South Tyneside NHS Foundation Trust

South Tyneside District Hospital

Quality Report

Harton Lane
South Shields
Tyne and Wear
NE34 0PL
Tel: 0191 404 1000
Website: www.stft.nhs.uk

Date of inspection visit: 11 – 12 July 2017
Date of publication: 25/09/2017

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

Ratings

Services for children and young people

Summary of findings

Letter from the Chief Inspector of Hospitals

We previously carried out a focussed inspection at South Tyneside District Hospital in July 2016 to review processes, procedures, and practices for safeguarding children and young people. We looked at areas within the safe and well-led domains. Following our visit, we issued a warning notice because:

- The trust's safeguarding children processes, procedures and practices did not support the identification and protection of children who may be at risk.
- There was insufficient management oversight and governance of safeguarding children and young people.

We carried out a focussed follow-up inspection on 11 and 12 July 2017 to review the action taken by the trust in response to the warning notice. We did not rate the service.

Our key findings were as follows:

- The trust had a good understanding of its strengths and areas for development in relation to safeguarding children and young people. It had developed a robust action plan, which managers frequently reviewed and there was significant senior management oversight of the whole process.
- The trust had reviewed its systems to ensure managers had a more robust oversight of training. Compliance levels for safeguarding children training had improved since our last visit.
- Governance arrangements at senior level and at the frontline in the adult and paediatric emergency departments were sufficiently robust to identify sub-optimal or poor practice quickly, enabling managers to address this promptly with individual practitioners and staff groups.
- The trust had strengthened its safeguarding team by appointing an assistant director safeguarding, a dedicated named nurse safeguarding children for acute services and a safeguarding children advisor, who was based in South Tyneside District Hospital.
- Safeguarding children was a standard agenda item at departmental meetings and the director of nursing chaired monthly safeguarding assurance group meetings, the membership of which included key leads from across all services.
- The trust had revised the paperwork in the paediatric and adult emergency departments. The medical safeguarding children proforma was also compliant with the recommendations from the Royal College of Paediatrics and Child Health.
- The safeguarding children advisor reviewed all attendances of children and young people under the age of 18. The trust had also improved its recording and monitoring of children who had previously attended the emergency department.
- Staff spoke positively about the changes the trust had implemented since our last visit. They felt these changes had contributed to a shift in the culture to ensure safeguarding children was everyone's responsibility. Although some cultural challenges remained, it was evident staff and senior managers would continue to work collaboratively to ensure children and young people were safe and protected from risk of harm.

We also identified areas where the trust needed to make improvements. Importantly, the trust should:

- Continue to take appropriate action to mitigate the risk in relation to the named doctor provision at South Tyneside District Hospital.

Summary of findings

- Continue to ensure effective peer review meetings are held every 4-6 weeks, with a rotating chairperson. The minutes should include evidence of debate and critical analysis as outlined in the RCPCH intercollegiate document.
- Continue to embed good child safeguarding practice and exercise professional curiosity. This includes effective risk assessment and the completion of safeguarding templates/tools.

Professor Edward Baker
Chief Inspector of Hospitals

South Tyneside District Hospital

Detailed findings

Services we looked at
Services for children and young people

Detailed findings

Contents

Our inspection team

The team included CQC inspectors and a specialist in paediatrics and safeguarding children and young people.

How we carried out this inspection

This was a focussed follow-up inspection to review safeguarding processes, procedures, and practices for children and young people. We asked the trust to provide information, which we analysed during and after the inspection. We spoke with nursing and medical staff in children's services, maternity and the emergency department, senior managers and the executive team. We also reviewed 33 records across all three units.

Services for children and young people

Safe	
Well-led	
Overall	

Information about the service

This was a focussed follow-up inspection to review safeguarding processes, procedures, and practices for children and young people. We asked the trust to provide information, which we analysed during and after the inspection. We spoke with nursing and medical staff in children's services, maternity and the emergency department, senior managers and the executive team. We also reviewed 33 records across all three units.

Summary of findings

The trust had a good understanding of its strengths and areas for development in relation to safeguarding children and young people. It had developed a robust action plan, which managers frequently reviewed and there was significant senior management oversight of the whole process.

Staff spoke positively about the changes the trust had implemented since our last visit. They felt these changes had contributed to a shift in culture to ensure safeguarding children was everyone's responsibility.

Governance arrangements at the frontline in the adult and paediatric emergency departments were sufficiently robust to identify sub-optimal or poor practice quickly, enabling managers to address this promptly with individual practitioners and staff groups.

The trust had strengthened its safeguarding team. It had appointed a dedicated named nurse safeguarding children for acute services and a safeguarding children advisor, who was based in South Tyneside District Hospital. An independent domestic abuse advisor had also recently joined the team and worked with staff in the adult emergency department. Through discussions with staff, it was evident the new appointments had made a positive impact and safeguarding children was a high priority with everyone we spoke with.

The trust had revised the paperwork in the paediatric and adult emergency departments an the safeguarding children advisor reviewed all attendances of children and young people under the age of 18. The trust had also improved its recording and monitoring of children who had previously attended the emergency department.

Services for children and young people

Are services for children and young people safe?

At the previous inspection in July 2016, we found that the trust's safeguarding children processes, procedures and practices did not support the identification and protection of children and young people who may be at risk.

At this inspection, we found the trust had improved:

- The trust had strengthened its safeguarding team. It had appointed a dedicated named nurse safeguarding children for acute services and a safeguarding children advisor, who was based in South Tyneside District Hospital. An independent domestic abuse advisor had also recently joined the team and worked with staff in the adult emergency department. Through discussions with staff, it was evident the new appointments had made a positive impact and safeguarding children was a high priority with everyone we spoke with.
- The trust had revised the paperwork in the paediatric and adult emergency departments. This supported the early identification of safeguarding risks to children and young people. It meant practitioners had a means of gathering information to safeguard children linked to adults attending the emergency department. The medical safeguarding children proforma was also compliant with the recommendations from the Royal College of Paediatrics and Child Health.
- The safeguarding children advisor reviewed all attendances of children and young people under the age of 18. The trust had also improved its recording and monitoring of children who had previously attended the emergency department.

However:

- The quality of referrals to social services was variable although we did see improvements since our last visit. The safeguarding children advisor and named midwife reviewed all referrals and shared feedback with relevant members of staff.
- There was no named doctor safeguarding children in post. However, the trust had taken appropriate steps to mitigate the risk through utilising support from the named professionals working in its partner trust in the South Tyneside and Sunderland Healthcare Group.

Safeguarding

- At the previous inspection, the named nurse community was based off-site and their presence in the hospital was limited. There was no paediatric liaison or other appropriate role in the adult emergency department. Since our visit, the trust had appointed a dedicated named nurse and safeguarding advisor for children's acute services.
- The safeguarding advisor was based in South Tyneside District Hospital and all practitioners spoke positively about their ability to seek immediate support and advice. The advisor was also included in daily staff huddles, during which staff were briefed on key events from the previous day and learning from specific cases.
- The safeguarding advisor reviewed all attendances of children and young people who were under the age of 18. This was a recent development that supported retrospective oversight and ongoing enquiry of child safeguarding in both the adult and paediatric emergency departments, and demonstrated good practice.
- In addition, the trust had recently appointed an independent domestic violence advisor (IDVA) who was based in the adult emergency department every Monday afternoon and evening. The IDVA meets with individual patients and will provide training to staff on domestic abuse and how to recognise risk indicators. Managers and staff spoke of the benefit of this role and there were plans to increase the IDVA hours at the hospital.
- The trust had increased the working hours of the named midwife in the maternity unit from 7.5 hours per week to 18.75. This was an improvement since our visit last year and has increased the named midwife's capacity to further develop safeguarding practice within the service.
- The trust had also introduced safeguarding champions who supported and 'sign-posted' staff to appropriate information and advice. They received training and the trust had developed a competency framework.
- At the previous inspection, we identified concerns in relation to the provision of the named doctor role, their level of expertise and the support provided to them. Following our visit, the role became vacant and the trust was unsuccessful in its attempt to appoint a suitable

candidate. To mitigate the risk, the trust secured support from its partner organisation within the South Tyneside and Sunderland Healthcare Group. The named and designated doctors from City Hospitals Sunderland NHS Foundation Trust have been providing professional advice and guidance to practitioners at South Tyneside District Hospital. The trust had made plans for the designated doctor from Sunderland to cover the named doctor role at South Tyneside and will continue to seek a long term sustainable solution. The trust had secured additional support to maintain the named doctor provision at Sunderland.

- At the previous inspection, we found there were limitations in the patient recording system in the emergency department, which meant staff had no means of gathering an overview of the cohort of hidden children linked to adults attending the unit. There was also a lack of information included in emergency department records to determine triggers about existing children in a household, self-harming behaviour or exploration of a child or young person's social circumstances.
- In response to this, the trust had added key safeguarding questions to each paediatric and adult emergency department record. We reviewed seven case records in the adult emergency department. All demonstrated that staff routinely asked adult patients key safeguarding children questions. The nurse co-ordinator for the shift completed regular snapshot audits to monitor this. Findings were recorded and any sub-optimal practice was addressed promptly with the practitioner concerned. Feedback was shared with staff during daily huddles. This helps to minimise the risk that safeguarding concerns are overlooked and is helping to drive continuous improvement.
- At the previous inspection, we found staff were not aware of previous attendances of children at the paediatric emergency department, which meant practitioners could not undertake a full risk assessment. At this inspection, we noted the trust had taken appropriate action in response. Individual paediatric emergency department records demonstrated that the number of previous attendances were highly visible to practitioners. There were plans to upgrade and improve the IT system to support this practice.
- Additionally, staff had developed pathways to underpin the management and follow up of children and young people that accessed the department a number of times in a year. For example, in one case, we could see previous attendances had been considered as part of the young person's most recent presentation. Such practice facilitates joined up working and provides an understanding of individual needs and outcomes of earlier attendances to inform future assessments and decision making.
- We saw evidence that demonstrated midwives routinely enquired about domestic abuse and were fully compliant with this trust expectation. The introduction of a women-only appointment at 22 weeks supported the opportunity to make further enquiries about domestic abuse and other medical or social matters that may be sensitive for women to disclose when accompanied. Enquires about domestic abuse could be strengthened by assessing the level of risk using an appropriate tool. This would support maternity staff to track the responses made by women and identify escalating abuse so they could take safeguarding action. Maternity staff had also created a process by which women could alert them if they wished to speak with a midwife alone (if they were accompanied).
- At the previous inspection, we found that the processes for child protection cases and children under one were insufficient. The documentation used did not comply with the Royal College of Paediatrics and Child Health (RCPCH). During this visit, we reviewed documentation that demonstrated the trust used a more thorough extended clerking form that was RCPCH compliant.
- Staff from the paediatric emergency department were compliant in their completion of the CWILTED (condition, witness, incident, location, time, escort, description) initial assessment tool. This aids the identification and further assessment of possible risks to children and young people.
- Staff were also expected to complete part one of the Missing, Sexually Exploited and Trafficked (MSET) document when they identified children and young people at risk or experiencing harm. This supports the early identification of risks to children and young people. Staff overall were compliant but the form was not evident in all sampled cases.

Services for children and young people

- Safeguarding documentation was easily accessible along with other safeguarding resources, collated together in one place on the trust intranet. In the adult emergency department, resource grab folders were located outside the door of each treatment room. This meant staff had quick access to safeguarding information and referral flowcharts if they identified any concerns about a child or young person. Staff told us this gave them prompt and efficient access to information to inform their actions.
- We saw good evidence that paediatric and adult emergency department staff liaised with social workers and mental health staff in order to share information about children and young people and to agree their care and management. This approach supports effective joint working to help meet the needs of children and young people.
- There were still areas for improvement and managers were fully aware of what they were. For example, we saw variable standards of practice in the recording of names and relationship of adults that accompanied children and young people to the emergency department. This limits exploration about the appropriateness of the relationship and may affect matters relating to consent.
- At the previous inspection, we found referrals to social care did not fully analyse or articulate the risk or expected outcome. During this visit, the quality of referrals made by staff in the adult and paediatric emergency departments had improved but there was room for development. Weaker examples were incomplete and lacked detail and analysis of the safeguarding risks to children and young people. Although the safeguarding children advisor reviewed all referrals, this was after the referral had been sent. Managers recognised there was still more to do to embed good practice and maintain high standards in all referrals.
- In the maternity unit, staff told us the named midwife quality assured all referrals before they were received by the children's social care team. Overall, the standard of referrals was satisfactory with all fields completed. We saw evidence of analysis with the expected outcome of the referral clearly set out.

Are services for children and young people well-led?

At the previous inspection in July 2016, we found there was limited management oversight and governance of safeguarding children and young people. There was no formally established safeguarding supervision or peer review process. Training systems did not provide accurate recording and identification of healthcare staff compliance with safeguarding training across the trust and evidence showed compliance with safeguarding training was inconsistent.

At this inspection, we found the trust had improved:

- The trust had a good understanding of its strengths and areas for development in relation to safeguarding children and young people. It had developed a robust action plan, which managers frequently reviewed and there was significant senior management oversight of the whole process.
- Safeguarding children was a standard agenda item at departmental meetings and the director of nursing chaired monthly safeguarding assurance group meetings, the membership of which included key leads from across all services.
- Governance arrangements at the frontline in the adult and paediatric emergency departments were sufficiently robust to identify sub-optimal or poor practice quickly, enabling managers to address this promptly with individual practitioners and staff groups.
- The trust had improved its safeguarding supervision model and had strengthened its peer review process for consultants. In addition, there was an audit plan and we found evidence of increased audit activity.
- The trust had reviewed its systems to ensure managers had a more robust oversight of training. Compliance levels for safeguarding children training had improved since our last visit.
- Staff spoke positively about the changes the trust had implemented since our last visit. They felt these changes had contributed to a shift in culture to ensure safeguarding children was everyone's responsibility.

Although some cultural challenges remained, it was evident staff and senior managers would continue to work collaboratively to ensure children and young people were safe and protected from risk of harm.

Governance, risk management and quality measurement

- The trust had improved its management oversight of safeguarding children and young people. Changes in executive leadership had introduced a more robust governance structure for safeguarding. The director of nursing chaired the monthly safeguarding assurance group. This group included relevant professionals from all services, including the named midwife and head of midwifery. We reviewed minutes from these meetings and found assurance the trust had developed a robust process to maintain safe and effective oversight of all safeguarding actions. Safeguarding was also a standard agenda item at operational departmental meetings.
- In addition to the appointment of a dedicated named nurse and safeguarding advisor for children's acute services, the trust had recently appointed an assistant director safeguarding to strengthen the operational management oversight and leadership of safeguarding children. This role reported directly to the director of nursing who was the strategic lead for safeguarding children.
- At the previous inspection, we found there were no formally established safeguarding peer review processes. The frequency and attendance did not comply with recommendations published by the Royal College of Paediatrics and Child Health. We reviewed minutes from recent peer review meetings and noted the frequency and attendance had improved. We spoke with clinicians who told us peer review meetings were now more structured and effective, however the minutes did not always reflect critical analysis and debate of the cases discussed.
- At the previous inspection, we found the training system used by the learning and development department did not provide accurate recording and identification of healthcare staff compliance with safeguarding children training across the trust. Following our last visit, the trust had improved its system and there was clear evidence of management oversight. Compliance for safeguarding children training had improved. Overall, 94% of staff had completed safeguarding children level one while 78% had completed level three. There were 26 members of staff in total (out of 91), who had not completed level three training. The largest non-compliant cohort was A&E medical staff, where 10 out of the 17 clinicians still required training.
- The safeguarding children advisor had developed a spreadsheet that detailed child safeguarding activity and referrals to children's social care from both the adult and paediatric emergency departments. This supported opportunity to track and maintain oversight of actions taken and the outcomes for children and young people.
- However, in maternity, record keeping systems were fragmented. This limited access to complete records that reflected escalating / de-escalating concerns. For example, safeguarding information held on the trust maternity drive was not visible to emergency department staff should a pregnant woman attend. This prevents access to known information that may support the assessment of the woman's presenting condition.
- The trust had improved its safeguarding supervision provision. Staff were expected to attend group safeguarding children supervision quarterly. Senior nurses had attended supervision training to enable them to provide supervision support to staff. Practitioners also had access to ad-hoc advice and support from the safeguarding team. Current compliance was 78% and there was an action plan to manage and monitor attendance.
- The named midwife had made some positive progress in the development of a more formal approach to safeguarding supervision for midwives. Caseload holding midwives accessed quarterly face-to-face supervision with hospital midwives accessing six monthly via different formats to include group supervision. There were plans to increase the number of supervisors to support the named midwife in the delivery of this practice. Current compliance was 59% and there was an action plan to manage and monitor attendance.
- At the previous inspection, we found there was insufficient audit activity to monitor the quality and effectiveness of safeguarding processes against current national guidelines and standards. The trust had

improved its focus around audit and had created a plan. Regular activities included monthly snapshot audits of emergency department patient records, child sexual exploitation screening tool audits, and the assessment and management of infants with bruising.

- Audit activity in the paediatric emergency department did not include the compliance and effectiveness of HEAADSSS (Home and relationships /Education and employment/ Activities and hobbies / Alcohol / Drugs / Sex and relationships / Self-harm, depression, self-image / Safety and abuse) assessments. Cases sampled demonstrated that this practice was not fully embedded as they were not always completed and the quality was variable. Furthermore, the existing practice did not support ongoing risk assessment, in particular for those children and young people cared for in the paediatric assessment centre.
- Managers acknowledged the immaturity of both the supervision and audit programmes, and recognised the need to develop and strengthen the processes.

Culture within the service

- Nursing, midwifery and medical staff, and the safeguarding team felt there had been a change in the trust's culture since our visit last year. There was recognition that safeguarding is the responsibility of all staff. Staff told us communication in relation to safeguarding children had improved between nursing and medical staff. There was more engagement and ownership within teams and staff worked collaboratively to ensure children and young people were safe.
- The trust acknowledged there was still significant challenge with some staff groups to accept that safeguarding is everyone's responsibility. Throughout the inspection, we found the staff we spoke with demonstrated a clear commitment to driving change.
- Nursing staff told us about the positive shift in culture in the emergency department where medical staff now demonstrated their involvement by making appropriate safeguarding referrals. We felt assured the trust had established a firm foundation upon which to build and strengthen its processes, procedures, and practices.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- Continue to take appropriate action to mitigate the risk in relation to the named doctor provision at South Tyneside District Hospital.
- Continue to ensure effective peer review meetings are held every 4-6 weeks, with a rotating chairperson. The minutes should include evidence of debate and critical analysis as outlined in the RCPCH intercollegiate document.
- Continue to embed good child safeguarding practice and exercise professional curiosity. This includes effective risk assessment and the completion of safeguarding templates/tools.