

South Tyneside NHS Foundation Trust

South Tyneside District Hospital

Quality Report

Harton Lane, South Shields, Tyne and Wear, NE43

OPL

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a focussed inspection at South Tyneside District Hospital on 27 and 28 July 2016 to review processes, procedures and practices for safeguarding children and young people. We looked at areas within the safe and well-led domains.

Our key findings were as follows:

- Staff understood their responsibilities for safeguarding children and young people. However, the trust safeguarding children processes, procedures and practices did not adequately support the identification and protection of children and young people who may be at risk.
- Limitations with the patient recording system in the emergency department meant clinical managers did not have an effective means of gathering data for an overview of the cohort of hidden children linked to adult's attending the emergency department for treatment. As a result, there was limited oversight and accountability to the Executive Management Team and Trust Board.
- There was a lack of information included in the emergency department records to determine triggers about existing children in the household, self-harming behaviour or exploration of a child or young person's social circumstances.
- There was limited management oversight and governance of safeguarding children and young people. There was no formally established supervision or effective peer review process.
- Training systems did not provide accurate recording and identification of healthcare staff compliance with safeguarding training across the trust.
- The trust safeguarding children policy stated all referrals should be copied to the safeguarding team for oversight and follow-up however we found this was not adhered to consistently.
- There was some learning and changes made from a serious case review in maternity.
- There was insufficient audit activity to monitor the quality and effectiveness of safeguarding processes against current national guidelines and standards.

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

Importantly, the trust must:

- Ensure that formal supervision processes for safeguarding children are in place in maternity, paediatrics and the emergency department.
- Ensure that formal peer review processes are in place.
- Ensure that the training data is accurate so that the trust has oversight of safeguarding children's training levels by staff group.
- Ensure that referral processes are consistent with trust policy.
- Ensure that records used for safeguarding children contain sufficient information to determine triggers about existing children in the household, self-harming behaviours and social circumstances.
- Ensure that documentation meets the requirements recommended by the Royal College of Paediatrics and Child Health.
- Ensure processes are in place for attendees under 18 to be reviewed to ensure all vulnerabilities and safeguarding risks are identified.
- Ensure there is sufficient audit activity to monitor the quality and effectiveness of safeguarding processes against current national guidelines and quality standards.
- Review the culture in the paediatric department and ensure that staff accountability, roles and responsibilities for safeguarding children are clear.

Professor Sir Mike Richards
Chief Inspector of Hospitals

South Tyneside District Hospital

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Our inspection team

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

How we carried out this inspection

This was a focussed unannounced inspection on safeguarding practices, processes and procedures for children and young people. We asked the trust to provide information, which we analysed during and after the

inspection. We spoke with nursing and medical staff in children's services, maternity and the emergency department, senior managers and the executive team. We also pathway tracked records.

Services for children and young people

Safe

Well-led

Overall

Requires improvement



Information about the service

This was a focussed unannounced inspection on safeguarding practices, processes and procedures for children and young people. We asked the trust to provide information, which we analysed during and after the inspection. We spoke with nursing and medical staff in children's services, maternity and the emergency department, senior managers and the executive team. We also pathway tracked records.

Summary of findings

There was limited management oversight and governance of safeguarding children and young people.

Although staff understood their responsibilities in relation to safeguarding children and young people, the trust's safeguarding children processes, procedures and practices did not support the identification and protection of children and young people who may be at risk.

Clinicians in the adult and paediatric emergency department were not utilising previous attendance information to inform their ongoing risk assessment, which leads to unsafe practice. The trust was unable to have assurance that children and young people had their safeguarding risks fully assessed at point of discharge.

Due to the limitations of the patient recording system in the emergency department, clinical managers did not have an effective means of gathering data for an overview of the cohort of hidden children linked to adults' attending the emergency department for treatment. Therefore, the trust board had no assurance of how effective the adult emergency department was in safeguarding children from hidden harm.

There was no formally established safeguarding supervision or peer review process. Peer review meetings were held bi-monthly which was not in line with best practice recommendations. Only one meeting had been held so far in 2016.

Training systems did not provide accurate recording and identification of healthcare staff compliance with safeguarding training across the trust. Evidence showed compliance with safeguarding level 3 and level 4 across

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paediatrics, but maternity and the emergency department was inconsistent and the trust could not provide assurance that staff were sufficiently trained in safeguarding practice.

Are services for children and young people safe?

Although staff understood their responsibilities in relation to safeguarding children and young people, the trust's safeguarding children processes, procedures and practices did not support the identification and protection of children and young people who may be at risk.

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Due to the limitations of the patient recording system in the emergency department, clinical managers and the trust executive had no means of gathering data for an overview of the cohort of hidden children linked to adults attending the emergency department for treatment. Therefore, the trust board had no assurance of how effective the adult emergency department was in safeguarding children from hidden harm.

Safeguarding

- Staff understood their responsibilities in relation to safeguarding children and young people. Staff from the paediatric emergency department (ED) told us they used the CWILTED (condition, witness, incident, location, time, escort, description) assessment tool to identify potential abuse when a child or young person was triaged by a member of staff. Children were prioritised for treatment and all of the case notes we reviewed indicated a rapid triage and treatment time.
- Staff we spoke with could explain the process of assessment and what to do if they had a safeguarding concern about a child or young person. This included making appropriate referrals to children social services, the drug and alcohol team, and the child and adolescent mental health service (CAMHS).
- However, when we reviewed four referrals to social care, we observed the quality of the information recorded was insufficient. Although staff made a telephone call to children's social services prior to sending a referral, the documentation did not sufficiently articulate the risk to the child or the expected outcome. For example, the information contained within clinical notes was not fully

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transposed onto the referral form and a small number contained overly clinical medical language which was not supportive of risk assessment by non-medical staff. It was unclear what the outcome of the referral had been, and outcomes from previous referrals were not informing further risk assessment if the child re-attended at the paediatric ED. In addition, we noted four cases in maternity and three in the ED where referrals to children's social care had been made but no copy retained on the patient's record.

- Although the paediatric ED received routine information from relevant partner organisations and services about children subject to a child protection plan, the IT system did not enable practitioners to undertake a full risk assessment. They were unable to utilise information from previous or multiple attendances, and there were no protocols in place, which meant clinicians were not automatically informed when children re-presented at the ED.
- The paperwork for children and young people in the ED was not compliant with guidance issued by the National Institute for Health and Clinical Excellence (NICE clinical guidance 89) and did not support safeguarding risk assessment. For example, paediatric records did not have safeguarding trigger questions to prompt all staff to consider possible safeguarding issues. In addition, adult records did not have 'children at home' questions.
- Overall, we looked at 11 cases in the ED and eight in the maternity unit. We saw limited evidence of effective safeguarding risk assessments. Cases we reviewed showed a lack of professional curiosity to ascertain triggers, such as in self-harming behaviour, the exploration of a child or young person's social circumstances or about existing children within the household. We found in one case poor notes by the doctor showed a lack of professional curiosity to the potential for harm to the health and well-being of the child.
- The review processes for child protection cases and children under one year old were insufficient. Although child protection cases and children under one year old were referred straight to a consultant, the forms used did not correspond to the Royal College of Paediatrics and Child Health (RCPCH) safeguarding children pro-forma for Section 47 child protection medical reports. They did not include a genital map, diagrams or findings and no space to record consent for clinical photographs.
- The trust safeguarding children policy stated all referrals should be copied to the safeguarding team for oversight and follow-up however we found this was not adhered to consistently. There was also no paediatric liaison or other appropriate role in the emergency department to ensure all vulnerabilities and safeguarding risks had been identified. This was combined with there being no capacity for the named nurse to review all under 18 presentations.
- The named nurse and safeguarding team (7 advisors, all based off-site in a community location) had a wide remit and covered the hospital plus all community services in South Tyneside, Gateshead and Sunderland. The presence of the safeguarding team in the hospital was limited; representatives from the team attended a weekly multi-disciplinary team meeting to discuss any safeguarding cases but there was no other visible presence. Acute staff we spoke with were unaware of the advisors names but knew they could ring for advice.
- The named midwife told us they had felt detached from the safeguarding team and did not attend routine meetings other than the designated nurse-led named professionals meetings. When we spoke with midwives we identified a common theme that staff felt most safeguarding issues would be picked up in the community prior to a midwife seeing the expectant mother in hospital. This suggested a reliance on community midwives picking up any relevant issues and taking appropriate action.
- Lessons from a recent serious case review had been learned within the maternity unit. For example, documentation for the first booking appointment in midwifery included prompts for identity and information about the father. We saw midwives had completed this information and if the mother declined to disclose, they also recorded this clearly.
- Midwives routinely attended strategy meetings and other child protection forums. A checklist was completed after each multi-agency meeting which recorded the key issues and safeguarding concerns. This was kept in a pink section on the case record which alerted the delivery suite and other midwifery staff that safeguarding concerns had been identified and prompted them to check the care plan.

Services for children and young people

Are services for children and young people well-led?

There was limited management oversight and governance of safeguarding children and young people.

There was no formally established safeguarding supervision or peer review process. Peer review meetings were held bi-monthly which was not in line with best practice recommendations. Only one meeting had been held so far in 2016.

Training systems did not provide accurate recording and identification of healthcare staff compliance with safeguarding training across the trust. Evidence showed compliance with safeguarding level 3 and level 4 across paediatrics, but maternity and the emergency department was inconsistent and the trust could not provide assurance that staff were sufficiently trained in safeguarding practice.

Governance, risk management and quality measurement

- Medical staff did not demonstrate understanding about the wider remit of safeguarding children, and the trust was unable to demonstrate adequate surveillance or quality assurance of safeguarding children processes.
- The named doctor was not a consultant and was unable to clarify if they were a specialty or trust doctor, which did not follow the guidance issued by the Royal College of Paediatrics and Child Health (RCPCH) in the intercollegiate document. Senior managers from the trust were unable to confirm the contract arrangements however they told us the named doctor had the required speciality competences and they had no concerns about their performance.
- The named doctor did not receive formal peer supervision from the designated doctor, which does not follow recommended practice. Clinical supervision was provided to the named doctor from outside the trust, but this was an informal agreement and there was no evidence to show its effectiveness.
- Safeguarding peer review meetings, which were planned to be held bi-monthly, did not meet the best practice recommendations outlined in the RCPCH intercollegiate document. The named doctor described the first part of the meeting as 'educational' and explained they usually presented a safeguarding-based lecture to staff, such as female genital mutilation. This

was aimed at all medical staff, including junior doctors and trainees although one trainee told us they, and their colleagues, could only attend a limited number of lectures due to their rota.

- The second part of the meeting was attended by consultants and the named doctor explained they only discussed cases where lessons could be learned. The named doctor told us only one meeting had been held so far in 2016 because consultants had not brought forward any cases for review. The named doctor did not select the cases. The minutes from the meeting showed only two cases had been presented and both related to non-accidental injuries. Both cases were presented as a case discussion and did not reflect the key purpose of peer review. The director of nursing confirmed there was a lack of rigour and issues around frequency and attendance.
- There were no formal safeguarding supervision arrangements in place for paediatric or maternity staff. A weekly multi-disciplinary team meeting, chaired by the named doctor and attended by medical and nursing staff, was generally acknowledged by staff as the forum to discuss safeguarding. However, we reviewed four sets of meeting minutes (in the form of case discussion notes) and found they lacked content, clarity and outcomes, and the cases selected were predominantly related to non-accidental injuries and bruising. There was also no evidence of analysis in the notes by safeguarding advisors attending this meeting.
- The named doctor told us they provided safeguarding clinical supervision for consultants however acknowledged this was on an un-planned basis and did not happen regularly. There was no management oversight to support the named doctor to provide this on a formal process.
- There was insufficient audit activity to monitor the quality and effectiveness of safeguarding processes against current national guidelines and quality standards. Staff we spoke with could tell us about audits relating to bruising in children under one (which demonstrated learning from recent serious case reviews). However, they were unable to identify any other activities or developments with the exception of the named doctor, who told us there was a plan to audit children who did not attend appointments, commencing in September 2016.
- Not all staff had received the relevant level of safeguarding children training and the trust was not

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compliant with RCPCH intercollegiate guidelines. Information received from the trust showed only 44% out of the 569 staff who required it had received level three training. The training system used by the trust learning and development department did not provide accurate recording and identification of healthcare staffs' compliance with safeguarding children training across the trust. The inconsistency in monitoring compliance with safeguarding training across paediatrics, maternity and the emergency department meant the trust could not provide assurance about which staff were sufficiently trained in safeguarding children's practice. The Director of Nursing confirmed that this area was an urgent priority for the trust.

Culture within the service

- Culture within the paediatric team was not cohesive. Processes relating to safeguarding supervision were informal and there was a lack of engagement and support between individual members of staff. The issues were ongoing and had not been resolved for a number of years. The executive team were aware of the problems and told us this was on their priority list. They were working with the relevant staff to resolve current concerns.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that formal supervision processes for safeguarding children are in place in maternity, paediatrics and the emergency department.
- Ensure that formal peer review processes are in place.
- Ensure that the training data is accurate so that the trust has oversight of safeguarding children's training levels by staff group.
- Ensure that referral processes are consistent with trust policy.
- Ensure that records used for safeguarding children contain sufficient information to determine triggers about existing children in the household, self-harming behaviours and social circumstances.
- Ensure that documentation meets the requirements recommended by the Royal College of Paediatrics and Child Health.
- Ensure processes are in place for attendees under 18 to be reviewed to ensure all vulnerabilities and safeguarding risks are identified.
- Ensure there is sufficient audit activity to monitor the quality and effectiveness of safeguarding processes against current national guidelines and quality standards.
- Review the culture in the paediatric department and ensure that staff accountability, and roles and responsibilities for safeguarding children are clear.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements

The Registered Providers safeguarding children processes, procedures and practices do not support the identification and protection of children and young people who may be at risk.
The Registered Provider does not have sufficient management oversight and governance of safeguarding children and young people.
We have issued a s.29A Warning Notice to the Registered Provider, as the quality of health care provided for the regulated activities listed requires significant improvement.

Where these improvements need to happen

South Tyneside District Hospital