North Tees and Hartlepool NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Good
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected North Tees and Hartlepool Hospital NHS Foundation Trust from 7-10 July 2015 and undertook an unannounced inspection on 29 July 2015. We carried out this comprehensive inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme.

The trust has a well-established executive team with the Chief Executive being in post since 1 April 2007 and the more recent appointment of the Director for Human Resources in 2014. It has been a Foundation Trust since 2007 and in 2008 became an integrated provider of acute and community services.

- The University Hospital of North Tees provides: urgent and emergency care; medical care; surgical care; critical care; maternity services; children's and young people's services; end of life care; outpatient services and diagnostic imaging.
- The University Hospital of Hartlepool provides: medical care; surgical care; outpatient services and diagnostic imaging
- Community services: urgent care centres; community adult and long term conditions; end of life care; community health services for children, young people and families and dental services

Overall the trust was rated as 'Requires Improvement' however the community services for this trust were rated as 'Good'

Our key findings were as follows:

- Across both the acute hospital and community services, arrangements were in place to manage and monitor the prevention and control of infection. There was a dedicated infection control team to support staff and ensure policies and procedures were implemented. We found that overall, areas we visited were clean. In the Accident & Emergency Department we saw that infection control procedures were not always followed.
- Infection rates for methicillin resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Difficile) were within an acceptable range for this size of trust
- Patients were able to access suitable nutrition and hydration, including special diets and they reported that, overall they were content with the quality and quantity of food.
- There were staffing shortages in across both nursing and medical professions with some wards unable to meet the safer staffing requirements. The trust used agency nurses and locum doctors to address the staffing requirements.
- There were processes for implementing and monitoring the use of evidence based guidelines and standards to meet the differing needs of patient groups across both the hospital and community services.
- There were a significant number of policies for medical and maternity services that we reviewed on the intranet that were out of date and required revising and updating.
- There were processes in place from ward and department level through to board level for the reporting of incidents and there was learning from incidents. Action plans from a sample of root cause analyses of serious incidents were reviewed and found to lack detailed information of actions needing to be taken.
- Equipment was well maintained both in hospital and community services.
- Governance processes were not fully developed or embedded across the divisions and there were concerns in some areas regarding the maintenance and use of risk registers. These were recognised by the trust in their revised Risk Management Strategy (2015, RM 11, V9) and plans were in place to improve the quality and effectiveness of risk registers; however these were in the early stages of implementation at the time of inspection.
- There was a clear strategic development plan called 'Momentum' which included both community and hospital services and focussed on integration of services and delivering care closer to home
- There were concerns regarding leadership of some services however the trust had addressed these in part

Summary of findings

at the unannounced inspection. There remained concern regarding the leadership capacity within maternity services and the impact this had on professional development and clinical standards.

We saw several areas of outstanding practice including:

- The development of advanced nurse practitioners had enabled the hospital to respond to patient needs appropriately and mitigated difficulties recruiting junior doctors.
- The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.
- A training suite had been set up to simulate procedures within surgery and enabled staff to practice and upskill in a safe environment.
- The critical care team achieved a network award, which recognised excellent work in relation to "target" training. The team had also achieved recognition for their work related to critical care competencies, difficult airway and skills drills.
- The critical care team achieved 58% for its consideration of patients for tissue donation. The team were the second highest achiever for corneal donations. Overall the team's approach to tissue and organ donation was impressive, demonstrating a compassionate and sensitive approach to patients and relatives.
- The paediatric and neonatal departments participated in a number of national and local research studies and were involved in a large number of clinical trials. The management team and several other staff told us the department had recently obtained a £3.5 million grant for an 'OSCAR study.' This study is for high frequency Oscillation in Acute Respiratory distress syndrome, comparing conventional positive pressure ventilation with high frequency oscillatory ventilation.
- The neonatal unit had implemented the 'Small Wonders' initiative for premature babies; this was designed by the charity Best Beginnings. Small Wonders supports parents in their baby's care in ways shown to improve health outcomes for their babies.
- Staff in the maternity day assessment unit attended training on Gestation Related Optimal Weight (GROW) software which aims to reduce the number of stillbirths by using customised growth charts.
- 'NIPE Smart' had recently been implemented within the maternity directorate. This is an information technology screening management system which has a robust system of capturing data on newborn and infant screening examinations with the aim of reducing the number of babies diagnosed with a medical congenital condition at a late stage.
- Outpatient department staff produced posters and delivered presentations at the International Society of Orthopaedic and Trauma nurses on the development of virtual fracture clinics and on the roles of speciality nurses.
- A number of staff within the outpatients department completed modules on service improvement including one current project to improve the staff engagement and sustainability in clinical supervision.
- Staff worked on the development of health promotion packs within main outpatients to be rolled out within the orthopaedic department as a pilot to explore how this can be sustained.
- The lead consultant radiologist for the specialist procedure known as CTPA (CT pulmonary angiography) presented the experiences of staff and patient outcomes to a panel at a major CT equipment manufacturer.
- A project in conjunction with Hartlepool Council was initiated to improve health care for people living with learning disabilities. When a patient with learning disabilities was admitted to the hospital, an alert was generated and they were admitted to a virtual ward managed by the learning disabilities lead nurse. This ensured that the trust was able to respond to their needs in an appropriate and timely manner.
- One of the senior dental officers made contact with the trust's learning disability lead nurse. They worked together to set up a pathway for people with a learning disability who were undergoing a general anaesthetic procedure. This meant that these patients were able to visit the day unit in advance and have additional planned support whilst they were having the procedure.
- We saw extremely kind, gentle and compassionate care being given to people, and the team-working between the dentists and the dental nurses was exceptional; all aimed at delivering a good outcome for the patient.
- The health visiting service provided for refugee and asylum seeking families was outstanding. This was

Summary of findings

largely driven by the specialist health visitor and her team. They demonstrated a clear passion and dedicated insight of the issues facing ethnic minority women and children seeking refuge in Stockton. The health visitor not only provided care for the children but ensured the parents were also supported to integrate into local society and minimise the risk of social exclusion.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must ensure that:

- There are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.
- Staff follow trust policies and procedures for managing medicines, including controlled drugs. Ensure that medicines are stored according to storage requirements to maintain their efficacy in maternity services.
- Risk assessments are documented along with personal care and support needs and evidence that a capacity assessment has been carried out where required.
- Pain in children and young people is assessed and managed effectively.
- The competency criteria for staff who are triaging patients are clearly documented and include recognised competency–based triage training.
- Infection control procedures are followed in relation to hand hygiene and use of personal protective equipment.
- Resuscitation and emergency equipment is checked on a daily basis in line with trust guidelines.
- Cleanliness standards are maintained.
- Effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.
- All policies and procedures in the In-Hospital care directorate are reviewed and brought up to date.
- Midwifery policies, guidelines and procedural documents are up to date and evidence based.
- There are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- All annual reviews for midwives take place on a timely basis.
- Aall staff attend the relevant resuscitation training.

In addition the trust should:

- Consider strengthening the senior nurse capacity in the A&E department.
- Consider reviewing the system for documenting the follow-up of admitted head injury patients by the A&E department
- Consider a system in A&E to enable patients with allergies to be recognised quickly and easily without the presence of medical records
- Ensure that staff are following the correct procedure when dispensing medication using the Omnicell including checking the prescription at the time of dispensing.
- Consider a continuous audit of all MCA and DoLs assessments and referrals and share lessons learned.
- Consider assessing the access to the emergency resuscitation trolley on the haematology day unit.
- Consider putting engaged notices on toilet doors to protect dignity if the door is kept unlocked for staff to gain access to vulnerable patients.
- Send electronic communication to the patient's GP on discharge from the critical care unit.
- Ensure handover meetings are held in a private and confidential area in children's services.
- Ensure that all patient documentation remains confidential during patient visits to the outpatients department.
- Ensure that all outpatient treatment rooms are cleaned before use.
- Ensure that formal drugs audits and stock checks carried out regularly in outpatients.
- Ensure that medicines are stored appropriately to ensure their quality is maintained.
- Ensure that clinic planning, room utilisation and staffing is effectively managed and controlled for outpatient clinics including those hosted by the trust.
- Ensure that patients in the children's outpatient department are afforded privacy when speaking with reception staff.
- Update the risk assessment related to paediatric resuscitation in the children's outpatient department.
- Ensure that some clean and safe methods for entertaining or distracting children are provided within the diagnostic imaging department.

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- Ensure that staff adhere to the coding system for recording on medication charts
- Ensure that staff fully adhere to infection control policies and close doors on side rooms where patients are being barrier nursed.
- Ensure the processes and documentation used for appraisal of non-medical staff monitors their performance and meets their personal development needs.
- Review the process for storage of post-transfusion blood bags while retained on ward areas.
- Review whether documentation for patients living with dementia are completed and comprehensive.
- Ensure that within outpatient services, action plans from audits, risk registers and meetings are maintained, regularly revisited and amended to show where actions have been completed or remain outstanding.
- Ensure that established models of regular nursing clinical supervision are implemented for all staff involved in patient care in outpatient services.
- Ensure that patients and staff are informed on a timely basis if clinics are cancelled, including those involving clinicians and staff from other trusts.
- Ensure that strategy and management plans regarding transforming the outpatients departments are communicated to all staff.
- Consider recording decision made at the evening medical ward rounds on the critical care unit.
- Consider how the critical outreach service will be maintained.
- Review the recruitment of medical staff, particularly junior doctors in the surgical unit.
- File maternity healthcare documentation according to the trust records management policy to avoid loss or misplacement of information
- Indicate benchmark data on the maternity performance dashboard to measure performance.
- Ensure that 'fresh eyes' checks are recorded when undertaken.
- Review the senior midwifery structure and experience resource to ensure that all the midwifery roles needed for coordination and oversight of each service are appropriately covered.
- Monitor and internally report the level of provision of 1:1 maternity care
- Hold staff handovers in maternity services in an environment that reduces the possibility of distraction and interruption.
- Have a competency based framework in place for all grades of midwives.
- Have systems in place to achieve the nationally recommended ratio of 1:15 for supervision of midwives.
- Consider safety briefings as part of daily communication with staff in maternity services.
- Include describing the reporting arrangements for Supervisors of Midwives following investigations, audits or reviews in the maternity services risk management strategy.
- Provide simulation training exercises to prevent the abduction of an infant
- Ensure that the review of the Specialist Palliative Care Team covers the educational, developmental and support needs of staff on the community inpatient unit at University Hospital of Hartlepool
- Ensure that pain control medicines are prescribed and administered at the intended interval of time.
- Evidence how the end of life care strategy and development of services is aligned at board level.
- The trust should ensure there is a consistent approach to clinical supervision across the community adult services.
- Have systems in place to enable staff to complete mandatory training within the required timescales.
- Use interpreting services appropriately to meet the needs of children, young people and families in the community.
- Complete and record lone working risk assessments in all appropriate documentation.
- Monitor the delivery of the Health Child Programme by reviewing and improving performance measures.
- Have standard operating procedures in place to support the transition of young people from community children's services to adult services
- Consider reviewing the trust process for prescribing antibiotics in the Minor Injuries Unit to enable them to be prescribed after 10pm when only one qualified nurse is on duty.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to North Tees and Hartlepool NHS Foundation Trust

North Tees and Hartlepool NHS Foundation Trust became a Foundation Trust in 2007 and has a turnover of approximately £250million. In 2008, the trust became an integrated provider of acute and community services. It provides services to a resident population of 400,000 people across Hartlepool, Stockton-on-Tees and parts of County Durham. The trust also provides bowel and breast screening services as well as community dental services and other community based services to a wider population in Teesside and Durham.

The trust has 563 general and acute, paediatric, maternity and critical care beds and employs 505 whole time equivalent medical staff; 2,482 whole time equivalent nursing staff and 1,675 whole time equivalent other staff. There are two acute hospital sites; the main acute hospital site is the University Hospital of North Tees at Stockton-on-Tees with a further acute hospital at Hartlepool providing predominantly elective services and outpatient and diagnostic services. The trust also provides community services across Stockton-on-Tees, Hartlepool and parts of County Durham. We visited six dental clinics and nine community services locations.

This was a comprehensive inspection carried out as part of the Care Quality Commission inspection programme.

Our inspection team

Chair: Helen Bellairs, Non-Executive Director, 5 Boroughs Partnership

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The trust-wide inspection team included: CQC inspectors and a variety of specialists including consultant in diabetology, a consultant in intensive care medicine and anaesthesia, a consultant in palliative care, a consultant paediatrician, a consultant general surgeon, a professor of gynaecological research, a junior doctor, a student nurse, senior midwives, matrons, senior nurses and three experts by experience. (Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services).

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following eight core services at University Hospitals of North Tees and Hartlepool NHS Foundation Trust:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and diagnostics.

The community health services were also inspected for the following core services:

- Community adult services
- Community end of life
- Community health services for children, young people and families
- Dental Services

Before the announced inspection, we reviewed a range of information that we held and asked other organisations

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to share what they knew about the hospitals. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held two listening events; on 1 July 2015 at Newtown Community Resource Centre, Stockton-on-Tees and on 6 July 2015 at the Grand Hotel, Hartlepool, to hear people's views about care and treatment received at the hospital and in community services. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas, outpatient services community clinics, hospice and in patients' homes when visiting with District nursing teams. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records. We undertook Short Observational Framework Interviews to watch how staff provided care for patients.

We carried out an announced inspection on 7 – 10 July 2015 and an unannounced inspection on 29 July 2015.

What people who use the trust's services say

The NHS Friends and Family test results (FFT) results between December 2013 and November 2014 indicated the response rate to be slightly worse than the England average at 29.1% compared to England average of 30.1%. The percentage of patients who would recommend the services was consistent with, or better than, the England average. In A&E however, the Friends & Family Test indicated 88% of patients would recommend the department; this figure had dropped steadily since January 2014.

In the Care Quality Commission In-Patient Survey (2014), the trust showed a slight increase (7.2 from 7.1) in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year. Similarly there was a slight increase (8.3 from 8.1) to say they received answers they could understand when asking important questions.

The Patient Led Assessments of the Care Environment (PLACE) scored the trust just above the England average for privacy, dignity and well-being (88, England average 87)

Results of the trust Children and Young People's Survey (2014) showed that out of 101 parents who completed the survey, 99 felt their child had a good experience and all children who participated said they had a good experience. In the trust young person's survey (2014/15) of the 91 respondents, 98% felt they were treated with dignity and respect and 93% were given enough privacy

Facts and data about this trust

North Tees and Hartlepool NHS Foundation Trust is an integrated provider of health care with a main acute hospital at Stockton-on-Tees and a further hospital site and a range of community services. The trust has 563 general, maternity, paediatric and critical care beds. There were no community inpatient wards. The trust operates their community services across North Tees, Hartlepool and parts of County Durham with breast and provides bowel and breast screening services as well as community dental services and other community based services across Teeside.

The trust employs 4,662 WTE staff across acute and community services. The staff are split into the following broad groups:

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505 WTE Medical

2,482 WTE Nurses

1,675 WTE Other

The trust inpatient activity (April 2014 – March 2015) included 5,589 elective admissions and 37,181 non-elective admissions. Day cases for the same period were 37,438 and there were 7,949 ambulatory care attendances. There were 205,122 outpatient attendances (total attendances). Accident & Emergency had 88,318 attendances. There were 3078 live births.

North Tees and Hartlepool NHS Foundation Trust (NTHFT) provide adult community services which form part of the Out of Hospital Care directorate. The services are organised around GP practices and adult community services are arranged and managed as three services – Adult Nursing (district nursing), the Community Integrated Assessment Team (CIAT) and Therapy Services. The trust has a community heart failure service, incontinence services and diabetes services.

Deprivation overall is significantly worse than the England average with high rates of child poverty noted in Hartlepool. The level of child poverty in Hartlepool and Stockton was worse than the England average with 30% and 22% respectively of children under 16 years living in poverty. The health and well-being of children is generally worse than the England average with infant and child mortality rates similar to the England average. The rate of family homelessness was better than the England average in both localities.

Children and young people under the age of 20 years made up 24.6% of the population in Stockton and in Hartlepool. 5.1% of school children in Hartlepool and 9.4% of children in Stockton were from a minority ethnic group.

In adults, the life expectancy is seven years lower than the England average for men and five years lower for women. In Hartlepool, the majority of health indicators are significantly worse than the England average in adults. Healthy eating is significantly worse with the population more obese than the England average in adults. Smoking related deaths are significantly worse than the England average. There are significantly high rates of hospital admission as a result of alcohol related harm.

There are high rates of smoking in pregnancy and teenage pregnancies in comparison to the England average and there are low breastfeeding rates. Children in Stockton and Hartlepool have worse than average levels of obesity with 22% and 24% respectively of children aged 10 – 11 years being identified as obese. In children under the age of 18 there were worse rates of hospital admission due to alcohol.

The trust was last inspected 19th to 25th November 2013 and was found to be compliant witht the standards inspected.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Across both the acute hospital and community services, arrangements were in place to manage and monitor the prevention and control of infection. There was a dedicated infection control team to support staff and ensure policies and procedures were implemented. We found that most areas we visited were clean however there were areas in maternity, medicine and Accident & Emergency (A&E) department that were not clean. We saw that infection control procedures were not always being followed in medicine and A&E. There were concerns with medicines management across the trust, with particular concerns on Holdforth Unit, University Hospital Hartlepool, with medicines not having specific times for administration entered onto the prescription sheet and gaps where medicines had not been signed to confirm they had been administered. Clinical pharmacy services were only available Monday to Friday and this impacted on the ability to reconcile medicines within the national guidelines. Trust medicines management audits in 2014 and 2015 had identified concerns that medicines refrigerator temperatures were not being properly monitored and were poorly documented with little improvement. This remained a concern during our inspection and we identified further concerns about the safe use and storage of insulin on two wards. There were robust reporting arrangements of incidents across the organisation through the electronic reporting system, with staff in the acute and community teams able to articulate how incidents were recorded, disseminated and lessons learnt. There was an open culture to reporting incidents across the organisation with staff saying they were encouraged to report incidents. The trust had reported one never event classified as wrong site surgery. The trust had established Patient Safety Co-ordinators whose role was to provide support to the directorate senior staff in relation to all aspects of clinical governance, quality, risk and safety. There were processes in place for safeguarding for both adults and children and staff were aware of what action to take in both acute and community settings. The trust used an evidenced based acuity tool to calculate nursing establishments at ward level including the Safer Nursing Care tool; this was carried out every six months. In addition we saw that	Good

directorates would undertake their own review of nurse staffing levels for example the In-Hospital Care Directorate undertook a review twice each year. However there were some wards that did not meet the required staffing levels.

Duty of Candour

- We saw that the Trust Board, Council of Governors and the Trust Directors Group had received a presentation on the requirements of the Duty of Candour Regulation. These took place in September 2014 and January 2015 with a further update to the Board in March 2015. A report was also submitted to the Board regarding the implementation and embedding the Duty of Candour throughout the organisation.
- We reviewed ten serious incident root cause analyses and saw examples of where the trust had informed the patient or relative of the harm and provided an apology.
- Staff throughout acute and community services were able to explain the requirements of the Duty of Candour regulation. In a focus group for Health Care Assistants, staff present were able to articulate what the Duty of Candour meant.
- We reviewed a serious incident that involved the death of a baby. We saw evidence that the family had been contacted shortly after the incident, staff had met with the family and there was an apology in writing.
- The application of Duty of Candour is reviewed at the weekly Patient Safety Meetings

Safeguarding

- The Director of Nursing, Patient Safety and Quality has responsibility for Adult Safeguarding with management of the operational team by the Deputy Director of Nursing, Patient Safety and Clinical Governance.
- There were two safeguarding teams for adults and children. The trust had secured funding for a domestic abuse link worker which was on a fixed term basis. There had been a recent appointment to a Lead Consultant post for safeguarding.
- The Adult Safeguarding Steering Group received an activity report and developed an action plan to improve care in trust hotspots and communicate areas of excellence. There was a Safeguarding Children Steering Group and the trust child protection policies and procedures were in the process of being updated.
- The trust recorded 246 safeguarding adult alerts over the last 12 months as compared to 248 in the previous 12 months. Concerns were raised through the safeguarding process and

recorded within the trust database. The 246 alerts raised by directorates were from across the organisation and were investigated through the agreed Teeside adult safeguarding process.

- The trust had achieved 95% compliance for level 1 safeguarding training and 82% compliance for level 2 (March 2015). Focused work was being undertaken to improve level 2 compliance. Staff told us they were all trained to the relevant safeguarding level. Administrative staff from the child health team had achieved 80% of the 100% target for Safeguarding Children Level 1. The target for Level 3 training (clinical staff working with children, young people and families or carers) was 100%. Health Visiting Hartlepool had achieved 90% compliance; Health Visiting North Tees had achieved 80% compliance; School Nursing North Tees achieved 62% and Children's Speech and Language staff achieved 97% compliance.
- The Adult Safeguarding team included a specialist nurse for people with learning disabilities.
- The trust maintained a robust board level focus led by the Director of Nursing, Patient Safety and Quality. A bi-monthly steering group, chaired by a Non-Executive Director maintained responsibility of performance monitoring the Children's Safeguarding work programme. This group had representation from commissioners across Stockton, Hartlepool and North Durham. The Clinical Director of Out of Hospital Care Services had delegated responsibility for Children's Safeguarding and operationally managed the Safeguarding Children Team up until the end of January 2015. The team was then managed by the trust Professional Lead Nurse. The trust maintained membership at senior level on the three Local Safeguarding Children Boards
- In community children and young people's services there were robust safeguarding policies and procedures in place. Staff received regular safeguarding supervision and were knowledgeable about their responsibilities regarding safeguarding vulnerable people.
- All of the staff we spoke with in community children's services were aware of or had undergone training about female genital mutilation (FGM). They knew what action they should take if they identified a patient at risk. School nurses also delivered awareness sessions to children through school assemblies to raise awareness amongst children and parents.
- We saw evidence of the systems in place to monitor and track looked after children (LAC). The team received weekly notifications from the local authority and would plan the initial health assessment. If a child was transferred straight into the

justice system, the LAC team were not always informed when that child was discharged. Staff were working collaboratively with social services and the local authority to improve the system.

- The trust had a pathway in place for following up children who miss outpatient appointments and there were systems in place for flagging children who were subject to a child protection plan.
- The porters told us they had not received training on restraint; however were required to attend incidents on a daily basis to manage verbal violence but occasionally physical violence. The security manager told us that he had undertaken conflict management training and delivered training within the trust and had delivered in-house training to the porters.

Incidents

- The trust reported 6,178 incidents during the period January 2014 to December 2014. For the period March 2014 to February 2015, the trust had reported 96 Serious Incidents of which 48 related to pressure ulcer Grade 3 incidence and 20 were slips, trips and falls. There was also one Never Event reported as wrong site surgery. The trust were below the England average for reporting incidents per 100 admissions at 8.3 compared to the England average of 9.4 for the period January 2014 to December 2014. According to the national NHS staff survey 2014, the organisation scored slightly worse than the national average for percentage of staff reporting errors, near misses or incidents witnessed in the last month at 88% compared to the national average of 90%
- Across the acute and community services we saw established good practice of reporting incidents through an electronic reporting system. Staff were able to explain how they would report and escalate incidents.
- There were processes in place across acute and community services to review and learn from incidents. Serious incidents had root cause analyses with action plans to address areas of poor practice. An example of this was in critical care following a misplaced central venous catheter which resulted in a review of the guidance and revision of the documentation which was in use at the time of the inspection. There had been a re-modelling of the critical care outreach team after themes of poor communication and escalation of the deteriorating patient had been identified through an analysis of incidents. With regard to the never event of wrong site surgery, there had been a root cause analysis and practice had been changed to address the identified causes

Summary of findings

- The national NHS Staff Survey 2014 reported that 93% of staff said the last time they witnessed an error, near miss or incident that could have hurt staff, patients or service users, either they or a colleague reported it. This was in line with the national average which was 94%.
- From April 2015, all Serious Incidents had a lead investigator identified; these lead investigators were senior members of the organisation who were not directly involved with the clinical team and could provide an external objective view of the incident whilst promoting compliance with timescales.
- We reviewed 14 root cause analyses of serious incidents selected from August 2014 to June 2015. It was noted that the RCA documentation was changed in 2015 and that this had improved the quality of reports overall subsequent to the change. However, the quality of the root cause analyses varied and lacked evidence of how the analyses were conducted, i.e. what tool had been used (such as 'the five why's') to arrive at conclusions. This in turn impacted on the quality of the action plans. The Serious Incident Panel quality assured each report and made recommendations for amendments where required. There was evidence of dissemination of learning to medical and nursing staff.
- Community paediatric therapy services produced a monthly newsletter called "The Special Ones" which served as a tool to disseminate information about incidents, risks, complaints and compliments. Staff told us they valued the publication and said it was informative, easy to read and kept them updated on what was happening within the service.

Staffing

- The trust used an evidenced based acuity tool to calculate nursing establishments at ward level including the Safer Nursing Care tool; this was carried out every six months. In addition we saw that directorates would undertake their own review of nurse staffing levels; for example, the In-Hospital Care Directorate undertook a review twice each year. As well as the Safer Nursing Care tool, the trust also used professional judgement and a workforce methodology tool that calculated staffing needs based on hours per patient per day x number of beds plus sickness absence. Staffing in areas such as radiology were addressed through the quarterly performance meetings.
- Planned and actual staffing numbers were displayed on all of the wards we visited and at the time of the inspection, the trust

had 51 whole time equivalent (wte) nursing vacancies. There were particular concerns regarding the staffing on the Holdforth Unit at Hartlepool which at the time of inspection had a nurse to patient ratio of one nurse to 15 patients.

- The trust did use agency staff and we saw examples of induction processes in place for this group of staff. There was a trust wide recruitment strategy which included an adaptation programme for overseas nurses who reside in the UK and overseas recruitment.
- There were daily staffing meetings which identified any staffing issues and agreed actions to mitigate identified risks. In community services, there were processes in place to monitor caseloads and ensure there was flexibility within the community nursing teams to respond to increased demand or changes in workload. Each community team completed a daily situation report and staffing level proforma.
- In community there were staffing vacancies in the children's nursing teams which resulted in children who required antibiotic therapy after discharge from hospital needing to return to hospital for administration of the antibiotics for between one to 21 days
- Data showed that caseloads for community SPCT nurses were generally between 15 and 22 patients at the time of our inspection.
- Up to and including May 2015, the number of whole time equivalent health visitors in Stockton and Hartlepool was 61.93. This fell below the national trajectory goal of 73.49 wte, which was what the organisation was aiming for. We were informed that the service expected the workforce to increase to 71 wte by September 2015. Most of the health visitors we spoke with felt that staffing levels had improved significantly since the launch of the 'Health Visitor Implementation Plan – A Call to Action' recruitment drive. Health visiting staff caseloads were within the Lord Lamming 2009 recommended case load level of 300 families per health visitor. Only 3 teams exceeded this threshold: Stockton Central had 325 per wte; Stockton South had 306 per wte and Billingham had 346 per wte (where, we were told, there were staff vacancies). This had an impact on the service's ability to meet its targets.
- In maternity services, the midwife to birth ratio was 1:30; this was not in line with the Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour set by the Royal College of Obstetricians and Gynaecologists (RCOG) who recommend a ratio of 1:28. There were a number of related

factors identified by the trust including 8.4 wte staff on maternity leave and 6.6 wte staff on long term sick leave. The maternity and gynaecology service also reported a nursing and maternity vacancy rate of 15%.

- We were told that A&E would have a paediatric nurse available on every shift however there was evidence that not all shifts had a paediatric qualified nurse on duty and on one shift the paediatric nurse had only been qualified for seven weeks.
- There were examples of the development of new roles. For example in the In-Hospital Care directorate had employed 14 wte Band One Support Workers to support a programme of falls reduction. These were non-clinical staff whose role was to protect patients at risk of falls from harming themselves or others.
- The ratio of consultants to other medical staff was worse than the England average with 28% of all medical posts being consultants compared to an England average of 33%. The ratio of middle grade doctors was below the England average however there were 36% junior doctors compared to 22% nationally. Within specialities there were some vacancies; for example, in haematology where the service was supported by two locum posts with the trust finding recruitment to these posts challenging.
- There were robust on-call arrangements in place with medicine providing speciality on call rotas 24 hours per day, seven days per week including gastroenterology, cardiology and stroke services.

Cleanliness, Infection Control and Hygiene

- Across both the acute hospital and community services, arrangements were in place to manage and monitor the prevention and control of infection. There was a dedicated infection control team to support staff and ensure policies and procedures were implemented. We were told that the team undertake unannounced visits annually to each ward. The team attended the Infection Control Operational Group that reported to the Infection Control Committee.
- There were examples of staff not always adhering to the trust infection control policies and procedures. In the A&E department, we saw staff not always using hand gel after contact with patients or using personal protective equipment. In medicine on Ward 37, we saw doors left open in side rooms where patients were being barrier nursed.
- Infection rates for Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Difficile) were better than the England average with 28 cases of C Difficile and one case of

MRSA reported from May 2014 to May 2015. Performance in MSSA bacteraemia had worsened with 18 trust attributed cases being reported from April 2014 to June 2015. A review of all cases since April 2012 and investigation findings had been undertaken and no theme or recurrent source of infection had emerged over the last 12 months.

- The Infection Control Team worked in the community with the district nursing teams and attended community services meetings to discuss infection control issues.
- In surgery services, there had been the introduction of ward rounds with the microbiologist to ensure appropriate antibiotic usage and infection issues were addressed.
- Independent observation of hand hygiene practice was carried out on all wards by the Infection Prevention and Control team each month. Hand hygiene results from April 2014 to March 2015 showed variable but improving performance over the period with the trust achieving 96.38% compliance in March 2015. Performance regarding hand hygiene was reported to the Board every month and the Director of Nursing was the Director of Infection Prevention and Control.
- In 2014, the Patient Led Assessments of the Care Environment (PLACE) showed that the trust scored the same as the England average of 98 for cleanliness.
- The trust had 'Ward Hygienist' roles in place with responsibility for deep cleaning and decontaminating ward areas and taking equipment for deep cleaning.
- Clinical areas were mostly clean; however in maternity we found dust on high and low level surfaces such as bed frames and heaters over the neonatal resuscitation equipment. There were gaps in the completion of daily cleaning records; for example, Room Six on the delivery suite had a gap of 13 days of recording of cleaning. The delivery suite had the lowest domestic cleaning audit score of 89.2% for March 2015; this was against a trust target of 93%.

Medicines

- Trust policies that covered most aspects of medicines management were regularly reviewed. These were accessible via the hospital intranet to all staff.
- Patient Orientated Pharmacy (POP) had been introduced on a limited number of wards to improve the speed of patient discharge by having a ward based pharmacy team.
- A finger print recognition system (Omnicell®) was being used in a number of clinical areas to help improve medicines organisation and storage. In the A&E, staff were not always adhering to trust policy regarding the dispensing of medication

from the Omnicell system and on four occasions we saw staff dispensing medication without the prescription present. This meant that the second person present could not check whether what was being dispensed matched the medication prescribed.

- A self-medication policy was being developed but this was still to be ratified; we saw patients self-medicating on several wards but no formal guidelines or policy was in place to make sure patients were supported to do this safely, including arrangements for risk assessment and care planning.
- On one ward, nursing staff were inconsistent when recording insulin self-administration which had resulted in some inaccurate and incomplete records.
- Pharmacy staff checked (reconciled) patients' medicines on admission to wards. However, we found the clinical pharmacy service was limited to weekdays so current guidance [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE 2015] that requires reconciliation to be completed within 24 hours was not being met when people were admitted at the weekend. The trust's current figures showed on average approximately 30% of patients' medicines were not reconciled within 24 hours by the pharmacy team. A trust business plan was being developed to extend the pharmacy service but no specific timeframes had been agreed.
- Medicines management was regularly audited across the trust and action plans were developed where improvements were required. Audits included antibiotic management, missed medicines doses, controlled drugs, medicines storage, medication errors and prescribing quality. However audit processes across the trust for ensuring medicines had been administered to patients correctly were limited in scope and detail. Ward matrons carried out a monthly audit of healthcare documents but this did not effectively identify medicines administration errors.
- Following an audit of medication errors in 2014, the responsibility for investigating and managing the risks had been split into three distinct areas; prescribing, administration and dispensing. Checks by inspectors during this inspection found a significant number of recording and administration errors that had not been identified, appropriately reported and managed.
- Medicines management training for staff was delivered on induction and trust figures showed 97% of appropriate staff

had been trained. This training was not repeated or refreshed unless staff had made an error or concerns were identified in their practice. All medical trainees employed within the trust were required to complete a Safe Prescribing Test.

- A missed dose audit of all wards for one administration time carried out by the trust in 2015 showed an increase in errors compared to a 2009 audit and confirmed inspection findings regarding medicines errors including medicines not being signed for (1.71%) and medicines not available to administer (2.97%).
- Trust medicines management audits in 2014 and 2015 had identified concerns that medicines refrigerator temperatures were not being properly monitored and were poorly documented with little improvement. This remained a concern during our inspection and we identified further concerns about the safe use and storage of insulin on two wards.
- Arrangements were in place to ensure that medication incidents were reported, recorded and investigated through the Trust governance arrangements. We found there was an open culture around the reporting of medicine errors. Trust policy stated that all medication errors should be reported and investigated to ensure lessons are learnt but inspectors found a significant number of errors that had not been identified and so had not been reported.
- Patient Group Directions (PGDs) were in use in some clinical areas in the trust and there were clear procedures and policies to make sure they were prepared and used in a safe way. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked a PGD used by the oncology team and saw this was being used effectively to support patient access to medicines in a timely way.
- The organisation had a process and standard operating procedures to manage the cold chain for storage and transportation of immunisations and vaccines to schools. Evidence provided to us by the organisation included up-to-date, documented procedures for vaccine spillage, disposal and vaccine transport. The organisation also had procedures for the storage and routine childhood vaccination scheduling for Hepatitis B vaccinations.
- Inpatients and community patients who were identified as requiring end of life care were prescribed anticipatory medicines. (Anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of increases in pain and other symptoms.)

- The trust also provided information before the inspection which stated that the service had a number of community nurse prescribers and non-medical nurse prescribers within adult community nursing. We found at inspection that within the district nursing teams, staff were being supported to undertake extended prescribing. We found in the heart failure nursing team, all staff were nurse prescribers and were expected to attend updates at least three times per year

Medicines - Holdforth Unit

- Medicines were administered to patients at set times during the day. Nursing staff were responsible for ensuring patients received their medicines in a timely and consistent way. We found there was a risk some medicines that were time sensitive might not be given correctly because medicines records did not always direct the right time to administer them. For example two patients were receiving regular pain relief that should be given 12 hours apart but we saw this was not always effectively managed.
- We checked six patients' prescription charts on the Holdforth Unit and found 23 gaps where nursing staff had not signed to record a medicine had been administered. These errors had not been identified and investigated. Trust policy was that all medicines errors should be reported but this was not being followed on the Holdforth Unit.
- One person that was prescribed a medicine to be taken once weekly missed five weeks doses over the previous two months. This had not been identified and investigated. We found audits of prescription charts were limited and clinical staff including nurses, doctors and pharmacy staff had not identified administration errors. A recent audit of the unit in April 2015 concluded 'There are very few incidents reported regarding medication in the last 6 months and no trend identified'.
- Medicines were securely stored in a suitable room. However the medicines fridge was not properly monitored because the maximum and minimum temperatures were not recorded. Insulin was not safely stored and managed because it was not dated upon opening and not correctly stored once opened. We also found insulin pens for individual patient use were being used incorrectly as stock.

Mandatory Training

- Staff told us that they could access mandatory training and there were a number of different ways in which training was provided including work books and training days.

- We reviewed the statutory and mandatory training records for both the acute and community services and found overall that the trust met or exceeded the trust targets for each statutory and mandatory training subject with the exception of resuscitation training. The trust was aware of the need to improve resuscitation training levels and had a recovery plan; however 21% of reporting areas had resuscitation training levels of 50% or below. There were a small number of clinical areas that had not met other trust targets, for example only 50% of staff in paediatric diabetes service had attended training for bullying and harassment and no administrative staff in this speciality has attended fire training. Fire training was also below target in urology administrative teams. Only 50% of specialist palliative care staff had attended training in dementia, against a target of 75%.
- In community adult services we reviewed the report for May 2015 and found that overall 96% of staff had undertaken mandatory training
- In community children's services did not meet the trust target for a range of mandatory training topics including Level 1 safeguarding and resuscitation training.

Assessing and Responding to Patient Risk

- The trust used the National Early Warning Score (NEWS) which was designed to identify deterioration of a patient. The NEWS chart incorporated a clear escalation policy and guidance on what intervention was required and by whom. In maternity a Maternity Early Warning Score (MEWS) was used to support the identification of women who may need additional medical support or closer monitoring. Children's services used the Paediatric Early Warning Score (PEWS).
- In the A&E, there were concerns regarding the triage process. We observed triage of paediatric patients being carried out by a newly qualified staff nurse without visible supervision and in one case a child was not triaged for two hours. The trust aimed to triage patients within 15 minutes however we saw that patients who walked into the A&E department had to wait longer than 60 minutes before being triaged. Reception staff did not have guidance regarding the escalation of patients who may deteriorate whilst waiting to be seen in the waiting area and we were told they used their common sense.
- The trust used the World Health Organisation (WHO) surgery checklist in surgery, radiology and an adapted version in maternity. In maternity we reviewed 12 records, five sets of records included the checklist. A review of a further nine sets of records showed that four women had been to theatre but had

incomplete WHO checklists. An audit of WHO checklists from October to December 2014 identified improvement was required regarding completion of the checklists. No issues were identified in surgery regarding the completion of the WHO checklist.

- We observed that across both acute and community core services there were patient risk assessments for falls, pressure ulcers, MUST, Venous Thrombo Embolism risk. In addition core services had specific risk assessments relating to the speciality; for example in the Outpatients department there was a risk assessment for the administration of eye drops and pregnancy testing prior to radiological examination.
- The Gold Standards Framework (GSF) is a model that enables good practice in the care of patients at the end of life. We observed the GSF in use throughout the community and as a tool to optimise care for patients in the last year or the last days of life. The team used a virtual ward approach to managing their patient caseload and enabled the team to provide multidisciplinary care in the community and prevent unplanned admissions to hospital.
- In children's acute services, there were no facilities in the children's ward for deteriorating patients and children were transferred to the adult Critical Care Unit. There were procedures in place in critical care to support this transfer until the patient was transferred to children's critical care services at another hospital.
- Two senior radiologists; one for the main diagnostic imaging departments across the trust and another for breast services, were the Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holders for diagnostic imaging. Their role was to be available and contactable for consultation and provide advice on aspects relating to radiation protection concerning medical exposures in radiological procedures. They led on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations (IR(ME)R).
- The clinical care co-ordinators in community shared work across the teams to ensure patients were seen as their health needs required and there was an escalation process to deal with emergencies and urgent patients. However staff told us and we found there was no documented process to ensure consistency across the trust on how staff dealt with workloads including urgent patients that needed to be seen. Staff in district nursing told us they used a RAG system to categorise

patient needs and organise workloads; we found there was no written guidance to support the categorisation. As a result across the teams there was a potential for discrepancy in the way teams organised and categorised patients.

Records

- The organisation was in the process of transitioning all community paper records to SystmOne, an electronic record system. There were systems in place for the safe retrieval of archived records and staff were able to identify those children who had both a paper and electronic care record.
- The SPCT used an electronic record system that enabled sharing of patient information within the team and with other health care professionals.
- District nurses told us they used the same electronic record system and we saw that both specialist and generalist staff were able to access the records of patients at the end of life. Staff told us there had been some issues accessing the system when out on community visits but that the trust was working with them on developing a solution to problems with access. Staff did not feel that this had impacted on patient care.
- Healthcare record audits were completed on a monthly basis in community adult services. A quality standards audit tool had been developed and was in a pilot phase in order to provide assurance of compliance with completion of the electronic healthcare records that were used within adult nursing. We spoke with the lead nurse who told us the audit did not look at both the electronic patient record and the patient held record stored in the patient's home.
- The A&E department used a dual record keeping system, with some information being stored on an electronic patient system called EDIS and some being written in paper records. This was a risk since patient information was stored in two different places for the same attendance and information could be missed by staff. Of the 38 sets of nursing records in A&E we looked at, none had any personal care or personal hygiene assistance needs documented. None had any evidence that a mental capacity assessment had taken place despite a number of patients with dementia being amongst the sample. Additionally we saw that only two of 38 patients had undergone a pressure area assessment. Pain scores were infrequently documented (5/38) and there was little evidence being recorded that patients had been offered pain relief and declined.
- We viewed a trend analysis report of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms across the trust and saw that action had been taken to improve the

recording of DNACPR decisions, particularly in relation to appropriate authorisation. Quarterly audits of DNACPR forms were being carried out. In the community, DNACPR forms were kept in a yellow envelope to be easily accessible to community staff and family members and sent with the patient in the event of a hospital admission. However, we saw on one visit that the DNACPR form was not in the yellow envelope and could not be found. The SPC Clinical Nurse Specialist took action to follow this up at the end of the visit. DNACPR forms were overall completed appropriately, for example we reviewed six DNACPR forms in the community inpatient unit (Holdforth). Five forms were kept in the front of patient notes, had clearly documented decisions with reasoning and clinical information and had been signed by a consultant. They had clearly recorded discussions with patients or relatives. However, one form was a photocopy, did not detail evidence of discussion with the patient or their family and cited frailty as a reason for the DNACPR. We viewed two DNACPR forms in the community that had been completed well and recorded discussion with the patient and relatives as appropriate.

Major Incident Awareness and Training

- The trust had a Major Incident Policy. We looked at the policy; it was detailed and set out the roles and responsibilities of staff during a major incident.
- The trust had a Business Continuity Policy which described the business continuity processes and set out the business critical functions and what impact disruption to these services would have. The trust also has stand-alone plans for specific business interruptions, for example industrial action. Departments across both acute and community had business continuity plans in place and staff were able to explain what these included.
- We found there was a business continuity plan in place for all of the adult nursing services which was reviewed on a regular basis. Each service also had its own local business impact assessment plan in place to identify critical functions within each service; this linked into the corporate business continuity plan.

Are services at this trust effective?

Requires improvement

The trust remained an outlier for mortality indicators for six consecutive quarters prior to the inspection. Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected, given age and sex distribution. In addition adjustments are made for other factors including

deprivation, palliative care and case mix. HSMR is usually expressed using '100' as the expected figure based upon national rates. In 2014/15 the trust had an elevated risk of 128; this was an increase from the previous year's figure of 112. The Summary Hospital-level Mortality Indicator (SHMI) was also higher than expected at 119 from the period October 2013 to September 2014. The trust had an elevated risk for in-hospital mortality for respiratory conditions and this had been the case for 12 months prior to the inspection. An external review of mortality had been undertaken. It was noted that the trust in their data excluded ambulatory care patients and that there was a need to review palliative care coding. In addition the trust felt that there were a number of patients who were admitted in a poor clinical condition from care homes. The trust have taken a number of actions with regards to the elevated HSMR and SHMI and in-hospital mortality for respiratory conditions including assigning a dedicated professional lead in medical services and conducting a centralised weekly mortality review.

There were policies and procedures in place across the clinical areas in both acute and community settings and these were evidence based. There was an audit programme in place with both local and national audit participation. However many of the policies we reviewed on the trust intranet and in clinical areas for maternity and medical services were out of date and required reviewing and updating and although these had been updated by the unannounced inspection we were not assured that processes were in place and embedded to ensure that there was regular review and updating.

Staff understood their responsibilities in relation to taking consent however in Accident & Emergency documentation of consent was found to be poor. Staff understood the principles of the Mental Capacity Act however this was also not well documented in some clinical areas and patients were not always identified as lacking capacity.

The trust was not meeting the midwife to supervisor ratio of 1:15 with a ratio of 1:18 and 27% of midwives had not received their annual review. There were processes in place to ensure staff received annual appraisals; 90% of staff stated they had had an appraisal in 2014 according to the staff survey.

Patients nutritional and hydration needs were assessed using the Malnutrition Universal Screening Tool (MUST) and there was a 'red tray' system in use to identify those patients who required assistance at mealtimes. Patients told us that the food was

satisfactory and they were able to choose the size of meal which they valued. In the Patient Led Assessments of Care and Environment (PLACE) the trust scored lower than the England average for food (86, England average 90).

Evidence based care and treatment

- The care and treatment provided were based upon guidance from National Institute of Clinical Excellence (NICE), Royal College Guidance relevant to the core service and evidence based practice. Services had systems and processes in place for reviewing and implementing new and existing guidance.
- There were policies and procedures in place across the clinical areas in both acute and community settings and these were evidence based. There was an audit programme in place with both local and national audit participation. However many of the policies we reviewed on the trust intranet for maternity and medical services were out of date and required reviewing and updating. In medicine, 53 policies were reviewed with only 13 of these being in date and 16 had not been approved. . In maternity services, guidelines in the early pregnancy unit were found to be out of date. When raised with the Head of Midwifery and checked at the unannounced inspection, these had been updated. Critical care were in the process of reviewing their policies and guidelines at the time of inspection.
- There was an annual audit programme in place across the core services, with audits undertaken being monitored and actions being taken to improve clinical practice. In critical care the unit had a Directorate Annual Summary and Forward Plan which included the guidelines the unit had audited, what actions had been taken and the implementation strategy to ensure practice was changed. The trust had an Audit and Clinical Effectiveness Manager who was responsible for the co-ordination of national audit activity.
- There were examples of evidence based care pathways in use across the core services, for example in stroke services and assessment of thrombolysis
- In surgery, there was an enhanced recovery programme in place for a range of clinical surgical conditions including fractured neck of femur and acute knee injury.
- In critical care, there were guidelines available for common intensive care conditions. These included Ventilator-Associated Pneumonia (VAP), sepsis bundles and Central Line Associated Bloodstream Infection (CLABSI).
- The trust had in place a number of action plans in response to national audit outcome data; an example of this is the British Thoracic Society Community Acquired Pneumonia Audit.

- The trust had developed a 'Caring for the palliative care patient and their family in the last year of life' policy and framework for end of life care which was developed using national guidance including the National End of Life Strategy (2008), the National End of Life Programme: Routes to Success Guide (2012) and the NICE QS13 Quality Standards for End of Life Care for Adults (2011), Derbyshire End of Life Guidance (2010) and 'More Care, Less Pathway' A Review of the Liverpool Care Pathway (2013), as well as the document produced by the Leadership Alliance for the Care of Dying People (2013).
- Community services worked in conjunction with the medical directorate in the trust to develop integrated care pathways to facilitate the delivery of care closer to home and reduce the length of time a patient needed to remain as an inpatient. For example, there were pathways for the delivery of intravenous antibiotics within the home, a venous thromboembolism pathway to provide care safely to patients with a diagnosis of deep vein thrombosis or pulmonary embolism.
- We saw the Community Integrated Assessment Team followed NICE guidance for falls assessment by using a multifactorial risk assessment tool. The tool also included a screen for bone health, mental health screen and assessment of social needs. Staff we spoke with told us the effectiveness of the service had improved
- The organisation followed the national initiative called the Healthy Child Programme (HCP). This is a Department of Health programme of early intervention and prevention for health visitor contacts with babies and children

Patient outcomes

- Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected given age and sex distribution, in addition adjustments are made for other factors including deprivation, palliative care and case mix. HSMR is usually expressed using '100' as the expected figure based upon national rates. In 2014/15 the trust had an elevated risk of 128; this was an increase from the previous year's figure of 112. The Summary Hospital-level Mortality Indicator (SHMI) was also higher than expected at 119 from the period October 2013 to September 2014. The trust also had an elevated risk in the in-hospital mortality for respiratory conditions and this had been the case for 12 months prior to the inspection.
- The trust have taken a number of actions with regards to the elevated HSMR and SHMI and in-hospital mortality for respiratory conditions including assigning a dedicated professional lead in medical services, reviewing clinical

documentation templates and conducting a centralised weekly mortality review. The review meeting was led by the deputy medical director and attended by consultants, clinical coding, palliative care specialist nurses and the deputy director of clinical governance. An external review of mortality had also been undertaken. It was noted that the trust in their data excluded ambulatory care patients and that there was a need to review palliative care coding. In addition the trust felt that there were a number of patients who were admitted in a poor clinical condition from care homes.

- The trust participated in the Sentinel Stroke National Audit and was given an overall rating of D'. The trust has shown variable results with several areas showing improvement and the stroke unit and specialist assessments performing consistently well. However CT scanning and speech and language therapy scored consistently poorly. The trust had a team centred approach on the stroke unit and this generated a consistently high score. We were informed that six weeks prior to the inspection, a new stroke pathway had been developed with the aim of reducing delays to CT scanning and thrombolysis.
- In the heart failure audit, two out of four In-Hospital Care indicators and five out of seven discharge indicators were better than the England average.
- Performance in the National Diabetes Inpatient Audit (NaDIA) indicated that out of the 21 indicators, the trust was better than the England average in 17 areas and worse than the England average in two at University Hospital of North Tees. At the University Hospital of Hartlepool the audit results showed 12 indicators scoring better than the England average and six indicators scoring worse.
- Two out of three non-ST-Segment-Elevation Myocardial Infarction (nSTEMI) indicators were worse than the England average. There had however been a large drop in the percentage of patients admitted to the cardiac ward. The trends in n-STEMI indicators were the same across both North Tees and Hartlepool hospitals.
- The endoscopy unit had achieved Joint Advisory group (JAG) accreditation.
- The National Bowel Cancer Audit (2014) showed better than the England average results for clinical nurse specialist involvement (93%, England average 88%); discussion at MDT (100%, England average 99%); scans undertaken (99%, England average 89%) and the trust had a slightly lower number of patients undergoing major surgery who stayed in hospital for an average of more than five days (66%, England average 69%)

Summary of findings

- The trust participated in the National Hip Fracture Audit (2014) which showed the trust performed better than the England average in areas such as patients being admitted to an orthopaedic ward within four hours (83%, England average 48%)
- The trust reported data to the Intensive Care National Audit and Research Centre (ICNARC) which allowed the trust to be benchmarked against similar units nationally with regard to care delivered and mortality and morbidity outcomes. Critical care performance and patient outcomes were monitored through the Critical Care Delivery Group.
- In the National Care of the Dying Audit (NCDAH, 2014), five out of seven key performance organisational indicators were not achieved. Most notably the trust scored zero for the Key Performance Indicator 'Care of the dying: continuing education, training and audit'. In the clinical key performance indicators, 8 out of 10 were below the England average with the lowest score noted for 'review of the patient's hydration requirements.
- Patient specific outcome measures were widely used within therapy services. The EQ-5 tool included an assessment of walking, activities such as leisure and housework and pain and discomfort. We saw these were monitored on the directorate dashboard to ensure compliance with commissioner targets. For example in March 2015, we saw 100% of patients had been assessed using the EQ-5 tool. We saw for each month between April 2014 and March 2015, more than 90% of patients had achieved an improvement from their initial assessment.
- The immunisation rate for the measles mumps and rubella (MMR) vaccine (children aged two) was 89.2% in Hartlepool which was worse the England average of 92.3%. The rate in Stockton was better than the England average at 94.1%. The immunisation rates for children in care were 88.9% in Stockton and 100% in Hartlepool. This was better than the England average of 83.2%.
- The health visiting service did not meet the antenatal contact target. This was the percentage of women who received a first face-to-face antenatal contact with a health visitor at 28 weeks or above. The target in quarter one was 25% and the service achieved 2.4%. The target in quarter four was 95% and the service achieved 48.5%. Each quarter did demonstrate an upward trend towards achieving the agreed targets and evidence presented to us by the organisation suggested that this would improve once a full complement of staff was achieved.
- Health visitors in Hartlepool told us they were not delivering 3-4 month contact assessments. Although they were

commissioned to do so as part of the Healthy Child Programme delivery, staff we spoke to said this work was not being undertaken due to staffing capacity issues. We were told an action plan had recently been developed to address the issue and had been submitted to the community services general manager.

Multidisciplinary working

- Across the core services inspected we saw good multi-disciplinary processes in place. Staff teams and services worked together well to deliver effective care and treatment for people using services across both acute and community settings.
- We found good examples of multidisciplinary working in children's services where there were strong links with the pathology service, social services, community children's nursing teams and the local safeguarding teams.
- The transition arrangements for children were variable with arrangements in place for children with asthma and diabetes. However we were told that transition arrangements for young people with complex or long term conditions was not as good due to the different models used by different trusts.
- In end of life care, we saw that the palliative care team had established positive working arrangements across acute and community services with a weekly palliative care meeting to facilitate discussion of patients newly referred into the service.
- In the Holdforth Unit, we saw that there was a weekly multi-disciplinary team meeting; however the outcomes of this were only recorded on the electronic whiteboard and not saved; this arrangement had been changed by the unannounced inspection visit and meetings were being recorded.

Competent staff

- There were processes in place to ensure staff received annual appraisals and 81% of staff stated they had had an appraisal in 2014 according to the staff survey.
- All members of the specialist palliative care team were trained in level two psychology support.
- Specialist palliative care nurses were trained in advanced communication skills and the nurse consultant in palliative care offered cognitive behavioural therapy (CBT) to patients with anxiety and depression. We were told that CBT was available in patients' own homes if they were unable to attend a clinic appointment.
- The trust had submitted a paper to the Board detailing proposals for the implementation of revalidation of nurses.

- Student nurses told us that they received good support from the ward based mentors and received a good balance of practical skills training and theoretical knowledge, with students receiving feedback from staff, patients and relatives.
- In maternity services, there was a lack of a competency based framework that would allow progression of band five midwives through to a band six. We were told that this was in development. Midwife to supervisor ratios were worse than the recommended ratio of 1:15 and were 1:18 at the time of inspection. In addition 27% of annual reviews for midwives had not taken place.

Nutrition and hydration

- Patients' nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) and in medicine we saw that patients weights were recorded if indicated; this was corroborated in the review of patient records. The trust used the 'red tray' system to enable those patients who required help at mealtimes to be identified. In addition there were different coloured plates and bowls for people with dementia. The trust had a Fluid and Nutrition Group (FaNG) in place to oversee the management of nutrition and hydration across the trust.
- In the Patient-led Assessment of the Care Environment (PLACE), the trust scored slightly lower than the England average for food (86, England average 90)
- The Care Quality Commission national A&E survey showed that the trust performed 'about the same' as other similar trusts for people being able to access food and drink whilst in the department. A review of 14 patient records showed that nutrition and hydration needs had not been documented therefore we were concerned that needs had not been identified. However we saw that food packs were available in the department.
- A dietetics department provided support at ward level and on an outpatient basis. We saw examples of dieticians being involved in multi-disciplinary meetings for example on the fragility fractured neck of femur ward (Ward 32).
- There were examples of good practice including the role of the housekeeper in critical care. The housekeepers were very involved in patient nutrition and they told us they saw it as their duty to encourage nutrition in those patients on the unit who could eat. We observed this happening in practice.
- In children's services, children could choose food from a children's menu or the adult menu and there were drinks and snacks available throughout the day. The organisation had an

Infant Feeding policy however progress towards the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) was not robustly adopted within the organisation. Some staff we spoke with were very unclear about plans to achieve accreditation.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Consent training was reviewed and in each core service was found to be meeting the trust target of 95%. Nursing and medical staff understood their roles and responsibilities regarding consent and were aware of how to obtain verbal and written consent; staff in core services were able to describe how they would obtain consent. In children's services, Gillick guidelines were followed to ensure that people who used the services were appropriately protected.
- We saw that staff had completed Mental Capacity Act and Deprivation of Liberty Safeguard competencies however training numbers were varied with surgery.
- There was variation in practiceacross the core services for assessing capacity. For example in A&E there was a specially designed form to document whether patients had capacity; however we found that this was rarely used. A review of 38 records found no evidence of patient capacity being assessed, despite a number of patients being diagnosed with advanced dementia.
- We reviewed Mental Capacity Act documentation and saw that there was variation in the quality of this documentation. For example on the Holdforth Unit, three healthcare records were reviewed and were not fully completed to show that relatives were consulted. Senior staff on the unit were unable to identify which patients had been assessed and deemed as lacking capacity. There had been no formal audit of the application of the Mental Capacity Act in practice; however at the time of the unannounced inspection we were provided with evidence of audit and staff had received additional training in response to concerns raised at the time of the comprehensive inspection.
- We viewed eight DNACPR forms, six on Holdforth and two in the community. We saw two examples of DNACPR decisions being recorded for patients who did not have the capacity to be involved in discussions about the situation. In both cases we saw that the decision had been discussed with the patient's relatives and that the decision had been recorded to be clear that due consideration had been taken for the patient's ability to be involved.

Summary of findings

Are services at this trust caring?

Good

Patients and their relatives spoke positively about the care they received in the acute and community settings. We observed interactions between staff and patients and saw that these were kind, caring and compassionate. Relatives we spoke with told us staff would spend time supporting them alongside the patient and that they demonstrated a good deal of care and compassion. Relatives and friends of patients were encouraged to participate in the Family's Voice research where they could feedback on their experience of care as it happened.

The NHS Friends and Family test results (FFT) results between December 2013 and November 2014 indicated the response rate to be slightly worse than the England average at 29.1% compared to England average of 30.1%. The percentage of patients who would recommend the services was consistent with, or better than, the England average. In A&E however, in the Friends & Family Test 88% of patients would recommend the department, this figure had dropped steadily since January 2014. The trust also scored well in the Patient-Led Assessment of the Care Environment (2014) and in the Cancer Patient Experience Survey (2014).

On the Holdforth Unit, there had been concerns regarding the reporting from patients and relatives we spoke with of variation in their experiences of care. We observed call bells not being answered in a timely manner and at the time of the inspection there was no comfort rounds in place. This had been addressed at the unannounced inspection.

Compassionate care

- The NHS Friends and Family test results (FFT) results between December 2013 and November 2014 indicated the response rate to be slightly worse than the England average at 29.1% compared to England average of 30.1%. The percentage of patients who would recommend the services was consistent with, or better than, the England average. In A&E however in the Friends & Family Test 88% of patients would recommend the department, this figure had dropped steadily since January 2014.
- The Patient Led Assessments of the Care Environment (PLACE) scored the trust just above the England average for privacy, dignity and well-being (88, England average 87)
- The trust scored well in the Cancer Patient Experience Survey (2014) with 93% of respondents rating their care as excellent or very good compared to the England average of 89%. For 16 out of the 32 statements, the trust scored in the top 20% of trusts

nationally. The key theme of the 16 statements were around communication with patients and relatives, symptom management during chemotherapy and management of pain and privacy.

- The trust had delivered the nursing and midwifery 6 'C's (compassion, competence, compassion, communication, courage and commitment). In critical care there were three 'caremakers' who were responsible for leading on the 6 'C's.
- Children's services in the acute hospitals did not use the Friends and Family test; we were told by the Matron that it was to be introduced. Results in the Children's Survey (2014) showed that out of 101 parents who completed the survey, 99 felt their child had a good experience and all children who participated said they had a good experience. In the trust young person's survey (2014/15) of the 91 respondents, 98% felt they were treated with dignity and respect and 93% were given enough privacy.
- The children's service had 'You're Welcome' accreditation from the Department of Health; this meant that the service was meeting the needs of children and young people who used it.
- There were concerns regarding the privacy and dignity of women in maternity where we observed labour room doors being left open. This was raised at the time of our inspection and at the unannounced inspection, this practice was no longer taking place. In the maternity day assessment unit, privacy during sensitive discussions were difficult to achieve due to cubicles being divided by curtains. This was recorded as a risk on the risk register and staff told us that to maintain privacy they used the counselling room to speak to women and their partners.
- We spoke with 19 women on the maternity unit and 17 of them told us they had a positive experience on the maternity unit.
- There were concerns regarding the level of care provided to patients on the Holdforth Unit. Of the 14 patients and seven relatives we spoke to there was variation in the quality of their experiences whilst on the unit. . We observed call bells not being answered in a timely manner and not all patients were aware of their named nurse for the shift. However the Staff & Patient Experience and Quality. Standards (SPEQS) reports for April and June 2015 showed that 97% of patients were happy with their experience on this unit.
- The health visiting service designed a questionnaire to capture patient experience feedback from families and carers. 84% of those surveyed said the health visitor always listened to them, 87% felt they were treated with kindness and understanding and 82% said the health visitor involved them as much as they wanted in decisions about their baby's care

Summary of findings

Understanding and involvement of patients and those close to them

- We saw that staff spoke with patients so that they could understand and be involved in the decisions being made about their care across services in both community and acute settings. 98% of patients felt they understood the answers to their questions.
- In acute children's services, 99% of the 91 respondents to a young person's survey (2014/15) felt that the doctor or nurse practitioner were easy to talk to
- In End of Life Care, the Family Voice had been implemented. This is a diary given to family members and friends of a patient who is dying and is a way of involving them in the care of the patient. By using the diary, relatives and friends are invited to assess the care the patient is receiving and whether it meets the agreed standards. The diary includes questions about pain, sickness, agitation, breathlessness and whether staff are treating the patient with dignity. It also invites suggestions from relatives and friends as to how things could be improved and done better. Feedback from the 'Family's Voice' project was visible in the community services we visited. Staff we spoke to told us the feedback had enabled them to look at their practice and make changes if needed. We were also told that it had helped them to communicate more openly with relatives.
- Critical care had open access visiting to allow flexibility for relatives; patients were involved in their care and treatment which was reflected in the patient records that were reviewed.
- We saw the issue of organ donation in critical care being addressed sensitively and staff treated family members with compassion and in a professional and calm manner.
- In the Care Quality Commission In-Patient Survey (2014), results showed a slight increase (7.2 from 7.1) in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year. Similarly there was a slight increase (8.3 from 8.1) in the belief that they received answers they could understand when asking important questions.
- On the Holdforth Unit, staff we spoke with informed us they did not use the 'This is Me' tool for people with dementia even though patients may be admitted with this document.
- Parents and carers felt involved in discussions about care and treatment options for their child and told us they felt confident to ask questions about the care and treatment they were receiving and make decisions based on the information they received.

Emotional support

- In children's services, debrief meetings were held to provide support to the staff following a death of a child or a traumatic event
- We saw in critical care the exceptional approach to family support at the end of a patient's life using memory boxes, teddy pairs and the use of friendship bracelets.
- An Intensive Care Unit Support Team for ex-patients (STEPS) had been set up in the Tees Valley and we were told that nurses from the critical care unit attended these meetings but would often do so in their own time to support ex-patients and their families.
- In surgery, we saw that assessments were carried out to identify anxiety and depression at the pre-assessment stage to enable additional emotional support to be put in place.
- In medicine, we were told that there were a number of therapeutic volunteers who provided support to patients, especially those with dementia. The volunteers attended the wards in the afternoon however staff told us that they felt volunteer support would be more beneficial in the morning when the ward is exceptionally busy.

Are services at this trust responsive?

Good

There were processes in place to ensure that the divisions were responsible for planning the capacity and demand for the services which fed into the overarching capacity and demand model for the trust. There were examples of services being developed and delivered to meet the needs of the local people across acute and community settings. The trust had processes in place on a daily basis to meet fluctuations in demand throughout the day.

Trust performance against the national access targets was better for treating outpatients within 18 weeks; however the trust did not meet the inpatient referral to treatment times consistently across all specialities.. The department had met the national four hour waiting time target since March 2015 and most patients were discharged within three hours of admission. The trust was undertaking a review and had identified key risks to patient flow as discharge processes across the trust and assessment and triage in A&E.

Service planning and delivery to meet the needs of local people

- There were good links with commissioners and other providers, including the ambulance service, during the planning and delivery of services.

- The trust had developed a 'framework for supporting adults with progressive, life limiting illnesses'. The framework embedded the Leadership Alliance for the care of the dying patient (LACDP) priorities of care; recognition of dying; sensitive communication; patient and those close to them involvement in decisions; the needs of those important to the patient are actively explored; and, an individualised plan of care is agreed.
- Divisions were involved and responsible for developing capacity and demand plans and business plans annually for their services.
- All community Specialist Palliative Care Team (SPCT) nurses were aligned with GPs and district nursing teams. The trust had developed a virtual ward approach to end of life care and we saw the impact of this in terms of the recognition of patients in the last year of life. Specific innovations relating to this was the recommendation within discharge summaries for GPs to add patients to their palliative care registers so that ongoing specialist support could be provided in the community.
- Staff on the Holdforth Unit told us the SPCT staff were quick to respond to referrals although they did not proactively attend the ward to support ward based generalist staff in the delivery of end of life care. This was a disparity of service compared with the proactive input into the acute wards and senior SPCT staff told us this was a gap that had developed when acute services moved from University Hospital of Hartlepool and there are no longer hospital based SPCT nurses based at Hartlepool. A review was being implemented as part of ongoing work on an integrated care pathway for end of life care across the region. This was due for completion in March 2016 with an expected new model of working and integration to ensure the needs of patients in the community are met.
- The trust had developed hub and spoke models of care with acute providers an example of this was in urology services which included shared on call arrangements which resulted in a more sustainable service for the local population.

Meeting people's individual needs

- There were facilities including specialist beds and wheelchairs for bariatric patients.
- Some patients with learning disabilities had patient passports. When these were presented at the A&E department by the patient or carer, staff used the information to assist them in making decisions about patient needs and wishes.
- The records of patients living with dementia or a learning disability were marked using a flower sticker. Alerts were also put on to the electronic record system to alert staff if patients

had specific needs. The electronic records system had a built in alert system which highlighted any patients attending the department who were at risk of self-harm, or harming others. This made sure that staff were aware of safety risks to patients and to themselves. Security staff were called to the department when necessary, for the safety of patients and staff.

- We were also informed of a project working with Hartlepool Council where the details of all clients with learning disabilities had been shared with the trust.When a client with learning disabilities was admitted to the hospital an alert was generated and they were admitted to a 'virtual ward'.This ensured that all the trust was able to respond in an appropriate and timely manner.
- The trust had a specialist nurse for people with learning disabilities to provide support to both patients who are in hospital and staff who are caring for this group of patients.
- There was 24 hour access to chaplaincy services for patients and relatives of all faiths.
- The trust operated a system of virtual wards.These were described and observed as wards or groups of patients which had similar characteristics.For example the dementia specialist nurse had a virtual ward of patients assigned which included patients formally diagnosed with dementia along with those who showed possible signs of dementia but with no formal diagnosis.
- Staff we spoke with were able to use language line if interpreting services were required.
- In community there was a Family Nurse Partnership to support young mothers.
- The Gold Standard Framework (GSF) was in use within the community to develop good quality end of life care based on the wishes and preferences of the individual and was used to help staff identify the needs of patients at each stage of their care through detailed assessment.
- The trust had a shuttle bus that operated between the two hospital sites; however we were told that this service was not well used by the public.

Dementia

- The trust had a Dementia Strategy in place and there was a dementia specialist nurse in post. The dementia strategy supported the specific needs of patients such as the person centred tool "All about me" which was offered to all families.The dementia specialist nurse had implemented the "grab bag" which had activities; all 1:1 staff had been trained in how to use them.

Summary of findings

- We saw that services were responsive to the needs of people living with dementia as wards had dementia leads who were able to provide support and caring for patients with dementia.

Access and flow

- The percentage of non-admitted patients seen within 18 weeks of referral was consistently over 98% and higher (better) than the England operational standard of 95%. The percentage of patients with incomplete care pathways who started their consultant-led treatment ranged between 96 and 98%. The operational standard in England is 92%.
- The percentage of patients seen within four hours in A&E has been worse than the England average since September 2014.The trust did not meet the government target of 95% of patients being seen within four hours in June 2014, November and December 2014 and January, February and March 2015. The trust were undertaking a review of patient flow and had identified key risks to flow as discharge processes across the trust and assessment and triage in A&E.
- The percentage of admissions via A&E waiting between four and 12 hours was consistently better than the England average between March 2013 and January 2015 at approximately 0.5%.
- The department had a target that all patients with fractured neck of femur (broken hip) should be admitted within two hours. This was a Royal College of Emergency Medicine standard. They had failed to meet this target consistently between April 2014 and March 2015. The percentage of patients who met the target varied between 36% and 67%.
- We identified some concerns about the way ambulance handover times were recorded. We noted at least four occasions when ambulance staff were yet to check the patient into the department but department staff had recorded that handover was complete. In one case, the patient was still in the ambulance. We discussed this with the department manager who told us that formal handover was calculated as the time the patient was moved from the ambulance trolley to a hospital chair or trolley. They told us that ambulance staff chose to complete the handover of patient details at the reception and make sure the patient was registered on the system, but that this could be done by hospital staff.
- We were informed that patients would not be moved after 22.00 at night; we reviewed data which identified 22% of patient moves in the In-Hospital Care Directorate occur between 22.00 and 07.59, and this accounted for 2% of all emergency admissions to the In-Hospital Care Directorate.

- The In-Hospital Care Directorate referral to treatment time (RTT) for elective care was consistent.Data provided by the trust identified that the 97.9% of cardiology patients and 100% of gastroenterology, general medicine, rheumatology and geriatric medicine referrals met the standard
- In surgery performance against the inpatient 18 week referral to treatment time varied across specialities with general surgery not meeting the target at 88% (national target 90%) however orthopaedics, 91% and urology, 90.7% were meeting the target for the same period.
- In the Outpatient Department information about which clinics would run on behalf of other trust specialties was regularly missing and staff were unable to plan resources effectively. This included staff and facilities. Managers told us that clinics could be cancelled at very short notice and outpatients staff would have to contact patients to let them know. During our visit, two patients arrived for an audiology clinic and outpatients staff had to telephone the commissioned trust to find out if a clinic was expected to run.
- New to follow-up ratios were above the national average at 1:2.58 compared to England average of 1:2.18.
- We reviewed the cancer two week wait data; a target had been set at 93% of patients seen in two weeks. Between April 2014 and March 2015 an average 94% of patients were seen within the required 2 weeks.
- The trust performs better than most peers for day case surgery with 87% against peer group average of 84% however the trust informs us that performance varies across the individual procedures. The trust is currently reviewing theatre list scheduling to accommodate the more complex day case procedures earlier in the day to enable same day discharge.

Learning from complaints and concerns

- The trust received 1,202 complaints from April 2014 to March 2015; of these 69 were open. The most common reason for complaint was communication followed by issues regarding failure to monitor the patient's condition. The trust has a target of 25 days for responding to the complaint.
- We reviewed six complaints against the Care Quality Commission review grid and against the trust complaints policy. There was variation in the quality of the complaint responses; all of the responses showed a good level of support and awareness and simplicity of making a complaint. In two of the complaints, there was concern that the investigation of complaints was not always thorough; however four of the complaints did have evidence of robust investigation of the

issues. Although complaints were risk assessed, it was not always clear who had been responsible for carrying out the risk assessment. The Patient Experience Team Manager informed us that she would risk assess the complaint although this was not evident from the complaint review of the hard copies of the complaints.

- The trust was following the complaints process in line with the trust complaints policy with the exception of the acknowledgement letter that should go out to patients following receipt of the complaint. None of the six complaints reviewed had acknowledgement letters with them however the Patient Experience Team manager informed us that acknowledgement letters were sent to people who complain.
- The trust has set up an independent complaints review panel which consisted of a Non-Executive Director, Governor, member of the Patient Experience Team, external stakeholder representatives and other specialists if required. The panel was responsible for monitoring and challenging the investigation process and to ensure actions plans are robust.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at local team meetings, actions agreed and any learning was shared.
- The trust told us that intentional rounding by senior staff in the out-patient setting enabled staff to provide local resolution to concerns or complaints as they were raised. They said that staff followed up with phone calls to patients to ensure satisfactory resolution. All concerns and complaints where applicable were recorded via the Datix system.

Are services at this trust well-led?

Requires improvement

Prior to the inspection, the trust had identified concerns that processes to identify, record and mitigate risk were not fully developed or embedded consistently across the trust. The trust revised the Risk Management Strategy for 2015-18 and developed a supporting action plan to address these concerns. The trust was in the early stages of implementing the plan to improve risk management systems at the time of inspection. We found that risk registers in the core services were not updated regularly and that risks were being left on risk registers for long periods of time without actions being taken to mitigate or address the risk. There were examples of long periods between the risks being reviewed and no further action, closure or escalation of these risks taking place.

Summary of findings

The trust did have an overarching strategy called 'Momentum' supported by a clinical strategy and a number of enabling strategies. This had originally been based upon the development of a new hospital; however this was no longer financially viable and the overarching strategy was being re-developed in view of this. There was a governance and performance framework in place however we were concerned that this was not fully embedded.

Staff told us that there was an open and supportive culture and this was reflected throughout the interviews with the executive team, the non-executive directors and focus groups across all of the professional groups. Focus groups described a stable and visible leadership team and a culture of inclusiveness and one of support. The Chief Executive was described as having an open door and the Chief Operating Officer was very supportive particularly when things were under pressure. However the staff survey (2014) identified that 21% of staff reported experience of bullying and harassment from other staff although the trust were aware of this and were putting plans in place to address this problem.

Vision and strategy

- The trust had an overarching corporate strategy known as 'Momentum: Pathways to Healthcare' which sets out how services will be provided in the future and included the principles underpinning it. The strategy focussed on integration of services and working closely with other providers including social care.
- The executive team and Non-Executive Directors, including the chairman, gave a well-articulated and consistent story about the vision and values of the trust and the strategic direction of the organisation, including the need to look beyond the trust and work with other external stakeholders to ensure financial and clinical sustainability.
- The trust had several enabling strategies that support both the clinical and corporate strategies. These included quality, workforce, estates, nursing and information management & technology. The nursing strategy was based upon the 6 'C's which had been rolled out across the organisation; this included the development of the 'caremaker' roles within all staff groups.
- A Trust Directors Group brought together a wider managerial group including clinical leaders and senior managers to review the trust strategic direction. Directorates are required develop

their own business and strategic plans with key milestones identified to be able to monitor progress. Plans are submitted via delivery groups into the Transformation Committee which is a sub-committee of the Board.

- The trust seemed to have effective relationships with key external stakeholders with the Chief Executive sitting on all three health & wellbeing boards and having regular engagement with commissioners.
- In outpatients, senior managers were familiar with the trust's vision for the future of the outpatients department and were aware of the risks and challenges. However staff told us they felt the service was fragmented and changes to meet current and future departmental needs could not be considered because there was no clear departmental strategy following a pause in plans for a new hospital at Stockton.
- There was a vision for end of life care that was consistently articulated by staff we spoke with. Staff told us the strategy was in the process of being reviewed alongside a revised service delivery model. A number of work streams were in place to develop the strategy, including education, communication and the development of the service model.
- The trust had an estate strategy however the planned new hospital build was paused due to lack of capital funding.
- The vision and values of the organisation were included in the trust corporate induction programme and developed with staff in the organisation through a series of staff engagement meetings.

Governance, risk management and quality measurement

- The trust had a recently revised Board Assurance Framework in place which identified the trust strategic aims and objectives with key risks identified and described and responsibility and accountability for delivery clearly identified. Risks were risk rated and key controls and gaps were identified. The Board Assurance Framework was reviewed quarterly at the Trust Board meeting. There was a corporate risk register in place.
- The Trust produced a quarterly CLIP report (Complaints. Litigation, Incident and Patient Experience) Report. This report provided an overview of safety, quality and risk and was developed by the corporate team with the support of all directorate safety teams and other specialist teams within the organisation. The directorate patient safety teams were integral to the development of this report as they provided details of emerging concerns and local initiatives introduced to resolve these; as well as identifying evaluation of progress in relation to previously identified trends.

Summary of findings

- Prior to the inspection, the trust had identified concerns that processes to identify, record and mitigate risk were not fully developed or embedded consistently across the trust. The trust revised the Risk Management Strategy for 2015-18 and developed a supporting action plan to address these concerns. The trust was in the early stages of implementing the plan to improve risk management systems at the time of inspection.
- There were risk registers in place across the clinical services; however we had concerns about how effectively these were used to ensure risks were identified and mitigated in a timely way. For example in the A&E department there were 46 risks recorded. We found that some risks had been on the register since 2001 and remained as moderate risks. Some risks such as the robustness of business continuity plans remained as moderate risks on the register. It was also identified in January 2011 that the department was not adequately prepared to respond to a chemical incident. The latest review of this risk was in July 2014 when the risk remained moderate, suggesting that the department was still not adequately prepared to deal with a chemical incident. Some risks remained on the risk register despite being resolved. For example, relating to pager use during major incidents.
- The risk register in inpatient children's services was not regularly reviewed and risks were not actively managed. One matron told us the risk register was reviewed annually to see whether the risk remained applicable, but documents we reviewed stated the risk register was reviewed monthly, as a minimum.
- All risks rated as red were escalated to the Audit Committee. There was a trust annual audit plan that was reviewed and approved by the Audit Committee. We were told that there was a review of topics not yet audited being carried out and risk rated.
- The senior nursing and midwifery teams along with the governors of the trust undertook monthly visits to ward areas to assess the quality and safety within the wards and departments. Findings from the visit were then fed back to the clinical areas and to the Matron and highlighted areas of good practice and areas for improvement. These teams are known as the Staff and Patient Experience and Quality Standards teams (SPEQS).
- The trust had a Patient, Quality and Safety Committee that was a sub-committee of the Board. This committee monitored and provided assurance that lessons were learnt from incidents, complaints and claims and that action plans were implemented.

Summary of findings

- There was a performance management framework in place with directorate management teams being held to account through a quarterly meeting with the executive team. If a team's performance was deteriorating then they would have escalated monitoring and support until performance improved. Performance was monitored through a dashboard with key metrics identified and measured including access targets, finance, quality and workforce. Service line reporting was being implemented although this was still evolving
- Across the core services morbidity and mortality meetings were established including a centralised weekly process to review deaths from the previous week. This meeting was led by the Deputy Medical Director and involved palliative care specialist nurses, a patient safety coordinator, a representative from the clinical coding team and the Assistant Director of Clinical Governance.
- The trust had a cost improvement programme in place with clinical services having a target of 2.5% of their budget and non-clinical services having a target of 4% of their budget. There was a quality impact assessment process in place for cost improvement plans and business cases and all quality impact assessments were required to be signed off by the Chief Nurse and Medical Director.
- In community services there was a lack of clear key performance indicators through which to measure performance and quality; for example the children's community nurses told us they were unaware of any key performance indicators (KPI) for the service. They were also unsure of a community nursing service specification.

Leadership of the trust

- The Board had undertaken Board development in conjunction with an external facilitator. In addition the trust had held two sessions with the Trust Director Group and the associate directors which aimed to set the context for the need for change and to involve and align the associate and clinical directors in developing and shaping the trust's transformational priorities.
- There was access to a clinical leadership programme that was delivered in partnership with a local university. The programme was aimed at current and future Clinical Directors to provide them with the leadership skills required for the delivery of effective services. The executive team acknowledged the importance of the need for strong clinical leadership and there was a commitment to the development of clinicians.

Summary of findings

- There was a ward managers' leadership programme again delivered in partnership with a local university and aimed to provide skills to enable first line managers to support the transformational agenda. The Band 1 to 5 leadership programme was aimed at empowering and motivating staff.
- The trust worked collaboratively with the North East Leadership Academy (NELA) and staff could access training through this academy.
- We had some concerns about nursing leadership capacity in the A&E department. This was because there was only one band seven employed to manage the department clinically and one band eight nurse to operationally manage the department. This meant that there were times when the department was being led by a band six sister.
- We also had concerns about leadership capacity in midwifery. The way midwifery management was structured meant that some individuals had a wide range of responsibilities which limited capacity for maternity leadership. Concerns included the management of midwifery staffing numbers and skills mix, the lack of performance benchmarking and effective learning from patient safety incidents. Additionally we were not provided with sufficient evidence that midwives 'acting up' in the band seven co-ordinator role, due to gaps in the band seven establishment, had the required skills and experience to carry out this role.
- Concerns about the leadership on Holdforth Unit were recognised by the trust in the past and reactive support was provided to the unit on a number of occasions; however, our inspection raised significant concerns about the leadership and confirmed that the quality of care was not maintained. We spoke with senior managers during the inspection about our concerns relating to nurse staffing, nursing documentation and care plans, mental capacity assessments, deprivation of liberty safeguards and medicines management. The trust responded immediately and developed an action plan to manage the identified risks. We went back to Holdforth Unit unannounced to check that improvements had been made. We found there had been a change in ward leadership and measures were in place to ensure patients were getting the care they required.
- The trust had a triumvirate management structure in place that provided managerial, clinical and nursing leadership team with clinical directors having their job plans reflect their management commitments. In community services the trust had recently appointed an associate director for community services.

- There was an executive lead in post for end of life care. We viewed minutes of board meetings and saw that end of life care had been discussed in relation to mortality reviews and included in a general agenda item about integrated care pathways across the trust. Staff we spoke with told us that the development of the end of life care strategy was largely the responsibility of the specialist palliative care team and that a number of resources for development had been sought from external funds. However, we were told that the trust board had committed to longer term funding of posts that had been initially funded via this method.
- Non-executive directors had attended the NHS development programme. Although there were only three non-executive directors in post at the time of the inspection, they were challenging to the executive team and visible in the organisation. One of the Non-Executive directors was the trust lead for whistleblowing.
- The trust sickness absence rate was 4.25% for April 2015 – June 2015 and the Director of HR told us that the trust had an ageing workforce with 51% of staff being over the age of 45. The main cause of sickness absence was stress. The Occupational Health team had recruited to ensure there was mental health skills within the team and were looking at what action was needed to address the issues around stress.

Culture within the trust

- Staff told us that there was an open and supportive culture and this was reflected throughout the interviews with the executive team, focus groups across all of the professional groups and the non-executive directors. Focus groups described a stable and visible leadership team and a culture of inclusiveness and one of support. The Chief Executive was described as having an open door and the Chief Operating Officer was very supportive particularly when the trust was under pressure
- The national Staff Survey 2014 showed that the trust as a whole was performing worse than similar trusts for staff thinking their role made a difference to patients, effective team working, receipt of health and safety training, staff reporting errors, near misses or incidents witnessed, staff feeling pressure to attend work when unwell, staff motivation, staff receiving equality and diversity training in the last year and overall engagement.
- The survey also identified that 21% of staff had experienced harassment or bullying from other staff. The Director of HR was aware of the issues raised in the staff survey and had developed an action plan that took into account the findings from the Freedom to Speak Up review.

- The trust had a raising concerns policy and felt staff were generally happy to raise issues with their managers or through the formal system.

Fit and Proper Persons

- The trust was prepared to meet 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 NHS providers are fit and proper to carry out this important role.
- A paper was submitted and approved by the Board on 29th January 2015 which set out the actions the trust would need to take to ensure compliance with Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This included the additional actions to the existing pre-employment checks that the trust already had in place for executive level appointments along with the policies that would need to be updated to reflect the regulation and the assurance process that would be implemented.
- The trust agreed to extend the requirements of the Fit and Proper Person test to any post that reports directly to the Chief Executive or Executive Directors.
- We reviewed the 11 files of the Executive and Non-Executive Directors and found no concerns; however the directors had all been appointed prior to the implementation of the regulation. The Non-Executive Directors had not had a Disclosure and Barring (DBS) check however any future appointment would be subject to the new requirements.

Public engagement

- The use of the Family's Voice diary enabled staff to engage with relatives of those patients at the end of life, both in terms of the immediacy of care issues and in terms of learning from their experiences.
- Patient stories were regularly presented to the Board.
- The trust had a communication strategy which we were told included public engagement however we were unable to find this in the strategy. The Director of Human Resources clarified that a public engagement strategy was currently in development and this was being done in collaboration with the communications network across the North East.
- The trust had a hospital user group which visited the departments and carried out surveys. The results of these surveys were fed back to departments regarding patient experience and measures that could be taken to improve it.

- There had also been a 'youth parliament', which gave feedback about the food and music available to young people using the service.

Staff engagement

- The trust had a draft workforce and organisational development strategy that was being developed by the recently appointed Director of Human Resources called 'Our People Strategy 2015 – 2020'. This set out how staff would be engaged within the organisation.
- Staff told us they participated in team meetings and were confident to talk about ideas and sharing of good news as well as issues occurring the previous day or anticipated problems for the day ahead. Staff survey results for the whole trust showed that 78% of staff felt satisfied with the quality of work and patient care they were able to deliver. Outpatients and diagnostic imaging staff told us that they enjoyed working for the trust and we interviewed several people who had been employed for 20 years or more. Staff were proud of the service they provided and felt they worked in highly skilled teams. Staff told us that they would be proud if members of their family were cared for by staff in the department.
- The Chair took three members of staff annually to the Mayor's Ball.
- The Chief Nurse had a clinical day once a month and the Chief Executive held community forums to ensure a mechanism for community staff to raise concerns directly.

Innovation, improvement and sustainability

- Staff had worked on development of health promotion packs within main outpatients which were to be rolled out within the orthopaedic department as a pilot to explore how this could be sustained.
- The trust had established and developed a nurse consultant role which had been key in the delivery of the Family's Voices research, as well as the practice of providing cognitive behavioural therapy for patients at the end of life. The project was embedded into the trust and plans were in place to pilot this project in other trusts around the country.
- The trust had a research programme in place with each of the directorates having a research lead. In paediatrics there was a successful recruitment programme into national trials. There was a business case in development for the establishment of a clinical trials unit.

Overview of ratings

Our ratings for University Hospital North Tees

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Requires improvement	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Requires improvement	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Overview of ratings

Our ratings for University Hospital Hartlepool

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Inadequate	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Requires improvement	Good
Overall	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement

Our ratings for Minor Injuries Unit, One Life Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Not rated	Good	Good	Good
Overall	Good	Good	N/A	Good	Good	Good

Overview of ratings

Our ratings for Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Community health services for children	Good	Requires improvement	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Community dental services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for North Tees and Hartlepool NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall trust	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement

Notes

1. There no patients present and we were therefore unable to collect sufficient evidence to rate caring for the Minor Injuries Unit, One Life Centre and Maternity Services at University Hospital Hartlepool.
2. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients.

Outstanding practice and areas for improvement

Outstanding practice

- The development of advanced nurse practitioners had enabled the hospital to respond to patient needs appropriately and mitigated difficulties recruiting junior doctors.
- The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.
- A training suite had been set up to simulate procedures within surgery and enabled staff to practice and upskill in a safe environment.
- The critical care team achieved a network award, which recognised excellent work in relation to "target" training. The team had also achieved recognition for their work related to critical care competencies, difficult airway and skills drills.
- The critical care team achieved 58% for its consideration of patients for tissue donation. The team were the second highest achiever for corneal donations. Overall the team's approach to tissue and organ donation was impressive, demonstrating a compassionate and sensitive approach to patients and relatives.
- The paediatric and neonatal departments participated in a number of national and local research studies and were involved in a large number of clinical trials. The management team and several other staff told us the department had recently obtained a £3.5 million grant for an 'OSCAR study.' This study is for high frequency Oscillation in Acute Respiratory distress syndrome, comparing conventional positive pressure ventilation with high frequency oscillatory ventilation.
- The neonatal unit had implemented the 'Small Wonders' initiative for premature babies; this was designed by the charity Best Beginnings. Small Wonders supports parents in their baby's care in ways shown to improve health outcomes for their babies.
- Staff in the maternity day assessment unit attended training on Gestation Related Optimal Weight (GROW) software which aims to reduce the number of stillbirths by using customised growth charts.
- 'NIPE Smart' had recently been implemented within the maternity directorate. This is an information technology screening management system which has a robust system of capturing data on newborn and infant screening examinations with the aim of reducing the number of babies diagnosed with a medical congenital condition at a late stage.
- Outpatient department staff produced posters and delivered presentations at the International Society of Orthopaedic and Trauma nurses on the development of virtual fracture clinics and on the roles of speciality nurses.
- A number of staff within the outpatients department completed modules on service improvement including one current project to improve the staff engagement and sustainability in clinical supervision.
- Staff worked on the development of health promotion packs within main outpatients to be rolled out within the orthopaedic department as a pilot to explore how this can be sustained.
- The lead consultant radiologist for the specialist procedure known as CTPA (CT pulmonary angiography) presented the experiences of staff and patient outcomes to a panel at a major CT equipment manufacturer.
- A project in conjunction with Hartlepool Council was initiated to improve health care for people living with learning disabilities. When a patient with learning disabilities was admitted to the hospital, an alert was generated and they were admitted to a virtual ward managed by the learning disabilities lead nurse. This ensured that the trust was able to respond to their needs in an appropriate and timely manner.
- One of the senior dental officers made contact with the trust's learning disability lead nurse. They worked together to set up a pathway for people with a learning disability who were undergoing a general anaesthetic procedure. This meant that these patients were able to visit the day unit in advance and have additional planned support whilst they were having the procedure.
- We saw extremely kind, gentle and compassionate care being given to people, and the team-working between the dentists and the dental nurses was exceptional; all aimed at delivering a good outcome for the patient.

Outstanding practice and areas for improvement

- The health visiting service provided for refugee and asylum seeking families was outstanding. This was largely driven by the specialist health visitor and her team. They demonstrated a clear passion and dedicated insight of the issues facing ethnic minority women and children seeking refuge in Stockton. The health visitor not only provided care for the children but ensured the parents were also supported to integrate into local society and minimise the risk of social exclusion.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve:

- Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.
- Ensure staff follow trust policies and procedures for managing medicines, including controlled drugs. Ensure that medicines are stored according to storage requirements to maintain their efficacy.
- Ensure that risk assessments are documented along with personal care and support needs and evidence that a capacity assessment has been carried out where required.
- Ensure pain in children and young people is assessed and managed effectively.
- Ensure that the competency criteria for staff who are triaging patients are clearly documented and include recognised competency–based triage training.
- Ensure that infection control procedures are followed in relation to hand hygiene and use of personal protective equipment.
- Ensure that resuscitation and emergency equipment is checked on a daily basis in line with trust guidelines.
- Ensure cleanliness standards are maintained.
- Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.
- Ensure that all policies and procedures in the In-Hospital care directorate are reviewed and brought up to date.
- Midwifery policies, guidelines and procedural documents must be up to date and evidence based.
- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Ensure that all annual reviews for midwives take place on a timely basis.
- Ensure all staff attend the relevant resuscitation training.

Action the trust SHOULD take to improve:

- Consider strengthening the senior nurse capacity in the A&E department.
- Consider reviewing the system for documenting the follow-up of admitted head injury patients by the A&E department
- Consider a system in A&E to enable patients with allergies to be recognised quickly and easily without the presence of medical records
- Ensure that staff are following the correct procedure when dispensing medication using the Omnicell including checking the prescription at the time of dispensing.
- Consider a continuous audit of all MCA and DoLs assessments and referrals and share lessons learned.
- Consider assessing the access to the emergency resuscitation trolley on the haematology day unit.
- Consider putting engaged notices on toilet doors to protect dignity if the door is kept unlocked for staff to gain access to vulnerable patients.
- Send electronic communication to the patient's GP on discharge from the critical care unit.
- Ensure handover meetings are held in a private and confidential area in children's services.
- Ensure that all patient documentation remains confidential during patient visits to the outpatients department.
- Ensure that all outpatient treatment rooms are cleaned before use.
- Ensure that formal drugs audits and stock checks carried out regularly in outpatients.
- Ensure that medicines are stored appropriately to ensure their quality is maintained.
- Ensure that clinic planning, room utilisation and staffing is effectively managed and controlled for outpatient clinics including those hosted by the trust.

Outstanding practice and areas for improvement

- Ensure that patients in the children's outpatient department are afforded privacy when speaking with reception staff.
- Update the risk assessment related to paediatric resuscitation in the children's outpatient department.
- Ensure that some clean and safe methods for entertaining or distracting children are provided within the diagnostic imaging department.
- Ensure that staff adhere to the coding system for recording on medication charts
- Ensure that staff fully adhere to infection control policies and close doors on side rooms where patients are being barrier nursed.
- Ensure the processes and documentation used for appraisal of non-medical staff monitors their performance and meets their personal development needs.
- Review the process for storage of post-transfusion blood bags while retained on ward areas.
- Review whether documentation for patients living with dementia are completed and comprehensive.
- Ensure that within outpatient services, action plans from audits, risk registers and meetings are maintained, regularly revisited and amended to show where actions have been completed or remain outstanding.
- Ensure that established models of regular nursing clinical supervision are implemented for all staff involved in patient care in outpatient services.
- Ensure that patients and staff are informed on a timely basis if clinics are cancelled, including those involving clinicians and staff from other trusts.
- Ensure that strategy and management plans regarding transforming the outpatients departments are communicated to all staff.
- Consider recording decision made at the evening medical ward rounds on the critical care unit.
- Consider how the critical outreach service will be maintained.
- Review the recruitment of medical staff, particularly junior doctors in the surgical unit.
- File maternity healthcare documentation according to the trust records management policy to avoid loss or misplacement of information
- Indicate benchmark data on the maternity performance dashboard to measure performance.
- Ensure that 'fresh eyes' checks are recorded when undertaken.
- Review the senior midwifery structure and experience resource to ensure that all the midwifery roles needed for coordination and oversight of each service are appropriately covered.
- Monitor and internally report the level of provision of 1:1 maternity care
- Hold staff handovers in maternity services in an environment that reduces the possibility of distraction and interruption.
- Have a competency based framework in place for all grades of midwives.
- Have systems in place to achieve the nationally recommended ratio of 1:15 for supervision of midwives.
- Consider safety briefings as part of daily communication with staff in maternity services.
- Include describing the reporting arrangements for Supervisors of Midwives following investigations, audits or reviews in the maternity services risk management strategy.
- Provide simulation training exercises to prevent the abduction of an infant
- Ensure that the review of the Specialist Palliative Care Team covers the educational, developmental and support needs of staff on the community inpatient unit at University Hospital of Hartlepool
- Ensure that pain control medicines are prescribed and administered at the intended interval of time.
- Evidence how the end of life care strategy and development of services is aligned at board level.
- The trust should ensure there is a consistent approach to clinical supervision across the community adult services.
- Have systems in place to enable staff to complete mandatory training within the required timescales.
- Use interpreting services appropriately to meet the needs of children, young people and families in the community.
- Complete and record lone working risk assessments in all appropriate documentation.
- Monitor the delivery of the Health Child Programme by reviewing and improving performance measures.
- Have standard operating procedures in place to support the transition of young people from community children's services to adult services

Outstanding practice and areas for improvement

- Consider reviewing the trust process for prescribing antibiotics in the Minor Injuries Unit to enable them to be prescribed after 10pm when only one qualified nurse is on duty.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9(3)(a) • Ensure pain in children and young people is assessed and managed effectively. • Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(c)(e)(g) • Ensure that the competency criteria for staff who are triaging patients are clearly documented and include a recognised competency–based triage training. • Ensure staff follow trust policies and procedures for managing medicines, including controlled drugs. Ensure that medicines are stored according to storage requirements to maintain their efficacy. • Ensure that infection control procedures are followed in relation to hand hygiene and use of personal protective equipment. • Ensure that resuscitation and emergency equipment is checked on a daily basis in line with trust guidelines. • Ensure that risk assessments are documented along with personal care and support needs and evidence that a capacity assessment has been carried out where required. • Ensure cleanliness standards are maintained.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(a)** • Ensure that all policies and procedures in the In-Hospital Care directorate are reviewed and brought up to date. • Midwifery policies, guidelines and procedural documents must be up to date and evidence based.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1),18(2)(a)** • Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service. • Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner. • Ensure that all annual reviews for midwives take place on a timely basis. • Ensure all staff attend the relevant resuscitation training.