**Sunderland Royal Hospital**

Sunderland Royal Hospital, Kayll Road, Sunderland, SR4 7TP

Tel: 01915656256

Date of Inspections: 11 December 2013
10 December 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

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## Details about this location

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<td><strong>Type of services</strong></td>
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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 December 2013 and 11 December 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We spoke with one or more advocates for people who use services, talked with people who use the service, talked with carers and / or family members and talked with staff. We reviewed information given to us by the provider, reviewed information sent to us by commissioners of services, reviewed information sent to us by other regulators or the Department of Health and reviewed information sent to us by other authorities. We reviewed information sent to us by local groups of people in the community or voluntary sector, talked with commissioners of services, talked with other regulators or the Department of Health and talked with other authorities. We talked with local groups of people in the community or voluntary sector, took advice from our specialist advisors, were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

The focus of this inspection was the accident and emergency department, care of the elderly and out patients. We undertook a visit over two days and visited accident and emergency, human resources, outpatients, and wards B21, E54, D43, F61 and E55. We also spent time with the Patient Advice and Liaison Service (PALS) and complaints teams. The inspection team included a compliance manager, three compliance inspectors, two specialist professional advisors and an expert by experience.

We found that patients' needs were assessed and their treatment plans were discussed with them and reflected relevant research and guidance. Patients told us they felt informed about what was happening to them regarding their care and discharge arrangements. People told us they were happy with the care and treatment they received.

We saw staff were recruited in a safe and effective way. The human resources department undertook checks to make sure people applying to work for the Trust had appropriate qualifications, skills and competencies prior to commencing employment.
The hospital was well-led and had a thorough system of checks to monitor the quality of the care provided at ward level. There was a clear route to ensure that any issues or risks were raised to the executive team and the senior management team.

There were significant changes being made to the complaints procedures and where there had been some delay in managing complaints in the past, the actions taken by the Trust to make it more responsive and inclusive for people who have raised concerns was impacting in a positive way.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Respecting and involving people who use services  

Met this standard

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

We looked at the information we held about the Trust from external surveys and reports from other agencies. The majority of the information we had regarding this outcome showed that the Trust was performing and delivering the service at the same level as other similar Trusts.

The inspectors, specialist advisors and the expert by experience spent time on the accident and emergency unit, outpatient departments, wards B21, E54, D43, F61 and E55. They spoke with people using the service, visitors and staff and spent time observing the way the staff engaged with people in these areas.

On the ward areas we saw that patients' diversity, values and human rights were respected. We saw the environment supported patients' privacy; they were accommodated in single sex bays in the ward areas we visited. Toilets and bathrooms were designated for male or female patients. We observed that personal care and consultations were conducted in private with fixed screening used at the bedside.

During our visit we saw staff engaging with patients in a way that maintained their dignity and we saw they were treated with respect. We saw patients were dressed appropriately and where they had clinical needs, for example a catheter, the catheter bag was placed safely and discreetly.

We heard evidence that patient choice was an important care component. For example, a male patient said, "They keep asking me if I want a shower, but I hate showers. I have two showers at home and never use them. I like a strip wash so they bring me the bowl and towel." A female patient said, "They'll ask if you want a wash or a shower. I had my hair washed the other day and it was lovely. I didn't want a shower, so the nurse washed my hair using the bowl. They always give you a bowl and nice hot water." We saw most patients who were not in bed, had their feet safely covered, although one patient did not.
He said, "They keep asking if I want my slippers on, but I don't. I lived in West Africa for years and got into the habit of being bare foot. I hate wearing shoes and slippers. They're fine about it and just tell me to ask them if I change my mind."

When we observed people being cared for on wards E55 and F61, the nurse-led unit and the discharge lounge, we saw that people's dignity and privacy was being maintained. We saw staff supported people appropriately in a way that maintained this, for example when assisting them to the toilet or to get out of or into bed. We saw that these wards were calm and staff were available to give the support people needed. We noted that call bells were answered promptly. We spoke with three patients individually: the comments they made included "The nurses are lovely and look after me well" and "food is nice". Not all of the people in the ward areas could access their nurse call buzzer easily and this was brought to the attention of the senior staff who agreed to remind staff. Those people who could not access the call buzzer told us they were not worried as they could just ask for assistance.

We saw on the elderly care wards that portable phones were being used to facilitate a faster contact response for callers needing to speak to either ward staff or patients. We saw that the Patient Advice and Liaison services also provided a ward based role in enabling improvement in communication by handling telephone calls.

One person on the elderly care ward told us, "The doctors and nurses have listened to me about my recent fall and home." People told us that staff explained their treatment to them in a way that they could understand. Comments included, "They talk to me in simple terms, not using medical words I don't understand." Another person told us how the consultant was "marvellous" and had explained to her why her discharge home would be delayed and "what they were going to do to treat me differently".

One person told us, "The doctor has explained everything and what needs to be done and checked that I am happy with his suggestions". People told us they understood the care and treatment choices available to them. Another person told us they had had to be undressed for a procedure and that this had been done in a sensitive manner and that they had been given time and their privacy maintained to get changed. Staff told us they encouraged people to give feedback about their care and treatment.

When we visited the accident and emergency department we saw that white boards were displayed in each clinic area we visited that detailed the doctors and nurses on duty and any delays in clinic times. We observed in area 4 that staff were taking the blood pressures and bloods of patients in open view of the waiting area. In one room, the chair for the patient to sit in was wedging open the clinic room door and this was at the front of the waiting area. This meant that patients' privacy and dignity was not upheld and we spoke with the managers to ensure that staff would be reminded to close doors and protect people's privacy.

We saw in the accident and emergency department that patients were given appropriate information and support regarding their care or treatment. For example we saw leaflets were available for patients and visitors about specific medical conditions. There were also leaflets explaining what happened on leaving hospital and what services would be available, such as patient support groups.
Care and welfare of people who use services  ✔ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare.

Reasons for our judgement

We saw there was an obvious presence of the ward managers in the clinical areas. They were seen to lead, manage and deliver quality nursing care on the wards. We heard and saw the recorded information about the spot checks the ward matrons undertook to monitor care delivery. They told us this was to make sure they remained fully involved in the running of the wards. The ward areas were all run with slight differences that related to specific aspects relevant to the individual ward such as staffing patterns, allocation of work in bays, named nurse processes and general day-to-day running of the wards.

We saw people had their own belongings and a drink was within their reach. One patient said, "They're a friendly lot. They're very kind and they look after you well." Another person said, "They'll always try and help you. When you ask for something they do their best to get you it." Patients said they were well looked after and were offered personal care. People could access showers and toilets. None of the patients we interviewed could recall any offer of help with oral hygiene, although most said their relatives assisted them with dentures and mouth care.

Staff described hourly patient contact rounds, known as 'comfort rounds' piloted on some wards where staff assessed and recorded fundamental patient care needs. They said this had been very successful to date. It was confirmed they were planning to introduce this to other areas. One patient said, "I'm in bed because I can't move. It's a moving bed and really comfortable as it takes the pressure off my back." We heard from all patients interviewed that their pain was managed immediately and, "you always get your tablets on time."

A ward manager told us, "The doctors and nurses work in bays so they're in teams. It helps with continuity and also with discharge planning." A nurse told us, "It's a great ward to work on. We all help each other out. It's very busy but that's better like that."

Patients' comments included: "I can't praise them enough. They always make time for you"; "I was scared stiff when I came in here. The ambulance brought me. They've all been absolutely brilliant"; "The food's good. I've put on 5 lbs since I came in 4 weeks ago"; "The food's fine. I could eat the puddings all the time"; and "There's plenty of food for you".
In response to a strategy for reducing ward-based falls on the orthopaedic and trauma ward, staff were piloting a falls alert device. The nurses carried a remote sensor which responded to change of position the patient made. We heard very positive feedback from staff about its potential successful impact on reducing falls, although the statistics were not available at the time to show the impact it had made.

We reviewed the records held for patients about their condition, needs and the medical and nursing care provided. The majority of the records were held electronically. Those looked at contained completed assessments, including falls, assessments of nutrition Malnutrition Universal Screening Tool (MUST), and pressure area care (Braden). These assessments were evaluated at least daily depending upon the level of risk identified for the person. On the nurse-led discharge ward patient records showed collaborative working between nurses, occupational therapists, physiotherapists and social workers. They were working in various ways to discharge patients in an effective and timely way. Initiatives included the introduction of a discharge nurse who facilitated a daily meeting to discuss a multidisciplinary approach for complex cases. Staff said they felt there was good interaction between staff and relatives, and patients described that they understood and were kept informed of what their condition and treatment was. We saw in one of the wards a survey testing patients' views of their experience and length of stay in hospital, which was part of collaborative project with the Readmission Avoidance Team.

We looked at end of life care. We heard from people who told us their relative (who was at the end of their life) had experienced "absolute respect and dignity" during this time. The ward manager told us that they had reviewed the facilities as part of the annual planning process and put in place an action plan to improve it by allocating a suitably furnished and decorated side room specifically fit for this purpose.

In the accident and emergency department people were seen within the four-hour national waiting time limit. We saw suitable levels of observations by staff and there was a visible presence to attend to patients quickly. They had introduced three key senior nursing roles to assist the service delivery. These roles were a co-ordinator, a flow facilitator and a nurse navigator. The nurse navigator role worked on the front desk of the department to assess and prioritise patient need on arrival.

Staff used electronic trackers to record how quickly people were "handed over" to the team and trackers to ensure people were seen by doctors within the target time of four hours. The service had reviewed staffing levels and there were staggered finishes to shifts to improve the service. Two healthcare assistants had been appointed as well as an environmental support staff. Staff told us the environmental role ensured that stock and equipment were always available and their focus on infection control checks meant that the ward's performance in this area had improved.

The dedicated children's department was run by qualified children's nurses with paediatric consultants available on call. Staff said the biggest challenge was the environment as the children's resuscitation bed with facilities was located in the adults' resuscitation area and that people presented inappropriately to the department. Patients in the waiting area told us, "The staff were lovely and very interested in what was wrong" and "I have been told how long we will have to wait."

Senior staff had a weekly meeting to discuss breaches in the four hour waiting time targets. It is a formal weekly escalation meeting chaired by the Acting Director of Operations against a dedicated action plan. There was a plan to help mitigate the risk of
this occurring including an escalation plan. The senior managers acknowledged that patient flow was an issue at times; however they showed us how they were using a multidisciplinary approach including North East Ambulance Service, Clinical Commissioning Group, local authority and community services. This meant that patients could be confident that the hospital was taking appropriate steps to reduce the risk of them breaching the four waiting time targets resulting in them having unnecessary waiting times.

We visited the rheumatology department and found that there was not enough seating for people waiting for the clinic. This meant that several (about 10 during the course of our visit) frail and elderly people were in other waiting areas or standing. The staff we spoke with said this was a regular occurrence and we saw they tried hard to ensure people were comfortable and would go and collect them when their turn was called. Staff told us that the service had recently had a "LEAN" review which meant looking at how they could improve the service including the waiting situation for patients. We discussed this with the Executive Director Nursing and Quality who agreed to review the situation to determine if there were any quick win actions which could be identified.
Requirements relating to workers

People should be cared for by staff who are properly qualified and able to do their job

Met this standard

Our judgement

The provider was meeting this standard.

There were effective staff recruitment and selection procedures in place to ensure the protection and wellbeing of patients using this Trust.

Reasons for our judgement

We spoke with the director of human resources about the recruitment and monitoring of staff employed by the Trust. We saw how the Trust used an electronic recording system referred to as employee services record (ESR) that showed how appropriate checks were carried out before staff began work. We saw that before commencing employment, the Trust carried out checks in relation to staff's identity, their past employment history, qualifications, authorisation to work in the UK (where applicable) and a disclosure and barring service (DBS) check. We also saw a process for checking the annual professional registrations of professional staff such as nurses and doctors. We were told that if staff allowed these to lapse, they were either suspended from practice or downgraded to healthcare worker status until such time the person's renewal verification was confirmed. This meant that patients were protected from staff who were not qualified to practice.

Staff records were held within the Trust's headquarters where we saw that appropriate checks were undertaken before staff began working. The staff files we looked at included proof of staff identity, copies of references detailing staff conduct in previous employment, and records relating to staff qualifications. Each file included a copy of the employee's contract of employment, as well as notices of contractual changes. Application forms were on file and were checked to ensure that personal details were correct and there were no gaps in employment history.

We spoke with staff on the wards about how they were supported to maintain their clinical skills and competencies. They told us they accessed training and were prompted when their mandatory training was due to be renewed. We were told that training was discussed with staff as part of their annual appraisals, supervisions and were therefore reviewed annually. Staff could access mandatory training in-house and could access specialist training both within the hospital and at other hospitals. This meant that staff were trained and supported to carry out their specific roles.

We saw records for staff induction and training and found that all statutory courses were covered. A training matrix showed when staff had received training and when any mandatory updates were next due. This meant that staff were given training and support to carry out their roles.
Staff we spoke with told us that they were kept informed about developments relating to their area of work and the Trust more generally. Where staff were experiencing organisational change, such as the changes to the way complaints were managed, staff told us they felt they had been involved in the changes made and the way they would be introduced. Staff we spoke with told us they were kept informed via meetings and records about the timescales and change processes as they happened.

The managers of all wards were positive about their role and expressed satisfaction with their roles and the good support and communication they received from the senior managers and executive team of the Trust. Ward managers told us they had no problems with having direct access to senior management for support and advice.

We spoke with a nurse manager in the accident and emergency department who was undertaking sickness reviews with staff on the day of our visit. She clearly understood the sickness management systems for the Trust and told us she felt supported by the human resources department to address this area of work. She told us there was a good support system in place for staff including occupational health, counselling services and a phased return to work. She said, "We are good at supporting our staff through sickness." However, she did say that sickness levels were currently high in the department, and this was currently at 8.4 whole time equivalent staff on the day of this visit. We were told by staff working on a ward that the recruitment process felt "sluggish" in how quickly posts were advertised to people being appointed and starting work. A nurse manager described the recruitment process and explained how interviews were planned so they were based on the role and how staff would work within a team. She explained questions were based on key policies, current issues in relation to the clinical area and scenarios. She told us, "We need to find out the caring and compassionate staff. We need to get the staff right so we can give the care we would all like to give." Data was provided which indicated the average recruitment time for advert to filling the post was not excessive.

We spoke to a newly recruited nurse practitioner in the department who explained the selection process he had undertaken. He told us the interview was based on scenario type questions such as what would an applicant do if they weren't happy with advice from a senior doctor and an observation of a clinical situation. He also told us about the induction and support systems and it said, "You never feel you are just left."

We spoke with a band 5 nurse who had worked in the department for 26 years. She told us her training was up to date and that she received clinical supervision whenever she needed or asked for it. She also said the training had much improved over the years and she could access most courses fairly quickly.

We spoke to a support worker who had been in post for a month. She confirmed that she had received an induction which covered both the corporate information and a specific element which covered the information they needed at ward level. She told us she had been assigned a buddy who would support her in her new role. She said, "Staff have been lovely and helpful." She confirmed that she had received the appropriate training to ensure she had the skills and competencies to deliver her role.

Staff in the accident and emergency department told us that they could access training. They said it is "no problem" and the Trust was fully committed to developing staff. One ward manager said, "There's no bother at all about getting training. We have a really good system here."
Assessing and monitoring the quality of service provision

Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

City Hospitals Sunderland NHS Foundation Trust had a number of different ways in which it assessed and monitored the quality of service delivered at Sunderland Royal Hospital. We looked at performance reports, audit schedules, the organisation's quality accounts, risk management/governance systems and patient experience/satisfaction reports.

We looked at the way quality and governance were managed by the Trust and the key areas of risk to quality identified by the Board. These included: the workforce, the management of Clostridium Difficile; patient safety never events; and financial governance going forward into 2015.

A six monthly review of staffing levels was in place, which had been initiated in part in response to the anticipated Francis recommendations. There had already been an agreed increase of nurse staffing levels for elderly services. This was 27 whole time equivalent Registered Nurses and 24 healthcare assistants. Further review was due in January 2014, and that early indications suggested a small increase in staffing numbers which would help increase staffing at night for the elderly.

We were told by the Executive Director Nursing and Quality that the Trust was reviewing the strategies going forward into 2015. This included issues such as the high levels of ambulance attendance. We saw plans were being developed regarding the refurbishment of the accident and emergency and the development of an adjacent health centre to provide additional walk-in centre facilities, and to manage urgent care while developing the new Emergency Department.

We saw that in 2012 the Trust, at the request of Monitor, underwent an independent review of the Trust's Quality Governance Assurance Framework (QGAF). The independent review was undertaken by Price Waterhouse Cooper (PWC), and the Trust scored 1.5. This was extremely positive given Monitor required Trusts performance to score 4 or less (that is, the lower the score the better).

The independent review identified three areas where further improvement could be made.
Medication errors showed as a low incidence of reporting, however this was in part explained by the e-prescribing facility which eradicated a number of prescribing and administrative errors.

Monitor found that pressure ulcer reporting was not consistent in being reported as serious untoward incidents. The Trust had since ensured all required pressure ulcers were reported appropriately. We were told that the Trust's Rapid Review Group was used for reviewing all moderate and serious graded pressure ulcers, for example grade 3 and above. The Trust also had a system in place to ensure a tissue viability nurse was involved for all incidents and these were reported and reviewed at the weekly Safeguarding Rapid Review Group.

The third element was the incidence of clostridium difficile, as the Trust failed to meet its target last year. We saw the Trust had undertaken a number of initiatives to meet this year's target which was 36. The initiatives included an independent review from Doncaster and Bassett Law NHS Trust to provide assurance and recommendations on improving their healthcare acquired infection processes. This did not highlight any gaps in the delivery but as a result the Trust had introduced the use of 'Pods' which were additional separated bed spaces to improve infection control. The Trust had also purchased a virtual nurse facility which was in the process of being installed to prompt staff and visitors about the need for hand washing.

With reference to cost improvement programmes we were told and shown the reporting mechanisms where each directorate developed their own proposals. This also gave the opportunity for the Director of Nursing and Quality and Medical Director to challenge them. A commitment to transformation of service delivery rather than the concept of cutting services was advocated. For example, an increase in ambulatory care pathways and increase in day surgery provision. A quarterly review mechanism was in place with every directorate to review the potential impact on quality. Local Clinical Governance and Risk Management meetings with ward leaders and matrons were given as an example of the mechanisms for front line staff to raise any concerns regarding cost improvement initiatives.

The Board was made aware of service quality issues through a number of initiatives. These included Board walkabouts taking place fortnightly accompanying the Director of Nursing in collaboration with Non-Executive Directors, Lead Matron and the invited attendance of CCG (Clinical Commissioning Groups) representatives. It was also reported that a senior manager from the estates and facilities team joined some of these visits. We were told this gave all of the participants the opportunity to see the operation of the hospital and to address any issues they saw immediately.

We saw that a quality risk and assurance report was produced for the attention of the Board. There were also separate risk reports in place which identified risks. The Director of Nursing and Quality reported a ward accreditation quality scheme was also under development.

We saw in the clinical areas that there was a clear escalation system for reporting breaches of target times and there were weekly meetings to review performance and to review action plans arising from lessons learnt. One staff member told us, "We had a lot of breaches in a fortnight period in November because there were just no beds anywhere in the hospital. What can you do, it's very frustrating because we are a good accident and emergency service and staff are working to capacity."
Other Board members were reported to be involved in 'safety thermometer visits' including Director of HR and Director of Finance. In addition the Chief Executive and Chair also undertook observational walkabouts across Trust departments.

The Trust had indentified through electronic staff record (ESR) data that the uptake of mandatory training and staff appraisals was not meeting the required performance dashboard targets. The reason for this was suggested by the Director of Nursing as being that staff can find it difficult to attend training if there are increased work demands. It was also reported that, with reference to appraisals, staff salary increments may also be withheld if every endeavour had not been made by both staff and managers to ensure an up to date appraisal was carried out and recorded in ESR. They are also reported as part of the Quality Report and also identified in the Annual Report.

We looked at the clinical audit activity. We spoke with the Medical Director and Director of Nursing who reported they were satisfied with the level of clinical audit activity. It was reported that the Trust had 87% compliance with National Audit (some audits would not be relevant at this location) and 100% compliance with National Confidential Enquiries. The Trust undertook a risk-based prioritisation of audit activity. There were approximately 150 department audits undertaken annually. Audits were reported to the Audit Committee, and National Audit reports were received by the Governance Committee and the Trust's Board.

The Medical Director and Director of Nursing described the clinical audit agenda. One example of an audit which identified areas of potential improvement was the audit of fractured neck of femur treatment. An internal report received by Governance Committee and the Trust Board and internal audit findings indicated that access to senior clinicians for the patients with co-morbidities was a clear requirement. As a result of this finding, a business case had been put together for a Consultant Orthopaedic Geriatrician.

We were told that the quality priorities of the Trust included dementia services, medication errors, falls, pressure ulcers and clostridium difficile. There was evidence of committee structure reporting on clinical governance and clinical audit activity. The Rapid Review Group was cited as reviewing patient safety incidents, for example pressure ulcers of grade 3 and above. The Trust's patient safety team was responsible for actively monitoring patient safety, risk and inquest, and safeguarding.

In terms of performance measures and metrics it was reported by the Director of Nursing that these measures were monitored at directorate level but that the Trust was working towards having reports that "drill down" by ward area. We were told that the ward manager would eventually update the respective wards performance on a white board. This would enhance the openness and transparency agenda for staff, patients and visitors.

Risk Registers were managed by each Directorate, and a quarterly performance report was produced for each. There was a Risk Register Review Group which reported to the Governance Committee. Risk was reviewed from a clinical and corporate perspective. The Corporate Risk Register was provided. It was noted that risk management training was provided for appropriate staff as part of induction in addition to which specific risk management training was made available. It was also noted that there was a workshop on risk management as part of the Trust's Board Development programme. This meant that the Trust was ensuring that they had a robust mechanism in place and that staff had the skills and competencies to work within the risk management strategy.
We saw that risk management was undertaken using a software package known as Safeguard for developing and strengthening the Trust's risk management strategies. This system was found to be comprehensive allowing staff on each of the ward and department areas to report clinical and non-clinical incidents. Directorate Managers are responsible for ensuring investigation at directorate level. A report is generated and shared with directorates and Trust Board members through the Governance Committee. All untoward serious incidents were reviewed and an investigation set up if required. A report was then produced with recommendations and an action plan drawn up. This was then passed down to areas for implementing a "lessons learnt" approach. It was noted there was not always a timely closure on incidents, however this had been recognised as requiring additional resources along with complaints management. A business case had been put forward to request these resources.

It was reported that some Strategic Executive Information System (StEIS) reportable Serious Untoward Incidents (SUIs) were not dealt with within the 45 working day report completion timeframe. This was attributable to in-house performance and capacity issues. This had been identified as a resource issue and the requirement for additional resources had been flagged up by the Director of Nursing. All SUIs and StEIS reports were reviewed and the Rapid Review Group met weekly to review all incidents to determine if they were reportable as an SI and to review findings and progress on SUI investigations. Any risks were escalated to the Governance Committee. All incidents received were triaged by a Risk Manager as they were reported onto the Safeguard system. When a serious incident was identified against the agreed StEIS/SUI criteria, it was rapidly escalated via email/telephone to the key members of the Rapid Review Group (RRG) for their information and for a decision on reporting to StEIS via the Corporate Affairs Team within the 48 hour timescale. Each such incident would then also be added for ongoing consideration to the RRG until the investigation and any actions were completed. The Rapid Review Group also determined if an incident required an RCA investigation and whether the incident was StEIS reportable. This meant that a strategy was in place to manage StEIS and SUI incidents.

The Trust appeared to have a robust quality reporting and monitoring mechanism. An example was given as to how the Trust had recently dealt with a neonate contact with TB in which this was promptly reported on StEIS. Liaison with Public Health England was obtained, pro-active management and all Board Directors were notified in a timely manner. All families were contacted immediately by a phone call followed up with a hand delivered letter the next day and the setting up of a helpline. It was suggested by the Trust that negative publicity had been minimised as a result.

In terms of escalation of risks, we were informed that pressure ulcers and health care acquired infections were both scored at 15+ on the Corporate Risk Register. It was reported that seminars were regularly facilitated to disseminate lessons learned from serious incidents. We were given information about the number of SUIs outstanding for over 45 working days and the plan in place to address this shortfall.

In terms of openness and transparency the Director of Nursing visits the wards with Non-executive Directors in attendance and also Senior Managers and CCG Commissioners. Real time feedback was collected, these reports are reviewed by non-executive directors at the Patient, Carer and Public Experience Committee.

Governor appointments were reported as having no vacancies with a stable membership of approximately 14,000. Non Executives chaired a number of Board sub committees
including the Governance Committee, Patient, Carer and Public Experience Committee and Audit Committee, Policy Committee and Communications and Marketing Committee.

Council of Governor Meetings also received information on SUIs reported clinical practice issues, for example breast cancer and patient-led assessments of the care environment (PLACE) reports. Governors also received all Part One of the Trust Board papers and were invited to attend the meeting in public, and were invited to attend the second part. We looked at the records of Board meetings. These were typically attended by two or three governors on a regular basis. It was noted that the issues surrounding the revised electronic patient scheduling system had been fully discussed and challenged at governor meetings and the minutes for these were provided. In terms of assurance it was noted that an audit which had been undertaken prior to April 2013 about mental capacity act (MCA) compliance had provided limited assurance and had required action.

We noted that no whistle blowing reports had been received by the Trust in the last year. We saw that there was a whistle blowing / cause for concern policy. When we discussed this with a service manager it was suggested that staff used the incident reporting mechanism or even the grievance system if they had issues. However staff can raise issues anonymously outside of line management as described in both the Grievance Procedure and the Whistleblowing Policy.

We were given information about how service users were involved. These included the Patient Carer and Public Experience Committee, Patient Forum, the Carers Reference Group and the Community Panel National Outpatient survey, PLACE Assessments, other National In-patient Surveys. Involvement was also ensured through Governors Committee attendance and Non-executive Directors unannounced visits including visits by CCG Commissioners.

When we looked at the records of claims against the Trust we saw that they had 531 open or active claims in progress. We reviewed this information and found that this included active claims and completed, dormant and non-pursued claims. We discussed the potential for associated quality risks in terms of these not being dealt with and understood by the organisation in a timely manner. It was acknowledged that action was required to address the delay in managing this and we saw evidence that this process had been started with identification and analysis of the work necessary.
Complaints

People should have their complaints listened to and acted on properly

Met this standard

Our judgement

The provider was meeting this standard.
There was an effective complaints system available.

Reasons for our judgement

Before we visit the hospital we noted that CQC had been contacted by nine people who were concerned about the way complaints they raised with the hospital had been managed. We looked at this outcome partially in response to this information.

We spoke with the Executive Director Nursing and Quality who told us that they had identified a delay in the response times for the complaint process.

We were told that there had been a period when the complaint team had been depleted and although staff had been replaced these were temporary staff and had less understanding of the processes. A new line manager had been recently put in place following a restructuring. We spoke with the previous manager. We spoke with her about the changes which had been made and those planned for the near future.

We were told that there had been a recent exercise in which patients with a learning disability, who were part of the patient participation programmes in the learning disability patient forum, had been actively involved as 'mystery shoppers'. They had delivered their experiences in the form of a presentation to the Trust Board. A specialist learning disability liaison nurse was also contracted from Northumberland, Tyne and Wear NHS Foundation Trust to participate in the review of services. The learning disability patient forum also reported into the Patient, Carer and Public Involvement Committee.

We were told there had been a review of complaint management undertaken by the Trust. A rapid process improvement workshop had been carried out which included all of the staff involved in complaint management.

The process had initial changes made six months ago and the staff we spoke with were aware of these. There were a series of pilots to introduce the new procedure and these were evaluated so that they could be improved where necessary before rolling it out to the rest of the hospital. We saw that it had been reported to the Board in the 2013/14 quarter one complaints report (August 2013) that the pilot results had been encouraging with 32% (13) complaints identified as green, which meant that rapid turnaround of these with the maximum response time being 10 days. It identified that complainants had expressed positive comments about the early telephone contact.
We were told that complaints could be received through a variety of routes including a complaint form, a letter or an email. Each could be received directly by the directorate the ward or directly to the chief executive. The complaint would be reviewed to ensure the identity of the complainant to ensure they would be able to have confidential information shared with them and it would then be allocated to a named individual. This new complaint management structure began with an initial triage process when the issues were reviewed and a risk level determined, for example green, (complaints which could be dealt with over the telephone) amber or red (complex multi-agency, speciality complaints).

All complaints were acknowledged and complainants contacted within 24 hours (where possible) of the complaint being triaged, to inform them of the planned action to investigate the issues raised. The complaint was then allocated by the Directorate Manager for example to the Matron where it involved nursing care or the Clinical Director where it involved medical care. There were timescales in place to ensure that each person involved in the investigation was aware of their responsibilities and an audit could be used to determine when these targets were breached.

We were told by the Executive Director Nursing and Quality management that a business case had been put together which identified the need for additional resources to assist in the investigation and complaint management process. This was for the appointment of four Band 6 staff that would assist in the collection of information and review of care records and supporting information. We were told that they were confident that this recommendation would be successful.

We spent time in the complaints and PALS offices and were told that the way that people are informed of the ways to raise a complaint or concern was being changed and it involved the views of patient groups and a review of the current service. The newly appointed complaint manager told us that they had recently moved the complaint team into the main hospital building from the headquarters building to make them more accessible. She acknowledged that the way that people were informed about making a complaint needed to be made more high profile and told us about how this was going to be achieved. Examples included an open front to the complaint office and new leaflets and posters.

In the accident and emergency unit we did not see any information that related to how people could make a complaint but saw in three areas a poster about the PALS service that offered "Help and advice". Four people we spoke with said they didn't know how to make a complaint and said they would probably just speak to the staff who were dealing with them at the time. We asked a reception staff member about what they would do about acknowledging a complaint. They stated they "didn't know". Another staff member at the clinic said they had some leaflets about the PALS service but the leaflet was in relation to another hospital service in the region. We discussed this during our feedback of the inspection visit and it was agreed that this would be looked into.

When we spoke with the staff on the wards they told us that nursing and medical staff were committed to listening to patients and learning from any feedback, either negative or positive. We saw that one ward offered a comprehensive admissions folder which invited feedback comments from patients and relatives from the beginning of the patient's stay onwards. In the event of a complaint, this was addressed as a matter of priority. The ward manager we spoke with said, "I like to nip these things in the bud, because no matter what or how small it might be, it can ruin the patient's experience of their stay in hospital both at the time and in the future."
Other staff told us that feedback and lessons learned was received from complaints through clinical governance meetings and ward/departmental meetings. They also described the use of the 'family and friends' test, to get people's views. The 'friends and family' test information was clearly displayed in the accident and emergency department and staff we spoke with knew how to deal with concerns or complaints arising from patients or their families/carers. One nurse told us, "If I had any concerns I would speak to the senior sister but we try and address things as they crop up with people."

A ward manager on one of the older people's wards told us, "I'm very up front if there's a problem. If something's raised then I'll deal with it head on."

Some of the patients interviewed said that if they had to complain about anything it would be that sleeping is difficult at night because of the noise of other patients needing assistance. One female patient acknowledged, "You can't help the noise at night. It's just people coming in who are ill and need help." Another patient said, "If there was something wrong my daughter would complain, but I'd say nothing. They're all very good."

Examples of organisational learning from complaints were given by staff. For example, the car parking technology had been identified as causing difficulties for patients and the Trust's new patient appointment computer system had created a number of complaints which had been some of which were due to the understanding about the system by staff. A newly appointed senior officer from Healthwatch had met with colleagues at the Trust and although they have just made their board appointments she had advised that to date no major issues have been flagged for the Trust.

We saw that the Trust used a number of mechanisms to disseminate lessons learned from complaints, serious untoward incidents and Coroner reports. Examples of these included lessons learned briefing sessions which were facilitated by the Head of Nursing and Patient Safety. It was reported that often over 100 people would attend these sessions. Patient Experience Symposia were also facilitated. The Trust intranet was also used to communicate high impact messages to all staff who would be directed by their ward or unit managers to read and would be discussed at team meetings.
About CQC inspections

We are the regulator of health and social care in England.

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

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

**Met this standard**

This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

**Action needed**

This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

**Enforcement action taken**

If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

**Essential standard**

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

**Regulated activity**

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.