Special Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Wednesday 2 May 2018**
Time	**9.30 am**
Venue	**Committee Room 2 - County Hall, Durham**

Business

Part A

Items during which the Press and Public are welcome to attend. Members of the Public can ask questions with the Chairman's agreement.

1. Apologies for Absence
2. Substitute Members
3. Declarations of Interest, if any
4. Any Items from Co-opted Members or Interested Parties
5. County Durham and Darlington NHS Foundation Trust - Review of stroke rehabilitation services - Presentation by Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust
6. County Durham and Darlington NHS Foundation Trust - CQC Re-inspection report and action plan - Report and presentation by Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust (Pages 3 - 78)
7. Teams around the practice, Community Services contract and review of Community Hospitals in County Durham - Presentation by Lesley Jeavons, Director of Integration (Pages 79 - 86)
8. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration

Helen Lynch
Head of Legal and Democratic Services

County Hall
Durham
24 April 2018

To: **The Members of the Adults, Wellbeing and Health Overview and Scrutiny Committee**

Councillor J Robinson (Chairman)
Councillor J Chaplow (Vice-Chairman)

Councillors A Bainbridge, R Bell, P Crathorne, R Crute, G Darkes, M Davinson, J Grant, E Huntington, C Kay, K Liddell, L Mavin, A Patterson, S Quinn, A Reed, A Savory, M Simmons, H Smith, L Taylor and O Temple

Co-opted Members: Mrs B Carr and Mrs R Hassoon

Contact: Jackie Graham **Email: 03000 269704**

County Durham and Darlington NHS Foundation Trust

Inspection report

Darlington Memorial Hospital
Hollyhurst Road
Darlington
County Durham
DL3 6HX
Tel: 01325380100
www.cddft.nhs.uk

Date of inspection visit: 12 Sept to 20 Oct 2017
Date of publication: 01/03/2018

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

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

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

County Durham and Darlington NHS Foundation Trust (CDDFT) operates acute hospital services from two main hospital sites:

- University Hospital North Durham
- Darlington Memorial Hospital

In addition, outpatient services and some acute services are provided at Bishop Auckland Hospital, and the trust provides a range a community services. We only inspected the two main hospital sites during this inspection.

The trust serves a population of approximately 650,000 people across County Durham and Darlington, North Yorkshire, Tees Valley and South Tyneside. The trust employs around 8000 staff to deliver its services.

Services are commissioned by:

- North Durham Clinical Commissioning Group (CCG), Darlington CCG, and Durham Dales, Easington and Sedgefield CCG.
- NHS England – for dental services.

The trust has 1,116 beds of which 1,029 were general and acute beds, 67 were maternity beds and 22 were critical care beds.

Overall summary

Our rating of this trust stayed the same since our last inspection.

We rated it as Requires improvement 

What this trust does

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

It provides the following acute core services:

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

The trust also provides the following community health services;

Summary of findings

- Community Health inpatient services
- Community health services for adults
- Community health services for children, young people and families (school nursing and

health visiting are provided by Harrogate and District NHS Foundation Trust).

- End of life care
- Community dental services
- Community urgent care services

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

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

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 12 and 15 September 2017 we inspected urgent and emergency care, medical care, surgery and maternity services provided by this trust at its two main hospitals because at our last inspection we rated the trust overall as requires improvement.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well- led key question at the trust level. Our findings are in the section headed "is this organisation well-led?"

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective and well led as requires improvement; caring and responsive were rated as good at service level.
- We rated both the University Hospital North Durham and Darlington Memorial Hospital as requires improvement.

Summary of findings

- Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.
- We rated well led at the trust level as good.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Although staffing levels had improved, the trust still did not have enough staff with the right qualifications, skills and training. Staff numbers were lower than planned in urgent and emergency care.
- Within urgent and emergency care, consultant presence in the departments did not meet the RCEM guidance of consultant presence of 16 hours a day. ST3 doctors (those in year three of speciality training) were part of the middle grade rota. This goes against the RCEM guidance that a minimum of an ST4 or equivalent is in the department at all times.
- Within urgent and emergency care, the service did not always manage medicines well.
- Within urgent and emergency care, the department missed key targets for caring for patients promptly. Patients did not always get a face-to-face assessment within 15 minutes of arrival or registration. Patients brought in by ambulance were not always handed over to the department within 30 minutes and this was getting worse.
- Within urgent and emergency care, staff did not record patient care consistently.
- Within urgent and emergency care, although the service had a separate room to assess patients with mental health needs, it did not conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.
- Within medical care services at University Hospital North Durham, members of staff did not comply with hospital policy on the administration of covert medicines. We found evidence of staff providing medication covertly for patients without ensuring capacity assessments were in place.
- Within medical care services, medical and nursing records were not stored securely in all areas we visited.
- Eleven never events were reported over 13 months from May 2016 to May 2017. Three of the never events reported in the second half of 2016/17 related to 2014 or before. This meant there had been a large 'batch' of never events in the first half of 2016/17; and two clusters of two never events, which occurred in February and April 2017, and October and November 2017. Joint working with stakeholders and a trust wide programme of learning had taken place following these never events reduce risks of harm to patients; however, despite this, two further never events occurred after September 2017. There was a strong need to further embed safer practices and learning across the trust.

However:

- Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Staff understood and followed procedures to protect vulnerable adults or children.
- The trust had plans for dealing with major incidents and staff understood their roles. The plans had been tested and reviewed.
- The wards and department areas were clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice. Cleanliness within the urgent and emergency care departments had improved since the last inspection.
- Care and treatment of patients requiring non-invasive ventilation (NIV) had improved since the last inspection.

Summary of findings

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not understand their roles and responsibilities under the Mental Capacity Act 2005. They did not always follow legislation and best practice for those who lacked the capacity to make decisions about their care.
- The trust did not meet targets for Mental Capacity Act and Deprivation of Liberty Safeguards training. The knowledge and practice of staff on the wards raised concern over the effectiveness and numbers trained.
- The trust policies 'Policy and guidance notes for staff on the Mental Capacity Act 2005' (reviewed January 2017) and 'Deprivation of Liberty Safeguards' (reviewed December 2016) did not direct staff to guidance or tools for use by staff.
- Clinicians did not update or review care pathways regularly in emergency department.
- Nursing staff in the emergency department looking after children were not aware of the Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children.
- Results from the national neonatal audit programme (NNAP) indicated some lower than average standards; for example in the percentage of mothers who were given antenatal steroids and also the percentage of premature babies who had their temperature taken within an hour of being born.

However:

- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Managers monitored the effectiveness of care and treatment through continuous local and national audits.
- The electronic patient record system provided up to date patient clinical information available to all members of staff.
- There was effective multi-disciplinary (MDT) working to secure good outcomes and seamless care for patients across the trust.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- Referral to treatment (RTT) times for admitted performance was above the England average. Where RTT shortfalls existed, the trust had identified actions to improve performance.
- The escalation policy and procedure guidance was followed during busy times. The director of nursing, matrons and service managers attended capacity bed meetings to monitor bed availability, discuss concerns and identify flow issues.
- Services were planned and delivered in a way that met the needs of local people. They worked with commissioners, external providers and local authorities.

Summary of findings

- Systems were in place for the management of complaints, and there was evidence of improvements following complaints.

However:

- The service did not meet the Department of Health's target of 95% of patients admitted, transferred or discharged within four hours of arrival at the emergency department. It breached this target 11 times between October 2016 and September 2017.
- Over the 12 months from August 2016 and July 2017, four patients trust wide waited more than 12 hours in the emergency department from the 'decision to admit' until being admitted.
- Between September 2016 and August 2017 the percentage of patients leaving this hospital before being seen for treatment in the emergency department was consistently worse compared to the England average.
- Between September 2016 and August 2017, the time spent in the emergency department was consistently worse than the England average.

Are services well-led?

Our rating of well-led at core service level stayed the same. We rated it as requires improvement because:

- There was a need to strongly embed learning from never events in order to minimise risk to patients. Seven never events occurred between May and October 2016. The trust took actions to address this. However a further four never events occurred at the trust between November 2016 and May 2017. The trust took further action but despite this two further never events occurred after September 2017.
- At the time of inspection, in medical care services, we had concerns about Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training, the knowledge and practice of staff on the wards related to capacity assessments and DoLS applications and the trust policy for Mental Capacity Act and Deprivation of Liberty.
- Meetings with directorate managers and trust senior managers did not give assurance that they were aware of these concerns before the inspection. We were given assurance that these issues would be addressed as a matter of urgency.
- Not all risks were identified by the urgent and emergency care department and risk assessments were not carried out for patients with mental health needs.

However:

- Most services had a clear vision and strategy, which was understood by staff.
- Services had governance, risk management and quality measures to improve patient care, safety and outcomes.
- Services had a clear management structure at both directorate and care group level. The managers knew about the quality issues, priorities and challenges.
- The culture within services was open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- There was a newly formed senior leadership team in the maternity service covering business, midwifery and clinical leadership. We found that this team was cohesive and that there was a real drive to continue improve the quality of the service.

Summary of findings

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in maternity throughout the trust.

For more information, see the outstanding practice section in this report.

Areas for improvement

We found areas for improvement including three breaches of legal requirements that the trust must put right. We also found 22 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of services.

For more information, see the areas for improvement section of this report.

Action we have taken

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of legal requirements in urgent and emergency services, medical care and surgery.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

In maternity services:

- The transitional care team had won the service improvement award in the annual staff awards and was shortlisted for the Royal College of Midwives (RCM) annual midwifery awards 2017. The trust had identified a way of providing care for vulnerable babies outside of the neonatal unit. They had employed and set up a training course for transitional care baby support workers. These were support staff, dedicated to work with babies, parents and staff including paediatricians during transitional care. They helped to ensure babies could be cared for on the ward and avoid where possible admission to the neonatal unit. Staff told us there had been significant positive outcome results following implementation of this role.
- The team were involved in Wave 2 of the National Maternity and Neonatal Safety Collaborative. This work was recognised nationally when a member of the team was asked to speak at the Royal College ‘Each Baby Counts’ conference in 2016.

Summary of findings

- The majority of staff were trained in recruiting and supporting clinical research projects. The team had been recognised nationally for recruiting to an industry trial for the blind testing of prophylactic antibodies in patients following instrumental deliveries.
- UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast feeding and promote parent/ infant relationships. The trust told us that the north of the service had successfully achieved UNICEF recognition for its breastfeeding support and had been recommended to apply for gold accreditation in June 2017.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with legal requirements**.** This action related to three services: urgent and emergency services, medical care and surgery.

In urgent and emergency services:

- The trust must ensure that the rooms used to care for patients with mental health needs conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.
- At Darlington Memorial Hospital (DMH) The trust must ensure that documentation of the administration of controlled drugs is line with the Nursing and Midwifery Council (NMC) Standards for Medicine Management.
- At University Hospital North Durham (UHND) the trust must ensure that controlled drug balance checks are carried out in accordance to trust policy.
- At UHND the trust must store intravenous infusions containing potassium separately and the store patients own medication securely.
- The trust must ensure that oxygen therapy is prescribed in line with national guidance.
- The trust must ensure that patients' blood sugar levels are recorded as required.

In medical care:

- The trust must ensure that staff understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 at University Hospital North Durham.
- The trust must ensure that they meet targets for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training. The knowledge and practice of staff on the wards raised concern over the effectiveness and numbers trained. This was specifically relevant at University Hospital North Durham.
- The trust must ensure that policies 'Policy and guidance notes for staff on the Mental Capacity Act 2005' (reviewed January 2017) and 'Deprivation of Liberty Safeguards' (reviewed December 2016) direct staff to guidance or tools for use by staff.

In surgery:

- The trust must ensure that operating theatres are fully established against the 'Association for Perioperative Practice' (AfPP staffing recommendations). Staffing levels at night and on late shifts fell below recommended guidance.

Summary of findings

- The trust must continue to embed the theatres culture review action plan.
- Following never events the trust must ensure that improvements in practice are effectively embedded and maintained.
- The trust must ensure that checks of the difficult intubation trolley in recovery at UHND take place as per trust policy.
- The trust must ensure there is compliance with safeguarding adults and children training where staff are required to have this training.

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

In urgent and emergency services:

- The trust should consider planning the nursing off duty to have more staff on duty at busy times.
- The trust should ensure that when patients enter the emergency department they are assessed within 15 minutes of arrival.
- The trust should ensure that patients are admitted, transferred or discharged within four hours of arrival in the emergency department and reduce the amount of time patients spend in the department.
- The department should ensure that patients brought in by ambulance are handed over to the department within 30 minutes and that the time patients should wait from time of arrival to receiving treatment is no more than one hour.
- The department should ensure patients do not leave the department before being seen.
- The trust should increase consultant presence in the department in line with the RCEM guidance and ensure a minimum of an ST4 doctor is in the department at all times.
- The trust should increase the number of children's nurses on duty to reflect the RCN staffing requirements.
- The trust should ensure that nursing care assessments are completed.
- The trust should ensure that all patients in non-visible cubicles have access to call bells
- The trust must ensure that patients are given name bands in line with trust policy.
- The trust should ensure that staff update and review care pathways regularly.
- The trust should ensure that nursing staff caring for children are aware of the Fraser guidelines and Gillick competency principles when assessing patients' capacity for decision-making and obtaining consent from children.
- The trust should improve engagement with staff particularly those with protected characteristics.

In medical care:

- The trust should ensure that staff are compliant with hospital policy on the administration of covert medicines.
- The trust should ensure that medical and nursing records are stored securely in all areas.
- The trust should improve engagement with staff particularly those with protected characteristics.

In surgery:

- The trust should ensure that equipment is stored in designated areas and boxes of equipment are stored off the floor where appropriate.

Summary of findings

- The trust should ensure patient records are complete and staff signatures legible.
- The trust should ensure that protected time is available for theatre staff to attend regular training.
- The trust should assure themselves that relevant staff have access to sepsis training.
- The trust should ensure that patients discharge plans are completed.
- The trust should ensure increased visibility of the executive team at University Hospital North Durham as staff feedback identified limited visibility on this site in surgery.
- The trust should ensure ongoing engagement from senior management with theatre staff.
- The trust should improve engagement with staff particularly those with protected characteristics.

In maternity:

- The trust should seek to improve outcomes for women and new born babies with regards to standards in the National neonatal audit programme.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

This was our first review of well led at the trust under our next phase methodology. We rated well led as good because:

- We found the trust executive leadership team had an appropriate range of skills, knowledge and experience. A number of the executive directors had defined areas of responsibility for several roles; they were clear they were accountable for quality in these areas. We saw members of the non-executive team had a range of desired experience, knowledge and were suitably fit for the needs of the services provided.
- The trust leadership team demonstrated a level of awareness of the priorities and challenges facing the trust and how these were being addressed. Executive leaders spoke with insight about these challenges which included recruitment and retention of medical and nursing staff, winter pressures, learning from never events and serious incidents, and the estate issues faced by the trust locations.
- The board reviewed executive leadership capacity and capability. This was undertaken via a number of methods, including individual performance review and service related performance measures. Leaders at every level were visible and approachable.
- The non-executive directors had a variety of skills, knowledge, and experience which was relevant to their roles. They had worked in leadership and management positions in the NHS, social care, charities, or in private organisations. They brought skills such as strategic development, partnership working, quality improvement, and acting as the public voice.
- There was a clear statement of vision and values. The vision of the trust was linked to the overall strategy and the component strategies and also linked to the values and behaviours framework.

Summary of findings

- The overall culture of the trust was patient focused and this was under-pinned by the promotion of the trust values. At ward level, staff were motivated by wanting to provide the best care for patients and they spoke positively about the care they delivered. They told us compassionate quality care was a priority.
- The trust was ranked 102nd out of 415 employers in the Stonewall Workplace equality index for 2016 and planned to seek staff views from December 2017 to February 2018. It had carried out a survey to identify barriers to staff participation in networks.
- The trust had implemented an Integrated Quality Assurance Committee (IQAC) which considered assurance around patient safety, patient experience, clinical effectiveness, workforce, policy approvals, and the board assurance framework.
- There were risk management processes in place for the services, with risks collated and reviewed at different levels of the organisation to ensure action plans were in place. The trust used the board assurance framework (BAF) to capture and monitor capture and monitor action plans for the management of strategic risks. The trust had taken some short term mitigation actions regarding risks to the estate.
- The integrated performance report (IPR) went to the board every month. It provided the board with information on indicators related to patient experience, efficiency, outcomes, and workforce. The board acknowledged the report could be enhanced to provide other information, to give an overarching snapshot of performance.
- The trust was under considerable financial pressure and we saw a strong awareness of this during our review. The governance around the cost improvement programme had been strengthened within the last two years by the introduction of the monthly finance committee as a formal trust board sub-committee.
- There was one safeguarding adults lead in the trust for acute and community services and no other named person or team. The trust told us they mitigated this by training matrons and other clinical leaders to a higher level.
- We saw there was a full team involved in children's safeguarding to ensure vulnerable children and young people were kept safe.
- The trust was on target for compliance with mandatory training.
- The trust had a partnership with an IT security company to protect records from attack. They had not been affected by the NHS wide cyber-attack in 2016

However:

- There was a need to further embed learning from never events in order to prioritise safety and reduce the levels of never events. Learning had not yet been fully embedded despite a trust wide programme and action plan to prevent them occurring.
- In theatres, the action plan to address culture issues was still in progress and there was a need to further embed improvements. . A review had been triggered and supported by the board. Task and finish groups were still working through culture and behaviour issues
- There had not been a formal training programme for all board members. Executive directors have been through a collective development programme, but this recently commenced for the board as whole in May 2017. There was a plan to use a board effectiveness seminar to consider collective training with a deadline of the end of September 2017; this deadline had not been met due to insufficient time for discussion, so it was due to be rescheduled and had not taken place by the time of our well led review.
- Training was offered to non-executive directors (NEDs) in line with a national NED programme but there had not been a way to monitor if this took place. There had been a plan for a register of training events to be complied and in place by the end of May 2017, however, the deadline for this moved to the end of September 2017.

Summary of findings

- The executive team articulated the strategy to us in different ways; there was no common way to describe their approach to how it would be achieved.
- Staff engagement was an area for development. Overall staff engagement had been an area of focus for the past three years. Progress had been made however staff satisfaction scores remained below the national average.
- Overall trust compliance with role specific training was 55% which was lower (worse) than the target.
- The information used in reporting, performance management, and delivering quality care had not always been accurate, or timely. There was some duplication of information presented to the board and sub committees; this was being addressed by revision of the work plans and terms of reference of the various committees.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Mar 2018	Requires improvement →← Mar 2018	Good →← Mar 2018	Good →← Mar 2018	Good ↑ Mar 2018	Requires improvement →← Mar 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
University Hospital of North Durham	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Darlington Memorial Hospital	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Overall trust	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018
Community	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall trust	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ↑ Mar 2018	Requires improvement ➔➔ Mar 2018

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for University Hospital of North Durham

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ↑ Mar 2018	Requires improvement ➔➔ Mar 2018
Medical care (including older people's care)	Good ↑ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ↑ Mar 2018
Surgery	Requires improvement ↓ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018
Critical care	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ↑ Mar 2018	Good ➔➔ Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires improvement Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Outpatients and Diagnostic imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Darlington Memorial Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Good ↑ Mar 2018	Requires improvement ➔➔ Mar 2018
Medical care (including older people's care)	Good ↑ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018
Surgery	Requires improvement ↓ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ↓ Mar 2018
Critical care	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Maternity	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ↑ Mar 2018	Good ➔➔ Mar 2018
Services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires improvement Sept 2015	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Outpatients and Diagnostic imaging	Good Sept 2015	N/A	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Requires improvement ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Good ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018	Requires improvement ➔➔ Mar 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health services for children and young people	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community health inpatient services	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Community end of life care	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Good Sept 2015
Urgent care	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Overall*	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Darlington Memorial Hospital

Hollyhurst Road
Darlington
County Durham
DL3 6HX
Tel: 01325380100
www.cddft.nhs.uk

Key facts and figures

Darlington Memorial Hospital is one of two acute hospitals forming County Durham and Darlington NHS Foundation Trust. It has 410 beds.

Darlington Memorial Hospital provides medical, surgical, critical care and maternity services, and services for children and young people in County Durham, Darlington, North Yorkshire and the Tees Valley. The hospital also provides emergency and urgent care (A&E) and outpatient services.

We inspected only emergency and urgent care, medical care, surgery and maternity services at this visit.

Between February 2016 and January 2017, there were 61,347 emergency department attendances in at Darlington Memorial Hospital. This equates to an average of 168 patients a day.

The trust had 63,037 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 30,224 (48%), 656 (1%) were elective, and the remaining 32,157 (51%) were day case.

In 2016 the trust completed around 4,800 operations.

Between April 2016 and March 2017 the trust delivered 4898 babies.

Summary of services at Darlington Memorial Hospital

Requires improvement ➔➔

Our rating of services stayed the same. We rated it them as requires improvement because:

- We rated safe and well led as requires improvement; effective, caring, and responsive were rated as good.
- Overall, urgent and emergency care, medical care and surgery stayed the same since our last inspection. Maternity services had improved.
- Seven never events had occurred between May and October 2016. The trust took actions to address this. However a further four never events occurred at the trust between November 2016 and May 2017. The trust took further action but despite this two further never events occurred after September 2017.
- The department was having difficulty meeting the four hour target. Between October 2016 and September 2017 the department had only met the monthly 95% four hour target once.

Summary of findings

- The hospital did not meet targets for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training.
- There were poor levels of overall compliance with mandatory training.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered. Equality and diversity were not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed.

However:

- In most areas nurse staffing had improved.
- Care and treatment of patients requiring non-invasive ventilation (NIV) had improved since the last inspection.
- Staff investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Wards and department areas were clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.
- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- The hospital escalation policy and procedure guidance was followed during busy times.

Urgent and emergency services

Requires improvement 

Key facts and figures

The department is a designated trauma unit but more severely injured patients go to the nearest major trauma centre if their condition allows them to travel directly. Otherwise, they would be stabilised at the Darlington Memorial Hospital, where staff follow a protocol to decide which injuries they could treat or would have to transfer.

The department has three adult resuscitation bays and a separate resuscitation room which specially equipped for children. There were two monitoring cubicles and six 'majors' cubicles. For patients who attended with minor injuries and illnesses there was an adult waiting room and a separate children's waiting room. Two rooms for the use for 'minors', an eye room and a separate room used for patients who attended with mental health needs. The trust's strategy includes a plan to co- locate urgent care services, which include GP services..

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them. Patients who attended by ambulance came in through the same entrance, they were brought to the main staff based where they waited to be allocated into an appropriate cubicle.

During this recent 2017 inspection , we inspected the whole core service and looked at all five key questions. In order to make our judgements we spoke with five patients, five carers and 19 staff from different disciplines including nurses, doctors, managers, support staff and ambulance staff. We observed daily practice and viewed 19 sets of records. Prior to and following our inspection, we reviewed performance information about the trust and reviewed information provided to us from the trust.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The department was having difficulty meeting the four hour target. Between October 2016 and September 2017 the department had only met the monthly 95% four hour target once.
- The room used to assess patients with mental health needs, did not fully conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.
- The service did not always have enough staff of the right level to keep patients safe from avoidable harm.
- The service did not always manage medicines well.
- Clinicians did not update or review care pathways regularly.
- The access was blocked to the major incident store cupboard.
- The children's resuscitation room doors were not closed or locked allowing easy access from the main corridor, which could be a potential security risk.
- The layout of the main reception desk did not provide privacy as patients booked in.
- Staff did not always record patients' blood sugar levels when necessary
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered.

However:

Page 22

Urgent and emergency services

We found some improvements since the last inspection.

- The service had improved on many of the issues for action highlighted in the previous inspection. It had a clear vision and strategy. The department had governance, risk management and quality measures in place to improve patient care, safety and outcomes.
- Cleanliness of the department had improved.
- Paediatric nurse staffing had increased.
- A new escalation process was introduced, to improve patient flow through the department to the rest of the hospital
- The difficult airway trolley had been standardised throughout the trust.
- The department had improved the care of patients requiring non-invasive ventilation (NIV).
- Resuscitation equipment and fridge temperatures were checked daily.
- Staff we spoke with had undertaken a two-day violence and aggression training. The lack of training was noted in the previous inspection.
- Staff recognised incidents and knew how to report them. Lessons learnt were shared amongst staff.
- Staff kept patients safe from harm and abuse.
- Staff were able to identify and respond appropriately to patients at risk of deteriorating.
- The department met the standard for patients receiving treatment within one hour.
- Staff provided care and treatment based on national guidance and evidence and audits took place.
- Patients had their pain monitored effectively and re-attendance rates were better than the national standard and England average.
- Staff cared for patients with compassion, dignity and respect. We received positive feedback from patients and carers.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

During the last inspection, the service was asked to review the number of consultants against the Royal College of Emergency Medicine (RCEM) guidance. The department had no further consultant vacancies however; consultant presence in the department did not meet the RCEM guidance of consultant presence of 16 hours a day. ST3 doctors (those in year three of speciality training) were part of the middle grade rota. This goes against the RCEM guidance that a minimum of an ST4 or equivalent is in the department at all times.

- The service did not always manage medicines well. During last inspection, it was found controlled drug balance checks were not carried out daily. During this inspection, we found the daily checks were in place; however, documentation of the administration of controlled drugs was not in line with the Nursing and Midwifery Council (NMC) Standards for Medicine Management.
- We found oxygen therapy was not prescribed in accordance with current national guidelines.

Urgent and emergency services

- The department did use patient group directions (which allow staff to give prescription medicines to a defined group of patients without them having to see a doctor). However, these were not signed by all staff using them in line with trust policy.
- Although the service had a separate room to assess patients with mental health needs, it did not conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.
- Overall compliance with mandatory training was 52% against the trust target of 95%.
- The department missed key targets for caring for patients promptly. Patients did not always get a face-to-face assessment within 15 minutes of arrival or registration. Patients brought in by ambulance were not always handed over to the department within 30 minutes and this was getting worse. A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff, the number of black breaches was high.
- The number of children’s nurses on duty did not meet the Royal College of Nursing guidance; however, the number of staff had increased since the last inspection.
- We did see computers logged on in the main corridor with patient information displayed not protecting patient confidentiality and not in line with information governance policy.
- We found the door to the major incident equipment storeroom, in the hospital kitchen, was blocked with large electronic cleaning equipment.
- The children’s resuscitation room doors were left open during the inspection and the door had no lock or keypad. This was near a main corridor and could be a potential security risk.
- When patients booked into the department at the reception desk, due to the layout of the department it did not provide patient confidentiality.

However:

- The cleanliness of the department had improved since the last inspection with the increase of domestic cover and a new cleaning schedule was in place for children’s toys in the children’s waiting room. Cubicles were clean although there was no check lists in place. The department was clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.
- Staff now checked resuscitation equipment daily and checked the anaphylaxis kits and grab bags regularly.
- When things went wrong patients received an apology and were given information about changes the service made to prevent the same thing happening.
- Staff recognised incidents and knew how to report them. Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable adults or children.
- Staff now predominately checked the medication fridge temperatures daily to ensure that drugs were stored safely.
- Staff were able to identify and respond appropriately to patients who were at risk of deteriorating. They used the National Early Warning Scores (NEWS) effectively.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard every month between September 2016 and August 2017. This hospital performed mainly better than the England average.

Urgent and emergency services

- Between September 2016 and August 2017, this hospitals unplanned re-attendance rate to the department within seven days was consistently better than the national standard and consistently better than the England average.
- The percentage of filled qualified nurse shifts was average 94%. The unqualified nurse filled shifts were average 99%. There was appropriate skill mix and an internal bank of nurses was used.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- The department had improved the care of patients requiring non-invasive ventilation (NIV).
- Managers monitored the effectiveness of care and treatment through continuous local and national audits.
- New staff received a package of support including a mentor, an induction programme and a period of working supernumerary, which was flexible according to their previous experience and training.
- Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff described how they would deal with of violence and aggression and the lack of training was noted in the previous inspection. Staff we spoke with had since undergone a two-day training course.
- Staff used a pain score tool was used to assess if a patient had pain. The majority of patients had a pain score recorded. We observed the triage nurse giving timely pain relief to adults and children.
- Staff offered patients food and drinks and monitored patients' nutrition and hydration effectively.
- The trust's unplanned re-attendance rate to the emergency department was better than the national standard and the England average.

However:

- Clinicians did not update or review care pathways regularly.
- New staff did not have written competency assessments to complete, however, we were told these were in the process of being developed.
- We found patients did not have blood sugar recorded when necessary.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

Urgent and emergency services

- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service did not meet the Department of Health's target of 95% of patients admitted, transferred, or discharged within four hours of arrival at the department. They breached this target 11 times between October 2016 and September 2017.
- Although the service had a separate room to assess and respond to patients with mental health needs it did not conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.
- Over the 12 months from August 2016 and July 2017, four patients waited more than 12 hours from the decision to admit until being admitted across Durham and Darlington NHS Foundation Trust.
- Between September 2016 and August 2017, the monthly percentage of patients leaving this hospital before being seen for treatment was in general better compared to the England average. Performance showed a pattern of decline between December 2016 and January 2017, and again between March 2017 and May 2017. Both in January 2017 and May 2017, this site performed worse than the England Average.
- Between September 2016 and August 2017, the monthly total time spent in the department for all patients was consistently higher the England average.

However:

- Since the previous inspection, the department had introduced a new escalation process and framework to provide a consistent approach in times of pressure.
- Staff made every effort to make sure they saw patients who came to the department. The number of patients leaving the department before being seen was below the England average.
- The percentage of patients waiting between 4 and 12 hours from the decision to admit until being admitted for this trust was similar to the England average.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The trust planned and provided services in a way that met the needs of local people. They worked with commissioners, external providers and local authorities. Since the previous inspection, the trust had increased mental health provision providing 24 hours a day access to the mental health liaison team who were on site and provided a rapid assessment of patients with mental health needs within one hour.

Urgent and emergency services

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- The service had improved on many of the actions highlighted in the previous inspection.
- The service had a clear vision and strategy for the department, which looked to transform patient access to urgent and emergency care.
- The department had governance, risk management and quality measures to improve patient care, safety and outcomes. The governance system supported the delivery of the strategy and provided continuing assurances up to board level with the clear focus on patient safety.
- The emergency department had a clear management structure at both divisional and departmental level. The managers knew about the quality issues, priorities and challenges.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- There were high levels of staff satisfaction within the service and staff we spoke to were proud of being a part of the department and felt very well supported
- Staff at all levels were encouraged and supported to explore innovative ways of working; leaders drove continuous improvement and there was a clear, proactive approach to seeking out and embedding new and more sustainable models of care.
- The department had plans for dealing with major incidents and staff understood their roles. The plans had been tested and reviewed.

However:

- Not all risks were identified by the department.
- The department missed key national targets for caring for patients promptly such as the four hour waiting time target.
- We found concerns regarding the management of medicines.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered. Equality and diversity were not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, did not always feel they were treated equitably.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section.

Medical care (including older people's care)

Good

Key facts and figures

The medical care service at the trust provides care and treatment for 24 specialties. There are 882 medical inpatient beds located across 37 wards.

Darlington Memorial Hospital provided medical care in 182 beds across eight wards.

The trust had 63,037 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 30,224 (48%), 656 (1%) were elective, and the remaining 32,157 (51%) were day case.

Admissions for the top three medical specialties were:

- General Medicine; 27,222
- Gastroenterology; 12,614
- Clinical Haematology; 4,664

(Source: CQC Insight)

Darlington Memorial Hospital was previously inspected in February 2015. All five domains were inspected and an overall rating of requires improvement was given. Safe, and effective were rated as requires improvement. Caring and responsive and well-led were rated as good.

The main areas of concern from the last inspection in February 2015 and the actions the trust were told they must take were:

- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance and taking into account patients' dependency levels, on medical wards, particularly where patients are receiving non-invasive ventilation (NIV) and require level 2 intervention.
- Undertake a review of current documentation relating to the care and management of patients receiving NIV to ensure that it is consistent across both the University Hospital North Durham and Darlington Memorial Hospital.
- Have arrangements in place for patients receiving NIV that comply with the British Thoracic Society guidelines (2008) for the use of NIV for acute exacerbation of chronic obstructive pulmonary disease.
- Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and of appropriate quality.
- Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with best practice guidance.

We also said that the trust should take action to improve:

- Review dedicated management time allocated to ward managers.
- Review the flow of higher dependency patients throughout the hospital to ensure care is given in the most appropriate setting.
- Have an up-to-date standard operating procedure (SOP) which clearly sets out the management of patients requiring NIV who are admitted to both acute hospitals.

Medical care (including older people's care)

- Ensure that this guidance/ SOP which includes clarity on the setting/specific ward in which patients can be managed.
- Ensure that this guidance/SOP includes staffing-to patient ratios that are in line with current guidance.
- Ensure that there is a plan in place to deliver training to all staff involved in the care of patients receiving NIV, and that it is competency-based and in sufficient detail to demonstrate competence in all aspects of NIV.
- Ensure that any guidance/SOP includes an escalation plan that includes action to be taken when no bed is available in an appropriate setting and when patient numbers do not match agreed staffing ratios.

During this inspection we visited wards 41 (general medicine), 43 (gastroenterology), 44 (general medicine, respiratory), 51 (cardiology), 52 (elderly care), the coronary care unit, the acute medical unit and ambulatory care and the discharge lounge.

We spoke with 26 patients and relatives and 42 members of staff. We observed care and treatment and looked at 22 care records.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The hospital had enough staff with the right skill mix for the care and treatment of patients requiring non-invasive ventilation (NIV). Escalation plans, separate treatment areas and the assessment of staff competence had been developed.
- There was a standardised and documented clinical pathway for the care and treatment of patients requiring NIV across the trust.
- Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Staff understood and followed procedures to protect vulnerable adults or children.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They supported patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Wards and directorate areas were clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.
- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care and treated patients with compassion, treating them with dignity and respect.
- The directorate treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The directorate had a clear vision and strategy that all staff understood and put into practice. The directorate had governance, risk management and quality measures to improve patient care, safety and outcomes.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.

However:

- The hospital did not meet targets for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training.
- The trust policy for Mental Capacity Act and Deprivation of Liberty was brief and did not direct staff to guidance or tools for use by staff. Guidance available was incorrect and not in line with the Mental Capacity Act or the code of practice.
- Meetings with directorate managers and trust senior managers did not give assurance that they were aware of these concerns before the inspection. We were given assurance that these issues would be addressed as a matter of urgency.
- Medical and nursing records were not stored securely in all of the areas we visited.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered. Equality and diversity were not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The hospital had enough staff with the right skill mix for the care and treatment of patients requiring non-invasive ventilation (NIV). Escalation plans, clinical pathways, separate treatment areas and the assessment of staff competence had been developed.
- There was a standardised and documented clinical pathway for the care and treatment of patients requiring NIV across the trust.
- When things went wrong patients received an apology and were given information about changes the service made to prevent the same thing happening.
- The trust reported no incidents classified as never events and staff recognised incidents and knew how to report them.
- Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Staff understood and followed procedures to protect vulnerable adults or children.
- The directorate had plans for dealing with major incidents and staff understood their roles. The plans had been tested and reviewed.
- The wards and directorate areas were clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.

However:

- Medical and nursing records were not stored securely in all of the areas we visited.
- Overall compliance with mandatory training was 54% against a target of 95%.

Medical care (including older people's care)

Is the service effective?

Good 

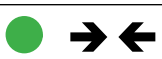
Our rating of effective stayed the same. We rated it as good because:

- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Managers monitored the effectiveness of care and treatment through continuous local and national audits.
- Outcomes for patients were good.
- The electronic patient record system provided up to date patient clinical information available to all members of staff.
- Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care.

However:

- The trust did not meet targets for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Only 30% of staff had been trained in the MCA, and just 32 % of staff had been complaint with DOLS training.
- The trust policy for Mental Capacity Act and Deprivation of Liberty was brief and did not direct staff to guidance or tools for use by staff. Guidance available was incorrect and not in line with the Mental Capacity Act or the code of practice.

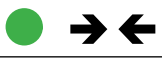
Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- Wards had literature and resources available for people living with and caring for people with a dementia.
- The directorate treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Medical care (including older people's care)

- The directorate planned and provided services in a way that met the needs of local people. They worked with commissioners, external providers and local authorities.
- Estimated dates of discharge were planned for all patients. The discharge management team supported patients and staff with complex discharges.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

- The directorate had a clear vision and strategy that all staff understood and put into practice.
- The directorate had governance, risk management and quality measures to improve patient care, safety and outcomes.
- Staff and managers were clear about the challenges the directorate faced. They explained the risks to the directorate and the plans to deal with them.
- The directorate had a clear management structure at both directorate and care group level. Managers knew about the quality issues, priorities and challenges.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- We saw innovative practice in 'Think Kidneys' awareness, undernutrition, clinical photography, cancer studies, dermatology and the weight and wellbeing service.

However:

- At the time of inspection we had concerns about Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training and the trust policy for Mental Capacity Act and Deprivation of Liberty. Only 30% of staff had been trained in the MCA, and just 32 % of staff had been complaint with DOLS training.
- Overall compliance with mandatory training was 54% against a target of 95%.
- Meetings with directorate managers and trust senior managers did not give assurance that they were aware of these concerns before the inspection. We were given assurance that these issues would be addressed as a matter of urgency.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered. Equality and diversity were not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, did not always feel they were treated equitably.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Requires improvement 

Key facts and figures

Darlington Memorial Hospital was previously inspected in February 2015. Safe, effective, caring and responsive and well-led were rated as good within surgery at this hospital.

Surgical services operate at three main sites with elective and emergency surgery undertaken at two main sites (Darlington Memorial Hospital and University Hospital North Durham). Day surgery takes place at Shotley Bridge Hospital. The trust has 222 inpatient surgical beds. The trust confirmed that their surgical activity in 2016 / 2017 had included 55,952 operations. A breakdown of this activity identified the following surgical episodes: 37,241 – day case, 6,646 – elective in patient, 12,065 – non elective in patient and 245,859 outpatient contacts. Within surgery, urology, vascular and ophthalmology close working relationships exist with other NHS Trusts within the North East.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Seven never events occurred between May and October 2016. The trust took actions to address this. However a further four never events occurred at the trust between November 2016 and May 2017. The trust took further action but despite this two further never events occurred after September 2017.
- Operating theatres were not fully established against the 'Association for Perioperative Practice' (AfPP staffing recommendations). Staffing levels at night and on late shifts fell below recommended guidance.
- Limited sepsis training was available to staff.
- We raised concerns with the trust that equipment servicing had not taken place. The trust said a new system was implemented and equipment service records were up to date. We did not receive documentary confirmation that the equipment whose service dates had passed were serviced.
- Gaps in information were observed in some of the patient records we reviewed. Staff signatures were not always recognisable and signatures were not printed.
- Theatre staff said they had not attended regular training, as they were too busy to attend.
- Task and finish groups were still in progress working on culture issues in theatres, further improvements needed to be embedded.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered. Equality and diversity were not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed.
- There had been high rates of falls which met the serious incident criteria and amounted for around a third of all incidents.
- Treatment delay and a failure to act on test results together accounted for 38% of all serious incidents.

However:

Surgery

- There had been some learning from surgical never events and identified the changes in clinical practice which resulted. More recent audits of the 'World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery showed improvement.
- Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Concerns and complaints were taken seriously, investigated, lessons learned, and outcomes shared with all staff.
- Staff had an understanding of how to raise safeguarding concerns.
- People gave positive feedback about the care they received. They said they were involved in decisions about their care and staff considered their emotional as well as physical needs.
- Staff treated patients with compassion, dignity and respect.
- Referral to treatment (RTT) times admitted performance was above the England average. Where RTT shortfalls existed, the trust had identified actions to improve performance.
- The service was responsive to people's needs and worked with external providers to improve people's care and access to care pathways.
- Staff across both hospitals said joint working between surgical services had strengthened.
- Staff said they felt supported by their immediate management teams and matrons were visible in clinical areas.
- Care was provided in line with NICE guidance CG50 (Acutely ill adults in hospital: recognising and responding to deterioration). Patient's risks were assessed to determine their fitness for surgery. The service had protocols and guidelines in place to assess and monitor patient risk in real time.
- Staff provided care and treatment based on national guidance.
- The trust vision and strategy was understood by staff and put into practice.
- The surgical care group had implemented governance, risk management and quality measures to improve patient care, safety and outcomes.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care and treated patients with compassion, treating them with dignity and respect.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Learning from never events had not been embedded. Risks to patients existed as a result of this and safety needed to be further prioritised.
- Operating theatres were not fully established against the 'Association for Perioperative Practice' (AfPP staffing recommendations). Staffing levels at night and on late shifts fell below recommended guidance.
- Limited sepsis training was available to staff.

Surgery

- We raised concerns with the trust that equipment servicing had not taken place. The trust said a new system had been implemented and equipment service records were up to date. We did not receive documentary confirmation that the equipment whose service dates had passed were serviced.
- Gaps in information were observed in some of the patient records we reviewed. Staff signatures were not always recognisable and signatures were not printed.
- There had been high rates of falls which met the serious incident criteria and amounted for around a third of all incidents.
- Treatment delay and a failure to act on test results together accounted for 38% of all serious incidents.

However:

- Staff demonstrated some learning from surgical never events in some areas and identified the changes in clinical practice which resulted.
- The service identified guidelines and protocols to assess and monitor patient risk in real time, and react to changes in risk level.
- Recent audits of the 'World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery had shown improvements.
- Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Staff had an understanding of how to raise safeguarding concerns.
- Staff understood and could describe what to do when they believed a patient was at risk of abuse. Staff received training and managers discussed safeguarding themes with their teams each month.
- Records showed risk assessments were completed at each stage of the patient journey from admission to discharge, with the National Early Warning Score (NEWS) system used for the management of deteriorating patients. We observed theatre staff practice the 'Five Steps to Safer Surgery' and complete the World Health Organisation (WHO) checklist appropriately.
- All the staff we spoke with were aware of the safeguarding policies and procedures and had received training.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- Staff provided care and treatment based on national guidance and service policies reflected this.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Staff made sure that patients had enough to eat and drink when they needed it. They supported vulnerable patients who had additional needs or could not eat or drink themselves.
- Staff at all levels and from all disciplines worked together as a team for the benefit of their patients. Staff also worked closely with teams outside the hospital when preparing to discharge patients.
- Outcomes for patients were generally good

Surgery

- Mental capacity assessments were undertaken and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion and treated them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good because:

- Managers planned and provided services in a way that met the needs of local people. They were flexible and made changes to improve services and support patients more effectively.
- Staff took account of patients' individual needs, particularly for patients with dementia, learning disabilities, and mental health problems through champions and advocates.
- The hospital had an escalation policy and procedure to deal with busy times and matrons and ward managers held capacity bed meetings to monitor bed availability.
- The service was responsive to the needs of patients living with dementia and learning disabilities. The surgical division had dementia champions. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.

However;

- There were high numbers of treatment delay and a failure to act on test results

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- There was a need to more strongly embed learning from never events in order to minimise risk to patients.
- None of the staff who should have undergone safeguarding children level 3 had done so up to March 2017.
- Staff identified poor engagement from senior management with theatres. Senior managers were told of a perceived communication deficiency from senior management.

Surgery

- Staff were not always able to articulate the vison or strategy, or say how they would contribute to the strategy, although they told us their aim was to do their best for patients.
- The culture review in theatres had identified problems within the theatres culture. The outcome of this review resulted in the development of an action plan, which had been instigated but changes were yet to be embedded.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered.

However:

- Monthly joint clinical governance and directorate meetings took place. The directorate risk register was updated following these meetings and we saw that action plans were monitored across the division. Staff said managers were available, visible, and approachable. They also said leadership of the service and staff morale was good with staff supported at ward level.
- A culture review action plan was in place following the culture review in theatres.
- A 'task and finish' group was recently implemented to discuss theatre staffing and agree actions and progress made in this area.
- The directorate risk register was updated following these meetings and we saw that action plans were monitored across the division.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience. Staff on the wards and in theatres worked well together with respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Managers monitored performance and used the results to help improve care. All staff identified risks to good care and the service took action to eliminate or minimise risks.
- Managers supported their staff and encouraged training. Staff said they felt supported and respected by colleagues at all levels and that this had improved since the last inspection.
- Staff told us they received feedback at monthly or bimonthly ward meetings.
- A governance framework was in place and regular governance meetings took place attended by the multi-disciplinary team.
- Most of the 'National Safety Standards for Invasive Procedures' (NatSSIPs) had been implemented trust wide. The NatSSIPs were fully implemented in theatres.
- A surgical risk register identified current risks, the risk rating, actions and review dates. Staff showed an awareness of the risks through discussion.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience. Staff on the wards and in theatres worked well together with respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

Darlington Memorial Hospital provided maternity services for County Durham and Darlington NHS Foundation Trust. The maternity services offered at the Darlington Memorial Hospital consisted of antenatal, intrapartum and postnatal services. There were obstetric outpatient clinics, pregnancy assessment unit, delivery suite, with its own dedicated theatre, antenatal and postnatal ward , and a special care neonatal unit. There was also a community midwifery team, assessment unit and outpatient clinic at Bishop Auckland community hospital. The service delivered 4898 babies between April 2016 and March 2017.

We carried out a focussed unannounced inspection. We looked at all areas within all domains.

We visited the labour ward, the antenatal and postnatal ward, the pregnancy assessment unit and antenatal clinic. We spoke with16 staff, nine women, and three of their partners or relatives. We also reviewed 12 sets of records as part of the inspection.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- There was a newly formed senior leadership team in the maternity service covering business, midwifery and clinical leadership. We found that this team was cohesive and that there was a real drive to continue to improve the quality of the service. There were no concerns around bullying or challenging behaviour.
- Staff were encouraged and knew how to report incidents. We saw evidence from actions plans and root cause analysis that serious incidents were identified and investigated appropriately.
- There was a full and robust system to review cases at risk meetings. Completion of the World Health Organisation surgical safety checklist was closely monitored and regularly met trust targets.
- Recommended midwifery to birth ratios were met.
- Recruitment of medical staff had improved with good support for junior and middle grades from consultants.
- Midwifery staff had a competency framework which evidenced their progression from preceptorship. Development of midwives continued to a senior level.
- Guidelines and action plans were in place, regularly reviewed and ratified at formal, planned meetings.
- Changes in practice were based on national guidelines and best practice, then audited to ensure they were embedded throughout the team.
- Patient outcomes were in line with national averages.
- Women we spoke to all felt involved in their care and had been provided with information to allow them to make informed decisions.
- Staff were compassionate and caring and there were counselling and bereavement services available in the unit when required.
- All women had a named midwife and staff were available if they needed them.

Maternity

- Patient pathways and flow through departments was planned and reviewed.
- Effective governance structures were in place.
- Staff spoke positively about their leaders and felt respected. Plans were in place to strengthen clinical leadership.
- Teams were working proactively with local networks to improve outcomes.

However:

- Results from the National neonatal audit programme (NNAP) indicated some lower than average standards; for example in the percentage of mothers who were given antenatal steroids and also the percentage of premature babies who had their temperature taken within an hour of being born.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good because:

- Staff were aware of and followed the process to follow to report incidents.
- Weekly risk meetings were held to discuss incidents and key messages in various formats informed all staff of lessons learned. Risks were managed following national guidelines and best practice.
- Paper records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how they were to be managed. An electronic record of observations was relatively new and staff were competent in its use.
- There was a monthly programme of skills and drills that took place within the department, usually based on recent risks.
- The completion of the World Health Organisation (WHO) surgical safety checklist was previously not meeting trust targets. However, this had been addressed and monthly audits showed compliance rates were more consistent and much improved.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review fetal heart tracings.
- Risk assessments were carried out throughout the patient pathway for all women using trust guidance to determine whether individuals were high or low risk, from antenatal booking to postnatal discharge to health visitors and community midwives.
- Recommended midwifery to birth ratios were met.
- Recruitment of medical staff had improved with good support for junior and middle grades from consultants.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

- Midwifery staff had a competency framework which evidenced their progression from preceptorship. Development of midwives continued to a senior level.

Maternity

- Guidelines and action plans were in place, regularly reviewed and ratified at formal, planned meetings.
- Changes in practice were based on national guidelines and best practice, then audited to ensure they were embedded throughout the team.
- Patient outcomes were in line with national averages.
- A full seven day service was provided.
- A range of effective pain relief was available for women.
- The women we spoke to in midwifery said they felt they were in control and pain relief was good.
- Midwifery staff on duty highlighted any patients at medical or social risk and reviewed their care with the wider team

However:

- Results from the National neonatal audit programme (NNAP) indicated some lower than average standards; for example in the percentage of mothers who were given antenatal steroids and also the percentage of premature babies who had their temperature taken within an hour of being born.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Women we spoke to all felt involved in their care and had been provided with information to allow them to make informed decisions.
- Friends and family test data for maternity services from June 2015 (NHS England) showed very positive responses with 92-97% recommending services at the trust. Staff told us their feedback showed 100% positive responses.
- Staff were compassionate and caring and there were counselling and bereavement services available in the unit when required.
- All women had a named midwife and staff were available if they needed them.
- Following patient feedback, the department had made provision for partners to stay on the ward.
- Single rooms were provided for medical management of pregnancy or miscarriage.
- Families were encouraged to be involved in the care of vulnerable patients such as those with learning disabilities and teenage pregnancies.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Patient pathways and flow through departments was planned and reviewed.
- Staff had identified opportunities to improve patient pathways and flow through departments and had introduced a new transitional care pathway.

Maternity

- The trust served a community with a wide range of needs and there were good systems in place to ensure effective communication.
- The trust identified the demands on services and business planning was aligned to this.
- Complaints were discussed and recommendations given and learning from complaints took place in a multidisciplinary forum.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- There was a newly formed senior leadership team in maternity. The team was cohesive and there was a real drive to improve the quality of the service. The team were aware of the challenges and were able to articulate the actions required to take the service forward.
- Plans were ongoing concerning the configuration of maternity services. Whilst the trust continued to develop an overall strategy and supporting plans, the final configuration of services within the trust, would be determined through the work on the Sustainability and Transformation Plans (STP) in the North and South of the North East health economy
- Effective governance structures were in place.
- Staff spoke positively about their leaders and felt respected. Plans were in place to strengthen clinical leadership.
- We spoke with staff who were very engaged and felt involved in the service and its continuing development; this was evident throughout the service.
- There local leadership multidisciplinary team had been restructured, was strong and effective. This was evident throughout all parts of the service.
- There had been some very positive changes in culture and behaviours, especially amongst the consultant cohort.
- All areas we visited were patient focussed; this was evident from speaking with staff and patients.

Outstanding practice

- The transitional care team had won the service improvement award in the annual staff awards and was shortlisted for the Royal College of Midwives (RCM) annual midwifery awards 2017. The trust had identified a way of providing care for vulnerable babies outside of NNU. They had employed and set up a training course for transitional care baby support workers. These were support staff, dedicated to work with babies, parents and staff including paediatricians during transitional care. They helped to ensure babies could be cared for on the ward and avoid where possible admission to the neonatal unit. Staff told us there had been significant positive outcome results following implementation of this role.
- The team are involved in Wave 2 of the National Maternity and Neonatal Safety Collaborative. This work was recognised nationally when a member of the team was asked to speak at the RCOG Each Baby Counts conference in 2016.

- The majority of staff were trained in recruiting and supporting clinical research projects. The team had been recognised nationally for recruiting to an industry trial for the blind testing of prophylactic antibodies in patients following instrumental deliveries.
- UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast feeding and promote parent/infant relationships. The trust told us that the north of the service had successfully achieved UNICEF recognition for its breastfeeding support and had been recommended to apply for gold accreditation in June 2017.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

University Hospital North Durham

North Road
Durham
County Durham
DH1 5TW
Tel: 01325380100
www.cddft.nhs.uk

Key facts and figures

The University Hospital North Durham is one of two acute hospitals forming County Durham and Darlington NHS Foundation Trust. It has 460 beds.

The University Hospital North Durham provides medical, surgical, critical care and maternity services, and services for children and young people in County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside. The hospital also provides emergency and urgent care (A&E) and outpatient services.

We inspected only emergency and urgent care, medical care, surgery and maternity services at this visit. Between February 2016 and January 2017, there were 285,774 emergency department attendances in County Durham and Darlington NHS Foundation Trust. This equates to an average of 789 patients a day.

The trust had 63,037 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 30,224 (48%), 656 (1%) were elective, and the remaining 32,157 (51%) were day case.

The trust confirmed the surgical activity in 2016 / 2017 had included 55,952 operations. A breakdown of this activity identified the following surgical episodes: 37,241 – day case, 6,646 – elective in patient, 12,065 – non elective in patient and 245,859 outpatient contacts. Between April 2016 and March 2017 the trust delivered 4898 babies.

Summary of services at University Hospital North Durham

Requires improvement 

Our rating of services stayed the same. We rated it them as requires improvement because:

- We rated safe, effective and well led as requires improvement; caring and responsive were rated as good.
- Overall, surgery had gone down one rating to requires improvement overall, urgent and emergency care stayed the same since our last inspection. Maternity services and medical care had improved.
- Within urgent and emergency care, consultant presence in the departments did not meet the RCEM guidance of consultant presence of 16 hours a day. ST3 doctors (those in year three of speciality training) were part of the middle grade rota. This goes against the RCEM guidance that a minimum of an ST4 or equivalent is in the department at all times.
- Within urgent and emergency care, the service did not always manage medicines well.

Summary of findings

- Within urgent and emergency care, the department missed key targets for caring for patients promptly. Patients did not always get a face-to-face assessment within 15 minutes of arrival or registration. Patients brought in by ambulance were not always handed over to the department within 30 minutes and this was getting worse.
- Within urgent and emergency care, staff did not record patient care consistently.
- Within medical care services at University Hospital North Durham, members of staff did not comply with hospital policy on the administration of covert medicines. We found evidence of staff providing medication covertly for patients without ensuring capacity assessments were in place.
- Within medical care services, medical and nursing records were not stored securely in all areas we visited.
- Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They did not support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- The hospital did not meet targets for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training. The knowledge and practice of staff on the wards raised concern over the effectiveness and numbers trained.
- Eleven never events were reported over 13 months from May 2016 to May 2017. Joint working with stakeholders and a trust wide programme of learning had taken place following these never events reduce risks of harm to patients; however, despite this, two further never events occurred after September 2017. There were unacceptable numbers of never events and a strong need to further embed safer practices and learning across the trust.

However:

- In most areas nurse staffing had improved.
- Staff investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Wards and department areas were clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.
- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- The hospital escalation policy and procedure guidance was followed during busy times.

Urgent and emergency services

Requires improvement 

Key facts and figures

The trust provided urgent and emergency care service at the University Hospital North Durham and at Darlington Memorial Hospital. Community urgent care centres are at both those hospitals and at community hospital. We did not inspect the urgent care centres during this inspection visit.

The emergency departments at the University Hospital North Durham provided a 24-hour, seven-day a week service to the local population. Between February 2016 and January 2017, there were 70,151 emergency department attendances at University Hospital North Durham. This equates to an average of 192 patients a day.

The emergency department at Durham is a designated trauma unit but more severely injured patients go to the nearest major trauma centre if their condition allows them to travel directly. Otherwise, they would be stabilised at Durham and staff would follow a protocol to decide which patients they could treat or would have to transfer.

The department has two resuscitation bays, one of which is specially equipped for children. There are 11 cubicles to treat patients with major injuries and illnesses, two children's 'major' cubicles, which could also be used for adults, a triage room, and a treatment room. A monitoring bay has six cubicles and five single rooms in a short stay area for patients who need monitoring following a head injury or patients with complex social needs. The department has a separate prisoner waiting room for the use of prisoners from the nearby prison. The trust's strategy includes a plan to co-locate urgent care services, which include GP services.

Patients who go to the hospital with minor injuries or illnesses register with reception before a triage nurse assesses them.

On this recent inspection in 2017, we inspected the whole core service and looked at all five key questions. In order to make our judgements, we spoke with six patients, five carers and 34 staff from different disciplines, including nurses, doctors, managers, support staff and ambulance staff. We observed daily practice and viewed 34 sets of records. Before and after our inspection, we reviewed performance information about the trust and reviewed information provided to us by the trust.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not meet the Department of Health's target of 95% of patients admitted, transferred or discharged within four hours of arrival at the department.
- The department missed key targets for caring for patients promptly. Patients did not always get a face-to-face assessment within 15 minutes of arrival or registration. Patients brought in by ambulance were not always handed over to the department within 30 minutes and this was getting worse. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The hospital did not meet this standard for every month between September 2016 and August 2017.
- The room used to assess patients with mental health needs, did not conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.
- The service did not always have enough staff of the right level to keep patients safe from avoidable harm.
- The service did not always manage medicines well.

- Managers did not update or review care pathways regularly.
- Nursing staff looking after children were not aware competency principles when assessing capacity, decision making and obtaining consent.
- Staff did not always record patients' blood sugar levels when necessary.
- Compliance with some mandatory training subjects was well below trust targets.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered.

However:

We found some improvements since the last inspection.

- The service had improved on many of the issues for action highlighted in the previous inspection. It had a clear vision and strategy. The department had governance, risk management and quality measures in place to improve patient care, safety and outcomes.
- Cleanliness of the department had improved.
- Paediatric nurse staffing had increased. Advanced nurse practitioner roles had been appointed to support the medical rota and additional alternative roles were being introduced.
- A new escalation process was introduced to improve patient flow through the department to the rest of the hospital
- The difficult airway trolley had been standardised throughout the trust.
- The department had improved the care of patients requiring non-invasive ventilation (NIV).
- Resuscitation equipment and fridge temperatures were checked daily.
- Staff we spoke with had undertaken a two-day violence and aggression training. The lack of training was noted in the previous inspection.
- Staff recognised incidents and knew how to report them. Lessons learnt were shared amongst staff.
- Staff kept patients safe from harm from abuse.
- Staff were able to identify and respond appropriately to patients at risk of deteriorating.
- Staff provided care and treatment based on national guidance and evidence and audits took place.
- Patients had their pain monitored effectively and re-attendance rates were better than the national standard and England average.
- Staff cared for patients with compassion, dignity and respect. We received positive feedback from patients and carers.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not always have enough staff of the right level to keep patients safe from avoidable harm. During the last inspection, the service was asked to review the number of consultants against the Royal College of Emergency

Medicine (RCEM) guidance. Although the department had employed two new consultants, consultant presence in the department did not meet the RCEM guidance of 16 hours a day. ST3 doctors (those in year three of speciality training) were part of the middle grade rota. This goes against the RCEM guidance that a minimum of an ST4 (doctor in year four of speciality training) or equivalent is in the department at all times.

- The service did not always manage medicines well. Controlled drugs balance checks were not always carried out. Intravenous infusions containing potassium were not stored separately and oxygen therapy was not prescribed in accordance with current national guidelines. In the short stay area, patients' own medications were stored together with their notes and not in a locked cupboard.
- Staff documented all patients' allergy status but did not give name bands and red allergy bands to all patients.
- Although the service had a separate room to assess patients with mental health needs, it did not conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.
- Patients in cubicles, which were not visible from the nurses' station, did not have access to call bells.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The hospital did not meet this standard for every month between September 2016 and August 2017. This hospital performed consistently worse than the England average
- The department missed key targets for caring for patients promptly. Patients did not always get a face-to-face assessment within 15 minutes of arrival or registration. Patients brought in by ambulance were not always handed over to the department within 30 minutes and this was getting worse. A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The number of black breaches was high.
- Staff did not record patient care consistently. The records did not always show whether patients had received nursing care because staff did not always complete the nursing assessments.
- The number of children's nurses on duty did not meet the Royal College of Nursing guidance. However, paediatric nurse staffing had increased following the last inspection. Paediatric nurses provided cover between 7.30am and 8pm. Out of these hours, there was support from the nurses from the paediatric ward.
- Compliance with some training subjects was well below trust targets; for example nutrition training was 36%; dementia awareness was 46%; mental capacity act training was 15%. The trust target for all these subjects was 95%.
- We reviewed eight weeks of nursing rotas and found the percentage of unfilled qualified nurse shifts was an average 16%. The unqualified nurse unfilled shifts were an average of 9%.
- Around 52% of staff had been complaint with core training against a trust target of 95%.

However:

- The cleanliness of the department had improved since the last inspection with the increase of domestic cover and a new cleaning schedule for children's toys in the children's waiting room. Cubicle cleaning checklists had been introduced and they had been completed daily. The department was clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.
- During the last inspection, staff did not know where the difficult airway trolley was kept. Staff were now able to locate it when asked and the equipment had been standardised throughout the trust.
- Staff now checked resuscitation equipment daily and checked the anaphylaxis kits and grab bags regularly.
- When things went wrong patients received an apology and were given information about changes the service made to prevent the same thing happening.

Urgent and emergency services

- Staff recognised incidents and knew how to report them. Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable adults or children.
- Staff now checked the medication fridge temperatures daily to ensure that drugs were stored safely.
- Patient group directions (which allow staff to give prescription medicines to a predefined group of patients without them having to see a doctor) were all up-to-date and signed by the nurses who used them in line with trust policy.
- Staff were able to identify and respond appropriately to patients at risk of deteriorating. They used the National Early Warning Scores (NEWS) effectively.
- Between September 2016 and August 2017, this hospitals unplanned re-attendance rate to the department within seven days was consistently better than the national standard of 5% and consistently better than the England average.
- There was appropriate skill mix and an internal bank of nurses was used. Advanced nurse practitioner roles had been recently appointed to support the medical rota and additional roles were being introduced.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- Staff provided care and treatment based on national guidance and evidence, and used this to develop new policies and procedures.
- The department had improved the care of patients requiring non-invasive ventilation (NIV).
- Managers monitored the effectiveness of care and treatment through continuous local and national audits.
- New staff received a package of support including a mentor, an induction programme and a period of working supernumerary, which was flexible according to their previous experience and training.
- Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff we spoke with had undertaken a two-day violence and aggression training. The lack of training was noted in the previous inspection.
- Staff used a pain score tool to assess if a patient had pain. The majority of patients had a pain score recorded. We observed the triage nurse giving timely pain relief to adults and children.
- Staff offered patients food and drinks and monitored patients' nutrition and hydration effectively.
- The trust's unplanned re-attendance rate to the emergency department was consistently better than the national standard and the England average.

However,

- Clinicians did not update or review care pathways regularly.
- Nursing staff looking after children were not aware of the Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children.
- Staff did not record patients' blood sugar levels recorded when necessary.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion, treating them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service did not meet the Department of Health's target of 95% of patients admitted, transferred or discharged within four hours of arrival at the department. It breached this target 11 times between October 2016 and September 2017.
- Over the 12 months from August 2016 and July 2017, four patients trust wide waited more than 12 hours from the decision to admit until being admitted.
- Between September 2016 and August 2017 the percentage of patients monthly leaving this hospital before being seen for treatment was consistently worse compared to the England average.
- Between September 2016 and August 2017, the median time spent in the department was consistently higher than the England average.

However:

- Since the previous inspection, the department had introduced a new escalation process and framework to provide a consistent approach in times of pressure.
- Staff made every effort to make sure they saw patients who came to the department. The number of patients leaving the department before being seen was below the England average.
- The percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was similar to the England average.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Urgent and emergency services

- The trust planned and provided services in a way that met the needs of local people. They worked with commissioners, external providers and local authorities. Since the previous inspection, the trust had increased mental health provision, providing 24 hours a day access to the mental health liaison team who were on site and provided a rapid assessment of patients with mental health needs within one hour.
- A short-stay area provided overnight care for patients with complex discharge needs.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- The service had improved on many of the issues for action highlighted in the previous inspection.
- The service had a clear vision and strategy for the department, which looked to transform patient access to urgent and emergency care. The strategic plan for this service set out defined realistic objectives for the future growth and sustainability of the department in line with national priorities. These included short, medium and long-term plans to co-locate urgent care services and commence GP streaming.
- The department had governance, risk management and quality measures to improve patient care, safety and outcomes. The governance system supported the strategy and provided continuing assurance up to board level with the clear focus on patient safety.
- The emergency department had a clear management structure at both divisional and departmental level. The managers knew about the quality issues, priorities and challenges.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- There were high levels of staff satisfaction within the service within the staff we spoke with. Staff we spoke with were proud of being a part of the department and felt very well supported
- Staff at all levels were encouraged and supported to explore innovative ways of working, leaders drove continuous improvement, and there was a clear, proactive approach to seeking out and embedding new and more sustainable models of care.
- The department had plans for dealing with major incidents and staff understood their roles. The plans had been tested and reviewed.

However:

- Not all risks were identified by the department and risk assessments were not carried out for patients with mental health needs.
- The department missed key national targets for dealing with patients promptly, for example the four hour waiting time targets.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered. Equality and diversity were not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, did not always feel they were treated equitably.

Urgent and emergency services

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Medical care (including older people's care)

Good ↑

Key facts and figures

The medical care service at the trust provides care and treatment for 24 specialties. There were 580 medical inpatient beds across 25 wards.

The University Hospital North Durham provided medical care in 322 beds across twelve wards.

The trust had 63,037 medical admissions between February 2016 and January 2017. Emergency admissions accounted for 30,224 (48%), 656 (1%) were elective, and the remaining 32,157 (51%) were day case.

Admissions for the top three medical specialties were:

- General Medicine; 27,222
- Gastroenterology; 12,614
- Clinical Haematology; 4,664

(Source: CQC Insight)

University Hospital North Durham was previously inspected in February 2015. All five domains were inspected and an overall rating of requires improvement was given. Safe and effective were rated as requires improvement. Caring and responsive and well-led were rated as good.

The main areas of concern from the last inspection in February 2015 and the actions the trust were told they must take were:

- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance and taking into account patients' dependency levels, on medical wards, particularly where patients are receiving non-invasive ventilation (NIV) and require level 2 intervention.
- Undertake a review of current documentation relating to the care and management of patients receiving NIV to ensure that it is consistent across both the University Hospital North Durham and Darlington Memorial Hospital.
- Have arrangements in place for patients receiving NIV that comply with the British Thoracic Society guidelines (2008) for the use of NIV for acute exacerbation of chronic obstructive pulmonary disease.
- Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and of appropriate quality.
- Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with best practice guidance.

We also said that the trust should take action to improve:

- Review dedicated management time allocated to ward managers.
- Review the flow of higher dependency patients throughout the hospital to ensure care is given in the most appropriate setting.
- Have an up-to-date standard operating procedure (SOP) which clearly sets out the management of patients requiring NIV who are admitted to both acute hospitals.

Medical care (including older people's care)

- Ensure that this guidance/SOP includes clarity on the setting/specific ward in which patients can be managed.
- Ensure that this guidance/SOP includes staffing-to patient ratios that are in line with current guidance.
- Ensure that there is a plan in place to deliver training to all staff involved in the care of patients receiving NIV, and that it is competency-based and in sufficient detail to demonstrate competence in all aspects of NIV.
- Ensure that any guidance or standard operating procedure includes an escalation plan of action to be taken when no bed is available in an appropriate setting and when patient numbers do not match agreed staffing ratios.

During this inspection we visited wards 1 (elderly care), 2 (stroke), 5 (elderly care, dermatology), 6 (respiratory), the coronary care unit, endoscopy, the acute medical unit and ambulatory care and the discharge lounge.

We spoke with 44 patients and relatives and 56 members of staff. We observed care and treatment and looked at 34 care records.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The hospital had enough staff with the right skill mix for the care and treatment of patients requiring non-invasive ventilation (NIV). Escalation plans, separate treatment areas and the assessment of staff competence had been developed.
- There was a standardised and documented clinical pathway for the care and treatment of patients requiring NIV across the trust.
- The wards and directorate areas were clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.
- Staff understood and followed procedures to protect vulnerable adults or children.
- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care.
- Staff cared for patients with compassion, treating them with dignity and respect and involved patients and those close to them in decisions about their care and treatment.
- The directorate treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The directorate had a clear vision and strategy that all staff understood and put into practice.
- The directorate had governance, risk management and quality measures to improve patient care, safety and outcomes.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.

However:

- Members of staff did not comply with hospital policy on the administration of covert medicines.

Medical care (including older people's care)

- We found evidence of staff providing medication covertly for patients without ensuring capacity assessments were in place. We pointed this out at the time and this was addressed immediately by the trust.
- Staff did not understand their roles and responsibilities under the Mental Capacity Act 2005. They did not always follow legislation to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- The trust did not meet targets for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training. The knowledge and practice of staff on the wards raised concern over the effectiveness of training and numbers trained.
- The trust policy for Mental Capacity Act and Deprivation of Liberty was brief and did not direct staff to guidance or tools for use by staff. Guidance available was incorrect and not in line with the Mental Capacity Act or the code of practice.
- At the time of inspection we had concerns about Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training, the knowledge and practice of staff on the wards related to capacity assessments and DoLS applications and the trust policy for Mental Capacity Act and Deprivation of Liberty.
- Medical and nursing records were not stored securely in all areas we visited.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The hospital had enough staff with the right skill mix for the care and treatment of patients requiring non-invasive ventilation (NIV). Escalation plans, clinical pathways, separate treatment areas and the assessment of staff competence had been developed.
- There was a standardised and documented clinical pathway for the care and treatment of patients requiring NIV across the trust.
- Risks to patients were appropriately escalated.
- When things went wrong patients received an apology and were given information about changes the service made to prevent the same thing happening.
- The trust reported no incidents classified as never events and staff recognised incidents and knew how to report them.
- Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Staff understood and followed procedures to protect vulnerable adults or children.
- The directorate had plans for dealing with major incidents and staff understood their roles. The plans had been tested and reviewed.
- The wards and directorate areas were clean and equipment well maintained. Staff followed infection control policies that managers monitored to improve practice.

However:

- Members of staff did not comply with hospital policy on the administration of covert medicines.

Medical care (including older people's care)

- We found evidence of staff providing medication covertly for patients without ensuring capacity assessments were in place. This was addressed immediately by the trust after we raised this with them.
- Medical and nursing records were not stored securely in all areas we visited.

Is the service effective?

Requires improvement 

Our rating of effective stayed the same. We rated it as requires improvement because:

- The trust did not meet targets for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training. The knowledge and practice of staff on the wards raised concern over the effectiveness and numbers trained.
- The trust policies 'Policy and guidance notes for staff on the Mental Capacity Act 2005' (reviewed January 2017) and 'Deprivation of Liberty Safeguards' (reviewed December 2016) did not direct staff to guidance or tools for use by staff.
- Staff did not understand their roles and responsibilities under the Mental Capacity Act 2005. They did not always follow legislation to support patients who lacked the capacity to make decisions about their care.

However:

- Staff provided care and treatment based on national guidance and evidence and used this to develop new policies and procedures.
- Managers monitored the effectiveness of care and treatment through continuous local and national audits.
- Outcomes for patients were good.
- The electronic patient record system provided up to date patient clinical information available to all members of staff.
- Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion and treated them with dignity and respect.
- Patients, families and carers gave positive feedback about their care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients.

Is the service responsive?

Good 

Medical care (including older people's care)

Our rating of responsive stayed the same. We rated it as good because:

- Wards had literature and resources available for people living with and caring for people with a dementia or those with special needs.
- The directorate treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The directorate planned and provided services in a way that met the needs of local people. They worked with commissioners, external providers and local authorities.
- Estimated dates of discharge were planned for all patients. The discharge management team supported patients and staff with complex discharges.
-

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- The directorate had a clear vision and strategy that all staff understood and put into practice.
- The directorate had governance, risk management and quality measures to improve patient care, safety and outcomes.
- Staff and managers were clear about the challenges the directorate faced. They explained the risks to the directorate and the plans to deal with them.
- The directorate had a clear management structure at both directorate and care group level. The managers knew about the quality issues, priorities and challenges.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- We saw innovative practice in 'Think Kidneys' awareness, undernutrition, clinical photography, cancer studies, dermatology and the weight and wellbeing service.

However:

- At the time of inspection we had concerns about Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training, the knowledge and practice of staff on the wards related to capacity assessments and DoLS applications and the trust policy for Mental Capacity Act and Deprivation of Liberty Safeguard's.
- Staff satisfaction was mixed according to the staff survey. Staff did not always feel actively engaged or empowered.
- Equality and diversity were not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, did not always feel they were treated equitably.
- Meetings with directorate managers and trust senior managers did not give assurance that they were aware of these concerns before the inspection. We were given assurance that these issues would be addressed as a matter of urgency.

Medical care (including older people's care)

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Requires improvement  

Key facts and figures

The University Hospital North Durham (UHND) was previously inspected in February 2015. The five domains were inspected and an overall rating of good was given in 2015. After this inspection we rated surgery as requires improvement. Safe and well led were rated as requires improvement; effective, caring, responsive, and well led were rated as good.

Surgical services operated at three main sites with elective and emergency surgery undertaken at two main sites (Darlington Memorial Hospital and University Hospital North Durham). Day surgery took place at Shotley Bridge Hospital. The trust had 222 inpatient surgical beds. In 2016, the service undertook approximately 4,800 operations.

Within surgery, the services of urology, vascular and ophthalmology had close working relationships with other NHS Trusts within the North East.

Surgical clinical services at the hospital included, ear, nose and throat surgery; orthopaedics, vascular surgery, colorectal surgery, ophthalmology and endoscopy. Anaesthetics and critical care services supported surgery on this site.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- Seven never events occurred between May and October 2016. The trust took actions to address this. However a further four never events occurred at the trust between November 2016 and May 2017. The trust took further action but despite this two further never events occurred after September 2017
- Operating theatres were not fully established against the 'Association for Perioperative Practice' (AfPP staffing recommendations). Staffing levels at night and on late shifts fell below recommended guidance.
- Limited sepsis training was available to relevant staff.
- Gaps in information were observed in some of the patient records we reviewed. Staff signatures were not always recognisable and signatures were not printed.
- Theatre staff told us they had not attended regular training, as they were too busy to attend. Overall compliance with mandatory training in surgery was 51% against a trust target of 95%.
- Task and finish groups were still in progress working on culture issues in theatres, further improvements needed to be embedded
- There had been high rates of falls which met the serious incident criteria and amounted for around a third of all incidents.
- Treatment delay and a failure to act on test results together accounted for 38% of all serious incidents.
- Staff satisfaction was mixed according to the staff survey. Staff did not always feel actively engaged or empowered.

However:

Surgery

- There had been some learning from surgical never events and identified the changes in clinical practice which resulted. More recent audits of the 'World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery showed improvement.
- Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Concerns and complaints were taken seriously, investigated, lessons learned, and outcomes shared with all staff.
- Staff had an understanding of how to raise safeguarding concerns.
- People gave positive feedback about the care they received. They said they were involved in decisions about their care and staff considered their emotional as well as physical needs.
- Staff treated patients with compassion, dignity and respect.
- Referral to treatment (RTT) times admitted performance was above the England average. Where RTT shortfalls existed, the trust had identified actions to improve performance.
- The service was responsive to people's needs and worked with external providers to improve people's care and access to care pathways.
- Over the two years, the percentage of cancelled operations at the trust showed a very minor upward trend and was generally lower than the England average.
- Staff across both hospitals said joint working between surgical services had strengthened.
- Staff said they felt supported by their immediate management teams and matrons were visible in clinical areas.
- Care was provided in line with NICE clinical guideline CG50 (Acutely ill adults in hospital: recognising and responding to deterioration). Patient's risks were assessed to determine their fitness for surgery. The service had protocols and guidelines in place to assess and monitor patient risk in real time.
- Staff provided care and treatment based on national guidance.
- The surgical care group had implemented governance, risk management and quality measures to improve patient care, safety and outcomes.
- Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to. They said leaders were visible and approachable.
- Staff worked together as a team for the benefit of patients. Doctors, nurses and other healthcare professionals supported each other to provide care and treated patients with compassion, treating them with dignity and respect.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

- Learning from never events had not been embedded. Risks to patients existed as a result of this and safety needed to be further prioritised.
- Operating theatres were not fully established against the 'Association for Perioperative Practice' (AfPP staffing recommendations). Staffing levels at night and on late shifts fell below recommended guidance.
- Limited sepsis training was available to staff.

- There was very poor compliance with safeguarding adults and children's training
- Sporadic checks of the difficult intubation trolley in recovery at UHND had taken place.
- Gaps in information were observed in some of the patient records we reviewed. Staff signatures were not always recognisable and signatures were not printed.

However:

- Staff demonstrated some learning from surgical never events in some areas and identified the changes in clinical practice which resulted.
- The service identified guidelines and protocols to assess and monitor patient risk in real time, and react to changes in risk level.
- Recent audits of the 'World Health Organisation (WHO) surgical safety checklist and five steps to safer surgery had shown improvements.
- Managers investigated incidents quickly, and shared lessons learned and changes in practice with staff.
- Staff had an understanding of how to raise safeguarding concerns.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good because:

- Care was provided in line with NICE clinical guidelines. Patient's risks were assessed to determine their fitness for surgery. The service had protocols and guidelines in place to assess and monitor patient risk in real time.
- Staff provided care and treatment based on national guidance.
- Ongoing reviews and discussions took place across the trusts multi-disciplinary teams in relation to clinical standards, guidelines and protocols.
- Patients' pain was well controlled.
- In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 4.7%, which falls within expected limits. This was an improvement on the 2015 results of 6.5%.
- Protected mealtimes took place at the trust.
- The majority of nursing staff we spoke with confirmed they had yearly appraisals.
- The majority of consultant staff had appraisals completed. However, the annual appraisals of two consultants had not been completed.
- Staff confirmed effective multi-disciplinary team (MDT) working throughout the service and with external stakeholders.
- We observed people accessed some information through patient handovers in the ward and theatre environment. These handovers were clear, concise and complete.
- Patient consent was obtained in line with trust guidance.

Surgery

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- We spoke with 23 patients who spoke highly of the staff and the care received.
- Members of medical and nursing staff provided compassionate and sensitive care that met the needs of patients.
- Monthly audits of patients' experiences took place as part of the trusts quality matters initiative. Results were positive.
- Patients and their families were involved in discussions about their care and treatment.
- People's spiritual needs were supported through the chaplaincy service.
- A palliative care team was available for patients and their families to access.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- The 'Accountable Care Network' in County Durham represented a new way of working, to provide better healthcare and a better experience for patients, service users and carers.
- Joint working existed with the Cancer Alliance in relation to breast services.
- Managers planned and provided services in a way that met the needs of local people.
- The hospital escalation policy and procedure guidance was followed during busy times. The director of nursing, matrons and ward managers attended capacity bed meetings to monitor bed availability, discuss concerns and identify flow issues.
- Patients accessed the service via the GP, through the emergency department, the clinical decisions unit (CDU) or as planned admissions.
- Initiatives to improve patient access were identified in general surgery and trauma and orthopaedic specialities.
- Between June 2016 and May 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgery performed consistently above the England average, outperforming by 7% to 10% throughout the period. The trust showed little fluctuation in its performance.
- Over the last two years, the percentage of cancelled operations at the trust showed a very minor upward trend and was generally lower than the England average.
- Staff took account of patients' individual needs, particularly for patients with dementia, learning disabilities, and mental health problems through champions and advocates.
- Patients could access the services through a variety of access points.
- Learning disability nurses, dementia champions and mental health team support was easily accessed for patients.

- Patients said staff looked after their mental health needs, were approachable and easy to talk with. The inpatient mental health liaison team was available 24/7.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- There was a need to more strongly embed learning from never events in order to minimise risk to patients. The trust had taken some actions to minimise risk.
- Some staff feedback identified the executive team who were based at Darlington Memorial Hospital who were rarely seen at University Hospital North Durham.
- Staff identified poor engagement from senior management with theatres. Senior managers were told of a perceived communication deficiency from senior management.
- Staff were not always able to articulate the vison or strategy, or say how they would contribute to the strategy, although they told us their aim was to do their best for patients.
- None of the staff who should have undergone safeguarding children level '3' had done so up to March 2017.
- The trust vision was displaced in flow chart format throughout the ward areas. The strategies ambition was identified as 'Right first time, every time.' Staff we spoke with told us they had not been consulted in development of the strategy so were unsure how the ambition came about.
- The culture review in theatres had identified problems within the theatres culture. The outcome of this review resulted in the development of an action plan, which had been instigated but changes were yet to be embedded. Task and finish groups were still working through action plans.
- Staff satisfaction was mixed according the staff survey. Staff did not always feel actively engaged or empowered.

However:

- Monthly joint clinical governance and directorate meetings took place.
- The directorate risk register was updated following these meetings and we saw that action plans were monitored across the division. Staff showed an awareness of the risks through discussion.
- Staff said managers were available, visible, and approachable. They also said leadership of the service was good with staff were supported at ward level.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience. Staff on the wards and in theatres worked well together with respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Managers monitored performance and used the results to help improve care. All staff identified risks to good care and the service took action to eliminate or minimise risks.
- Managers supported their staff and encouraged training. Staff said they felt supported and respected by colleagues at all levels and that this had improved since the last inspection.
- Staff told us they received feedback at monthly or bimonthly ward meetings.

Surgery

- A governance framework was in place and regular governance meetings took place attended by the multi-disciplinary team.
- Most of the 'National Safety Standards for Invasive Procedures' (NatSSIPs) had been implemented trust wide. The NatSSIPs were fully implemented in theatres.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

The University Hospital North Durham provided maternity services for County Durham and Darlington NHS Foundation Trust. The maternity services offered at the University Hospital North Durham consisted of antenatal, intrapartum and postnatal services. There were obstetric outpatient clinics, pregnancy assessment unit, delivery suite (ward 8), with its own dedicated theatre, antenatal and postnatal ward (ward 10), and a special care neonatal unit. There was also a community midwifery team, assessment unit and outpatient clinic at Shotley Bridge community hospital. The service delivered 4898 babies between April 2016 and March 2017.

We carried out a focussed unannounced inspection. We looked at all areas within all domains.

We visited the labour ward, the antenatal and postnatal ward, the pregnancy assessment unit and antenatal clinic. We spoke with 21 staff members, ten women, and three of their partners or relatives. We also reviewed 13 sets of records as part of the inspection.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- There was a newly formed senior leadership team in the maternity service covering business, midwifery and clinical leadership. We found that this team was cohesive and that there was a real drive to continue to improve the quality of the service. There were no concerns around bullying or challenging behaviour.
- The local leadership multidisciplinary team had been restructured, was strong and effective. This was evident throughout all parts of the service.
- Staff were encouraged and knew how to report incidents. We saw evidence from actions plans and root cause analysis that serious incidents were identified and investigated appropriately.
- There was a full and robust system to review cases at risk meetings. Completion of the World Health Organisation surgical safety checklist was closely monitored and regularly met trust targets.
- Recommended midwifery to birth ratios were met.
- Recruitment of medical staff had improved with good support for junior and middle grades from consultants.
- Changes in practice were based on national guidelines and best practice, then audited to ensure they were embedded throughout the team.
- Patient outcomes were in line with national averages.
- A full seven day service was provided.
- Women we spoke to all felt involved in their care and had been provided with information to allow them to make informed decisions.
- Staff were compassionate and caring and there were counselling and bereavement services available in the unit when required.
- Staff had identified opportunities to improve patient pathways and flow through departments and had introduced a new transitional care pathway.

Maternity

- The trust served a community with a wide range of needs and there were good systems in place to ensure effective communication. Teams were working proactively with local networks to improve outcomes.

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good because:

- Staff were aware of and followed the process to follow to report incidents.
- Weekly risk meetings were held to discuss incidents and key messages in various formats informed all staff of lessons learned. Risks were managed following national guidelines and best practice.
- Paper records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how they were to be managed. An electronic record of observations was relatively new and staff were competent in its use.
- There was a monthly programme of skills and drills that took place within the department, usually based on recent risks.
- The completion of the World Health Organisation (WHO) surgical safety checklist was previously not meeting trust targets. However, this had been addressed and monthly audits showed compliance rates were more consistent and much improved.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review fetal heart tracings.
- Risk assessments were carried out throughout the patient pathway for all women using trust guidance to determine whether individuals were high or low risk, from antenatal booking to postnatal discharge to health visitors and community midwives.
- Recommended midwifery to birth ratios were met.
- Recruitment of medical staff had improved with good support for junior and middle grades from consultants.

However:

- Between July 2016 and June 2017, there had been one incident which was classified as a never event; despite learning and action plans, a further similar never event took place later in 2017.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- Midwifery staff had a competency framework which evidenced their progression from preceptorship. Development of midwives continued to a senior level.
- Guidelines and action plans were in place, regularly reviewed and ratified at formal, planned meetings.
- Changes in practice were based on national guidelines and best practice, then audited to ensure they were embedded throughout the team.

Maternity

- Most patient outcomes were in line with national averages.
- A full seven day service was provided.
- A range of effective pain relief was available for women.
- The women we spoke to in midwifery said they felt they were in control and pain relief was good.
- Midwifery staff on duty highlighted any patients at medical or social risk and reviewed their care with the wider team.

However:

- Results from the National neonatal audit programme (NNAP) indicated some lower than average standards; for example in the percentage of mothers who were given antenatal steroids and also the percentage of premature babies who had their temperature taken within an hour of being born.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Women we spoke to all felt involved in their care and had been provided with information to allow them to make informed decisions.
- Friends and family test data for maternity services from June 2015 (NHS England) showed very positive responses with 92-97% recommending services at the trust. Staff told us their feedback showed 100% positive responses.
- Staff were compassionate and caring and there were counselling and bereavement services available in the unit when required.
- All women had a named midwife and staff were available if they needed them.
- Following patient feedback, the department had made provision for partners to stay on the ward.
- Single rooms were provided for medical management of pregnancy or miscarriage.
- Families were encouraged to be involved in the care of vulnerable patients such as those with learning disabilities and teenage pregnancies.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good because:

- Patient pathways and flow through departments was planned and reviewed.
- Staff had identified opportunities to improve patient pathways and flow through departments and had introduced a new transitional care pathway.
- The trust served a community with a wide range of needs and there were good systems in place to ensure effective communication.
- The trust identified the demands on services and business planning was aligned to this.

- Complaints were discussed and recommendations given and learning from complaints took place in a multidisciplinary forum.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- There was a newly formed senior leadership team in maternity. The team was cohesive and there was a real drive to improve the quality of the service. The team were aware of the challenges and were able to articulate the actions required to take the service forward.
- Plans were ongoing concerning the configuration of maternity services. Whilst the trust continued to develop an overall strategy and supporting plans, the final configuration of services within the trust, would be determined through the work on the Sustainability and Transformation Plans (STP) in the North and South of the North East health economy
- Effective governance structures were in place.
- Staff spoke positively about their leaders and felt respected. Plans were in place to strengthen clinical leadership.
- We spoke with staff who were very engaged and felt involved in the service and its continuing development; this was evident throughout the service.
- The local leadership multidisciplinary team had been restructured, was strong and effective. This was evident throughout all parts of the service.
- There had been some very positive changes in culture and behaviours, especially amongst the consultant cohort.
- All areas we visited were patient focussed; this was evident from speaking with staff and patients.

Outstanding practice

- The transitional care team had won the service improvement award in the annual staff awards and was shortlisted for the Royal College of Midwives (RCM) annual midwifery awards 2017. The trust had identified a way of providing care for vulnerable babies outside of NNU. They had employed and set up a training course for transitional care baby support workers. These were support staff, dedicated to work with babies, parents and staff including paediatricians during transitional care. They helped to ensure babies could be cared for on the ward and avoid where possible admission to the neonatal unit. Staff told us there had been significant positive outcome results following implementation of this role.
- The team were involved in Wave 2 of the National Maternity and Neonatal Safety Collaborative. This work was recognised nationally when a member of the team was asked to speak at the RCOG Each Baby Counts conference in 2016.
- The majority of staff were trained in recruiting and supporting clinical research projects. The team had been recognised nationally for recruiting to an industry trial for the blind testing of prophylactic antibodies in patients following instrumental deliveries.

- UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast feeding and promote parent/infant relationships. The trust told us that the north of the service had successfully achieved UNICEF recognition for its breastfeeding support and had been recommended to apply for gold accreditation in June 2017.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Our inspection team

Sandra Sutton, Interim Head of Hospital Inspections, chaired this inspection.

The team included a CQC inspection manager, seven inspectors, 13 specialist advisers, and an expert by experience.

Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

All actions to be monitored and tracked through the Executive Directors Group and the Board.

CQC COMMENT	TRUST ACTION	HOW WILL THIS BE EMBEDDED	**OUTCOME**: what do we want to achieve	**MONITORING ARRANGEMENTS**: How will we monitor this?	PROGRESS	LEAD	TARGET DATE	DATE COMPLETE
Need to further embed learning from never events in order to prioritise safety and reduce the levels of never events	For Surgery, actions S3 and S4. Similar actions to be agreed with Family Health and additional actions including further safety conferences and roll out of LocSSIPs (including the LocSSIP audit strategy)in line with the project plan.	As per Actions S3 and S4 of the Services action plan, and in particular delivery of training and roll out of observational audits in line with the LocSSIPs project plan.	As per Actions S3 and S4, plus roll ot of LocSSIPs, and related training plans in line with the Project Plan. Regular, positive audit results.	Through bi-monthly meetings of the Clinical Effectiveness Committee and assurance reporting to IQAC.	As per Actions S3 and S4 / LocSSIP Project Plan (currently on track)	K Burn, N Scanlon and J Cundall	30/09/2018	
In theatres, the action plan to address culture issues was still in progress and there was a need to further embed improvements	See Actions S2 and S13 in the Services Action Plan	See Actions S2 and S13 in the Services Action Plan	See Actions S2 and S13 in the Services Action Plan	See Actions S2 and S13 in the Services Action Plan	See Actions S2 and S13 in the Services Action Plan	K Burn, N Scanlon and J Cundall	On-going from 01/04/2018	
There had not been a formal training programme for all board members. Executive directors have been through a collective development programme, but this recently commenced for the board as whole in May 2017	Programme for collective Board development, with sub-sets for Executive Directors and Non-Executive Directors, to be brought to the Board for approval in May and effected through the seminar programme for 2018/19. Provisional details included in the Well-Led Action Plan report for April 2018	Through the Board Seminar Programme.	Completion of a programme of four collective development sessions per annum; active and regular review of training needs by NEDs, and evidence that they have been met; completion of collective training events for Executive Directors in line with their assessment of need.	Formal report to be provided to the Board every six months	Provisional collective development programme identified in the Board Business Programme for 2018/19 and first ED event scheduled.	W Edge / M Smith	Programme in place from May 2018, delivery reported on in October 2018 and March 2019	
Training was offered to non-executive directors (NEDs) in line with a national NED programme but there had not been a way to monitor if this took place	Training register now in place. SOP to be developed for monthly updates and quarterly reporting to the Board alongside the Register of Sealings.	Quarterly reporting to the Board.	Complete recording of training provided to NEDs, reporting in place on a quarterly basis and evidence of agreed training needs being serviced through both the reports and registers	Formal reporting every quarter	Training register in place	W Edge	On-going from 01/04/2018	
The executive team articulated the strategy to us in different ways; there was no common way to describe their approach to how it would be achieved	Board Business Programme to include two sessions to refresh and update the strategy. Strategy Handbook to be updated for the Board's review and an overall infographic developed to support a common understanding of the strategy and common terminology.	Through the Board Seminar Programme (Board actions), discussions at the Strategic Change Board and publication of the infographic, to be assessed and confirmed on ward walk-arounds.	Common and clear understanding of strategy among Board members, managers and staff evidenced through interviews and focus groups as part of the Well-Led Follow Up Review.	Through the Board Seminar Programme and the Well-Led Follow Up Review		S Jacques / W Edge	From 30/06/2018	
Staff engagement was an area for development. Overall staff engagement had been an area of focus for the past three years. Progress had been made however staff satisfaction scores remained below the national average.	Roll out of staff survey activity plan included in the paper to the Board meeting held in April 2018 and any additional actions arising from discussion of the results between the Board and Executive Directors. As the analysis of results and discussion with Care Groups and Corporate Directorates continues, there are likely to be additional actions captured ahead of the Board meeting in May 2018.	Through Care Group Staff Matter Action Plans, reported on formally to SCB every quarter.	Improved engagement scores in Staff FFT and in National NHS Staff Survey for 2018	Quarterly reporting on Staff Matter to SCB, IQAC and, on staff engagement specifically, to the Board	On-going programme of engagement in place to be refreshed following the most recent staff survey results	M Smith / EDs for own areas	From 01/05/2018	
Overall trust compliance with role specific training was 55% which was lower (worse) than the target.	Roll out of new process agreed by Executive Directors which requires: 1. Agreement of a Training Needs Assessment for all role-specific competencies by policy owners, overseen by Training Priorities Group and approved by Executive Directors. 2. Monthly reporting of compliance with training requirements to policy owners, Care Groups and Executive Directors 3. Monitoring of Care Group requirements through Monthly and Quarterly Performance Review meetings 4. Escalation of issues through ECL.	Through meetings of the Training Priorities Group, monthly and quarterly performance reviews and monthly reporting and escalation to Executive Directors.	The ambition is to ensure that high levels of compliance (over 90%) are achieved for all role-specific competencies, by the middle of the year.	Through monthly reporting and escalation via performance review meetings and Executive Directors	New process agreed and being rolled out	M Smith / EDs for own areas	Training needs analysis from 01/05/2018 Monitoring process from 01/05/2018 Improved compliance rates evidenced by 31/07/2018 Compliance in date for over 90% of eligible staff for all comptencies by 31/10/2018	
The information used in reporting, performance management, and delivering quality care had not always been accurate, or timely. There was some duplication of information presented to the board and sub committees; this was being addressed by revision of the work plans and terms of reference of the various committees.	1. Review of the Integrated Performance Report to introduce thematic analysis and clearer alignment to regulatory monitoring indicators. 2. Stock-take of the cut-off dates for core board reports and discussion with the Board on additional reporting requirements to address any timeliness issues.	1. Through updated reporting to the Board. 2. Through the paper being presented to the Board, minuted agreement of changes and updated reports.	Improved thematic analsis in IPR and confirmation of cut-off dates and additional reproting requirements for all key, routine reports.	Via the Board		1. C Langrick 2. W Edge	1. 31/07/2018 2. 31/07/2018	

	Page 72		CQC REQUIREMENT	Where referenced in the reports	TRUST ACTION	HOW WILL THIS BE EMBEDDED	OUTCOME: what do we want to achieve	MONITORING ARRANGEMENTS: How will we monitor this?	PROGRESS	LEAD	CARE GROUP	TARGET DATE	DATE COMPLETE
U&E	U&E 1	Must Do	The trust must ensure that the rooms used to care for patients with mental health needs conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.	Evidence appendix pages 12, 25, 45, 52 & 186	**University Hospital of North Durham** 1. The assessment room is to be adapted to meet all PLAN requirements. 2. A risk assessment of patient toilets and other general areas is to be undertaken and submitted to Safety Committee for approval. 3. Approved works to mitigate ligature risks to be undertaken based on the risk assessment above. 4. A checklist for the assessment room environment will be developed which will be reviewed at each daily huddle. 5. Checklist will be used by the Health and Safety Team in carrying out annual compliance audits	Back to Practice checks and annual ED H&S audit	The rooms used to care for patients with mental health needs conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.	Daily checks of the assessment room environment. Back to Practice checks. Annual H&S audit	March 2018: It is estimated that the new Assessment Room (to meet PLAN requirements) will become available at the end of April/beginning of May. Risk assessment of patient toilets has been undertaken. Confirmation of costs to be obtained.	Bill Headley, John Holmes, Claire Beckwith	AEC	30/06/2018	
U&E	U&E 2	Must Do	(As above) The trust must ensure that the rooms used to care for patients with mental health needs conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.	Evidence appendix pages 12, 25, 45, 52 & 186	**Darlington Memorial Hospital** 1. The assessment room is to be adapted to meet all PLAN requirements. 2. A risk assessment of patient toilets and other general areas is to be undertaken and submitted to Safety Committee for approval. 3. Approved works to mitigate ligature risks to be undertaken based on the risk assessment above. 4. A checklist for the assessment room environment will be developed which will be reviewed at each daily huddle. 5. Checklist will be used by the Health and Safety Team in carrying out annual compliance audit.	Back to Practice checks and annual ED H&S audit	The rooms used to care for patients with mental health needs conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.	Daily checks of the assessment room environment. Back to Practice checks. Annual H&S audit	Works are being costed and the risk assessment has been completed.	Kerry Dawson, Shaz Afzal, Vikki Bailey, Alison McCree	AEC	30/06/2018	
U&E	U&E 3	Must Do	(As above) The trust must ensure that the rooms used to care for patients with mental health needs conform to the Psychiatric Liaison Accreditation Network (PLAN) standards.	Evidence appendix pages 12, 25, 45, 52 & 186	Ligature Policy updated. To be consulted on to ensure meets wider Trust requirements.	Policy monitoring processes and information sharing at huddles	As safe as possible environment for all patients	Monitoring arrangements will be defined within the policy	March 2018: Policy drafted	Claire Beckwith	AEC	30/06/2018	
U&E	U&E 4	Must Do	At Darlington Memorial Hospital (DMH) The trust must ensure that documentation of the administration of controlled drugs is in line with the Nursing and Midwifery Council (NMC) Standards for Medicine Management.	Evidence appendix page 173	1. Staff will be reminded of the policy in daily huddles 2. We will introduce regular (minimum weekly) spot checks by senior nurses with rigorous follow up of any incomplete entries or errors.	Reinforce through Back to Practice visits (monitoring checks by senior nurses)	Full compliance in line with NMC standards for Medicine Management.	Back to Practice visits	Matrons have reviewed records and reminded staff of Trust policy.	Vikki Bailey	AEC	30/04/2018	
U&E	U&E 5	Must Do	At University Hospital North Durham (UHND) the trust must ensure that controlled drug balance checks are carried out in accordance to trust policy.	Evidence appendix page 31	The policy for checking the registers will be standardised, with issues discussed in ward huddles and follow up checks completed.	Rigorous daily checks and monthly spot checks to be undertaken (to be included as part of Back to Practice)	All controlled drugs checked daily in line with Trust policy requirements	Rigorous daily checks and monthly spot checks to be undertaken (to be included as part of Back to Practice)	Standardised policy under discussion, with a proposal to move to once daily checks in all areas.	Denise Matthews/Claire Beckwith	AEC	30/04/2018	
	U&E 6		(As above) At University Hospital North Durham (UHND) the trust must ensure that controlled drug balance checks are carried out in accordance to trust policy.	Evidence appendix page 31	We will create and populate a "ward" dashboard (akin to Quality Matters), or a similar record, to include controlled drug monitoring in the Emergency Department	Rigorous daily checks and monthly spot checks to be undertaken (to be included as part of Back to Practice)	All controlled drugs checked daily in line with Trust policy requirements	Dashboard will be monitored as per Quality Matters reporting or similar	March 2018: Audit tool has been developed but dashboard to be devised.	Claire Beckwith /Vikki Bailey (Julie Race and Paul McGee to assist as required)	AEC	31/05/2018	
U&E	U&E 7	Must Do	At UHND the trust must store intravenous infusions containing potassium separately.	Evidence appendix page 31	Intravenous infusions containing potassium will be kept a locked cupboard in the Resus area. The cupboard will be clearly marked.	Reinforced in huddles to share learning	Intravenous infusions containing potassium will be separately and securely stored to prevent any potential medication errors occurring.	Check as part of stock control and further checks on Back to Practice visits by senior nurses	October 2017: Intravenous infusions containing potassium moved and are now kept a locked cupboard in Resus area. Cupboard is clearly marked to aid staff.	Claire Beckwith	AEC	30/04/2018	Oct-17

	Ref		CQC REQUIREMENT	Where referenced in the reports	TRUST ACTION	HOW WILL THIS BE EMBEDDED	OUTCOME: what do we want to achieve	MONITORING ARRANGEMENTS: How will we monitor this?	PROGRESS	LEAD	CARE GROUP	TARGET DATE	DATE COMPLETE
U&E	U&E 8	Must Do	At UHND the trust must store patients own medication securely.	Evidence appendix page 32	We will review policy & infrastructure for storage of patient's own medications, install compliant medicines cupboards and receptacles where necessary, train and audit to said policy and educate our patients and their families to utilisation of self medication as part of their rehabilitation plan including the use of regular lifelong medication such as Anti parkinsonian drugs.	Reinforced in huddles to share learning	Patients own medication will be separately and securely stored to prevent any potential medication errors or accidental ingestion by vulnerable patients or children visiting occurring.	Check as part of stock control and further checks on Back to Practice visits by senior nurses	Lockable cupboards have been procured for each of the short stay rooms at UHND.	J Harris, J McClelland, All Medical & IAC Matrons (all Matrons)	All Care Groups	30/10/2018	
U&E	U&E 9	Must Do	The trust must ensure that oxygen therapy is prescribed in line with national guidance.	Evidence appendix page 31 & 173	1. A Trust wide drive on correct prescribing will be undertaken with support from Medical Education and Pharmacy. 2. We will revisit BTS guidance on oxygen prescribing to ensure that our policy is in line with it. 3. We will review the prescription chart in ED and EPMA to record key information required under 2 above e.g. concentration, flow rate, target saturations	Spot checks and reinforced in huddles to share learning	The doctor will assess the patient's need for Oxygen and document target saturations in line with the clinical context of the patient. Both medics and nurses should monitor and record all saturations as well as take into consideration any arterial blood gases performed.	Spot checks to ensure that all Oxygen administration is clearly documented in the clinical records. These will be reinforced through Back to Practice visits by senior nurses.	March 2018: Already included in Resus Training	David Gibson and Sue Evison (C Beckwith and V Bailey to reinforce in ED)	AEC	31/08/2018	
U&E	U&E 10	Must Do	The trust must ensure that patients' blood sugar levels are recorded as required.	Evidence appendix page 34 &177	1. Outdated guidance on capillary blood sugars will be removed from the clinical area. 2. Staff will be required to adhere to the Sepsis Management Tool which is embedded within the Symphony electronic system and which advises lactate blood cultures and all relevant blood tests are performed, which may include a glucose. We now perform a venous gas and a serum blood glucose is taken on patients screened positively for sepsis.	Matron / ED sister spot checks and issues to be followed up with staff in real-time and in appraisal / revalidation	Adherence to our Sepsis Management Tool	The CAP/AI Team will support ED to undertake a twice yearly audit of the whole Sepsis Bundle in ED.	March 2018 UHND: audit of blood tests to be undertaken. DMH: weekly notes audit undertaken.	Claire Beckwith, Vikki Bailey, Lisa Ward	AEC	30/04/2018	
Medical	M1	Must Do	The trust must ensure that staff understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 at University Hospital North Durham.	Evidence appendix pages 13 & 15	1. We will undertake an additional audit to obtain baseline of compliance with mental capacity Act 2005 using PISAT tool / augmenting with point prevalence study. 2. We will create and appoint to a role for Mental Capacity Lead. Once appointed, this role will supplement training and education by working daily with ward staff. 3. We have set up a Task & Finish Group which will develop and assurance programme for safeguarding adults that will move into the Quality Matters programme once key areas of development have been identified. This will support a context for challenging best interest and consent in every setting. 4. The Task & Finish Group will provide short-term awareness raising and support working with ward staff, to improve awareness of responsibilities.	Ward visits by the Safeguarding Adults team and through the assurance programme	To demonstrate compliance with The Mental Capacity Act 2005	Task and Finish group and then through Safeguarding steering group. Reporting to the Executive patient safety & experience committee	March 2018 Task and Finish group established. Paper developed for the executive team to highlight staffing requirements to achieve separate MCA role. Audit tool developed for baseline assessment and assurance matrix developed to support assurance rounds	Jason Cram	Corp Nursing	30/04/2018	
Medical	M2		(As above) The trust must ensure that staff understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 at University Hospital North Durham.	Evidence appendix pages 13 & 15	1. We will firm up the action plan in development with Tees, Esk and Wear Valleys NHS FT (TEWV - our MH provider) in response to the 'Treat As One' gap analysis completed jointly with TEWV, which includes actions to raise awareness and support staff in their understanding of their responsibilities under the MH Act. We will roll out agreed actions. 2. We will create and appoint a lead role for Mental Health matters, with specialist experience and dedicated responsibility for MH matters	Monitoring of implementation of actions through the Executive Patient Safety and Experience Committee	Implementation of good practice in line with Treat as One: Bridging the gap between mental and physical healthcare in general hospitals: The overarching theme of the report is that the divide between mental and physical healthcare needs to be reduced. This will require long-term changes in both organisational structures and individual clinical practice to produce a working environment where the mind and body are not approached separately. There are a series of recommendations that should be undertaken to help that process.	Monitoring of implementation of actions through the Executive Patient Safety and Experience Committee	March 2018: Gap analysis has been completed and a draft action plan is in development	Noel Scanlon	Trust	30/09/2018	
Medical	M3		(As above) The trust must ensure that staff understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 at University Hospital North Durham.	Evidence appendix pages 13 & 15	1. Nursing assessment documentation will be amended to include prompts to consider the need for a capacity assessment when the patient is subject to cohorting or supervision and there are indications that they may lack capacity to provide consent 2. Our falls risk assessment documentation will be amended to prompt similar assessments. 3. Relevant questions to support MCA will be included in the nursing assessments on Nerve Centre in 4 wards piloting from Q1 and made universal in Q2. Compliance to be audited weekly using nerve centre. 4. The Task and Finish Group will • Review MCA policy (Completed in draft form). • Review the training programme. • Review monitoring arrangements. • Implement frequent ward visit to support decision making. • Provide MCA overview and action plan using PISAT tool.	Nursing Assessment on Nervecentre Compliance monitoring in weekly performance reports Falls Documentation includes key questions	We will demonstrate compliance with The Mental Capacity Act 2005	Task and Finish group and then through Safeguarding steering group.	March 18 Task & Finish group has been established with initial remit. Paper developed to present to the executives to highlight additional requirements to augment staffing arrangements. Discussing with falls lead to supplement question into new falls protocol	Jason Cram	Corp Nursing	30/09/2018	

			CQC REQUIREMENT	Where referenced in the reports	TRUST ACTION	HOW WILL THIS BE EMBEDDED	OUTCOME: what do we want to achieve	MONITORING ARRANGEMENTS: How will we monitor this?	PROGRESS	LEAD	CARE GROUP	TARGET DATE	DATE COMPLETE
Medical	M4	Must Do	The trust must ensure that they meet targets for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training. The knowledge and practice of staff on the wards raised concern over the effectiveness and numbers trained. This was specifically relevant at University Hospital North Durham.	Evidence appendix pages 13, 75 & 76	1. The Task and Finish Group will review the training programme to scope training requirements, formats of training (face to face/e-learning) and levels of training required. 2. The Group will define procedures for monitoring of training and the resource required to deliver training.	Training Compliance matrix	To be compliant with The Mental Capacity Act 2005	Task and Finish group and then through Safeguarding steering group. Reporting to the Executive patient safety & experience committee	Task and Finish Group established	Jason Cram	Corp Nursing	30/09/2018	
Medical	M5	Must Do	The trust must ensure that policies 'Policy and guidance notes for staff on the Mental Capacity Act 2005' (reviewed January 2017) and 'Deprivation of Liberty Safeguards' (reviewed December 2016) direct staff to guidance or tools for use by staff.	Evidence appendix page 76	1. The policy has been updated to include all relevant tools and to effectively signpost staff to the correct tools and guidance. It has been shared with an external specialist in MCA for review and has already been reviewed by our legal advisers for the legal aspects. 2. We will update the policy for any further external advice, approve it through the governance process in the Trust and disseminate it to all staff.	Assurance Rounds Safeguarding adults	To demonstrate compliance with The Mental Capacity Act 2005	Task and Finish group and then through Safeguarding steering group. Reporting to the Executive patient safety & experience committee	The policy has been updated to include all relevant tools and to effectively signpost staff to the correct tools and guidance. It has been shared with an external specialist in MCA for review and has already been reviewed by our legal advisers for the legal aspects.	Mike Egan	Corp Nursing	31/05/2018	
Surgery	S1	Must Do	The trust must ensure that operating theatres are fully established against the 'Association for Perioperative Practice' (AfPP staffing recommendations). Staffing levels at night and on late shifts fell below recommended guidance.	Evidence appendix page 96/234	1. We will review our current staffing against AfPP staffing guidance to determine any changes to establishment required to ensure all shifts are staffed by staff with appropriate knowledge and skills for the procedures that they will be undertaking. An initial review has already been completed. 2. Follow up actions will be undertaken as appropriate to meet rotas. Monitoring will be established via the electronic staff rostering system 3. Six monthly safe staffing reviews will be completed for Theatres and submitted to Board	Electronic rostering of staff through Health Roster, with the sign off process for rotas to include checking for compliance with required standards, reinforce by Back to Practice Visits	1. Sufficient staff available at the right times to ensure shifts are compliant with AfPP standards 2. Rotas compliant with the AfPP standards 3. All shifts filled in compliance with the AfPP standards.	Through specialty performance meetings and nurse recruitment meetings	March 2018: Staffing paper in development (initial review complete)	Louise Shutt, Kathryn Burn	Surgery	30/09/2018	
Surgery	S2	Must Do	The trust must continue to embed the theatres culture review action plan.	Evidence appendix pages 98, 124, 235 & 259	1. The Theatres Culture Action Plan will to continue to be progressed. 2. EDs will continue to support monthly meetings to steer progress against the action plan. 3. Additional professional OD support will be provided to support the Care Group in driving culture change actions	Stage 1 - 3-6 months, stage 2 - 6-9 months, long term evaluation to be determined.	Completion of OD intervention	Quarterly executive summary through Care Group Governance to ECL	March 2018: Paper prepared for submission to Executive Directors in March 18, specifying OD roles to support implementation of further actions	Kathryn Burn, Steve Scott and Richard Morris (with OD support)	Surgery	31/03/2018	
Surgery	S3	Must Do	Following never events the trust must ensure that improvements in practice are effectively embedded and maintained.	Evidence appendix pages 13, 18, 95, 102, 125 & 233	1. We will roll out LocSSIPs (already developed and approved) building on training now in place and reinforce awareness and provide further training in key protocols. 2. We will develop and implement an observational audit tool within the theatre environment. 3. Care Group Governance Facilitators will be aligned to provide support to specialties - work is underway to develop and implement a staggered audit plan 4. We will undertake independent reviews to confirm implementation of actions using teams of senior care group / service representatives and staff from Assurance and Compliance.	Robust audit tool and scheduled audit days to complete with results shared to discuss within business unit in theatre strategy group	Robust audit tool and scheduled audit days to complete with results shared to discuss within business unit in theatre strategy group	Theatre Strategy Group and ECL to act on any issues identified. IQAC to receive formal audit outcomes for assurance purposes	March 2018: Work has commenced to develop audit tool and looking to gain share point access to generate performance reports	Debbie Harris / Sharon Farlow/ Julia Bartram	Surgery	On-going to 30/09/2018 with checks sustained thereafter	
Surgery	S4	Must Do	(As above) Following never events the trust must ensure that improvements in practice are effectively embedded and maintained.	Evidence appendix pages 13, 18, 95, 102, 125 & 233	We will implement robust training plans for theatre personnel. Annual plan to be developed.	Robust audit tool and scheduled audit days to complete with results shared to discuss within business unit in theatre strategy group	Robust audit tool and scheduled audit days to complete with results shared to discuss within business unit in theatre strategy group	Theatre Strategy Group and ECL to act on any issues identified. IQAC to receive formal audit outcomes for assurance purposes	March 2018: Work has commenced to develop an audit tool and we are looking to gain share point access to generate performance reports	Debbie Harris / Sharon Farlow/ Julia Bartram	Surgery	On-going to 30/09/2018 with checks sustained thereafter	
Surgery	S5	Must Do	The trust must ensure that checks of the difficult intubation trolley in recovery at UHND take place as per trust policy.	Evidence appendix page 95	We will remind theatre personnel of the importance of checking the difficult intubation trolley and implement daily checks overseen by the Matron.	Matron daily assessment	Checks of the difficult intubation trolley in recovery at UHND take place as per trust policy	To monitor compliance as part of the observational audits	March 2018: Work has commenced to develop an audit tool and we are looking to gain share point access to generate performance reports	Debbie Harris / Julia Bartram	Surgery	30/04/2018	
Surgery	S6	Must Do	(As above) The trust must ensure that checks of the difficult intubation trolley in recovery at UHND take place as per trust policy.	Evidence appendix page 95	The Care Group's Governance Facilitator will carry out observational audits.	As above	As above	Observational audit data	March 2018: Work has commenced to develop an audit tool and we are looking to gain share point access to generate performance reports	Debbie Harris / Julia Bartram	Surgery	31/07/2018	

	Ref		CQC REQUIREMENT	Where referenced in the reports	TRUST ACTION	HOW WILL THIS BE EMBEDDED	OUTCOME: what do we want to achieve	MONITORING ARRANGEMENTS: How will we monitor this?	PROGRESS	LEAD	CARE GROUP	TARGET DATE	DATE COMPLETE
All Care Groups	CG1	Must DO	The trust must ensure there is compliance with safeguarding adults and children training where staff are required to have this training.	Evidence appendix page 95	1. Safeguarding training plans will be agreed for each care group, which will be monitored and reported through the Exec Patient Safety and Experience Committee for escalation (and to IQAC for assurance) 2. Awareness raising will be carried out to ensure all staff are aware that safeguarding training is a personal, professional requirement which needs to be completed by the defined timescales	Monthly monitoring of training records	Staff compliant and training needs are met.	Monthly monitoring of training records	Central records in ESR have been fully reconciled to local records to provide an accurate baseline position.	Jason Cram/Care Group ADNs	All Care Groups	30/09/2018	
U&E	U&E11	Should Do	The trust should consider planning the nursing off duty to have more staff on duty at busy times.	Evidence appendix pages 21, 28, 168 & 169	1. We will seek to introduce shorter shifts and staggered start times in line with peak ambulance attendance and surges in demand (consultation to commence shortly) 2. Representatives from the Trust will visit Stevenage to see their Self Roster Programme for ED to identify any learning which can then be implemented within our Emergency Departments 3. A biannual safe staffing review will continue to be carried out in January/July. 4. The Medical Director will engage an external organisation to look at multi disciplinary staffing versus demands within the Emergency Department.	Continuing monitoring of staff roster. Analysis of surge with further adaptation of shifts should this be required.	Effective management of staffing to cope in times of surge. Right skill set in the right place at the right times.	Monitoring of staffing via staff roster.	The Board has already approved a safe staffing review recommendation to move to shorter shifts and staggered start times for nursing staff in line with demand. Consultation process about to be initiated. Executive Directors have approved engagement of third party organisation to review ED staffing as a whole	Claire Beckwith/Vikki Bailey (B Nicholson J Cundall)	AEC	30/06/2018	
U&E	U&E12	Should Do	The Trust should ensure that when patients enter the emergency department they are assessed within 15 minutes of arrival	Evidence appendix pages 26,167 & 168	We will review pathways for patients on arrival to maximise the numbers seen in 15 minutes	Matrons and ED sisters to monitor compliance with the approved pathways	Aim to assess within 15 minutes of arrival	National KPIs monitored daily and weekly will trigger escalation to ECL and action from the Care Group if targets not met		Kerry Dawson	AEC	30/06/2018	
U&E	U&E13		(As above) The Trust should ensure that when patients enter the emergency department they are assessed within 15 minutes of arrival	Evidence appendix pages 26,167 & 168	We will develop a business case to consider triage at front door, especially in relation to children attending ED, to ensure safe staffing in the Paediatric Area of the ED at DMH.	Improved staffing will act as an enabler to improved compliance rather than an action to be embedded in itself	To ensure safe staffing in the Paediatric Area of the ED at DMH.	As above		Vikki Bailey	AEC	30/09/2018	
U&E	U&E14	Should Do	The Trust should ensure that patients are admitted, transferred or discharged within four hours of arrival in the emergency department and reduce the amount of time patients spend in the department.	Evidence appendix pages 46 & 186	1. We will continue to implement all of the actions being overseen by the Transforming Emergency Care Programme. 2. We will implement any additional improvements agreed with ECIST following their support visit (which was requested by the Trust) in March 2018. 3. We will implement action plans to improve ambulance handovers (including new SOPs, use of Hospital Ambulance Liaison Officers and development of ambulance handover bays) 4. We will continue to work on system-wide actions through LADB	Perfect Month exercises, TEC Programme General and service managers and ED Matrons to lead implementation of new protocols, with additional emphasis on performance through the Command and Control structure	Patients are admitted, transferred or discharged within four hours of arrival in the Emergency Department and reduce the amount of time patients spend in the department.	Daily and weekly monitoring of 4 hour waiting time and ambulance handovers, with escalation via Command and Control and weekly escalation via EDs and ECL. Monthly reporting on TEC through ECL.	Existing plans are in place to improve ED turnaround times through TEC and also to improve ambulance handover times. SOPs are in development and ECSIT have been asked to provide further support. HALOs are also in place.	Paul Peter, Shaz Azfal and Kerry Dawson	AEC	On-going to 31/03/2018	
U&E	U&E15	Should Do	The department should ensure that patients brought in by ambulance are handed over to the department within 30 minutes and that the time patients should wait from time of arrival to receiving treatment is no more than one hour.	Evidence appendix page 26, 27 & 168			Patients brought in by ambulance are handed over to the department within 30 minutes and that the time patients should wait from time of arrival to receiving treatment is no more than one hour.					30/09/2018	
U&E	U&E16	Should Do	The department should ensure patients do not leave the department before being seen.	Evidence appendix pages 21, 49 & 189	1. We will complete the development of a SOP for patients with mental health conditions to ensure a risk assessment is completed before a patient leaves the department. This will include prompt triage, early assessment, review of observations, screening, co-ordination with carer/relatives regarding patient needs and to ensure the consequences of leaving the department unseen are clearly defined. 2. We will include data on people leaving the department without being seen in performance reports to ECL and IQAC 3. We will manage waiting times to prevent long waits and stream patients to right pathway.	ED service managers and matrons to monitor and reinforce compliance with SOP for MH patients triage, through spot checks and huddles Routine monitoring by EDs, ECL and IQAC will include consideration of the numbers of / trend in patients leaving the department without being seen	Patients leaving department to come within the national average	Back to Practice visits to review compliance with SOP. Performance reports to include review of patients leaving the department.	March 2018: GP Streaming is in place and a navigator is at the front door. Baseline audit of patients who have left department in previous 6 months so we can understand type of patients leaving department	Claire Beckwith	AEC	01/10/2018	

	Page 76		CQC REQUIREMENT	Where referenced in the reports	TRUST ACTION	HOW WILL THIS BE EMBEDDED	OUTCOME: what do we want to achieve	MONITORING ARRANGEMENTS: How will we monitor this?	PROGRESS	LEAD	CARE GROUP	TARGET DATE	DATE COMPLETE
U&E	U&E17	Should Do	The trust should increase consultant presence in the department in line with the RCEM guidance and ensure a minimum of an ST4 doctor is in the department at all times.	Evidence appendix pages 29, 34, 171 & 176	1. The Trust continues to recruit consultants. Taking account of appointments made subsequent to the inspection, the Trust now has 14 consultants across the two sites. We will continue to recruit consultants to increase the number of senior decision-makers on ED rotas. 2. The rotas at DMH do not rely on ST3s. 3. For UHND rotas: a) A specialist third party company is being engaged to review medical and staffing rotas. In addition to taking any opportunities identified to strengthen rotas, we will seek their advice to support the development of a competency framework (training, experience and qualifications) and supporting process with respect to the use of ST3s, building on existing support and training provided by consultant staff; and b) Revisit recruitment of Associate Specialists, with an enhanced pay scale more attractive to senior medical staff, to recruit Associate Specialists as senior decision-makers and reduce (and / or eliminate depending on the success of the initiative, in tandem with action 1 above) reliance on ST3s.	All rotas to be signed off only if ST4 / other senior decision-maker is in place. In the short-term, any ST3s will have their competencies and support arrangements reviewed and confirmed.	Appropriate level of senior cover in the ED departments	Rotas to be monitored by AEC management and reported to ECL on a quarterly basis	March 2018: DMH: on site consultant presence 14 hours per day, every day. No dependence on ST3s. Consultant recruitment in progress. Rate scale for recruitment of Associate Specialists has been revised and the Executive has approved the engagement of a third party company to review and advise on ED staffing rotas.	Kerry Dawson, Shaz Afzal & Jeremy Cundall	AEC	31/05/2018 (competency review) 31/07/2018 (third party recommendations in place) 31/10/2018 (review date for recruitment activity and outcomes)	
U&E	U&E18	Should Do	The trust should increase the number of children's nurses on duty to reflect the RCN staffing requirements.	Evidence appendix page 169	The Trust will take advice from the Royal College of Paediatricians (on site on 26th for 27th March) and will review staffing arrangements and pathways, taking account of their advice, to ensure children have access to children's nurses whenever they present.	Continuing monitoring of roster. Reinforcement of ensuring paediatric shifts are filled.	Children attending the Trust's sites will be seen by appropriately qualified nursing staff whenever they attend.	Management of shifts via staff roster	March 2018: DMH: 4 substantive paediatric trained nurses employed in ED. Cover 12 hours per day, 7 days per week and occasional night duty.	Vikki Bailey	AEC	31/07/2018	
U&E	U&E19	Should Do	The trust should ensure that nursing care assessments are completed.	Evidence appendix page 31	1. Key Messages regarding documentation will be reiterated together with standards for documentation re timing of entries and all assessments complete before transfer/discharge. 2. Checks to be undertaken as part of Quality Matters and Back to Practice Visits 3.Clinical audit to be undertaken with emphasis on chronology and whether or not the recorded action has been taken.	Daily Huddles will reinforce key messages	Improvement in completion of nursing assessments	Notes audit		Vikki Bailey, Claire Beckwith	AEC	30/06/2018	
U&E	U&E20	Should Do	The trust should ensure that all patients in non-visible cubicles have access to call bells	Evidence appendix page 25	All cubicle spaces in both EDs will be fitted with call bells	Call bells will be in place and checked for serviceability	Access to call bells in all cubicles	Environment checks will include checking of call bells.		Rob Warne	AEC	30/09/2018	
U&E	U&E21	Should Do	The trust must ensure that patients are given name bands in line with trust policy.	Evidence appendix page 31	1. Matrons will agree and document the criteria for patients to be issued with name bands and identify resource requirements (printers and staff) based on all patients being provided with bands at triage / patients meeting risk criteria 2. Implement printing of patient bands for all patients or in line with relevant risk categories	Audit and sharing of learning.	All relevant patients are given name bands in line with Trust policy	Name band audit to be carried out		Claire Beckwith / Vikki Bailey	AEC	31/07/2018	
U&E	U&E22	Should Do	The trust should ensure that staff update and review care pathways regularly.	Evidence appendix page 175	1. We will review ED care pathways to ensure all are updated and uploaded to shared drive. 2. A&E service leads will review RCEM standards to ensure care pathways that RCEM (and other professional bodies) recommend are in use or are developed. 3. The Care Group's process for version control will be followed (and will be reviewed to ensure that it is fit for purpose).	Process for review and archive established.	Care pathways updated and reviewed regularly	Via Care Group Governance Team progress update requests/discussions in bi-monthly specialty governance meeting.		John Holmes, Claire Beckwith, Angela Grundy, Ashleigh Jack	AEC	31/10/2018	
U&E	U&E23	Should Do	The trust should ensure that nursing staff caring for children are aware of the Fraser guidelines and Gillick competency principles when assessing patients' capacity for decision-making and obtaining consent from children.	Evidence appendix pages 41 , 148, 182 & 281	1. Matrons will disseminate key messages in the next monthly ED meeting. 2. Discussions will be held with paediatric nurses in ED and key messages shared with staff. (Linked to potential staffing requirements for MHA and Consent standards) 3. Longer term - training and support to be provided as part of improved MCA & Safeguarding arrangements	ED "Quality Matters" to be developed and to include monitoring of compliance	Nursing staff caring for children are aware of the Fraser guidelines and Gillick competency principles when assessing patients' capacity for decision-making and obtaining consent from children.	Include in ED Quality Matters		Claire Beckwith	AEC	30/04/2018 31/07/2018 (for ED Quality Matters)	
All Care Groups	CG2	Should Do	The trust should improve engagement with staff particularly those with protected characteristics.	Evidence appendix pages 8 & 17	A CDDFT Equality, Diversity & Inclusivity (E,D&I) strategy has been written and Board approval obtained	Sign off by the Board. Initially shared with Senior Managers and Heads of Dept., cascaded down to frontline staff	To promote equality among staff and value the diversity of the workforce	Progress against the strategy and associated action plans will be reported and monitored via the Workforce & OD SMT, Directors Meeting and IQAC for assurance.	March 2018: ED&I Strategy presented to the Board for sign-off	Morven Smith	WF&OD	31/03/2018	

	Ref		CQC REQUIREMENT	Where referenced in the reports	TRUST ACTION	HOW WILL THIS BE EMBEDDED	OUTCOME: what do we want to achieve	MONITORING ARRANGEMENTS: How will we monitor this?	PROGRESS	LEAD	CARE GROUP	TARGET DATE	DATE COMPLETE
All Care Groups	CG3	Should Do	(As above) The trust should improve engagement with staff particularly those with protected characteristics.	Evidence appendix pages 8 & 17	We will establish a Corporate Steering Group Chaired by a Director to set the strategic objectives around the ED&I agenda.	Sponsorship and involvement of Directors. Care Groups and Corporate areas will provide senior staff to sit on this group	Strategic Objectives and priorities identified and shared with the rest of the organisation	As above		Noel Scanlon and Jeremy Cundall	Trust wide	30/06/2018	
All Care Groups	CG4	Should Do	(As above) The trust should improve engagement with staff particularly those with protected characteristics.	Evidence appendix pages 8 & 17	We will develop an ED&I action plan which will be shared across the organisation	Actions will be incorporated into local staff matter action plans	Key areas of work identified and any issues addressed	As above		Noel Scanlon and Jeremy Cundall	Trust wide	31/07/2018	
All Care Groups	CG5	Should Do	(As above) The trust should improve engagement with staff particularly those with protected characteristics.	Evidence appendix pages 8 & 17	We will set up a working group with representatives from across the organisation to ensure actions are implemented at a local level.	Care Groups and Corporate areas will provide senior staff to sit on this group. Working group will report on progress to strategic steering group	Delivery of the actions outlined in the plan leading to improved staff engagement	As above		As above	Trust wide	31/07/2018	
Medical	M6	Should Do	The trust should ensure that staff are compliant with hospital policy on the administration of covert medicines.	Evidence appendix pages 64 & 76	Pharmacy will update Appendix 7 of the Trust Medicines Policy to develop a clearer care plan for covert administration Staff will discuss with Pharmacy where a patient is refusing medication, does not have capacity and covert administration is being considered. Where patients are assessed as not having capacity to make decisions, the use of medication should be part of any documented decision - we will change current "serious medical treatment" decision to "serious medical treatment including covert administration of medication"	Back to Practice visits to discuss awareness of covert medicines administration policy on all wards and require further training and awareness through ward huddles where issues identified.	Back to Practice visits to discuss awareness of covert medicines administration policy on all wards and require further training and awareness through ward huddles where issues identified.	Back to Practice visits to discuss awareness of covert medicines administration policy on all wards and require further training and awareness through ward huddles where issues identified.		Jamie Harris, ADNs	Pharmacy	31/07/2018	
Medical	M7	Should Do	The trust should ensure that medical and nursing records are stored securely in all areas.	Evidence appendix pages 63 & 204	1. Clinical Record Keeping and Health Records Management Policy to be updated to provide clear and specific guidance on storage of nursing and medical records. This will include the security of notes trollies (requiring them to be locked) 2. A risk assessment will be carried out with respect to notes being held at the bottom of patient beds. Clinical risks can arise if the notes are not readily available to support decision-making. Patient involvement is integral to the trusts Nursing process philosophy however bedside care plans should avoid explicit reference to sensitive data.	Matrons and Ward Sisters to undertake frequent observations and raise non-compliance in daily ward huddles	All notes to be stored securely but easily accessible. Where notes trollies are used ensure they meet the requirements detailed in the Trust policy.	Ad hoc spot checks and Back to Practice checks		Julie Race	Corporate Nursing Directorate	30/06/2018	
Surgery	S7	Should Do	The trust should ensure that equipment is stored in designated areas and boxes of equipment are stored off the floor where appropriate.	Evidence appendix pages 94 & 186	Equipment noted to be on floor of ward 13 and SAU at UHND, we will undertake frequent checks to ensure this does not occur.	Frequent observational checks	No equipment on floor	Weekly observational assessment		Kathryn Burn, Kay Stewart	Surgery	Started March 18 - on-going	
Surgery	S8	Should Do	The trust should ensure patient records are complete and staff signatures legible.	Evidence appendix pages 63, 99, 138, 204 & 273	1. Medical, nursing and AHP staff will be reminded of the Trust's policy on sign off of records 2. Additional checks will be undertaken on medical aspects of records to measure completeness, with clinical leaders, matrons and team leaders advised of any omissions for follow up with the individuals concerned 3. Improved education and reinforcement by senior medical staff, including where necessary retraining and sanction for any persistent non-compliance with Trust policy.	Back to Practice checks to review samples of records Clinical audits of record keeping to be undertaken. Quality Matters monthly audits	Adherence to Trust Policy with respect to name and signature on records.	Quality Matters audits		N Scanlon / ADNs / Senior Nurses	Trust wide	31/07/2018	
Surgery	S9	Should Do	The trust should ensure that protected time is available for theatre staff to attend regular training.	Evidence appendix pages 18	Same as the action for AfPP - appropriate headroom will be built into the establishment and rosters adjusted to reflect protected training time, attendance at which is mandatory. This will include elective shutdowns for training - attendance at which will be monitored and absentees sanctioned.	Paper will be presented. There will be approval required if additional staffing is required to be able to achieve this	To have the report submitted to Executive Directors. To have funding request for additional staff approved, if required. To complete recruitment programme to ensure staffing is appropriate	Through specialty performance meetings and nurse recruitment meetings	March 2018: Staffing paper in development	Louise Shutt	Surgery	30/09/2018	

	Page 78		CQC REQUIREMENT	Where referenced in the reports	TRUST ACTION	HOW WILL THIS BE EMBEDDED	OUTCOME: what do we want to achieve	MONITORING ARRANGEMENTS: How will we monitor this?	PROGRESS	LEAD	CARE GROUP	TARGET DATE	DATE COMPLETE
Surgery	S10	Should Do	The trust should assure themselves that relevant staff have access to sepsis training.	Evidence appendix pages 91	1. Staff to attend full day sepsis study day to be defined within the TNA Policy 2. Ward Managers and Clinical Team Leads to identify training needs and staff to be released from clinical activity to attend training	Training needs captured in appraisal and rostering of time to be released to be trained.	Staff have access to and are released from clinical duties to attend Sepsis training	1. Resus Steering Committee 2. Care Group training reports	March 2018: Sepsis training is undertaken by CAP for all clinical staff, delivered at essential training and on commencement of post through resuscitation induction. The Acute Intervention Team provided hotspot training on request.	1. Lisa Ward/Sepsis Steering Group 2. Kathryn Burn	Surgery	31/07/2018	
Surgery	S11	Should Do	The trust should ensure that patients discharge plans are completed.	Evidence appendix pages 71, 120 , 211 & 255	1. We will continue to monitor the completion of discharge plans via Quality Matters and where shortfalls are identified further training or action will be undertaken. Key messages will be reinforced in ward huddles where any gaps are identified. 2. Further monitoring will take place through Back to Practice Visits.	Clinical audit programme to include Discharge planning This is built into quality matters and reported on monthly and further monitoring will take place through Back to Practice visits	For all patients to have completed discharge plans	This is built into quality matters and reported on monthly - discussed at business unit performance meetings / SNMALG / IQAC	March 2018: This is built into quality matters and reported on monthly - discussed at business unit performance meetings / SNMALG / IQAC	Kathryn Burn	Surgery	31/05/2018	
Surgery	S12	Should Do	The trust should ensure increased visibility of the executive team at University Hospital North Durham as staff feedback identified limited visibility on this site in surgery.	Evidence appendix pages 4 & 123	EDs will review meetings to increase alternating of meetings between DMH and UHND and visibility of Executive Directors on the UHND site when on site.	Through management of ED diaries	Increased staff engagement with EDs at UHND, confirmed through staff feedback	Review of ED diaries by A&C and staff feedback	Executive Directors have attended regular (previously weekly now stepped down to monthly) meetings with theatres staff over the last quarter. Executive Directors are based at UHND every Friday and frequently on other days of the week. Frequent visits to all wards and clinical areas, including at UHND, by the Chief Executive and Chairman and other Board members.	S Jacques	Trust-wide	30/04/2018	
Surgery	S13	Should Do	The trust should ensure on-going engagement from senior management with theatre staff.	Evidence appendix pages 155, 258 & 290	Senior care group representatives will maintain frequent meetings, with the support of EDs, to ensure engagement with all theatre personnel.	Ensure monthly attendance by care group triumvirate representatives and ED on each site	Monthly attendance	Diary commitment of attendance	March 2018: Commenced	Richard Morris / Steve Scott / Kathryn Burn	surgery	On-going from 30/04/2018	
Maternity	Mat1	Should Do	The trust should seek to improve outcomes for women and new born babies with regards to standards in the National neonatal audit programme.	Evidence appendix pages 143 & 277	Results of 2016 National Neonatal Audit and 2017 Peer Reviews shared at speciality and Care Group Quality and Governance Meeting and areas requiring improvement identified.	Results of Audit shared annually at Care Group and Speciality Meetings	Ensure all staff are aware of standards audited as part of the NNAP and Trust performance against national average.	Minutes of meetings	March 2018: Complete for 2016 results	A Holt	Family Health	Complete	Feb-18

County Durham Integrated care partnership

Progress Update: Teams Around Patients and the Community Model

Adults Health and Wellbeing Overview and Scrutiny Session

2 May 2018

Agenda Item 7

Durham County Council

NHS

County Durham Integrated care partnership

Integrated Model – a reminder

- Health and Wellbeing Board -2016
- Ambition to integrate further
- Accountable Care Network
- Primary Care central
- Teams around Patients first stage
- Community offer redesign

County Durham Integrated care partnership

Teams Around Patients

- 13 Teams Around Patients (TAP) established.
- Staff aligned
- Cohorts identified
- Proactive care management of the frail elderly underway
- Voluntary Sector engaged

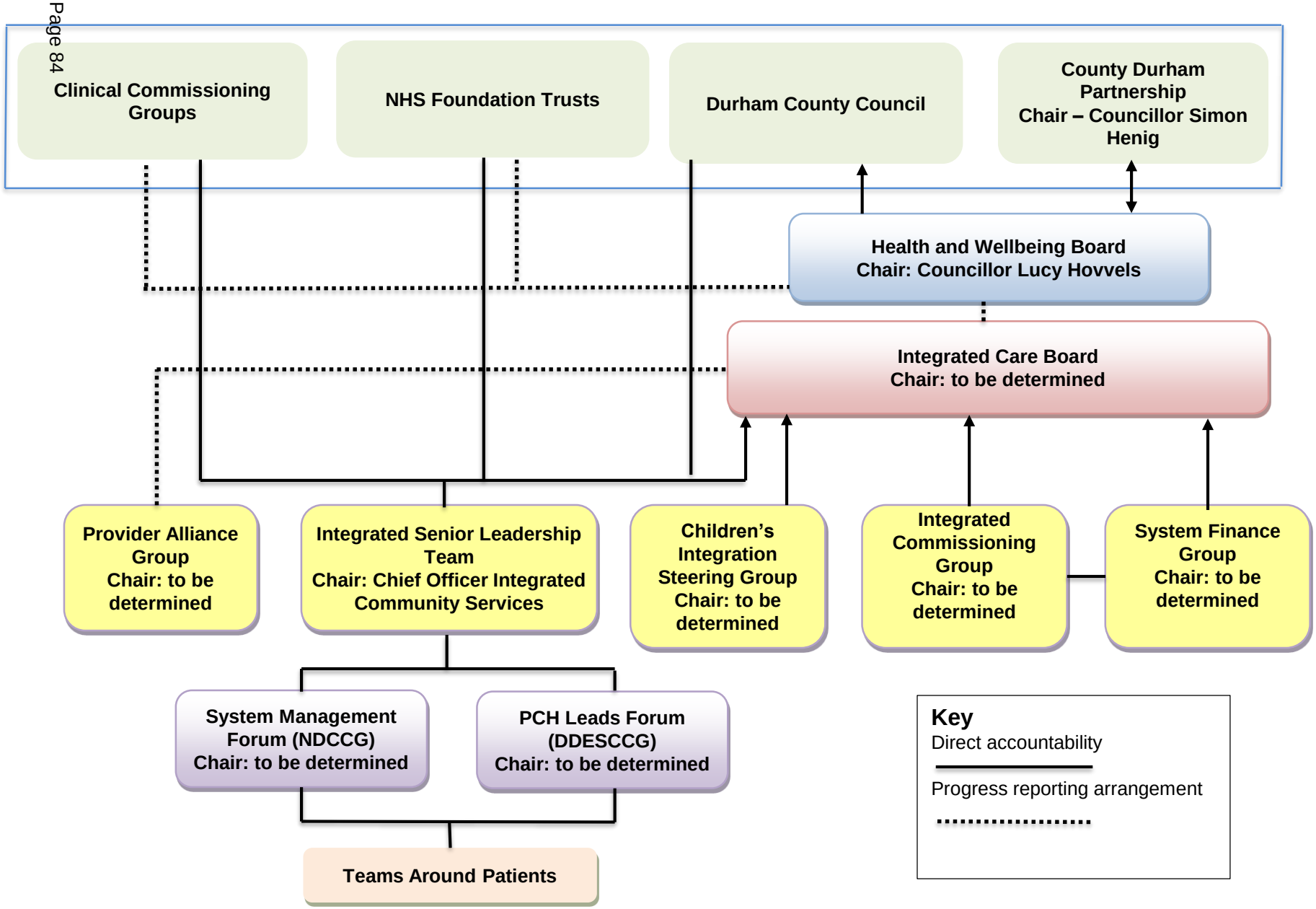
Our Ambition

- Health and Care Plan for County Durham
- True partnership approach
- Community service redesign
- Integrated service delivery
- Integrated commissioning

Progress to Date

- MoU in place
- TAPs established and operational
- Integrated Care Partnership established
- Community Service specification redesigned
- Integrated Commissioning model agreed
- Integrated models in mental health and learning disability strengthened
- Governance structure in place

Proposed Governance Structure for the Integrated Care System in County Durham



Next Steps

- Community contract procured with new identity for integrated delivery
- Implement integrated senior management arrangements across NHS and Adult Social Care
- Mobilisation work underway
- Community hospitals
  - Weardale
  - Sedgefield
  - Richardson
  - Shotley Bridge

The Future

- Deliver fully integrated service
- County Durham Health and Care plan
- Whole system approaches including all providers on patch
- Strengthen community offer