

South Tyneside NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Requires improvement



Are services at this trust caring?

Outstanding



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected South Tyneside NHS Foundation Trust from 5 – 8 May 2015 and undertook an unannounced inspection on 3 June 2015. We carried out this comprehensive inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme.

The trust had a well-established executive team with the Chief Executive being in post since 1997 and the Chairman since 2006. The Chief Executive planned to retire in September 2015 and at the time of the inspection the trust was in the process of appointing a new Chief Executive.

We inspected the following core services:

- South Tyneside District Hospital; urgent and emergency care; medical care; surgical care; critical care; maternity services; children's and young people's services; end of life care; outpatient services and diagnostic imaging.
- Community services: community adult and long term conditions; end of life care; community health services for children, young people and families and dental services

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

Our key findings were as follows:

- Across both the acute hospital and community services, arrangements were in place to manage and monitor the prevention and control of infection. There was a dedicated infection control team to support staff and ensure policies and procedures were implemented and adhered to. We found that the areas we visited were clean. Infection rates for Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Difficile) were within an acceptable range for this size of trust.
- Patients were able to access suitable nutrition and hydration, including special diets and they reported that, on the whole, they were content with the quality and quantity of food.

- There were staffing shortages in some areas across both nursing and medical professions with some wards unable to meet the safer staffing requirements. The trust used agency nurses and locum doctors to address the staffing requirements.
- There were processes for implementing and monitoring the use of evidence based guidelines and standards to meet the needs of differing patient groups across both the hospital and community services.
- There were processes in place from ward and department level through to Board level for the reporting of incidents.
- There were long waits in the Emergency Department through the winter period with patients being cared for in the department; it was noted that patients were placed on a bed after being in the department for six hours.
- There were six instances in a six month period when a lack of critical care capacity resulted in patients being cared for in theatre recovery unit rather than in the intensive care unit.
- Equipment was well maintained both in hospital and community services.
- Governance processes were not fully developed or embedded across the divisions.
- The staff engagement is set out in the overarching trust strategy and we saw examples of staff engagement such as team brief and the Chief Executive 'cheer up Friday' email message.
- There was a clear strategic development plan which included both community and hospital services.
- There were concerns regarding leadership of some services.

We saw several areas of outstanding practice including:

- 100% of patients at St Benedict's hospice died at their preferred place and for the out of hours team at the hospice, 399 out of 404 (99%) patients died at home. For patients cared for by the Gateshead out of hours team, 246 (98%) patients in the Gateshead area died in their preferred place of care.
- The trust came top of the league for best performing hospital in England in 'The Cancer Patient Experience Survey: Insight Report and League Table' (2014) and

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was in the top three in the same survey in 2013. Areas of excellent performance in the survey included emotional support from nursing and medical staff, clear explanations of what was wrong and what to expect, involvement of family members and easy contact with the cancer specialist nurse.

- An outstanding level of care and compassion for patients and their relatives using community end of life care services. Patients and relatives were truly respected and valued as individuals and were empowered as partners in their care.
- The Trust was one of the 40 hospitals to receive the CHKS Top Hospitals Award in May 2015 through the CHKS national assessment and award programme. The evaluation considers safety, clinical effectiveness, health outcomes and patient experience and quality.
- There was a bereavement ward specialist nurse who held bereavement meetings and the chaplain was also a trained psychotherapist who would also provide support to the patient and their family.
- The trust's electronic referral and caseload scheduling for community nursing system, Hydra, won the 'embracing technology' category at the lean healthcare awards in 2014. The awards recognised excellent service improvements and enhanced efficiencies carried out by healthcare organisations. Hydra was also a runner-up in the national patient experience (PEN) awards.
- The community dental service had developed a DVD for Learning Disability patients. This video was used to help prepare Learning Disability patients for visits to the dentist. The staff reported positive feedback from the Learning Disability Team about this innovation.
- The development of an intra-nasal sedation service within community dental services. This approach tried to ensure that patients did not receive an unnecessary general anaesthetic because there are inherent risks associated with this procedure.
- The Trust's services to support older people won the value in healthcare ward in the Health Service Journal national awards. The service works closely with older people in South Tyneside to support people who are malnourished to ensure they were receiving the right, high quality care regarding their diet. A training programme was also set up in local care homes, resulting in more than 1,000 carers being trained to ensure residents receive a high energy, high protein diet.

- The children's diabetic team used a computer system that allowed uploading of information from glucose meters, insulin pumps, and mobile apps. The system consolidated and presented the information in reports which allowed the clinicians to see a more accurate picture of the patient's health over a period of time.
- The staff from the Endoscopy Unit won the 2015 'Study Team of the Year' category awarded by the National Institute for Health Research North East and North Cumbria Clinical Research Network.
- The Endoscopy Unit had participated in an international programme 'Endo-live' where live investigations were carried out and transmitted via satellite to conferences. The event in 2014 was opened by a professor from the endoscopy unit at South Tyneside District Hospital.
- Ward 19 had received a quality mark in 2014 from the Royal College of Psychiatrists as a result of positive work in the delivery of good quality, essential care for older people.
- The IT department was working collaboratively with the community IT team to ensure both the acute and community electronic patient systems will be compatible.
- Maternity services used a telehealth system (the delivery of health information using telecommunications technology). This system enabled women to monitor their blood glucose levels and blood pressure in their own homes, avoiding unnecessary visits to the clinic.
- A new form of renal replacement therapy which improved outcomes for patients with renal failure and meant that they could be stabilised prior to transfer to a hospital with a renal service (South Tyneside does not have a renal service).

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

Importantly, the trust must:

- Review compliance with mandatory training and in particular training in safeguarding, medical device management, medicines management and Mental Capacity Act and Deprivation of Liberty Safeguards.
- Ensure that medical staff receive mandatory training including fire prevention and child and adult safeguarding.

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- Ensure all necessary patient risk assessments, for example, venous thromboembolism (VTE) and early warning scores for deteriorating patients are completed and recorded appropriately.
 - Ensure assurance processes are in place to confirm the 'five steps to safer surgery' (part of the WHO surgical safety checklist) is being consistently completed.
 - Review the policy, processes, procedures, training, and support arrangements for the safe care and treatment of medical 'boarders' within surgical wards and the impact on services.
 - Review the arrangements for the provision of a care pathway and formal medical rota for the management of patients with gastrointestinal bleeds.
 - Review how the flow of patients is managed through the emergency department (ED) and ensure that there is a documented escalation plan that is implemented when required to deal with patients waiting for more than four hours for transfer to a ward. This should include action to avoid patients staying in ED longer than 12 hours.
 - Review the quality of record keeping in the emergency department to ensure that records accurately reflect the standard of care provided including risk assessments, nutrition and hydration and provision of nursing care.
 - Improve the quality of documentation for the decision to admit time and discharge time if the primary record is the ED documentation.
 - Ensure that when patients complain about their care, there is an effective process in place for staff to receive feedback and learning.
 - Conduct a full environmental risk assessment for the Intensive Therapy / High Dependency Unit (ITU) and take action to mitigate the risks posed by lack of storage space.
 - Implement an escalation plan approved by operating theatre and critical care nursing and clinical leads that ensures that appropriate support systems are available on a timely basis if critical care patients are nursed in the recovery room.
 - Ensure that all theatre staff caring for Level 2 and Level 3 ITU patients have received the appropriate training and that training records are retained.
 - Implement dedicated pharmacy support for ITU.
 - Ensure appropriate staffing on all children's inpatient areas particularly the special care baby unit.
 - Ensure that all medical devices receive service testing as required.
 - Ensure that COSHH risk assessments are completed for all areas storing substances hazardous to health to ensure that these are stored securely.
 - Ensure that effective control measures are in place to monitor exposure levels of nitrous oxide and the checking of ventilation and scavenging systems on the delivery suite.
 - Ensure resuscitation equipment checks are carried out regularly and consistently across all areas of the department.
 - Ensure that all employees receive an annual appraisal.
 - Ensure that there is a formal strategy for maternity and gynaecology services which sets out how the service is to achieve its priorities and that staff understand their role in achieving service objectives.
- In addition the trust should:
- Review the continuing concerns raised by staff of bullying and harassment and the difficult working environment within theatres.
 - Review the concerns raised by medical staff from the trauma and orthopaedics department about individual bullying and harassment leading to concerns about patient care.
 - Develop a strategy to support dedicated educational support for critical care staff.
 - Develop a formal process for safeguarding supervision in maternity services.
 - Develop processes to ensure that there is an audit trail for submission of HSA4 (abortion notification) forms to the Department of Health.
 - Consider improving facilities for children waiting within the main outpatients department.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to South Tyneside NHS Foundation Trust

South Tyneside NHS Foundation Trust is a £215m provider organisation providing a full range of community services across South Tyneside, Gateshead and Sunderland and acute hospital services in South Tyneside. The trust gained foundation status at the beginning of 2005 and serves a population of 154,000 in South Tyneside, 275,000 in Sunderland and 191,000 in Gateshead.

From the 1st July 2011, community health services in Gateshead, South Tyneside and Sunderland transferred to South Tyneside NHS Foundation Trust from NHS South of Tyne and Wear as part of the Government's Transforming Community Services programme. The trust is participating in the Department of Health Vanguard programme.

The trust has a workforce of approximately 5000 staff and has 321 general, maternity critical care and paediatric beds on the acute hospital site. The trust has a maternity service and delivered 1,329 births in 2014-15.

There are eight community dental clinics spread over the three localities of Sunderland, Gateshead and South Tyneside. The dental service as a whole processes around 3,100 new referrals annually. There are community adult services provided through district nursing, cardiology, eye and diabetic screening clinics, podiatry and a range of other services such as planned care, intermediate care, learning disabilities, and urgent care. Children's and young people's services are provided by health visiting, allied health professionals and school nurses. The trust does not have any inpatient community care beds however there is a hospice providing community end of life care that is part of the trust's St Benedict's Hospice and Centre for Specialist Palliative Care inpatient unit which has 14 inpatient beds.

Health and deprivation in South Tyneside are generally worse than for England as a whole. Deaths from smoking and rates of early deaths from cancer and from heart disease and stroke all appear worse than the averages for England.

Our inspection team

Our inspection team was led by:

Chair:

Trish Rowson, Director of Nursing – Quality and Safety, University Hospitals of North Midlands NHS Trust

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a consultant in emergency medicine, a consultant paediatrician, a consultant physician, a consultant obstetrician and gynaecologist, a consultant surgeon, a consultant anaesthetist, a palliative care consultant, junior doctors, senior nurses, district nurses, community matron, health visitors, student nurses and experts by experience.

How we carried out this inspection

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

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

- Is it well-led?

The inspection team inspected the following eight core services at South Tyneside Hospital NHS Foundation Trust:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery

Summary of findings

- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostics

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

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

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospital and community services. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held a listening event on 27 April 2015 at The Sea Hotel, South Shields to hear people's views about care

and treatment received at the hospital and in community services. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

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

We carried out an announced inspection on 5 – 8 May 2015 and an unannounced inspection on 3 June 2015.

What people who use the trust's services say

Overall patients told us they were happy with the care and treatment they received. Patients told us staff were very caring and listened to what patients and their families said. Patients felt safe and well looked after by staff. Staff are polite and friendly, providing excellent care and all staff treat patients and their families with care, respect and dignity. Patients, their relatives and carer's were all positive about the care and treatment they had received from the dental team.

We observed patients being treated with compassion, dignity and respect throughout our inspection and saw that patients were spoken to and listened to promptly. The trust was scored higher than the England average in the Patient Led Assessments for the Care Environment and the trust scored higher than the England average for privacy, dignity and well-being (trust 91, England average 87).

In November 2014 the trust scored 95% in the Friends and Family Test (FFT) for recommending the hospital.

The specialist palliative care team sent out FFT questionnaires to families and these were reviewed quarterly. In January and March 2015, 100% of respondents would recommend the service to family and friends. St Benedict's Hospice completed real time reports – Family and Friends Plus for patient feedback. 100% of respondents in January and February 2015 were satisfied with the care and treatment they received.

The trust came top of the league for best performing hospitals in England in 'The Cancer Patient Experience Survey: Insight Report and League Table' (2014) and was placed third in the same survey in 2013. Areas of excellent performance in the survey included emotional support from nursing and medical staff, clear explanations of what was wrong and what to expect, involvement of family members and easy contact with the cancer specialist nurse.

We viewed the podiatry service FFT results for the first quarter, January 2015. This demonstrated that 79.3% of

Summary of findings

patients who completed the test were extremely likely to recommend the podiatry clinic to their friends or family, with none of patients responding that they were either unlikely or extremely unlikely to recommend the clinic.

We viewed the results of the learning disability community nursing service FFT from February 2015.

Patients had been provided with an easy read questionnaire. 95% of patients who completed the questionnaire indicated that they would recommend the service to their friends or family. None of the patients who responded to the survey gave a negative response.

Facts and data about this trust

South Tyneside NHS Foundation Trust is an integrated provider of health care with a single acute hospital site and a range of community services. The trust has 321 general, maternity, paediatric and critical care beds. There are no community inpatient wards. The trust operates their community services across three locations: South Tyneside, Gateshead and Sunderland. The trust provides community health services for children and young people up to the age of 19 years.

The trust employs 3631 WTE staff across acute and community services. The staff are split into the following broad groups:

240 WTE Medical

2,060 WTE Nursing, midwifery and health visitors

1,331 WTE Other

The trust inpatient activity (2013 -14) was 30,873 admissions. There were a total of 172,911 outpatient attendances (total attendances) and 180,019 accident & emergency attendances.

Deprivation overall is significantly worse than the England average with high rates of child poverty. The health and well-being of children is generally worse than the England average with infant and child mortality rates are similar to the England average.

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

There are high rates of smoking in pregnancy and teenage pregnancies in comparison to the England average and there are low breastfeeding rates. Children in South Tyneside, Sunderland and Gateshead have worse than average levels of obesity with 8-10% of children aged 4 – 5 years and 21-23% aged 10 – 11 years being identified as obese. In children under the age of 18 there were high rates of hospital admission due to alcohol.

The trust was last inspected on 19 to 25 November 2013 and was found to be compliant.

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? There were robust reporting arrangements of incidents across the organisation through the electronic reporting system, with staff describing how incidents were shared and lessons learnt. There was an open culture to reporting incidents across the organisation with staff saying they were encouraged to report incidents. However, there were examples of not all incidents being reported. An example of this was the lack of reporting of critical care patients being cared for in the theatre recovery department due to a lack of critical care beds. Nurse staffing levels across the trust had been reviewed by the Chief Nurse and there had been recent investment in increasing qualified nursing numbers on the ward areas. However, there were still wards where staffing was below safe staffing levels, for example, on Ward 2 we saw that staffing ratios were one qualified nurse to 15 patients at night. Midwifery staffing was within the national guidelines. Medical staffing showed the trust to have lower numbers of consultants than the England average and higher numbers of junior doctors. There were specific staffing issues in the stroke service and an inability to recruit to a substantive post in this speciality. There were staffing issues identified during the inspection in the Special Care Baby Unit with staff to baby ratios higher than 1:6 on a number of occasions. There were staffing shortages in pharmacy with no dedicated pharmacy support to the intensive care unit. There were variable rates of safeguarding training across the trust however staff we spoke to were aware of safeguarding procedures both in the acute and community settings. There was a process in the outpatient department for following up on patients of concern who failed to attend their appointment. There was a lack of a formal rota for the management of patients being admitted with a gastro-intestinal bleed which had been identified as a significant risk. A plan to address this issue was in development. There was a wide variety in the percentage of harm free care delivered on the medical and elderly wards. This ranged from 70 % to 100% between January to November 2014; this is compared to 88% for the whole trust and the England average of 93.82%. Duty of Candour	Requires improvement 

Summary of findings

- The Trust has implemented the process to meet the Duty of Candour requirements; however this was yet to be fully embedded. The trust had a policy in place which provided guidance for staff on the requirements and set out what should happen following a notifiable patient safety incident.
- There was variation in the understanding of the requirements of the Duty of Candour across all levels of the organisation.

Safeguarding

- Adult safeguarding training figures were low across the trust with surgery having significantly low figures with only 23% of staff receiving Level 1 training. However, staff told us that they had received training and in community staff were confident about safeguarding procedures for children and reported having open access to the safeguarding team. In contrast in dental services the mandatory training records reported 100% staff compliance at Safeguarding Adults Level 1 training and Safeguarding Children Level 1 and 3 training.
- Serious case review numbers were high with 26 serious case reviews across South Tyneside, Gateshead and Sunderland. The Chief Nurse informed us that the reviews were presented to the Board and this was evidenced by the Board minutes. In the community children's team there was evidence of learning from the Serious Case Reviews with staff reporting that health visitors were linked with GP practices and had monthly review meetings.
- The maternity service had recently developed processes for reporting female genital mutilation in response to the Department of Health multi-agency guidance. There was a plan to provide training to staff but this had not happened at the time of our inspection.
- In the outpatient department, there was a process in place for staff to follow up on patients who did not attend (DNA) and who may be of concern. Prior to the inspection, two patients who had failed to attend their appointments had been followed up and were found to have social issues; the safeguarding team had been alerted and one patient was found to have safeguarding needs.
- In maternity there was no formal safeguarding supervision in place although the staff were aware of this and were looking to develop a more structured approach to supervision.
- In some areas there were posters displayed relating to domestic violence which signposted women to appropriate agencies for further advice and support.

Incidents

Summary of findings

- There were robust reporting arrangements of incidents across the organisation through the electronic reporting system. There was an open culture to reporting incidents across the organisation with staff saying they were encouraged to report incidents. However, there were examples of not all incidents being reported. An example of this was the lack of reporting of critical care patients being cared for in the theatre recovery department due to lack of critical care beds.
- There were no Never Events reported between February 2014 and January 2015.
- There was an inconsistent approach to ensuring there was learning from incidents. For example, in medicine staff told us they received feedback through ward meetings, notice boards, and multidisciplinary team (MDT) meetings and at handover. However, others told us feedback was not consistently received about less serious incidents or about learning from incidents that occurred in other directorates of the hospital.
- The trust has a higher rate of incident reporting than the England average based on December 2013 to November 2014 data. Through the national reporting systems, the trust reported 95 serious incidents of which 33 were Grade 3 pressure ulcers and 31 were related to slips, trips and falls. However, in medicine there was concern that the trust falls policy had not met national institute for health and care excellence (NICE) guidelines since February 2014. This was due to be re-written by the end of May 2015. This was recorded on the risk register for elderly care.
- Senior staff within medicine told us root cause analyses had shown pressure ulcers were not routinely photographed. Wards had been provided with cameras, but flat batteries and lack of understanding of the reasons for taking the photographs meant the Tissue Viability Nurses could not always attribute the origin of pressure ulcers.
- The trust reported 4,486 incidents for the period December 2013 to November 2014, and of these, 2,561 resulted in no harm; 1,589 resulted in low harm, 333 were moderate to severe harm and 3 were deaths.
- Of the incidents that were categorised as serious incidents, the majority were Grade 4 pressure ulcers that we were told were predominantly acquired in community.
- We reviewed action plans developed from the root cause analyses of serious incidents. In maternity services we looked at one action plan and saw that actions and learning had been fully implemented.

Summary of findings

- Assurance Matrons were responsible for looking at trends through review of data taken from the incident reporting system. Any trends identified would be fed back to the ward areas and actions agreed.
- Incident reports were submitted to and reviewed by the Safer Care Panel monthly and then a comprehensive summary report was submitted to the Choose Safer Care Committee. The former group was chaired by the Director of Nursing and attended by Assurance Matrons and provided assurance to the Choose Safer Care Committee, a quality and safety sub-committee of the board.
- Morbidity and mortality meetings were held and we saw evidence of learning from these reviews and implementation of changes in practice.

Staffing

- The staffing skill mix overall showed the percentage of consultants was lower than the England average and for junior grades was higher. 32% of the medical workforce were consultants compared to 38% England average and there were significantly less registrar posts at 18% of the total workforce compared to 38% England average. Junior doctors made up 34% of the medical workforce compared to 15% England average.
- Nurse staffing levels across the trust had been reviewed by the Chief Nurse and there had been recent investment in increasing qualified nursing numbers on the ward areas. However, there were still wards where staffing was below safe staffing levels. For example, on Ward 2 we saw that staffing ratios were one qualified nurse to 15 patients at night. The Chief Nurse told us that the Safer Nursing Care Tool used was used to ensure staffing levels were safe. At the time of the inspection we were told that there were 58 WTE vacancies across the organisation.
- Maternity staffing met the national benchmark set out in the Royal College of Obstetricians and Gynaecologists (RCOG) guidance with a ratio of 1:23 births compared to the RCOG recommendation of 1:28 births.
- At the hospice, the service used the national hospice acuity tool and e-rostering to manage and monitor staffing levels.
- In community services, the vacancy rate for community nursing teams across South Tyneside from June 2014 to March 2015 was 3% on average. Staff absence figures for community nursing teams across South Tyneside from January to March 2015 were 7% on average.

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- There were escalation processes in place across both acute and community services to review and address staffing issues on a daily basis in the acute setting and a weekly basis in community.
- The Special Care Baby Unit (SCBU) had six cot spaces. We met with the children's management team who told us the SCBU mainly had level one patients but could take level two patients for up to 24 hours. The clinical lead told us babies requiring level two care may need non-invasive ventilation for a period of time. This would mean the dependency and acuity of the babies would change in the unit and they would require more nurses per patients.
- Within the British Association of Perinatal Medicine (BAPM) guidance on Service Standards for Hospitals providing Neonatal care (3rd edition 2010), it recommends the ratio of nurses looking after special care babies should be at least one nurse to four babies. For babies who receive level two care the recommendations were one nurse to two babies. We reviewed staffing levels within the SCBU. On one of the days we visited, we found one qualified nurse and one health care assistant to three patients on an afternoon shift. When we asked if the unit would refuse patients due to staffing, we were told the unit would admit to all the beds if that was needed.
- We reviewed the off-duty for the SCBU from January to May 2015. We found consistently up to April 2015, there was one nurse on duty on night shifts. This meant if the unit was full, there was one qualified nurse to six patients which did not meet the recommendations of the BAPM guidance.
- In addition we saw between 27 January 2015 and 6 February 2015, there had been between seven and nine babies on the unit. When we checked the off-duty we saw there was one qualified nurse on a night shift between 27 January 2015 and 6 February 2015. We also saw in this period through the day on 2 February 2015, 6 February 2015 and 8 February 2015 there was one qualified nurse for some or all of the day shift.
- We asked staff within the unit where they would record if additional staff had worked on the unit and they confirmed this would be written on the off-duty. We spoke with the children's services management team who were unable to confirm if additional staff had worked although they said they had tried to get additional staff and this had been escalated to the director of nursing.
- There were staffing shortages on the medical wards with one ward having a qualified nurse: patient ratio of 1:15 at night.
- Two consultants provided consultant cover on the stroke ward; one substantive consultant and a long-term locum consultant

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filling the second post which had been vacant since 2014. There was a collaborative consultant out-of-hours rota for stroke care across Tyne and Wear with two other trusts with whom the trust had formed a clinical network. We were told that a long-term absence resulted in the locum consultant working alone and this was an area of concern for staff.

- Pharmacist capacity did not allow for regular involvement in patient education, or in medicines counselling prior to discharge on all wards. The trust did not have a critical care pharmacist to ensure safe and effective drug therapy. This meant the trust did not comply with the national specification for adult critical care.
- Domestic and porter cover overnight was reduced which staff told us impacted on the ability to respond to requests from ward areas. With regard to the impact of reduction in the number of domestics at the weekends (and on nights especially), it resulted in no cleaning being undertaken.
- In the paediatric service advanced paediatric nurse practitioners were supporting the junior doctors due to lack of junior doctor capacity.
- In community children's services health visiting caseloads were 1:180 – 250 which were within the nationally recommended maximum caseloads of 1:400. There were some staffing capacity issues in the speech and language services due to maternity leave and recruitment difficulties which left two members of staff covering the service.
- For the period September 2013 to August 2014, the staff had an elevated risk for the proportion of days sick due to stress. The sickness rate across the trust was 6.2% at the time of the inspection. However, we were informed by the Director of HR that the trust's future aim was to reduce the sickness absence rate to 4%. The main cause was due to long term sickness.

Infection Control

- There was a Director for Infection Prevention and Control (DIPC) as well as doctor, strategic lead and matron for Infection Prevention and Control. In addition there were Infection Prevention and Control link practitioners in the ward/service/ departments.
- The trusts performance for MRSA, MSSA and Clostridium difficile infections was better than the England average aside from one MRSA incident in May 2013 and one MSSA incident in February 2014. There were seven cases of Clostridium difficile reported up to January 2015; this is better than the expected target of ten.

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- Environments were generally clean and there were processes in place for ensuring the equipment and clinical areas were cleaned and checked on a regular basis.
- Hand hygiene results for the trust were 99.53% Clinical areas we visited generally had antibacterial gel dispensers at the entrances and in the clinical areas. However, there was no gel dispenser at the entrance of the Emergency Department and we saw that staff did not routinely use the alcohol dispensers to wash their hands. There was a bare below the elbows policy and we saw that this was adhered to.
- The inspection team were concerned that there was an elective orthopaedic patient on a medical ward due to lack of beds. This is not in line with current practice of ring fencing elective orthopaedic patients due to risk of infection of joint replacements.
- MRSA screening was carried out in accordance with national guidance.
- There was personal protective equipment (PPE) such as gloves and aprons available and we observed these being used appropriately across the services. We observed staff disposing of these safely and appropriately.
- In services where decontamination of equipment was required, we saw that staff adhered to the trust procedures. For example, the systems in place ensured that the service was meeting HTM 01-05 (guidelines for decontamination and infection control in primary dental care) Best Practice Requirements for infection control.
- Community nursing teams included an infection control link nurse. The link nurse's responsibilities included attending infection control meetings and providing feedback at team meetings. The infection control link nurse also took the lead with infection control audits. We saw that hand hygiene audits were completed monthly. Community nursing had achieved 100% compliance in hand hygiene.

Assessing and Responding to Patient Risk

- In the surgical service the inspection team observed that the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklists were not always completed. An audit in February 2015 showed a compliance rate of 93% and as a result, an action plan had been developed to ensure 100% compliance. However, this was not the case in other services where this was used. For example, in dental services, audits of the WHO checklist demonstrated high levels of compliance.
- Staff reported to us that patients who could not be admitted to the intensive care unit due to lack of bed availability would be

Summary of findings

cared for in the recovery unit and cared for by theatre and recovery nurses. This equated to six patients from January 2015 to the date of the inspection. Staff told us that they did not have the skills or experience to care for this group of patients. Staff told us they had not received training to support them to look after this group of patients. We discussed this matter with the Chief Nurse who informed us he felt assured that staff were competent to care for critical care patients in the theatre recovery unit.

- There was a lack of a formal rota for the management of patients being admitted with a gastro-intestinal bleed which had been identified as a significant risk. A plan was in development to address this issue.
- Wards used an early warning score system to identify deteriorating patients. Patient observations were mostly recorded appropriately and concerns were escalated in accordance with the guidance. We were told the use of the NEWS (National Early Warning Score) system was due to be launched across the trust shortly after our inspection.
- We looked at eight early warning score charts on a number of wards; they were all completed appropriately with the correct observation frequency. On one ward completed weekly audits of early warning score charts and were showing 84%-100% compliance.
- There was wide variety in the percentage of harm-free care delivered on the medical and elderly wards. This ranged from 70 % to 100% between January and November 2014; this is compared to 88% for the whole trust and the England average of 93.82%.
- Not all senior nursing staff on the stroke ward were unaware of the Sentinel Stroke National Audit Programme (SSNAP) nor how they could contribute to improvement on the results. SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence based standards, and national and local benchmarks.

Record Keeping

- There were a number of record keeping concerns in the surgery service with a review of 12 records which showed in four of the records Venous Thrombo-Embolic (VTE) risk assessments had not consistently been completed and there were no early warning scores.
- In surgery there was a lack of information on handover of medical patients when transferred to medical wards.
- In acute and community services, staff used paper records to record the treatment and care given to patients. The inspection

Summary of findings

team saw evidence that records were generally stored securely. However, in the outpatient department there were concerns that records were accessible and were not kept securely. In radiology images were stored digitally.

- Inspection teams reviewed records across the organisation and we saw records were generally clearly set out, legible, dated and signed appropriately. There was good record keeping practices seen on the Emergency Assessment Unit. However, there were concerns regarding the standard of documentation in the Emergency Department. Five sets of records were reviewed and there was no information regarding the care patients had received, whether the patient had had anything to eat or drink or whether they had their pain reviewed. We saw several sets of medical notes where doctors did not sign clearly nor print their name and designation.
- There were processes in place in the services to ensure documentation was regularly subject to internal audit.
- In medicine, we found two patient handover sheets left openly on trolleys in the corridor of two wards. One sheet had no patient names on but included personal information about the patients in numbered beds.
- In maternity services, women carried their own records throughout their pregnancy and postnatal care and the personal child health record was given to parents prior to discharge.
- In end of life care, the trust was implementing a new regional care of the dying audit and was piloting the documentation on two wards in the hospital. Care plans and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were kept in a yellow envelope on discharge and sent with the patient to ensure information was shared appropriately between all services including GPs and the ambulance service. Drug information was also shared via a green envelope system. We looked at 11 patient records and found they were clear and fully completed, including DNACPR forms. They provided an audit trail of decisions, treatment and care. Notes were easy to follow and included detailed and sensitive discussions about end of life care.
- In community services records were paper based and staff told us that the service did not have direct access to GP records systems. Information from GP's was faxed to community services. Staff told us the trust was transitioning to EMIS, a computerised records management system for integrated community services. Arrangements were in place for staff to receive training in the new records management system.

Medicines

Summary of findings

- There was evidence across the trust that fridge temperatures were not checked regularly and in accordance with the standard operating procedures across all core services. For example, in surgery, fridge temperatures were not checked in accordance with the policy. However in some areas, staff were able to tell us what action to take if fridge temperatures fell below the expected range. On one checklist, the temperature was noted to be 14 degrees. (The temperature should be between two and eight degrees). It was not clear if action had been taken when the fridge was too warm, nor if the temperature had been reset.
- Controlled drugs were checked in accordance with the trust policy.
- The trust had implemented a campaign relating to allergic reaction to medication which was called 'Be Yellow. Be Bright. Think Allergies' and from July 2014 the trust used yellow wrist bands for patients identifying the allergy.
- The trust's own missed medication doses audit completed in November 2014 indicated that, contrary to trust policy, ward staff were not completing incident reports on the electronic reporting system when patients missed doses of medication. We visited five wards and identified omissions on six charts. In common with the audit results, these omissions had not been recorded as an incident. Failure to follow policy means that the trust is unable to assess the impact of missed doses on a trust-wide basis.
- In medicine there were a number of examples of medication errors including: a patient admitted on 2 May who received a different dose of medication from the information provided by the GP until the pharmacist checked the dose on 6 May; One patient had been prescribed a nasal spray on the 3 May; this was not ordered by the ward until the pharmacist checked the chart on 5 May. We saw Temazepam syrup which expired in December 2014 (we were on the ward in early May 2015) and had not been returned to pharmacy. While it was kept secure in a locked cupboard, it was not in the controlled drugs cupboard as required.

Environment and equipment

- We observed that resuscitation trolleys across services were checked. However, the frequency of these checks were variable. For example, a standard work compliance audit had demonstrated that compliance in the outpatient department had dipped to 50% for four out of seven weeks prior to the inspection.

Summary of findings

- There were a number of areas across the trust where space was restricted. This included the phlebotomy waiting area which was often crowded with insufficient seating at peak times. The Special Care Baby Unit was cramped with six cots. The intensive care unit was small and overcrowded with a lack of storage space with the relatives' room being used as storage for clinical equipment.
- The main outpatient department had no facilities for children and although the majority of children's clinics were held at Palmer Hospital, there were at the time of inspection, eight children due to attend a clinic at the main hospital site.
- The Emergency Admission Unit was notably uncluttered and tidy and had implemented the productive ward programme.
- The trust used a McKinley syringe driver across the trust for administration of end of life medications.
- There were concerns raised regarding the pharmacy environment which was reported to be cramped.

Managing Anticipated Risks

- The presence of business continuity plans was variable across services with some having plans in place to manage and mitigate potential risks including changes in demand; disruption to facilities and adverse weather conditions. However, in maternity services and the Emergency Department there were no business continuity plans or plans were still in draft.
- There were major incident plans in place and the trust had a major incident policy. There were also major incident action cards to support the emergency planning and preparedness policy. Major incident equipment was checked and was found to be in date however there was no routine checking of this equipment.
- The trust had a lone worker system in place to ensure staff safety which we were told worked well. Staff would input the address for each visit on to the computer system and if the emergency button was pressed the conversation with the patient would be recorded and the police would be aware of the address.
- The community services managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather. Staff told us that the HYDRA system identified vulnerable patients and allocated calls on the basis of care and complexity and that this ensured the needs of vulnerable and highly dependent patients were met during the winter and during heatwaves.

Summary of findings

- Community services had a winter plan in place. This included community staff having access to 4x4 cars to maintain staff safety and to support access to patients in all community settings; the plan also provided telephone access to specialist services, which would provide advice to patients and staff during adverse weather. Planning included using staff that may be snowbound to visit patients in the area where they lived who were within walking distance.

Are services at this trust effective?

There was national evidence based care guidelines in use to determine care and treatment provided across most of the core services provided by the trust. However, in children's services there was evidence to show that clinical practice for using the drug ketamine was not in line with the NICE guidelines. In critical care there was only one care bundle in use related to ventilator acquired pneumonia. The trust had received a rating of 'E' on the Sentinel Stroke National Audit Programme. The trust had higher than expected outcomes for the Hospital Standardised Mortality Ratio indicator and the Summary Hospital-level Mortality Indicator for the period April 2013 to March 2014. Various factors can influence the reporting of these figures such as the number of palliative care beds at this trust and the management of coding.

There were concerns regarding the training and competence of staff in the theatre recovery unit who were required to look after patients requiring Level 2 and Level 3 critical care but who could not be admitted to the intensive care unit due to lack of bed capacity. The recovery and theatre nurses told us they had not been trained to care for this group of patients. In the intensive care unit there was no dedicated nurse educator and development for band six nurses was not formalised with no competency framework in place.

Across the core services there were audit programmes in place at both a local and national level. Information about patient outcomes was routinely monitored and there was evidence that services were taking action to make improvements.

The trust used the Malnutrition Universal Screening Tool (MUST) core assessment of nutrition and hydration. The Patient-led Assessments of the Care and Environment (PLACE) for 2014 scored the trust above the England average for food (92, England average 90), privacy, dignity and well-being (91, England average 87) and facilities (93, England average 92). The trust scored the same as the England average for cleanliness (98).

Evidence based care and treatment

Requires improvement



Summary of findings

- The Trust accepted that the stroke service was not as effective as possible with SSNAP data showing that the Trust achieved the lowest rating of 'E'. The Trust had reviewed an options appraisal for the service with the Board of Directors which accepted that the service was not sustainable in its current form in the long-term. Two consultants provided consultant cover on the stroke ward; one substantive consultant and a long-term locum consultant filling the second post which had been vacant since 2014. There was a collaborative consultant out-of-hours rota for stroke care South of Tyne and Wear with two other trusts with whom the trust had formed a clinical network.
- The trust participated in the MINAP Audit.
- There were a number of examples where services were not following national evidence based guidance. This included the use of ketamine in children's services that was not in line with NICE guidance.
- There was an annual audit programme in place, with audits undertaken being monitored and actions taken to improve clinical practice. For example, in maternity services we saw that there had been changes made to practice to reduce caesarean section rates from 17% with no associated rise in maternal morbidity and mortality. The trust audited its compliance with the use and documentation of the Early Warning Score (EWS) system which showed there was 100% compliance with recording patients EWS in March 2015.
- There were a number of examples of the clinical teams participating in national audits including The British Society for Colposcopy and Cervical Pathology.
- In End of Life Care services across acute and community settings, the Liverpool Care Pathway had been replaced, documentation reviewed and a regional care of the dying care plan had been implemented. Priorities for the last day of life care plans were developed with patients and their families. They had a CQUIN (Commissioning for Quality and Innovation) target around 'Deciding Right' implementation in which they had achieved full compliance.
- The trust contributed to the National Care of the Dying audit (NCDAH) 2013 /14 which showed the trust achieved five of the key performance indicators including access to information; dignity and respect and clinical protocols for prescription of medications. The trust did not achieve a further five indicators including specialist support of care in the last hours of life; care of the dying and feedback processes for bereaved relatives.

Summary of findings

- We saw reviews of IR(ME)R regulations and learning were shared with staff through team meetings. The trust had radiation protection supervisors to lead on the development, implementation and monitoring of policies and procedures to comply Ionising Radiation(Medical Exposure) 2000 Regulations.
- In community, the trust participated in an enhanced model of the Healthy Child Programme (HCP) which is an early intervention public health programme. The programme was delivered across the 0 – 19 year age range by a multi-disciplinary group of staff including Health Visitors, school nurses and community support workers. The trust also had three Family Nurse Partnerships for first time young mothers.
- Domiciliary dental care was provided across the sector using the standards set out in the Guidelines for Domiciliary Care by the British Society for Disability and Oral Health (BSDOH).
- The SSKIN bundle (Surface, Skin inspection, Keep moving, Incontinence, and Nutrition), a five step model for pressure ulcer prevention had been adapted for use by Ward 10 staff and rolled out across the trust.

Patient outcomes

- Across the services, patients' pain was monitored and treated effectively, and there was use of anticipatory medication in end of life care.
- The trust had elevated risks for the Hospital Standardised Mortality Ratio indicator and the Summary Hospital-level Mortality Indicator for the period April 2013 to March 2014. The standardised hospital mortality index (SHMI) for 2013-2014 predicted 948 deaths in the hospital, but actual results showed 1092 deaths. Various factors can influence the reporting of these figures such as the number of palliative care beds at this trust and the management of coding. The HSMR remained elevated but the trust informed us that this was influenced by reduced specialist palliative care coding since the retirement of the palliative care physician and delay in the replacements taking up their positions.
- The trust used the Malnutrition Universal Screening Tool (MUST) core assessment of nutrition and hydration and across the core services and these were seen to be completed and actions taken appropriately.
- The Patient-led Assessments of the Care and Environment (PLACE) for 2014 scored the trust above the England average for food (92, England average 90), privacy, dignity and well-being (91, England average 87) and facilities (93, England average 92). The trust scored the same as the England average for cleanliness (98).

Summary of findings

- Overall the trust was matching the improvement seen nationally in the Patient Reported Outcomes Measures (PROMs) and had a lower proportion of patients worsening than the national average. The trust had identified actions to be taken to improve response rates this included changing the pre-assessment processes.
- The National Bowel Cancer Audit (2014) showed better than the England average results for specialist nurse involvement and scans undertaken and the trust were the same as the England average for discussion at MDT.
- Lung cancer audit results (2014) showed the percentage of patients receiving surgery was better than the England average, with the trust achieving 13% compared to an average of 15%. There were better than the England average results for multi-disciplinary team discussion and availability of scan results prior to bronchoscopy.
- The trust took part in the National Hip Fracture Audit (2014) which showed the trust was better than the England average in areas including: patients being admitted to an orthopaedic ward within 4 hours (67%, England average 48%); falls assessment performed (100% England average 97%) and bone health medication assessment (100%, England average 97%).
- The trust had a Did Not Attend (DNA) rate of 8% which was slightly worse than the England average of 7%. The trust reported that they had not cancelled any outpatient appointments.
- Outcomes for patient care and treatment in end of life services were routinely monitored and recorded. 100% of patients at the hospice died at their preferred place and for the out of hours team at the hospice 399 out of 404 (99%) patients died at home. For patients cared for by the Gateshead out of hours team 246 (98%) patients in the Gateshead area died in their preferred place of care. The service participated in the National Survey of Bereaved People. The aim of this survey was to assess experiences of care in the last three months of life for adults who die in England. Overall the quality of care that was rated as outstanding/excellent for the three localities was between 43% and 48%, with privacy and dignity being rated as excellent at between 78% and 80%.
- The trust's "choose high quality care" quality report for 2014 stated that the district nursing service saw approximately 50,000 patients per month. The trust used data from the NHS safety thermometer to compare the trust's performance with the national prevalence. For pressure ulcers the trust's

Summary of findings

prevalence in 2013-2014 was 0.74% compared with the national prevalence of 1.14%. The report stated that the trust was “not a national outlier in pressure ulcers and action was being taken to further improve in 2014/15.”

Multidisciplinary working

- Across the trust we saw evidence in the core services of multi-disciplinary working. Cancer multi-disciplinary working was in place. Staff across the organisation reported good multi-disciplinary working. Daily ‘huddles’ had been rolled out across the hospital following recommendations from an external audit. Staff on the wards and other clinical areas told us of very good working relationships within the multidisciplinary teams (MDT). We observed examples of good practice with MDT board round rounds and huddles, which included a cross section of team members including nurses, junior doctors, consultants, discharge team staff, allied health professionals, and social workers, all of whom contributed to discharge planning. However, on the stroke ward, health care assistants were excluded from the handover. On the EAU there was an MDT business meeting every day where safety and work priorities were discussed with the team. We saw the housekeeper on EAU was very much part of a team, and she carried out a variety of roles to support team working.
- In end of life care a range of health care professionals, including district nursing, equipment services, General Practitioners and Specialist Palliative Care Nurses worked well together, to coordinate and plan the care for patients at the end of their life.
- We saw multi-disciplinary handovers taking place across the core services.
- Ward staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists.
- In community dental services, there was effective and collaborative working across disciplines involved in patients' care and treatment. For example, patients would often present with complex medical conditions requiring consultation with the patient's GP and or Consultant Physician or Surgeon. The service also worked closely with health visiting, learning disability teams and drug and alcohol services to ensure that vulnerable groups requiring dental care can secure ready access to treatment and care as the needs arise.
- Work was in progress for community locations to move into shared accommodation, as part of the trust's integrated care

Summary of findings

agenda. Staff who had already moved told us they felt the joint arrangements for accommodation worked well and were an advantage in supporting joined-up working between community based teams.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust had a Mental Capacity Act policy and end of life documentation also included information regarding advance decisions. This policy covered the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards'.
- We saw that staff had completed Mental Capacity Act and Deprivation of Liberty Safeguard competencies however training numbers were varied within surgery
- Nursing and medical staff understood their roles and responsibilities regarding consent and were aware of how to obtain verbal and written consent, and staff in core services were able to describe how they would obtain consent.
- In the dental service staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead. A dentist we spoke to described to us the local service known as 'Your Voice Count's' which provides a system of independent mental capacity advocates or IMCA's. She explained how the service works with the agency to assist in the consent process for those patients who lack capacity to consent for treatment.
- Where nursing staff used photography to obtain a record of the patient's condition and symptoms, this was done with the patient's written consent.

Competent Staff

- We were told by staff that there were a number of patients who required admission to critical care but whom, due to lack of intensive care beds, were cared for in the theatre recovery unit. We were told by recovery and theatre nurses that they had not been provided with the appropriate training to care for level two and level three patients. We spoke to the Chief Nurse who assured us that recovery and theatre nurses are trained to look after critical care patients and when patients are in the recovery unit, the critical care outreach team provide additional support.
- The trust had preceptorship packages in place and there were examples of good practice in maternity where staff who were returning after a period of absence underwent an 'induction' back to work. However, there was no consistent approach to clinical supervision across the healthcare professional groups.

Summary of findings

- Appraisal rates across the trust were variable with an overall appraisal rate of between 25% to 100% with some services have lower rates. For example, in maternity rates were 53% between April 2013 to March 2014. In surgery, for the same period, appraisal rates were 50%. However, up to the time of the inspection, appraisal rates had improved to 69% of staff receiving an appraisal. In the outpatient department however the rates were 84% with dates booked for those yet to have an appraisal. The hospital appraisal data showed great variability in the rate of compliance with annual appraisals, these ranged from 25% - 100% for nursing staff; however, when we visited individual clinical areas, we were shown different data and told that there were problems with the way appraisal and training compliance was centrally recorded. Ward managers showed us compliance rates of over 90%.
- In community staff told us individual supervision took place every four to six weeks, and there was regular supervision in team meetings. However, managers and staff told us clinical supervision was an area the trust had identified as requiring improvement, as this had not been prioritised during the move to integrated working. Clinical supervision varied between core services in both acute and community settings.
- There were protected weekly teaching sessions in place for junior doctors. The results of the General Medical Council training scheme survey 2013 showed educational and clinical supervision, induction and adequate experience were within expectation for the trust.
- Medical revalidation was in place for consultants and there was a process to ensure that consultants were up to date with revalidation.
- Training was offered to non-specialist and specialist staff by the palliative care education team and staff based at St Benedict's Hospice. Training included 'Foundations in palliative care', 'Stepping into palliative care', 'Deciding right' training, advance statements, emergency health care plans and a master class in Mental Capacity Act and do not attempt cardio-pulmonary resuscitation training available for staff to attend.
- Staff on the stroke ward told us mandatory manual handling training did not include use of the equipment on the stroke ward. They said therapy staff provided training for equipment; however, this training was not extended to nursing auxiliaries. This meant that if a patient needed repositioning or moving and handling, auxiliaries were not trained to meet their needs.

Summary of findings

Are services at this trust caring?

We observed patients being treated with compassion, dignity and respect throughout our inspection and saw that patients were spoken to and listened to promptly. The trust came top of the league for best performing hospitals in England in The Cancer Patient Experience Survey: Insight Report and League Table 2014 and was placed third in the same survey in 2013. Areas of excellent performance in the survey included emotional support from nursing and medical staff, clear explanations of what was wrong and what to expect, involvement of family members and easy contact with the cancer specialist nurse. We observed this in practice in end of life care across the trust with staff being attentive to the needs of patients.

In community services teams observed care in patients' homes, clinic settings and observed staff speaking to clients on the telephone. Staff told us that they were passionate about delivering high quality care and the majority of people we spoke to receiving community services were happy with the care they received.

Compassionate care

- We observed patients being treated with compassion, dignity and respect throughout our inspection and saw that patients were spoken to and listened to promptly. We observed staff across the trust being attentive to the needs of patients, for example introducing themselves and drawing curtains when they were attending to patients.
- In community services teams observed care in patients' homes, clinic settings and observed staff speaking to clients on the telephone. Staff told us that they were passionate about delivering high quality care and the majority of people we spoke to receiving community services were happy with the care they received. In dental services the patients we observed were given explanations about their dental treatment in language that they could understand. They were treated with respect and dignity at all times. We saw extremely kind, gentle and compassionate care being given to patients. The team working between the dental nurses and the dentist was exceptional and delivered a very good patient experience.
- Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment they received. Patients were generally very complimentary about the staff across all of the core services in both the acute and community settings.
- The trust came top of the league for best performing hospitals in England in The Cancer Patient Experience Survey: Insight Report and League Table 2014 and was placed third in the

Outstanding



Summary of findings

same survey in 2013. Areas of excellent performance in the survey included emotional support from nursing and medical staff and easy contact with the cancer specialist nurse. However, the trust scored worse than the England average for nurses not talking in front of the patients as if they were not there but this was not reflected in the 2013 CQC In-patient survey with the trust scoring the same as the England average for this indicator.

- In November 2014 the trust scored 95% in the Friends and Family Test for recommending the hospital. In community services, the Friends and Family Test was introduced in January 2015 and we were told that results from the first quarter were not available at the time of the inspection.
- In outpatients we observed patients being asked by a member of staff whether they had been resident in the UK for the previous 12 months and although this is a requirement (and staff checked with patients if it would be acceptable to ask them some questions in the waiting room), other people waiting could overhear the conversation easily.
- The trust performed slightly better than the England average for the length of time taken to answer the call button (8.8 compared to England average of 8.0).
- Medical wards used an 'open and honest' report to demonstrate care results. These varied across the wards. On average 83% of patients said they received enough help with meals, 80% received care which mattered to them, 85% said they had access to a call bell, 95% said they had understandable answers to questions and 100% said they were given enough privacy.
- The same report indicated some staff felt: "busy and pressured, with high dependency levels", others said they: "couldn't give effective quality care and left work frustrated."

Understanding and involvement of patients and those close to them

- In the Cancer Patient Experience Survey, the trust scored higher than the England average for patients for a number of indicators relating to the provision of information and ensuring that this was understood by the patient. These included possible side effects being explained in an understandable way; patients' family had the opportunity to talk to the doctor and staff explained how the operation had gone in an understandable way. The trust was in line with the national average for patients receiving understandable answers to important questions all or most of the time.

Summary of findings

- In the Care Quality Commission In-patient Survey (2014) the trust were in line with the England average with regard to the patients belief that they were involved as much as they want to be in decisions about their care and treatment and to say they received answers they could understand.
- In children's and young people's services we saw staff tailoring advice to the needs of the patients.
- Results from the Real Time Questionnaire - Friends and Family Test Plus January and February 2015 showed that 100% of patients felt well informed and they were given information in a way you could understand. They also felt they could challenge decisions made about their care and treatment.
- There was some evidence of 'This is me' awareness. We saw posters on some of the wards but we saw little evidence of the use of the initiative in practice when looking in patient notes. Staff told us they didn't have time to complete the tool with families.

Emotional support

- The Care Quality Commission In-patient Survey (2014) showed a consistent score (7.9) in inpatients believing they had received enough emotional support from hospital staff.
- Chaplaincy services were available for patients and their families in the hospital. The trust employed two chaplains who were supported by a team of volunteers. The chaplaincy service could access spiritual leaders from other faiths to ensure that patients' religious beliefs were observed. There was a chapel and multi-faith room available in the hospital for patients and their relatives to attend. The multi-faith room had resources available including for example the Qur'an and prayer mats however the signage was only on the door of the room and the inspection team found it difficult to find. This was raised with the trust at the time of the inspection.
- There were bereavement rooms available in the trust however in the Emergency Department it was noted there was no specific room available for relatives to be with a deceased patient. We were told this usually took place in one of the rooms in the Emergency Department.
- In surgery there was information within care plans to highlight whether people had emotional or mental health needs and what support was required. Patients were able to access counselling services, psychologists and the mental health team if identified during clinical assessment. Assessments for anxiety and depression were done at the pre-assessment stage and additional support was then provided by nursing staff at the time of surgery.

Summary of findings

- In children's and young people's services families had access to more specialised support with staff able to refer to the child and adolescent mental health services, psychologists and counselling services. Health visiting teams managed their own caseloads which meant families had the same health visitor at each visit.
- The wards had bereavement link nurses and there were two bereavement midwives to support bereaved relatives and there were relative rooms available in the clinical areas.
- There was a counselling service available at the hospice for all patients in the community requiring end of life care. An evaluation of this service was completed in December 2014 which demonstrated that 82% of patients said that the service was beneficial and 95% of patients who stated that they felt heard and understood by their counsellor. In end of life services there were a number of other strategies for patients and carers including a monthly carers group and pets being allowed in to the hospice.

Are services at this trust responsive?

Community services were in transition to a model of integrated community teams across health and social care. The aim of the service model was to improve patient outcomes and experience through bringing existing community services from health and social care into a more combined way of working. The aim was to reduce the number of different professionals that patients needed to interact with, reducing duplication of work and increasing the focus on personalised care and self-care. There were processes in place to manage the operational pressures within both acute and community settings on a daily basis.

There was a lack of capacity in the intensive care unit on a number of occasions that resulted in patients requiring admission to intensive care being cared for in the theatre recovery unit by theatre and recovery nurses. The intensive care unit kept an empty bed overnight to manage acute demand. However, there were delayed discharges from the intensive care unit which had an impact on the trust's ability to admit to the unit. There were a higher number of patients discharged at night. The Intensive Care Society recommend that follow-up clinics be in place to ensure patients who have required admission to the intensive care unit can be followed up post discharge. The trust did not have these in place but a business case was being developed by the clinical and management team for the service.

In the Emergency Department, for the period January 2015 to February 2015, the inspection team identified 152 patients who

Requires improvement



Summary of findings

waited in the department for longer than 12 hours from the time when the decision was taken that the patient required admission to hospital. The trust however had not reported any breaches of the 12 hour target for this period. We were told by the executive team that patients who had waited for six hours from arrival were placed on a bed whilst in the Emergency Department and that this was seen as good practice. The executive team and senior management team for the department were assured that there had been no breaches and at the unannounced visit informed us that patients who had waited for longer than 12 hours were reviewed by the management team and were deemed to have received 'enhanced care' and were therefore validated and not reported as a breach. We were told that the enhanced care was in line with the NHS England guidelines. However, there were no wash facilities other than a sink in the cubicles, there were no facilities to keep their belongings and patients would have to walk to the toilet in the department. During interviews, the executive team were unable to inform the inspection team of the longest wait up to the time of the inspection. The trust did not meet the target of seeing 95% of patients within 4 hours on the accident and emergency from November 2014 with the lowest performance outcome being 80.15% in January 2015, however this is in line with the national position.

Service planning and delivery to meet the needs of local people

- The trust executive and divisional management teams worked with commissioners, local authority and other providers on developing integrated models of care for the local population. The trust was part of a community Vanguard programme across Sunderland - this included leading the implementation of three innovations in the delivery of community services including a city-wide Recovery at Home Service, an innovative partnership between Sunderland Care and Support and South Tyneside NHS Foundation Trust, which was transforming care and experience to patients in the city of Sunderland. The second was the creation of five integrated health and social care teams which was transforming how primary care, community health, and community care teams work together to transform experience and support to residents, and thirdly, enhancing and transforming primary care across the city.
- The trust had an escalation and surge policy to deal with times of increased demand and divisional leads and the executive team were able to describe these for both the acute and community services.

Summary of findings

- There were daily meetings in the acute setting to monitor bed availability in response to demand through the hospital. In community, staffing was monitored through the nursing teams and reviewed on a daily basis with staff being moved to meet changing workload demands.
- The divisions undertook capacity and demand planning on an annual basis and monitored activity and progress against the capacity plans on a monthly basis to ensure demand was met and changes to capacity or demand were identified.
- In maternity services, the team were reviewing current clinical pathways and developing a business case to progress a revised pathway of care. The new model was designed to address the existing traditional model of maternity care and out-dated facilities.
- With regard to end of life care, the trust was part of the regional end of life care group.
- The dental service had, over a period of years, moved from a traditional Community Dental Service to one which is a mixture of referral based specialised service and that of providing continuing care to a targeted group of patients with special needs due to physical, mental, social and medical impairment. Due to this change of focus these groups could access services when required to meet their needs and the needs of family and carers.
- Community services were in transition to a model of integrated community teams across health and social care. The aim of the service model was to improve patient outcomes and experience through bringing existing community services from health and social care into a more combined way of working; with the aim of reducing the number of different professionals that patients needed to interact with, reducing duplication of work, and increasing the focus on personalised care and self-care.
- We found that service specifications were in place for most community services which included the aims and objectives of the service, as well as the expected outcomes for patients. Staff we spoke with told us they had developed good working relationships with commissioners, other providers and stakeholders to ensure multi-disciplinary working and continuity of patient care. For example, staff told us about the trust's acute respiratory assessment service (ARAS). ARAS provided a specialist service for the assessment, management and treatment of patients with respiratory conditions.

Meeting people's individual needs

Summary of findings

- Bed occupancy in the trust fluctuated between 84.5% to 89.7% from April 2013 to November 2014.
- Services had access to interpretation services for patients either by phone or face to face.
- The trust had developed an orthopaedic outreach team which had shown an improvement in the average length of stay across all specialities (7.7 days with team input compared to 15.7 days without input from the team).
- In outpatients there were a number of examples of services meeting individual needs. For example, patients who had to wait for long periods of time for their appointments were provided with snack boxes and regular drinks by volunteers in the department. In cardiology, if patients could not attend outpatients, home visits could be organised on occasion.
- The hospital generally provided clinical areas with furniture and equipment for patients who were morbidly obese and required specialist bariatric equipment. However, in radiology the MRI scanner did not meet the needs of this group of patients and patients were offered the choice of accessing the scan with another provider.
- In outpatients, we saw that patients with learning disabilities were identified as part of their referral and in response were allocated longer appointment times. Their relatives, social workers or carers were accommodated to attend the consultation with the patient. Quiet areas in the department were used to allow the patient to feel safe with their relative or carer.
- Patient information leaflets were available in clinical areas and were plentiful, of good quality and up to date. Information was also available in large print version and in different languages.
- In maternity services there were specialist midwives available who provided support in areas such as services for the young pregnant woman, substance misuse and ethnic minorities.
- The dental service had developed a DVD for learning disability patients. The dentist working at Wrekenton who developed the DVD explained how this video is used to help prepare learning disability patients for visits to the dentist. The staff reported positive feedback from the Learning Disability Team about this innovation
- The learning disability service provided specialist multi-disciplinary assessment and intervention to individuals aged 18 and over with learning disabilities and complex health care needs. For example, physiotherapists in the community Musculoskeletal Clinical Assessment and. Treatment

Summary of findings

Service provided services for patients living with a learning disability and long-term conditions such as cerebral palsy. The team also provided advice and support to patients, carers and other professionals.

Dementia

- We saw that services were responsive to the needs of people living with dementia who were admitted to the hospital with wards having dementia leads who were able to provide support and caring for patients with dementia.
- Dementia awareness training was being rolled out to all staff working in community based teams. District nursing teams had completed dementia awareness training delivered in partnership with the Alzheimer's Society. Managers told us that teams had started to recruit dementia leads who would lead on dementia awareness. In community we saw an action plan was in place for all staff to receive dementia awareness training in 2015.
- The butterfly scheme provides a system for patients living with dementia which enables staff to identify them quickly. We saw that on some patient records the service used the butterfly symbol on patient records. Staff told us this acted as a visual prompt to aid staff in identifying patients with a diagnosis of dementia.
- We saw yellow food plates used on ward 19; we were told this helped patients with visual loss or those living with dementia to be able to notice food on their plate more readily. Staff on this ward invited partners and spouses to come in for Sunday lunch so patient could eat with them.
- We were shown reminiscence work on ward 19, where board and computer games and music were used to provide stimulation and orientation for patients. Families and carers were encouraged to bring in patients own belongings and photographs for the same reasons.

Access and flow

- There was a lack of capacity in the intensive care unit on a number of occasions that resulted in patients requiring admission to intensive care being cared for in the theatre recovery unit by theatre and recovery nurses. The intensive care unit kept an empty bed overnight to manage acute demand however there were delayed discharges from the intensive care unit which had an impact on the trust's ability to admit to the unit. There were a higher number of patients discharged at night. The Intensive Care Society Core Standards (2013) state that discharges from critical care overnight are associated with

Summary of findings

higher mortality rates. We discussed the capacity issues with the Chief Operating Officer who informed us that there were ongoing capacity issues but a business case had been developed to expand the bed base of the intensive care unit from 6 beds to 10 beds although this still had to be approved by the executive board.

- The Intensive Care Society recommend that follow up clinics are in place to ensure patients who have required admission to the intensive care unit can be followed up post discharge. The trust did not have these in place but a business case was being developed by the clinical and management team for the service.
- In the Emergency Department, for the period January 2015 to February 2015, the inspection team identified 152 patients who waited in the department for longer than 12 hours from the time when the decision was taken that the patient required admission to hospital. The trust however had not reported any breaches of the 12 hour target for this period. We were told by the executive team that patients who had waited for six hours from arrival were placed on a bed whilst in the Emergency Department and that this was seen as good practice. The executive team and senior management team for the department were assured that there had been no breaches and at the unannounced visit informed us that patients who had waited for longer than 12 hours were reviewed by the management team and were deemed to have received 'enhanced care' and were therefore validated and not reported as a breach. We were told that enhanced care was in line with the NHS England guidelines. However, there were no wash facilities other than a sink in the cubicles, there were no facilities to keep their belongings and patients would have to walk to the toilet in the department. During interviews, the executive team were unable to inform the inspection team of the longest wait up to the time of the inspection.
- The trust did not meet the target of seeing 95% of patients within 4 hours in the accident & emergency from November 2014 with the lowest being 80.15% in January 2015, however this is in line with the national position.
- The trust reported 528 patients having a delayed transfer of care for the period April 2013 to November 2014. The main reasons were awaiting nursing home placement which related to 102 patients (19% England average 12%) and a further 282 patients had a delayed transfer of care due to patient or family choice (53%, England average 14%).
- The trust was meeting the overall referral to treatment target for the admitted pathway (90%) for patients admitted for

Summary of findings

treatment within 18 weeks of referral with surgical specialities achieving between 95% to 100%. The average length of stay was better than the England average across the surgical specialities. Between October 2014 and February 2015 there were 149 patients cancelled due to no surgical bed available. For the non-admitted referral to treatment target (95%) the trust consistently achieved 98%. The trust also achieved the target for incomplete treatment pathways (92%) ranging from 94.5% in March 2014 to 95% in August 2014.

- In the maternity unit, bed occupancy between April and September 2014 was low ranging from between 25% to 29% compared to the England average of between 55% to 60%. There were 1,329 deliveries between July 2013 and June 2014 putting the trust into the lower quartile for the number of deliveries compared to other trusts.
- Diagnostics waiting times were lower than the England average with no patients waiting longer than 6 weeks from April 2013 to November 2014.
- The trust was better than the England average for the cancer targets of 31 days from diagnosis to first definitive treatment and the 62 day target from GP referral to first definitive treatment.
- In dental services between April 2014 and March 2015 the average time to first assessment appointments in the three localities were: Gateshead and South Tyneside 6 weeks and Sunderland 8 weeks. Between April 2014 and March 2015 waiting times for different procedures varied depending upon what type of sedation was required and if it was children or adults that required treatment. The longest average wait was for intravenous sedation in the Sunderland locality which was 30 weeks and general anaesthetic for adults which was 17 weeks.
- We viewed the district nurse quality indicators for Gateshead. We found that between April 2014 and March 2015 100% of patients who were triaged by the traffic light triage system as red, were seen within two hours of referral; 99% of amber triaged patients were seen within 24 hours; and 99% of green triaged patients were seen within 48 hours. This meant patient assessments were consistently within the expectations of patients and commissioners.
- In the musculoskeletal service, 100% of patients were given an appointment within the required timescale, with between 80% to 93% being seen within 18 days of referral to the service. Referral to the service was via GP or physiotherapy referral.

Learning from complaints and concerns

Summary of findings

- In 2012 to 2013 the trust saw a significant increase in the number of complaints however this was due to the integration of community services. The number of complaints in 2013 to 2014 had reduced to 225 for the year.
- Generally staff were able to describe the complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for patients to make a formal complaint. There was however variation in the management of feedback from complaints at core service level. In some services, for example the Emergency Department, staff told us there was no formal process for feeding back from complaints and ensuring learning. In contrast, in surgery, we were told that that complaints were discussed at team meetings.
- If patients or their relatives needed help with making a complaint the Independent Complaints Advocacy Services (ICAS) contact details were available on the wards.
- We looked at complaint responses and found that responses were comprehensive, signed by the chief executive and well worded to convey apologies. Staff reported that learning from complaints could be better shared.

Are services at this trust well-led?

The trust had a clear vision that described a change in focus for the trust into an integrated health and social care model. The trust's vision was to provide the best care for patients, in the best place, at the right time. To deliver the vision the trust had a quality strategy with the strategic objective of delivering high quality and safe services to patients. The strategic aims were: safe care; effective treatment; and quality services. The trust's value statement was displayed on notice boards for staff, in the community locations we visited, as well as on the trust's intranet and internet.

The trust governance processes were not fully embedded and there was lack of a consistent approach within the divisions regarding the governance structure. There was no formal quality report to the board and this was being developed by the Chief Nurse. However, the divisions did have integrated performance reports which included workforce, finance and performance metrics. Quality metrics were reviewed at the trust-wide Safer Care Panel and in summary by the Choose Safer Care Committee, a sub-committee of the board.

During the inspection there were a number of clinical and non-clinical areas where staff had raised concerns regarding a number of

Requires improvement



Summary of findings

issues. We saw evidence of the improvement plans for two wards, which had been in place since 2014. However, some of the ward staff were unaware of the improvement plans. Concerns were raised in a number of areas regarding bullying and harassment.

The trust had clear staff engagement plans which were set out under the 'Choose' strategic plan which set out five key priorities for staff. The Chief Executive sent out an email every Monday.

Vision and strategy

- The trust had a clear vision that described a change in focus for the trust into an integrated health and social care model. The trust's vision was to provide the best care for patients, in the best place, at the right time. To deliver the vision the trust had a quality strategy with the strategic objective of delivering high quality and safe services to patients. The strategic aims were: safe care; effective treatment; and quality services. The trust's value statement was displayed on notice boards for staff, in the community locations we visited, as well as on the trust's intranet and internet. The Chief Executive was able to articulate this vision very clearly and set out the strategic direction for the organisation.
- The trust's strategic plan 2014-2019, "choose change – driving transformation forward", involved community services working with commissioners to agree the scope of their moving to a model based on GP and local authority geographical areas. The approach would differ in each area to reflect local need, but the aim would be the same. Community services would have multi-disciplinary staff in local teams to smooth the patient pathway and ensure continuity of care. Some of the work had been completed in the last year.
- The trust had set out their values and there were examples within core services as to how these values were integrated in the delivery of services. For example, in dental services we saw and staff informed us that the value base of the trust was openly discussed as part of the performance and development review (PDR) system. The embedding of trust values is monitored through the staff survey; grievances, bullying and harassment claims and complaints. The roll out process of the values involved asking clinical areas to identify how they were going to embed the values in their clinical areas.
- The Trust was leading the transformation of community health and care services across the city of Sunderland as one of the national 'Vanguard' transformation schemes. The Chief Operating Officer leads the city's Provider Board which is transforming recovery at home services, enhancing Community

Summary of findings

Integrated Care, and revolutionising primary care. This transformation has been recognised nationally with both the award of 'Vanguard' status and in significant allocation of national resources to support the changes. In South Tyneside, the Trust's community services are a core part of the national 'Pioneer' programme which is transforming how services and organisations work together to empower patients to take greater control of their own health and care requirements.

- The trust participated in the national values based recruitment process.
- Staff confirmed they understood the vision of the trust, namely the 6 'C's and were aware that information on strategic plans for the organisation could be accessed via the trust's intranet.
- The trust did not have an End of Life strategy in place. However, we were told there was a steering group which was looking at the development of a strategy across all services.
- The trust had an estates plan in place to address a number of environmental issues including in pharmacy and the critical care unit.

Governance, risk management and quality measurement

- The trust had a Board Assurance Framework in place which identified the trust strategic aims and objectives with key risks identified and described. Risks were risk rated and key controls and gaps were identified. The Board Assurance Framework was reviewed quarterly at the Trust Board meeting.
- The trust had identified needing to embed patient focussed care with risks linked to poor clinical engagement and poor trust culture as the top risks.
- There was a corporate risk register in place with top risks as training for staff; however the executive team were not able to describe fully the risks on the register. The Chief Executive identified finance, staffing levels and service sustainability as the three top risks.
- The trust governance structures did not appear to be well embedded – for example, in medicine we spoke to four ward managers; they all reported a lack of sharing of incidents and complaints across medicine and elderly care. We were told that there was previously a monthly risk management meeting where themes and incidents were shared and this may be reintroduced. A divisional director when asked directly if there was a governance structure in place in their division informed us that there was no embedded structure at the time.
- There was a Non-Executive Director responsible for quality and who chaired the Choose Safer Care committee. Within the

Summary of findings

executive team, the Chief Nurse was identified as having responsibility for quality, governance and risk. Responsibility for staffing sat with the Chief Operating Officer with both the Chief Nurse and Medical Director having responsibility for assurance.

- Senior staff told us there was a Clinical Incident Review Group, developed to discuss and review clinical incidents and errors so that feedback could be given to ward teams. 'Uncle Ed's' meetings were a forum for medical and nursing staff to receive feedback and share learning from incidents. However, not all core services reported effective feedback from incidents and complaints.
- The divisions had an Integrated Performance Report which encompassed finance, performance and workforce however quality metrics were not included apart from an infection control metric of MRSA incidence. There were more detailed separate reports for finance, workforce and performance reviewed at Executive Board. South Tyneside was the first trust in the NHS to implement PERFORM, a people focused performance monitoring system. Divisions were held to account through this framework by the Chief Operating Officer. The Trust Board were informed by the use of exception reporting.
- There was no formal quality report to the board at the time of the inspection and we were told this was in development by the Chief Nurse but had not yet been implemented. Quality metrics were reviewed at the trust-wide Safer Care Panel and in summary by the Choose Safer Care Committee, a sub-committee of the board. Each Division had an Assurance Matron in place who monitored quality within the divisions. The Matrons would work with the Continuous Quality Improvement Team to provide assurance.
- In community services there were risk registers in place that were up to date and reviewed regularly. Most staff we spoke to were aware of the risks. However, we did speak to staff who were unaware of the risk register and felt it was not readily accessible.
- The trust's information management team monitored community services performance against a number of criteria. For example, patient contacts; failed visits; and inappropriate referrals. The information management team used data from the trust's electronic systems to identify any significant differences in community teams' performances on a month by month basis.
- The Medical Director confirmed that mortality and morbidity were reviewed in each speciality. However, the frequency and numbers reviewed varied. For example, in elderly care only 50%

Summary of findings

of deaths were reviewed. Mortality was reported to the trust board on an annual basis; mortality outlier intelligence was also reported. With regard to the trust Hospital Standardised Mortality Ratio (HSMR), the Medical Director informed us that the reason for this being higher than the England average was due to the inclusion of data from the palliative care inpatient unit and the impact of coding of ambulatory care patients.

- There was a cost improvement programme of £12.7 million for 2015 /16. We were told that cost improvement plans were reviewed and signed off by the Chief Nurse and Medical Director and a quality impact assessment would be undertaken on all schemes. The same process also applied to business cases.
- A patient story's presented to the beginning of every Trust Board meeting and this has been in place for the last two years.
- The trust produced a quality and clinical audit report annually. We viewed the 2014 report; this highlighted how the report prioritised its audit programmes on the basis of national priority, trust priority, national good practice, and clinical interest.
- Throughout the inspection staff informed us that the trust training register based on Electronic Staff Record was inaccurate which resulted in staff keeping their own manual records at ward level as evidence of training. We discussed this with the Chief Nurse who informed us that he was aware of the issues and that the trust was taking steps to try and improve the accuracy of the electronic record.
- There was a monthly executive walkabout that included commissioners however this was not to carry out self inspections.

Leadership of the trust

- The chief executive was well established in their role and known to staff in both acute and community services. Staff felt there was clear leadership at executive level. Staff told us the chief executive was approachable. Managers told us they had attended staff briefings with the chief executive.
- The trust had a 'Choose to lead' strategy that included the provision of a variety of leadership programmes. We were told an in house 'seven steps of leadership programme' was available for prospective leaders, but no ward based staff we spoke with had heard of the programme. We were told that all staff had a 360 degree appraisal and that coaching was planned to start within the organisation.

Summary of findings

- There were a number of areas of concern within the trust that were raised by trust staff at the time of the inspection and included recovery teams, orthopaedic surgery, anaesthetics, obstetrics, portering staff and switchboard teams.
- We discussed the issues in orthopaedics with the Medical Director who informed us that there had been an external review of clinical practices undertaken. The issues were predominantly human resource issues. At the time of the inspection, the middle grade doctors in the service were not at work. The trust adhered to the Maintaining High Professional Standards for addressing concerns within the medical profession where applicable.
- We discussed the issues within obstetrics as this related to concerns regarding changes to services and we were informed that there was currently an external facilitator working with the team.
- We discussed the Emergency Department processes and the patients waiting over 12 hours from decision to admit who were not declared as a breach of the twelve hour target. The executive team were assured that patients were being treated in accordance with the NHS England guidance and there were no breaches to declare. The Executive team were unable to state what the longest wait in the Emergency Department had been. We asked how the Board would be made aware of the issues in the Emergency Department and we were informed that this would occur through a paper to the Board summarising performance.
- We discussed the concerns regarding the care of critical care patients in recovery and the lack of training for the recovery and theatre staff. Both the Chief Nurse and Medical Director were assured that this was not an issue. At the inspection the Medical Director informed us that staff had been offered training but they had chosen not to take up this offer.
- There were concerns regarding the leadership of two wards within the trust. The Chief Nurse was aware of these wards and action plans had been developed with the staff to address the issues. We saw evidence of the improvement plans for the wards, which had been in place since 2014. However, some of the staff informed us that they had not been aware of these improvement plans.
- There were clinical lead posts in place and consultants told us they felt that clinical leadership within the organisation was good. However, the clinicians were not responsible for the divisions; this was the responsibility of the Divisional Directors and the lead clinicians reported into the Divisional Directors.

Summary of findings

- The Chair reported a lack of clinical representation within the Non-Executive Directors however they had recently appointed a Director with a clinical background. The Chair was assured that the Board had the right skills and expertise.
- Most staff we spoke with felt engaged and valued by ward managers, the Clinical Operations Manager and the Clinical Business Manager. However, they said more senior leaders were not visible, and the 'cheer up' emails did not make them feel engaged.
- On the trust intranet there was a site for 'You Said, We Did.'
- The Director of HR told us that there was a divide between the acute and community trusts and in response the Executive Team were planning to have more events away from the acute site.

Culture within the trust

- Staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role. Staff told us they were able to put forward ideas and discuss them as a team.
- Staff generally reported a positive culture in community services, although we encountered exceptions in some locations, where staff felt uncertain about the pace of roll out of the trust's integrated care agenda.
- The trust had a 'Raising Concerns at Work (Whistleblowing) Policy'.
- There were a number of areas within the trust that reported to the inspection team a culture of bullying and harassment. In one area it was reported that there were no departmental meetings, and that regular team meetings had only been agreed following a grievance being taken out by the staff. During the inspection there was an incident with a consultant who, it was alleged, was confrontational and aggressive with staff who had approached the inspection team. This was reported to the executive team and dealt with in a timely manner.
- At the consultant forum the organisational culture was described as one of openness and accessible with a visible executive team. Of particular note was the visibility of the Chief Executive.

Fit and Proper Persons

- The trust became subject to a new regulation (Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) on 27 November 2014. This regulation says

Summary of findings

that individuals in authority (board members) in organisations that deliver care are responsible for the overall quality and safety of that care. The regulation is about ensuring that board members are fit and proper to carry out that role.

- The Board had approved a paper for the implementation of the Fit and Proper Persons test in 2014 and we were told had received training from a local legal firm on the requirements of the regulation.
- The board had implemented enhanced arrangements for recruitment to executive and non-executive roles; however, most of the executive and non-executive team were long-standing employees of the trust and the relevant documentation to support the Fit and Proper Person Test was not included in their personnel files. Evidence of the search of the insolvency and bankruptcy register and disqualified director register were not present in seven of the nine files checked. Proof of identity was also omitted for six out of nine files checked.

Public engagement

- The trust did not have a public engagement strategy.
- The trust was holding a 'Dying Matters Awareness Week' in May 2015 to raise awareness about dying, death and bereavement and planning for end of life.
- The Patient Involvement team undertake an annual questionnaire.

Staff engagement

- There are five key 'Choose People Management Standards' that are part of the trust strategy of 'Choose'. These are:
 1. To communicate effectively and in a timely manner with all of the staff;
 2. To ensure all staff are made aware of new or reviewed policies;
 3. To ensure staff have the chance to discuss their performance through appraisal;
 4. To ensure new staff receive a good induction;
 5. To ensure staff have bullying and harassment concerns investigated properly.
- We reviewed a sample of information on the trust intranet that staff used to support their work. The information was clear and accessible. Staff told us they received briefings, newsletters,

Summary of findings

and updates about particular themes by email on a regular basis called “cheer up Friday”, where the chief executive shared some of the commendations and thanks the trust had received and provided staff with positive messages.

- The trust had a number of ways of engaging with staff. For example, the joint consultative committee and monthly health and safety committee. The trust also held a monthly management forum and monthly senior clinical forum where the chief executive discussed key topical issues, with senior and middle managers and senior clinicians.
- The trust had introduced a staff recognition strategy in April 2014. This introduced employee and team of the month awards, where staff had the opportunity to nominate colleagues and teams who they felt had gone the extra mile.
- The staff monthly bulletin provided staff across the trust with the opportunity to share news and information with each other about events.
- The trust has a health and wellbeing service that worked with frontline staff to help them with service changes in a supportive way

Innovation, improvement and sustainability

- The trust had a number of services where sustainability in the long term was challenging; these included the stroke service and orthopaedic services. However, the executive team were aware of these challenges and were working collaboratively with partners to look at alternative ways of working and service provision.
- The dental service had developed the KANBAN system for the ordering of dental equipment and consumable materials. This innovative system was introduced to make stock control more cost effective and prevent the over ordering of materials which can be a drain on departmental budgeting.
- Staff reported that they have used the Trusts ‘Good Ideas Form’ system, where staff members can suggest innovative ways of doing things to improve the efficient running of the Trust and improve patient care.
- A recent innovation in the dental service had been the development of an intra-nasal sedation service. This approach tried to ensure that patients did not receive an unnecessary general anaesthetic because there are inherent risks associated with this procedure. Using this method the clinicians could obtain a sufficient degree of sedation to assess if the patient definitely needed treatment under a general anaesthetic.

Summary of findings

- The hospice completed a Kaizen report which was a system of continuous improvement developed in Japan and looks at quality, technology, processes, company culture, productivity, safety and leadership. The service had developed an action plan to improve the service. For instance, getting patients to and from day services could be challenging; the service had appointed a volunteer driver co-ordinator and was piloting a booking system and using a minibus to transport patients to the hospice for appointments rather than patient transport services.
- Telemedicine is the use of modern telecommunications equipment, such as telephones and video, to allow health care professionals to communicate with each other and with patients in their homes, in order to provide medical care. The cardiology team had adopted the use of telemedicine to provide on-going management and support for stroke patients.
- The trust's electronic referral and caseload scheduling for community nursing system, Hydra, won the 'embracing technology' category at the lean healthcare awards in 2014. The awards recognised excellent service improvements and enhanced efficiencies carried out by healthcare organisations. Hydra was also a runner-up in the national patient experience (PEN) awards.
- Therapy teams on the stroke unit developed a red, amber, green (RAG) rating system for patients and developed RAG rated activities for families and nursing staff to work with patients over the weekend. There were coloured discs displayed behind beds to link to activities in the therapy room to activity in therapy room.
- Ward 19 had received a quality mark in 2014 from the Royal College of Psychiatrists as a result of positive work in the delivery good quality, essential care for older people.
- There were excellent examples of innovation in the endoscopy unit. They had participated in an international programme 'Endo-live' where live investigations were carried out and transmitted by satellite to conferences. The event in 2014 was opened by a professor from the endoscopy unit of South Tyneside.
- The staff from the endoscopy unit won the 2015 'Study Team of the Year' category awarded by the National Institute for Health Research North East and North Cumbria Clinical Research Network.

Overview of ratings

Our ratings for South Tyneside General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Inadequate	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Requires improvement	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community health services

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

Overview of ratings

Our ratings for South Tyneside NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	 Outstanding	Requires improvement	Requires improvement	Requires improvement

Notes

Outstanding practice and areas for improvement

Outstanding practice

- 100% of patients at St Benedict's hospice died at their preferred place and for the out of hours team at the hospice, 399 out of 404 (99%) patients died at home. For patients cared for by the Gateshead out of hours team, 246 (98%) patients in the Gateshead area died in their preferred place of care.
- The trust came top of the league for best performing hospital in England in 'The Cancer Patient Experience Survey: Insight Report and League Table' (2014) and was in the top three in the same survey in 2013. Areas of excellent performance in the survey included emotional support from nursing and medical staff, clear explanations of what was wrong and what to expect, involvement of family members and easy contact with the cancer specialist nurse.
- Staff provided an outstanding level of care and compassion for patients and their relatives using community end of life care services. Patients and relatives were truly respected and valued as individuals and were empowered as partners in their care.
- The Trust was one of the 40 hospitals to receive the CHKS Top Hospitals Award in May 2015 through the CHKS national assessment and award programme. The evaluation considers safety, clinical effectiveness, health outcomes and patient experience and quality.
- There was a bereavement ward specialist nurse who held bereavement meetings and the chaplain was also a trained psychotherapist who would also provide support to the patient and their family.
- The trust's electronic referral and caseload scheduling for community nursing system, Hydra, won the 'embracing technology' category at the lean healthcare awards in 2014. The awards recognised excellent service improvements and enhanced efficiencies carried out by healthcare organisations. Hydra was also a runner-up in the national patient experience network (PEN) awards.
- The community dental service had developed a DVD for Learning Disability patients. This video was used to help prepare Learning Disability patients for visits to the dentist. The staff reported positive feedback from the Learning Disability Team about this innovation.
- The development of an intra-nasal sedation service within community dental services. This approach tried to ensure that patients did not receive an unnecessary general anaesthetic because there are inherent risks associated with this procedure.
- The Trust's services to support older people won the value in healthcare ward in the Health Service Journal national awards. The service works closely with older people in South Tyneside to support people who are malnourished to ensure they were receiving the right, high quality care regarding their diet. A training programme was also set up in local care homes, resulting in more than 1,000 carers being trained to ensure residents receive a high energy, high protein diet.
- The children's diabetic team used a computer system that allowed uploading of information from glucose meters, insulin pumps, and mobile apps. The system consolidated and presented the information in reports which allowed the clinicians to see a more accurate picture of the patient's health over a period of time.
- The staff from the Endoscopy Unit won the 2015 'Study Team of the Year' category awarded by the National Institute for Health Research North East and North Cumbria Clinical Research Network.
- The Endoscopy Unit had participated in an international programme 'Endo-live' where live investigations were carried out and transmitted via satellite to conferences. The event in 2014 was opened by a professor from the endoscopy unit at South Tyneside District Hospital.
- Ward 19 had received a quality mark in 2014 from the Royal College of Psychiatrists as a result of positive work in the delivery of good quality, essential care for older people.
- The IT department was working collaboratively with the community IT team to ensure both the acute and community electronic patient systems will be compatible.
- Maternity services used a telehealth system (the delivery of health information using

Outstanding practice and areas for improvement

telecommunications technology). This system enabled women to monitor their blood glucose levels and blood pressure in their own homes, avoiding unnecessary visits to the clinic.

- A new form of renal replacement therapy which improved outcomes for patients with renal failure and meant that they could be stabilised prior to transfer to a hospital with a renal service (South Tyneside does not have a renal service).

Areas for improvement

Action the trust **MUST** take to improve

- Review compliance with mandatory training and in particular training in safeguarding, medical device management, medicines management and Mental Capacity Act and Deprivation of Liberty Safeguards.
 - Ensure that medical staff receive mandatory training including fire prevention and child and adult safeguarding.
 - Ensure all necessary patient risk assessments, for example, venous thromboembolism (VTE) and early warning scores for deteriorating patients are completed and recorded appropriately.
 - Ensure assurance processes are in place to confirm the 'five steps to safer surgery' (part of the WHO surgical safety checklist) is being consistently completed.
 - Review the policy, processes, procedures, training, support arrangements for the safe care and treatment of medical 'boarders' within surgical wards and the impact on services.
 - Review the arrangements for the provision of a care pathway and formal medical rota for the management of patients with gastrointestinal bleeds.
 - Review how the flow of patients is managed through the emergency department (ED) and ensure that there is a documented escalation plan that is implemented when required to deal with patients waiting for more than four hours for transfer to a ward. This should include action to avoid patients staying in ED longer than 12 hours.
 - Review the quality of record keeping in the emergency department to ensure that records accurately reflect the standard of care provided including risk assessments, nutrition and hydration and provision of nursing care.
 - Improve the quality of documentation for the decision to admit time and discharge time if the primary record is the ED documentation.
 - Ensure that when patients complain about their care, there is an effective process in place for staff to receive feedback and learning.
 - Conduct a full environmental risk assessment for the Intensive Therapy / High Dependency Unit (ITU) and take action to mitigate the risks posed by lack of storage space.
 - Implement an escalation plan approved by operating theatre and critical care nursing and clinical leads that ensures that appropriate support systems are available on a timely basis if critical care patients are nursed in recovery room.
 - Ensure that all theatre staff caring for Level 2 and Level 3 ITU patients have received the appropriate training and that training records are retained.
 - Implement dedicated pharmacy support for ITU.
 - Ensure appropriate staffing on all children's inpatient areas particularly the special care baby unit.
 - Ensure that all medical devices receive portable appliance testing as required.
 - Ensure that COSHH risk assessments are completed for all areas storing substances hazardous to health to ensure that these are stored securely.
 - Ensure that effective control measures are in place to monitor exposure levels of nitrous oxide and the checking of ventilation and scavenging systems on the delivery suite.
 - Ensure resuscitation equipment checks are carried out regularly and consistently across all areas of the department.
 - Ensure that all employees receive an annual appraisal.
 - Ensure that there is a formal strategy for maternity and gynaecology services which sets out how the service is to achieve its priorities and that staff understand their role in achieving service objectives
- Please refer to the location reports for details of areas where the trust **SHOULD** make improvements.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services 17(1) • The trust must ensure that there is a formal strategy for maternity and gynaecology services which sets out how the service is to achieve its priorities and that staff understand their role in achieving service objectives. • The trust must ensure all necessary patient risk assessments, for example, venous thromboembolism (VTE) and early warning scores for deteriorating patients are completed and recorded appropriately. • The trust must ensure assurance processes are in place to confirm the 'five steps to safer surgery' (part of the WHO surgical safety checklist) is being consistently completed. • The trust must review the policy, processes, procedures, training, support arrangements for the safe care and treatment of medical 'boarders' within surgical wards and the impact on services. • The trust must review the arrangements for the provision of a care pathway and formal medical rota for the management of patients with gastrointestinal bleeds. • The trust must review how the flow of patients is managed through the emergency department (ED) and ensure that there is a documented escalation plan that is implemented when required to deal with patients waiting for more than four hours for transfer to a ward. This should include action to avoid patients staying in ED longer than 12 hours. • The trust must review the quality of record keeping in the emergency department to ensure that records accurately reflect the standard of care provided including risk assessments, nutrition and hydration and provision of nursing care. • The trust must improve the quality of documentation for the decision to admit time and discharge time if the primary record is the ED documentation.

Requirement notices

- The trust must implement an escalation plan approved by operating theatre and critical care nursing and clinical leads that ensures that appropriate support systems are available on a timely basis if critical care patients are nursed in recovery room.
- The trust must ensure that when patients complain about their care, there is an effective process in place for staff to receive feedback and learning.
- The trust must ensure that all employees receive an annual appraisal.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

15(1)(a)(c)(e)

- The trust must ensure that Control of Substances Hazardous to Health (COSHH) risk assessments are completed for all areas storing substances hazardous to health to ensure that these are stored securely.
- The trust must conduct a full environmental risk assessment for the Intensive Therapy / High Dependency Unit (ITU) and take action to mitigate the risks posed by lack of storage space.
- The trust must ensure that all medical devices receive portable appliance testing as required.
- The trust must ensure resuscitation equipment checks are carried out regularly and consistently across all areas.
- The trust must ensure that effective control measures are in place to monitor exposure levels of nitrous oxide and the checking of ventilation and scavenging systems on the delivery suite.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

18(1)(2)a

Requirement notices

- The trust must review compliance with mandatory training and in particular training in safeguarding, medical device management, medicines management and Mental Capacity Act and Deprivation of Liberty Safeguards.
- The trust must ensure that medical staff receive trust mandatory training including fire prevention and child and adult safeguarding.
- The trust must ensure that all theatre staff caring for Level 2 and Level 3 intensive care patients have received the appropriate training to do so and that training records are retained.
- The trust must implement dedicated pharmacy support for the intensive care unit.
- The trust must ensure appropriate staffing on all children's inpatient areas particularly the special care baby unit.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors

- Ensure that compliance with the requirements to meet Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3) 5: Fit and Proper Person: directors can be evidenced.