radiologist staffing, delayed outpatients reporting and delivery of the breast service. The trust was trying to mitigate the paediatric radiologist staffing level risk by putting more sonographers and radiographers into the service, considering adding an additional two advanced practitioners into the service and the manager told us adult radiologists were assisting in the paediatric service within their scope and practice. Managers told us they had good links with the paediatric directorate and had regular meetings with directorate.

Managers told us the service were mitigating the delayed outpatient reporting risk by outsourcing, providing protected reporting time and additional recruitment. Managers told us they were mitigating the risk regarding the delivery of the breast service in training consultant mammographers and had successfully recruited more staff.

The services had access to the required performance reports and managers told us key performance indicators were discussed at the management executive meeting. The department had appointed a safety and risk lead radiologist who attended the trust clinical risk group and would feed back to the relevant department management meetings. The safety and risk lead role also supported incident investigations as needed.

Managers in the nuclear medicine department described the relevant site licenses the trust had in place and the licenses which some medical staff had as required by nuclear medicine. The DEXA team attended regional meetings once a year.

Managers told us the RVI had an emergency power supply, although this was only in one part of the building and there was no emergency power supply in ultrasound or main x-ray. The trust did have a backup generator for the department.

Information management

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

Staff had access to the required information systems. Staff could access the trust intranet for information and news about the trust. Nuclear medicine had systems which staff could access policies, procedures and risk assessments. In other departments such as x-ray staff could access policies and procedures on the computers in the department. Systems used by staff were password protected.
Diagnostic images were reported on the information system used and could be accessed in the hospital including the emergency department after the scan was completed. The radiology systems were available in the main x-ray rooms allowing staff to check previous x-rays. Staff had access to an internal information technology team for support as required.

**Engagement**

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The ECG department was in the cardiology department. The department had ‘how are we doing’ information board and there was a family and friends test self-service questionnaire where patients could complete surveys electronically, although this was used mainly for outpatients. There was limited patient feedback on display for ECG or other cardiology testing departments.

The mammography unit gathered feedback in three ways. The service used the ‘take 2 minutes’ system where patients could provide feedback, there was patient experience cards available and the friends and family test was used across the service, although this was used for staff to provide feedback also. However, the department did not have any patient feedback on display during the inspection.

The trust had completed a 2017 staff survey. This was used to provide feedback to the service from staff.

The trust completed a 2018 patient satisfaction survey for the radiology departments which detailed information such as positive comments and areas for improvement and feedback was provided on the environment, staff, location and waiting times. The document also included an action plan, although the action plan did not highlight whether the actions had been completed.

**Learning, continuous improvement and innovation**

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

There were various innovative pieces of work ongoing in different areas of the diagnostic imaging departments. The trust provided information highlighting the neuroradiology department had collaborated previously with a local university in different research. Managers told us that various departments were involved in research.

The hospital had worked jointly with other external partners on a ‘virtual radiology’ room which had computers available for staff and students to use to learn about reporting and this room could also be used for teaching students.

The sleep service had recently won a national award for innovation. The lung function service had links to the research going on across the trust.

The department had the 2018 ‘radiographer of the year’ and the 2016 ‘team of the year’. The diagnostic imaging department also had two consultant radiographers to provide further advice and knowledge in the services.

The diagnostic imaging service had been considering a pilot for working from home reporting to increase the appeal to staff working at the trust and add increased flexibility to staff working.
Information provided by the trust stated the RVI had implemented low dose CT scanning which lowered the level of radiation received by patients.

The trust provided a radiology new innovations and quality improvement document. This highlighted some of the innovation and improvement the service was doing. This document highlighted the iodine seeds use in the breast clinic and highlighted that the service supported training of other centres to learn the technique. The document highlighted the rapid access to highly specialist ultrasound examinations in the pregnancy and Crohn’s service.

The document highlighted that trust staff were involved in projects to assist in diagnosis and improve the patient pathway relating to artificial intelligence.

Managers in nuclear medicine could describe innovation the department had done such as keeping two slots a day available to provide patients with a next day appointment.
Community health services

Community end of life care

Facts and data about this service

End of life care is provided by all staff in the trust, as needed. In the community setting, care is provided by the specialist palliative care nurses, district nurses and allied health care professionals, and healthcare assistants. Community nursing provide a twenty-four hour, seven days’ a week service and community specialist palliative care nursing a seven-day service, between 8.30am and 5pm. The team aim to contact new community patients within three days of referral. Patients are triaged and those with the higher priority level receive a rapid response within an hour.

There is a dedicated 0.8 whole time equivalent (WTE) nurse specialist in palliative care to work alongside care homes. The specialist palliative care service is also commissioned to provide specialist palliative care and end of life support to patients in inpatient beds in Newcastle under the care of Northumberland Tyne and Wear NHS Foundation Trust. (Source: Acute Provider Information Request – Acute context tab)

The trust had 1,800 inpatient deaths from July 2017 to June 2018. (Source: Hospital Episode Statistics)

During the inspection we spoke with 27 members of the community palliative care team, including nurses, the lead consultant and a psychologist. We also spoke with three senior managers and two consultants. In addition, we spoke with two patients, whilst we accompanied specialist palliative care nurses to two patients’ homes to observe care. We reviewed records, policies and procedures, surveys, and other documentary evidence.

Is the service safe?

Mandatory training

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training.

The trust did not provide any medical staffing data for this core service.

A breakdown of compliance for mandatory training courses from April to September 2018 at the trust for qualified nursing & midwifery staff and health visiting staff in community end of life services is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Basic Life Support</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Nursing staff achieved 100% completion for 10 out of 14 mandatory training modules; four modules did not meet the 95% target all of which achieved 89%.

From April 2017 to March 2018 nursing staff within community end of life services achieved a 99% completion rate for mandatory training against a trust target of 95%.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff were meeting the trajectory to complete mandatory training by the end of March 2019 and could access training as required. Both the medical and nursing staff we spoke with showed an appropriate knowledge of the areas covered by mandatory training. This was linked with descriptions of their experience of these areas in practice.

**Safeguarding**

The trust set a target of 95% for completion of safeguarding training.

The trust did not provide any medical staffing data for this core service.

A breakdown of compliance for safeguarding training courses from April to September 2018 at the trust for qualified nursing & midwifery staff and health visiting staff in community end of life services is shown below:

**Trust wide**

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff achieved 100% completion for all three safeguarding training modules.

From April 2017 to March 2018 nursing staff within community end of life services achieved a 100% completion rate for safeguarding training against a trust target of 95%.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff were meeting the trajectory to complete safeguarding training by the end of March 2019 and could access training as required. Both the medical and nursing staff we spoke with showed an appropriate knowledge and experience of safeguarding.
Cleanliness, infection control and hygiene

Because of the nature of the advisory work being undertaken in patients’ homes we could not observe staff providing clinical care to patients that required a clean or aseptic environment. However, staff were aware of the principles of cleanliness and infection control.

Environment and equipment

The equipment most often used in the community end of life care service was a Micrel syringe driver. The same Micrel syringe driver was used throughout the Newcastle and North East England area covered by the service. The staff showed themselves to be knowledgeable in the safe use of the equipment, including in patients’ homes. Although it was a different make from those used elsewhere in England there were systems and processes in place to allow for its safe usage by carers and patients from outside of the north east.

Whilst the nursing teams were working in the community they were supplied with alarms connected electronically a control centre that could summon assistance in the event of any threat to their safety. The nurses informed the control centre when they were at a location and when leaving a location.

We spoke with a group of 14 district nurses who told us about the availability of equipment for community end of life care patients. They said there were a supply of syringe drivers kept a trust bases within the community that were easily accessible. They said historically beds and mattresses had been difficult to obtain. However, the trust had recently ensured that they were available within six hours, and this was happening in practice.

Assessing and responding to patient risk

Patient referrals to the end of life care team, whether in the community or in-patient, were received by the administrative team, and passed to a coordinator for triage. Follow up and assessment was then arranged, or advice given. New referrals were also discussed and triaged at the morning team meeting, where the team’s workload and current patients were discussed and prioritised. The team aimed for continuity of care wherever possible.

The patient’s journey through the end of life pathway is recorded in the; ‘Caring for the dying patient document’. This has sections for contact information, medical holistic nursing assessments, end of life core care plan, communications, and daily assessments sheets. As well as the above sections that are for completion by all end of life care staff the following sections are for completion by the community team only. These are controlled drugs stock balance, prescription sheet, administration sheets, care after death, nurse verification of expected death, and symptom control guidance sheets.

We were told that an end of life pathway would be initiated following discussion with the patient, their family, and the multi-disciplinary team involved in their care. A plan of care for the dying person was introduced, based on the five priorities of care, which was an individualised care plan and communication record. The five priorities of care were recognising that someone was dying, communicating sensitively with them and others important to them, involving them and others important to them in decisions, providing support, and creating an individualised plan of care and delivering it with compassion.

There was a liaison officer whose role was to ensure that arrangements were in place for the timely dissemination, action and review of national and local alerts. The trust monitored centrally
the response of each directorate to each alert and followed this up where this had not been timely. We were therefore assured that alerts would reach the right people and be followed up in a timely way.

In care homes when an end of life care patient became unwell and was assessed as needing hospital care, care home staff packed a dedicated black bag that included the resident’s standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items. This allowed for efficient transfer between the home and the hospital. Nationally this was described as a red bag system, however, in Newcastle it was described as a black bag system.

**Nurse staffing**

The specialist palliative care nurses in community end of life care worked seven days a week, with their hours being 8.30am to 5pm. We spoke with eight members of the specialist palliative care nursing team about nurse staffing issues. They told us that if they found the team were not able to meet a high demand they would share their workload with the district nursing team. They would escalate any staffing constraints with their managers.

The district nursing service also contributed to the community end of life care pathway and are a 24 hour service, seven days’ a week throughout the year.

The fill rate for both the last financial year (April 2017 to March 2018) and the most recent reporting period April to September 2018 is shown below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Planned Staff WTE LFY (Apr-17 to Mar-18)</th>
<th>Actual Staff WTE LFY</th>
<th>Planned Staff YTD (Apr-Sep-18)</th>
<th>Actual Staff WTE YTD</th>
<th>Fill rate LFY</th>
<th>Fill rate YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community end of life</td>
<td>9.5</td>
<td>9.7</td>
<td>8.9</td>
<td>6.7</td>
<td>100.9%</td>
<td>75.8%</td>
</tr>
</tbody>
</table>

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

The nursing service in community end of life care was delivered by specialist palliative care nurses, and district nurses. This allowed for a holistic and multidisciplinary approach, that was further strengthened by close working with palliative care doctors and clinical psychologists.

**Vacancy rates**

From October 2017 to September 2018 nursing staff in community end of life had a 4% vacancy rate compared to the trust average of 6% there was no target set by the trust for vacancy rates. (Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From October 2017 to September 2018 nursing staff in end of life had a 52% turnover rate compared to the trust average of 5% and a trust target of 8%. (Source: Routine Provider Information Request (RPIR) – Turnover tab)

When these figures were put to the service’s senior leaders they told us that the data was incorrect.

Further information provided by the trust showed there had been 0.00% between April 2016 and December 2018.
Sickness rates
From October 2017 to September 2018 nursing staff in end of life had a 1% sickness rate compared to the trust target of 3%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage
From October 2017 to September 2018 the trust did not require any bank or agency staff for community end of life services.
(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing
The trust did not provide total staffing for medical staff in end of life care.
(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
Discussions with the service, and further information provided by the trust, showed there was one consultant in palliative care working in the community end of life service. They were also the clinical lead for the service. They were a 0.8 whole time equivalent (WTE) working eight Programmed Activities (PAs).

Vacancy rates
The trust did not provide medical staff vacancy rate for this core service for the period from October 2017 to September 2018.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Further information provided by the trust showed that the vacancy rate for end of life medical staff is -0.2%. This is because there is only 0.8 WTE (8 PAs) worked in the community. The reason for the average vacancy showing as on over establishment was that the staffing levels included maternity and sickness cover for which there was no budget.

Turnover rates
The trust did not provide medical staff turnover data for this core service for the period from October 2017 to September 2018.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Further information provided by the trust for the palliative care service as a whole showed there had been a turnover rate of 0.00% between April 2016 and December 2018. These figures included the medical staff in the community end of life service.

Sickness rates
The trust did not provide medical staff sickness data for this core service for the period from October 2017 to September 2018.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Further information provided by the trust for the palliative care service as a whole showed there had been a sickness rate of 1.86% between January 2018 and December 2018. These figures included the medical staff in the community end of life service. More precise details were not provided.
Bank and locum staff usage

From October 2017 to September 2018 the trust did not require any bank or locum staff for community end of life services.
(Source: Routine Provider Information Request (RPIR) - Medical agency locum)

We found that the consultants, whether working in the community or the in-patient setting, would cover each other when they were unavailable because of leave or other professional commitments. They also provided an out of hours on-call telephone advice service. Trainee doctors worked with the team and were fully involved with patient care. Undergraduate training was provided to junior doctors at induction.

It was explained to us that the team always had trainee junior doctors with them, and also supported palliative care specialist trainees.

Out-of-hours consultant cover was through telephone provided by a 'Hospadvice Line'. This was not a funded service and used a rota of volunteers working out of the Newcastle hospices.

The trust's medical staffing met commissioning guidance for specialist palliative care.

Quality of records

There was an electronic records system that all the staff working in community end of life could use, as could general practitioners in primary care.

We reviewed the completion of records whilst accompanying two nurses who were visiting patients in their own homes in the community. We found clear and comprehensive communications recorded with entries from the community palliative care nurses, district nurses and oncologists. This showed good communication between different clinical disciplines.

We reviewed four sets of records at the main office. In the first set not all care plans included evidence of discussion with patients or family, skin integrity assessments were 18 months old and had not been re-done when the patient was re-referred. In response the band seven senior nurse told us that skin integrity was now part of the wound pathway and the electronic record, called ‘SystmOne’, that would actively indicate whether it had been done or not. In the second set of records the spirituality care plan had not been completed. In the third set of records not all the care plans were signed. All other areas; including ‘do not attempt cardio-pulmonary resuscitation’ (DNACPR), the emergency healthcare plan, and the holistic assessment were completed appropriately.

We reviewed a palliative care team audit for 2018, that was dated May 2018 and, in some cases, referred this back to a comparator audit completed previously. However, a date for the previous audit was not given. The audit had been signed by the nurse specialist in palliative care, and a consultant in palliative care. In this audit ten sets of records were examined under the headings initial assessment, review documentation, and holistic assessment. The summary for the initial assessment section said that the last audit cycle showed that only 40% of entries included the name of the people present at the initial assessment. it was recorded in the May 2018 that this was now 100%. In the May 2018 audit of the review documentation it was stated that there had been improvements, however only 70% of assessments had an entry regarding spiritual needs. For the holistic assessment section, it said that only 70% of patients had a documented skin assessment.

Our review of four sets of records and the end of life care team’s audit of ten sets of records showed deficiencies in the recording of skin integrity. However, an audit undertaken by the end of
life team showed improvements in this area from a previous audit they had undertaken. We also noted statement from the band seven senior nurse that changes to ‘SystmOne’ would prevent such errors in the future. Therefore, although errors were noted it can be concluded that action was taken to prevent a reoccurrence of such errors.

We spoke with eight palliative care nurses who told us that although the ambulance service was not on SystmOne they were able to share their records. They were also looking at being able to have an electronic solution that would allow all records to be shared through the ‘Great North Care Record’.

We spoke with a group of district nurses who told us they were not on SystmOne but on another electronic records system called EMIS. They could use the Medical Interoperability Gateway (MIG) that is in place to prevent losses of information and data where different systems were used. However, this did not allow them to see all the notes and did not contain all the contextual information.

**Medicines**

We found that alongside the patients' records there was a diary which documented patients prescribed medication, that was taken over a four week period.

Three of the specialist palliative care nurses were non-medical prescribers.

An on-call pharmacist service (clinical and medicines supply) was available twenty four hours a day throughout the year.

We spoke with a group of district nurses who told us that anticipatory drugs were prescribed in the hospital before discharge. This prevented the need for general practitioners to prescribe drugs for the patient, which prevented delays Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms.

**Incident reporting, learning and improvement**

We found that staff understood their responsibilities to raise concerns, to record safety incidents and near misses and to report them appropriately. They were aware of the incident reporting procedure. Any reported incidents involving the end of care pathway were highlighted by the person investigating and staff would be involved as necessary. Learning from incidents was used as an educational opportunity for all staff and we saw discussion around recent incidents taking place at the team meeting. Feedback was given to staff on a one-to-one basis with their manager.

Incidents were reported using an electronic system and those relating to the end of life team came direct to the team leaders for review. These were then discussed and formed a standing agenda item at each team meeting.

**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.
within end of life 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 no serious incident (SIs) in community end of life care which met the reporting criteria set by NHS England from October 2017 to September 2018.
(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The Trust process for providing assurance of compliance with NICE guidance is outlined within the Trust policy 'Implementation Policy for NICE Guidelines'. Responsibility for monitoring compliance with the policy sits with the Clinical Effectiveness and Audit Committee which reports to the Clinical Governance and Quality Committee, a sub-committee of the trust board. Non-compliance with NICE guidelines are escalated via this route as well as to the trust board.

The team were part of the pilot to develop a Public Health England dataset for palliative care in 2015. Following the initial implementation of this data set it became part of the team’s practice and was observed to be in use at daily team discussions.

Pain relief

There was evidence through observation and interviews with staff that pain relief was provided through syringe drivers provided to patients in their homes.

An audit of the use of strong pain medication had been conducted in August 2017. However, there was no evidence of any specific audit since that date.

Patient outcomes

Patient outcomes were audited in May/June 2017. This was done through a case note audit and a real-time survey of staff and users undertaken by the trust. Amongst other things it found that in 80% of cases there had been a discussion aimed at preparing the patient for the dying process. These discussions had taken place with relatives or carers in 100% of cases.

In May and June 2017 the end of life care team undertook an audit of the care delivered to patients and their relatives. With regard to the information that related to the community service the audit found that in 75% of the cases examined the ‘Caring for the dying patient document’ was not transferred across services with the patient. However, this was taken from a small sample of four patients. This was recognised as an area for improvement. It is however not possible to measure any improvement as we were not supplied with an audit for 2018.

We received a palliative care clinical data set and outcome measures, however this report covered April 2016 – March 2017, and was therefore was too old for any reasonable conclusions to be drawn about present practice outcomes.

Competent staff

Appraisal rates
The trust provided us with appraisal rates for end of life for April to September 2018. Qualified nursing staff met the 90% target set for the period up to March 2019.

Whereas the appraisal target for March 2018 was 80% this core service also achieved the target with a completion rate of 90%.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Staff Required Year to Date</th>
<th>Staff Received an Appraisal - Year to Date</th>
<th>% Of Staff Received an Appraisal YTD</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Further information provided by the trust showed that 62.50% of medical staff in end of life care had undertaken an appraisal. This was the figure for all palliative care consultants and was not broken down further for community end of life care. The palliative consultant informed us that they received regular appraisals.

The consultant lead for end of life and palliative care told us that the trust organised management training for consultants in leadership roles.

We reviewed the postgraduate skills and qualifications gained by the community specialist palliative care team nurses, and the medical consultant lead as of January 2019. The medical consultant had achieved advanced communication skills at level two, the cognitive behavioural therapy (CBT) foundation course, and the hypnotherapy level one qualification. They had also achieved the certificate of completion of specialist training (CCST) in palliative medicine, and membership of the royal college of general practitioners (MRCGP).

Ten of eleven nurse practitioners had achieved advanced communication skills at level two, ten had a teaching and/or assessing qualification, nine had the CBT foundation course, three had the CBT intermediate level course, three had postgraduate clinical skills qualifications, three were non-medical prescribers, four had the hypnotherapy level one qualification, and six had the specialist practitioner district nurse qualification. Other qualifications included a counselling diploma, therapeutic massage, a postgraduate certificate in palliative care, a level three in managing breathlessness, mentorship qualifications, and an Open University course in death and dying.

Of the four clinical psychologists three had doctorates in clinical psychology whilst other postgraduate qualifications had been achieved in CBT, palliative care, low intensity psychological wellbeing, and existential psychotherapy. In addition, all four had between them undertaken twenty other qualifications and courses including undergraduate degrees, and one person was also qualified as a registered general nurse (RGN).

This showed that the team had the advance qualifications necessary to work as specialists in the specialist area of end of life and palliative care.

**Multidisciplinary working and coordinated care pathways**

The community end of life care service was part of a clinical service within the trust that also provided end of life care to patients within the hospital in-patient service. This included training and
liaising with wards and departments within the trust to ensure appropriate care was delivered to patients on an end of life pathway. The service’s lead band seven nurse showed us how they had produced a training roadshow that they had taken throughout the trust’s two hospitals. Although this was aimed at the in-patient service part of the purpose was to show the intra-trust links with the community end of life service.

There were close links with general practitioners as this was a service that linked the trust’s hospital and community service with primary care. There were also strong links with the local hospices as there was a community end of life care service nurse dedicated to working in and with the local hospices. The lead consultant for community end of life care was also an honorary consultant at the local Marie Curie hospice.

Our review of two sets of records undertaken whilst accompanying community palliative care nurses in visits to patients’ homes showed how they would contact the consultant oncologist before the patients’ next clinic appointment. This direct contact was replicated when after the clinic appointment the oncologist would contact the nurse and update them directly.

As the specialist palliative care team cared for patients on the end of life pathway who had different terminal conditions they worked with different groups of specialists. When we spoke with a group of eight specialist palliative care nurses they explained how this worked in practice. They told us how they would liaise with the appropriate specialist nurses, doing joint visits to patients’ homes when it was indicated. They explained how, with one of the palliative care consultants, they had had meetings, and undertaken training, with the specialist heart failure nurses. They explained how this worked in the case of one patient. The patient was in hospital on intravenous frusemide (a drug used to treat fluid build-up due to heart failure) after not tolerating oral frusemide. Although they were on intravenous medication the team, in liaison with the heart failure nurses, were able to discharge the patient back to their own home.

When we met with the palliative care nurses they told us that they refer bereaved families to organisations such as Cruse Bereavement Care and ‘Maggie’s’ bereavement support groups. However, they told us there were constraints with responsiveness and getting pre-bereavement for children’s bereavement support. However, they said that the regional senior medical palliative care medical trainees were doing a project on mapping bereavement services in order to look at improving the services.

We spoke with a group of 14 district nurses who work on the end of life care pathway who explained how they access community response and rehabilitation teams. They told us that these teams have a two hour response time for urgent responses. They also said that when they are waiting for a care package to be put in place they can help provide interim solutions.

We saw minutes from a hospital end of life team meeting, dated 19 September 2018, which had a discussion item where updates from the community team were taken.

Seven day services

The specialist palliative care nurses worked a seven day week whilst the medical staff worked a five day week. Out-of-hours advice was given by palliative care consultants, general practitioners and other medical staff at a local hospice. The advice line had direct access to consultant advice when required.
Health promotion

The service promoted the national Dying Matters week once a year. The team told us that last year they held stalls at both sites, encouraging both patients and staff to discuss death and dying, and also highlighted the work of other services such as local hospices.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 95% for completion of safeguarding training.

The trust did not provide any medical staffing data for this core service.

A breakdown of compliance for mental capacity training courses from April 2018 to September 2018 at the trust for qualified nursing & midwifery staff and health visiting staff in community end of life services is shown below:

<table>
<thead>
<tr>
<th>Trust wide</th>
<th>Name of course</th>
<th>Number of eligible staff (YTD)</th>
<th>Number of staff trained (YTD)</th>
<th>Completion rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental Capacity Act</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Mental Health Act</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Nursing staff achieved 100% completion for both mental capacity training modules.

From April 2017 to March 2018 nursing staff within community end of life services achieved a 100% completion rate for mental capacity training against a trust target of 95%.
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff were meeting the trajectory to complete Mental Capacity Act and Mental Health Act training by the end of March 2019 and could access training as required. We spoke with a group of eight palliative care nurses who explained that they had all been trained to do mental capacity assessments. They told us there was a mental capacity lead in the trust and they were part of a regional group called ‘deciding right’ that reviewed issues around consent and capacity.

Is the service caring?

Compassionate care

We accompanied specialist palliative care nurses when they separately attended two patients in their own homes. We observed care being undertaken in a compassionate way. One of the patients told us that; “They treat me like a person not an illness and give me advice and support.”

We reviewed a survey of 21 people undertaken as part of an evaluation of bereaved relatives’ satisfaction with end of life care. This evaluation was undertaken by the Association of Palliative Medicine in 2017, and dated 19 February 2018, and is referred to throughout this domain. The survey was across the whole of the end of life care pathway and it has not been possible to disaggregate community services. However, it was an independent survey by a national professional association, and even taking into consideration its broader reach has value. With
regard to the way in which the team respected the patient’s dignity 83.3% were very satisfied, with the remainder reported that it was not relevant to their situation.

We also reviewed a patient and carer questionnaire undertaken by the palliative care team in August 2018. This was part of a yearly patient and carer satisfaction evaluation undertaken by the community end of life team. Nineteen questionnaires were sent out and eight were returned. The questions allowed for a yes, no, or not sure response. There was also the opportunity for comments to be made and recorded. To the question did the nurse or doctor show you respect and help to maintain your dignity all the respondents replied yes. One person commented; “My …… nurse is always respectful towards me and helps me get through some tough times whilst maintaining my dignity.” To the question did you feel able to talk with the nurse or doctor about any problems you might have all the respondents replied yes. One person said; “Every time my nurse comes to visit I talk to her about everything that I have been feeling, going through. I have also had advice and care via the phone and the nurse came to the house with no appointment when I was really low. She is amazing!”

We spoke with a palliative care nurse as part of a staff focus group meeting. They gave an example of working with a patient who was interested in assisted dying. They told us:

“I was the only person a certain patient would tell that he was considering going to Dignitas. I was open and honest and said I needed to work with him to look into why he felt like this. It was discussed in a small meeting at the time as we wanted to keep it out of the multidisciplinary team out of respect for the patient wanting to keep it private. We involved myself, the general practitioner (GP) and the psychologist. We worked through things using the Royal College of Nursing (RCN) guidelines. It became apparent that this man had capacity, knew what he wanted and knew there was a certain window for him to do this. We supported the daughters psychologically who were distressed. He allowed us to involve the GP. It went ahead, but his wishes were at the centre of everything. We weren’t on ‘SystmOne’ at the time, so all my notes were kept separately in a locked drawer, he knew who accessed his records. I was extremely well supported. One of the hospital consultants supported me because I was working so closely with the community consultant that I needed some support from someone outside the team. Because we were respecting the patient’s privacy, it wasn’t until after he passed away that my wider team were aware of what had gone on. No one knew until afterwards and his confidentiality was firmly protected. I shared the learning from this experience.”

**Emotional support**

We observed the nurses we accompanied providing emotional support to the patients. One of the patients told us; “The team are excellent and are very supportive. I get a response straight away when I call.”

We found that the nurses encouraged patients with their hobbies such as playing music with local bands.

We reviewed a survey of 21 people undertaken as part of an evaluation of bereaved relatives’ satisfaction with end of life care. This evaluation was undertaken by the Association of Palliative Medicine in 2017 and dated 19 February 2018. With regard to the emotional support provided to family members 75% were very satisfied, 8.33% were very dissatisfied and 16.67% felt it wasn’t relevant to their situation. The question concerning the emotional support provided to the patient by the team 66.67% were very satisfied, 8.33% were dissatisfied, and 8.33% were very dissatisfied. The remainder said the question was not relevant to their situation.
At a focus group meeting of eight palliative care nurses we were told how they liaised with national charities and support organisations to get emotional support for their patients. This included organising holidays for families who had children under the age of 18. They also told us they had helped organise weddings, nights ‘out on the town’, and beauty therapy amongst other things for their patients.

In the discussion with the specialist palliative care team they gave us examples where they had supported the families of patients for extended periods when the patient had died. They also sought additional support services for families when needed. They gave two examples of where family members had rung them after their loved one’s death and were considering ending their own lives. The team had supported them to access additional support services and then liaised with that service to offer any support that they could.

**Understanding and involvement of patients and those close to them**

The nurses we accompanied understood the needs of the patients and involved them in their care. One of the patients told us that they always involved their partner in their care. With one patient’s partner the nurse explained how they had supported them with their anxiety and accessed further assistance for them to help them access welfare benefits they were entitled to and facilitated assistance with financial issues.

With another patient the nurse showed an understanding of the patient’s needs and what they wanted. This was shown in a discussion when they explained the different types of hospice provision available and explained how this would meet their needs and being adaptable to needs that would change.

One of the patients told us that a diary that recorded their medication over a four week period was; “really helpful.”

Another patient told us that by being the main line of communication between them and the consultants, and the hospital, the nurse was very much appreciated.

In the survey conducted as part of the Association of Palliative Medicine evaluation. With regard to the question as to the way the family was included in treatment care decisions 83.33% were very satisfied, 8.33% were very dissatisfied and 8.33% felt it wasn’t relevant to their situation.

We reviewed ten compliments which were in free-form text as part of the evaluation of bereaved relatives’ satisfaction with end of life care undertaken by the Association of Palliative Medicine. A selection of the comments included: “The care felt personal to us and very responsive;” “The support they gave me, and the family was really very supportive and helpful;” and; “The fact that the consultant came out to visit meant an awful lot to my husband, he felt as though he was getting the best treatment ever.”

In the patient and carer questionnaire undertaken by the palliative care team, referred to above, it was asked if the team listened to and understood their needs during the visit. All eight respondents replied in the affirmative. One of the respondents said; “Myself and my husband could not have coped with my incurable cancer diagnosis without the help, care and love of the …. Nurse. I always feel much calmer whilst she is at my home talking about any worries or problems I have.”
Is the service responsive?

Planning and delivering services which meet people’s needs

The clinical lead for the service told us that as part of ‘dying matters awareness week’ the service had stalls in the local community in order to make people more aware of their service and discuss the work they did with members of the public. https://www.dyingmatters.org/overview/about-us

Meeting the needs of people in vulnerable circumstances

We found there was access to an interpretation service for people who did not speak English or whose first language was not English. A British Sign Language (BSL) interpretation service was also available for patients and relative who were profoundly deaf and communicated in BSL.

Leaflets were available or could be produced in languages other than English. We saw a leaflet for patients in Arabic explaining how the community end of life service worked.

We were told that when the team first engage with new patients they ask whether they have a religious faith, and what that faith is. They said they would be sensitive to the patient’s religious beliefs and mores and connect with the hospital chaplains or religious leaders in the communities. Where a patient wanted to contact a leader in the religious community they are helped to do so by the hospital chaplains.

We spoke with a focus group of eight palliative care nurses, one of whom told us an illustrative story of how they had helped a patient meet their individual needs. They said a patient had recently moved into Newcastle and been admitted to hospital a number of times However, on discussion with the patient, family and social worker it was apparent the patient wanted to move into a care home. This had been achieved with the specialist palliative care nurse emphasising the patient’s right to their preferred place of care. The patient was moved to a care home and their anxiety levels dropped.

We found the service had, through the implementation of the ‘Palliative, end of life and bereavement care strategy 2018-2021’, made an improvement to end of life care for hard to reach groups a particular focus. The service had formed links with the local ‘Fulfilling Lives’ charity: http://www.fulfillinglives-ng.org.uk/ that worked with homeless people. They then undertook training for the charities’ homelessness workers in the end of life care pathway. Following which they worked collaboratively with the charity to improve care for homeless people who were anticipated to be near death. The ‘Fulfilling Lives’ workers were therefore able to support homeless people in understanding the relevance of palliative care, help them navigate the local health systems, assist with planning for end of life, and facilitate a system of mutual support. The use of homelessness workers who had close relationships with their clients, and in some case had at some point been homeless themselves, gave credibility to work that might have been received by suspicion if directly organised by a health service organisation.

Access to the right care at the right time

Access and flow consisted of a pathway that included both community and in-patient end of life care service teams. The end of life care team aimed to contact new community patients within three days. Patients were triaged and those with the higher priority level received a rapid response within an hour, unless the patient did not feel this was appropriate. Evidence provided by the trust showed between April 2017 and March 2018 100% of patients who had urgent referrals were
contacted within one working day, and 99% of patients who had non-urgent referrals were contacted within three working days. This took place within the confines of the specialist palliative care nurses working schedule; which was seven days a week, 8.30am to 5pm.

Referral of patients for palliative for end of life care was done, following a multidisciplinary discussion involving those involved in a patient’s care on the ward, either by telephone or using the trust’s intranet referral system.

We saw evidence in a patient’s notes that they were reviewed by the palliative care team the same day as the referral was received. A specialist nurse reviewed the patient’s pain relief and began to make arrangements for the patient’s discharge.

The end of life team had implemented a traffic light rating system to help plan for a patient’s discharge. Red discharges are urgent and priority, amber less so, and green applied to a patient who can wait a little longer. A discharge checklist is printed and attached to the front of the patient’s notes, and both ward staff and the end of life team could contribute to putting things in place to facilitate discharge. Specialist nurses explained that red discharges would normally be overseen within the team, with amber and green discharges being ward led. A recent audit of red discharges showed that on the whole, people were going home in a timely way. The team’s discharge sub-group, having completed this audit, had begun to work on a review of electronic incidents relating to discharges to see what further improvements could be made. Once patients were discharged home, including to a care or nursing home, or to a hospice they became the responsibility of the community end of life service.

The end of life care team told us that they had access to an end of life care ambulance operated by the local ambulance trust. They said that since the introduction of this service there had been far fewer issues with timeliness or appropriate support during discharge.

**Learning from complaints and concerns**

**Summary of complaints**

Between September 2017 to October 2018 there were no complaints for community end of life services.

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

Staff we spoke with could not recall any complaints having been made. We could find no records of complaints being made.

**Number of compliments made to the trust**

From April 2017 to March 2018 there were no compliments about community end of life services recorded at the trust.

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

Despite them not being formally recorded we reviewed ten compliments which were in free-form text as part of an evaluation of bereaved relatives’ satisfaction with end of life care. This evaluation was undertaken by the Association of Palliative Medicine in 2017 and dated 19 February 2018.

The patient and carer questionnaire for 2018 also included 22 complimentary statements by patients and carers.
Is the service well-led?

Leadership

The community end of life care service was an integral part of the overarching palliative and end of life care service of the trust.

There was a palliative care consultant who was the clinical lead for community end of life care. They were also a trust representative on the Northern England Strategic Clinical Network. Out of a 32-hour weekly contract; they had four hours dedicated to working with the network, whilst the other hours were divided between clinical and managerial duties.

The overarching service had managers at all levels with the right skills and abilities to run a service providing high quality sustainable care. There was a clear management structure at directorate and departmental levels. Leaders knew about the quality issues, priorities and challenges in the department.

The specialist palliative care and end of life teams were divided between two directorates. The medical staff were in the cancer services directorate and the remainder of the staff were in the patient services directorate.

There was a dedicated non-executive and executive director aligned to the team. While the current non-executive director was new in post, the team had made contact with them and invited them to team meetings. The team spoke positively about the change brought about by the previous non-executive director who obtained funding to move to seven day services.

There was no operational manager post within the team, which was jointly consultant and nurse led. The team recognised that this role would further strengthen their leadership, and conversations had taken place at an executive level with a view to implementing this.

The team’s meeting minutes included sections considering wider corporate priorities as well as those of the directorate, meaning that locally, leadership was well positioned to be actively contributing to these.

Vision and strategy

There was a strategy document entitled; ‘Palliative, End of Life & Bereavement Care Strategy 2018-2021’. This strategy outlined six strategic aims; that each person is seen as an individual, each person gets fair access to care, maximising comfort and wellbeing, care is coordinated, all staff are prepared to care, and each community is prepared to help. Representatives from the palliative care consultants sit on the; ‘End of life and bereavement strategy group’.

Culture

The culture was open and supportive. We found a dedicated team of district nurses, palliative care nurses, and psychologists, led by a specialist palliative care consultant. It was a community service that linked seamlessly with the in-patient service delivered in the trust’s two hospitals. We found through talking with members of the team that there was a culture of respect; not just for the patients but for each other. The consultant team that encompassed the community and in-patient services cross-covered each other, and there were close links between the in-hospital and community work. Learning and reflection was encouraged. Through our conversations with the team, and observing interactions with patients in their homes, we found a strong empathetic element to the culture of the service. Nurses had different areas of responsibilities but would help
and support each other. There was also a culture of support for the team, exemplified by
dedicated psychologists who supported colleagues, in addition to supporting patients, family and
carers.

There was a culture of everybody working together in a non-hierarchical manner for a common
goal.

**Governance**

There was a clinical governance framework for the community specialist palliative care and end of
life teams, that included the specialist palliative care nurses. The document was dated 7
September 2018 with a review date of 7 September 2019. It showed a clinical governance
reporting system led by the community and in-patient teams, through the deputy director of
nursing and patient services, and the clinical director for cancer care, to the palliative care and end
of life strategy group. This latter group reported into the trust’s clinical governance and quality
committee.

The corporate governance framework showed that the specialist palliative care nurses reported to
the deputy director of nursing and patient services; whilst the district nurses, and the consultants
reported to the clinical director for cancer care.

**Management of risk, issues and performance**

The team did not hold its own separate risk register, and risks were held on the wider patient
services register. However, there were only three identified risks for the team, and the leadership
team were able to articulate these.

We were told the biggest risk at the time of our inspection related to the potential loss of the
enhanced home care support service if further funding could not be secured. The team was
currently funded to operate until June 2019; discussions around the future of the team were
ongoing.

In addition, a lack of suitable service provision in end of life care for children was noted on the risk
register for children’s services, also part of the over-arching patient services risk register. This
meant the service was not compliant with National Institute for Health and Care Excellence (NICE)
guidance NG61; “End of life care for infants, children and young people with life-limiting conditions:
planning and management". [https://www.nice.org.uk/guidance/ng61](https://www.nice.org.uk/guidance/ng61)

The risk register narrative stated that a specialist 24 hour, seven days a week, service needed to
be provided for children in their preferred place of death. It further said that there was a paediatric
oncology outreach nursing outreach team but that this highlighted the inequity of a service that
was not available to all children whatever their diagnosis. There also needed to be additional
resources for non-pharmacological therapies, and for bereavement support. In addition, a tertiary
level specialist was required to provide clinical care in relation to complex symptom management,
support for best interest decisions, and end of life care. The controls in place were said to be
support from existing clinicians.

However, a palliative care consultant told us their support for this was provided pro-bono and out-
of-hours. This was graded as a moderate risk. Although service provision that was not
commissioned was not directly attributable as a failing to the trust there was at the very least a
moral imperative to facilitate change. This necessity for change does not seem to be represented
by a finding of moderate risk, and there is no evidence of it being discussed at trust board level.
Senior staff told us another potential risk was related to the on-call out of hours advice system. This was often provided by the hospital's consultants and was not commissioned, so was recognised as being a vulnerable service. Regular joint meetings took place with local hospices to discuss possible changes and improvements to this service. Use of this service was regularly audited although we found no evidence of this being discussed at board level.

Information management

The end of life care teams had a social media page which they used to share projects, strategies and information across the trust.

Both the end of life community team, in-patient team, and 50% of local general practitioners in primary care were on the ‘SystmOne’ patient information system. However, the district nurses are not on SystmOne but on another electronic system.

A group of eight palliative care nurses we spoke with told that in the summer of 2018 they had implemented a system of mobile working, following a pilot phase, with new electronic connectivity. The only disadvantage was when there were areas where they could not get a stable signal.

Engagement

The community end of life service was part of the Northern England Strategic Clinical Network. The clinical lead for end of life care in the community held meetings with the local clinical commissioning groups. They also attended along with other senior clinicians the trust’s mortality and morbidity group.

The service was part of the ‘deciding rights’ group that met with other stakeholders including the North East Ambulance Service NHS Foundation Trust. The group was chaired by a consultant anaesthetist from the Newcastle Hospitals trust and managed policies such as a joint procedure for ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) that unnecessary and upsetting emergency procedures were not undertaken by the ambulance service.

Through engagement with the ambulance service there was a dedicated ambulance for patients on the end of life care pathway.

We reviewed the; ‘End of life and specialist care newsletter’, for July 2018. This was aimed at staff throughout the trust and aimed to build up a greater knowledge of the service, both at the community and inpatient level.

Learning, continuous improvement and innovation

Membership of the Northern England Strategic Clinical Network allowed the service to cooperate in the production of the multidisciplinary; ‘Caring for the dying patient document’, that allowed for a joined-up approach to the provision of end of life and palliative care services across northern England.

The service works towards a standard based on the principles of the national palliative care ‘Gold Standards’ framework. The ‘Gold Standards’ framework is aimed at ensuring there is a pathway to provide care for end of life patients in the right place at the right time.

http://www.goldstandardsframework.org.uk/
The clinical lead for the service was involved in project work aimed at improving palliative care in primary care, so that it reflected the principles of the ‘Gold Standards’ framework.

There was a journal club, which met every two weeks, where the service’s clinical team discussed service improvement with other members of the larger local palliative care community. In this context a journal club is a group of clinicians who meet regularly to critically evaluate recent articles medical literature.