

South Tyneside NHS Foundation Trust

South Tyneside District Hospital










Quality Report

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Date of inspection visit: 5 - 8
May, 23 June 2015
Date of publication: 01/12/2015

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

Ratings

Overall rating for this hospital	Requires improvement	
Urgent and emergency services	Requires improvement	
Medical care	Requires improvement	
Surgery	Requires improvement	
Critical care	Requires improvement	
Maternity and gynaecology	Good	
Services for children and young people	Requires improvement	
End of life care	Good	
Outpatients and diagnostic imaging	Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

South Tyneside District Hospital provides acute services for South Tyneside NHS Foundation Trust.

The trust gained foundation status in January 2005. 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 has a workforce of approximately 5000 staff and serves a population of around 154,000 in South Tyneside, 275,700 in Sunderland and 191,000 in Gateshead. South Tyneside District Hospital provided medical services, surgical services, critical care services, maternity services, and children and young people's services and has 321 beds.

We inspected South Tyneside District Hospital as part of the comprehensive inspection of South Tyneside NHS Foundation Trust, which included this hospital and community services on 5 to 8 May and 3 June 2015.

Overall, we rated South Tyneside District Hospital as 'requires improvement'. We rated it 'good' for being caring, but it required improvement in providing safe, effective, responsive and well-led care.

We rated maternity and gynaecology, end of life care and outpatient and diagnostic imaging services as 'good', with emergency & urgent care, medical care, surgery, services for children and young people and critical care as 'requires improvement'.

Our key findings were as follows:

- Across the acute hospital 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 was on occasion a lack of critical care capacity which resulted in patients being cared for in the theatre recovery unit rather than in the intensive care unit.
- Governance processes were not fully developed or embedded across the divisions.
- The staff engagement was 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:

- 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.

Summary of findings

- 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 is 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 on 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, 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 for 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.
- 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.
- Develop and implement an escalation plan approved by the 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 portable appliance testing as required.

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- 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 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

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

Overall we rated urgent and emergency services as requires improvement. We rated safe, responsive and well-led as requiring improvement and caring and effective as good.

There were occasions when patients had to be accommodated in the ED for long periods because of a lack of beds in the hospital. It was customary practice to place patients staying in the department over six hours onto a bed, and we were informed that this action in combination with the patient being nursed in the individual treatment rooms met the requirements of the Weekly Trust A&E Sitreps Guidance Version 1.04. Information on nursing care (such as evidence of when the patient had been transferred to a bed if required, received pressure area care and was offered nutrition and hydration) were inconsistently recorded. There was virtually no incident reporting of the occasions when patients had lodged in ED longer than 12 hours.

The escalation process to prevent patients from staying in ED longer than 12 hours was not documented and ineffective. The quality of ED documentation to reflect the nursing care provided and minimal internal reporting of patients lodging over 12 hours was poor.

We observed positive interactions between staff, patients and /or their relatives. Staff consistently demonstrated caring attitudes towards patients throughout the inspection. The majority of patients spoke positively about their care and treatment.

Medical care

Requires improvement



Overall we rated medical services as requires improvement. We rated caring as good and safe, effective, responsive and well-led as requires improvement.

The key risks related to: learning from incidents, medicines management, staffing levels, lack of equipment maintenance and insecure storage of chemical products and razors in the sluice areas. We observed inaccurate prescribing and medication errors including missed doses and delays in administration. There had been difficulty in

Summary of findings

recruiting to a vacant consultant post for the stroke service since January 2014; this post was covered by a locum consultant. There was difficulty in recruiting to registrar posts across medical services. Nurse staffing levels were affected by high sickness rates and vacancies and were regularly supported by use of bank and agency staff. We observed equipment ready for use with out-of-date service test dates including a suction pump and an electrocardiograph machine.

As a result of an audit on the use of the nutrition and hydration assessment tool, ward based training and competency assessments were introduced. Also the screening tool and dietetic referral forms were amended to enable an accurate audit to take place. Further, there was monitoring by the nutrition and hydration steering group and the development of individual ward based action plans. Patients we spoke with told us they had received good pain relief and nurses had asked them regularly if their pain was controlled.

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 of over 90%. We found that senior leaders in medicine and elderly care were not able to clearly communicate the five year plan or vision for the specialties. Governance systems were in place but staff reported there was a lack of sharing of the learning from incidents and complaints across the directorate. The role of assurance matron supported the patient safety and quality agenda but these were not based at South Tyneside District Hospital. Most staff we spoke with felt engaged and valued by ward managers, the clinical operations manager and clinical business manager. However they said more senior leaders were not visible. There were excellent examples of innovation in the endoscopy unit

Summary of findings

Surgery

Requires improvement



Overall, we rated surgical services as requiring improvement. Surgical services were caring and effective but required improvement in order to be safe and responsive. We rated well-led as inadequate.

There was no medical rota for the management of patients with gastrointestinal bleeds. Staff identified this as a major risk to the safety of patients. We reviewed care records within surgical wards and saw these did not all contain a completed risk assessment for early warning scores for deteriorating patients. Staff were aware of safeguarding policies and procedures but information provided by the trust showed low compliance with safeguarding training.

Nursing staff said they did not have the experience or skills to give appropriate and safe care to ITU patients when nursed within the surgical recovery area. We were unable to find evidence surgical staff had been trained to look after the needs of ITU patients. We raised this issue with the division's management team. It was subsequently reported staff had been berated for sharing this concern with us.

Staff said divisional managers were not always available, visible nor approachable; leadership of the service was remote and morale, particularly within theatres, was not good. Members of nursing and healthcare staff from theatres raised specific concerns with us about individual bullying and harassment leading to concerns about patient care. Staff said incidents had been raised through the department's management structure and on occasions through the human resources department but had not been addressed and difficult working conditions continued.

We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital and saw that patients were spoken and listened to promptly. Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. The Friends and Family response rate within surgery varied from 30% to 34% and scored similarly with the England average across all areas.

Summary of findings

Critical care

Requires improvement



We rated critical care as good for caring and requires improvement for safe, effective, responsive and well-led.

There were known risks posed by the limitations of the infrastructure and environment of the Intensive Therapy Unit (ITU). An outline business case had been approved by the trust executive team to refurbish and expand the critical care services. However the final business case was not yet finalised or agreed and there was no evidence of a contingency plan should the final business case not be approved.

There were known capacity issues regarding the number of Level 2 ITU beds during periods of hospital-wide bed pressures. This posed potential risks to the safety and welfare of patients as, when demand exceeded capacity, it was necessary on occasion to care for patients within the surgical recovery area. Critical care management were confident that patients were cared for appropriately in the surgical recovery area but the recovery nurses said they did not have the experience or skills to give appropriate and safe care to ITU patients when nursed within the surgical recovery area. Additionally patients were discharged to ward areas during the night, which national data and guidance have associated with increased mortality. Patients were also remaining in critical care beds when they no longer needed them due to bed pressures on the wards, which could result in mixed-sex breaches and lack of privacy and dignity. The unit was not meeting the requirements of the Core Standards for Intensive Care Units (2013) particularly in relation to educational support and management arrangements. The unit manager spent most of their hours giving direct patient care and had little or no time for management or leadership activities.

There were areas of good practice in the Intensive Therapy High Dependency Unit (ITU). These included fully and comprehensively completed care documentation, well maintained and serviced equipment, evidence in investment in new equipment, an increase in nursing, medical and critical care outreach establishments and the introduction of new renal replacement therapy for patients with renal failure.

Summary of findings

Patients and their relatives were treated by staff with compassion, dignity and respect. Feedback from patients and their relatives showed that there was a caring and supportive, person-centred culture in the unit and thank-you cards and letters praised the unit highly for their care.

Maternity and gynaecology

Good



Overall, we rated maternity and gynaecology services as good for being safe, caring, responsive and effective and requiring improvement for well-led.

The service provided safe and effective care in accordance with recommended practices. Outcomes for women using the service were monitored and where improvements were required action was taken. Care and treatment was planned and delivered in a way to ensure women's safety and welfare. Resources, including equipment and staffing, were sufficient to meet the needs of women. Staff had the correct skills, knowledge and experience to do their job.

The individual needs of women were taken into account in planning the level of support throughout their pregnancy. Women were treated with kindness, dignity and respect. The service took account of complaints and concerns and took action to improve the quality of care. A positive culture of openness and candour was evident and senior managers were visible and approachable. Although the senior management team were aware of the challenges to the service and had a vision for the future there was no formal strategy for maternity or gynaecology services, which set out how the service was to achieve its priorities or to ensure that staff understood their role in achieving the services objectives.

Services for children and young people

Requires improvement



Overall we rated children's services as requires improvement for safety, effective and well-led and good for services being caring and responsive. We had serious concerns over the arrangements for staffing and the number of babies cared for at certain times on the Special Care Baby Unit (SCBU). We found from January 2015 to April 2015 there had been 10 occasions when there had been more than six babies cared for on the unit at one time. When we checked staffing on these days we found there were a number of occasions (particularly on night

Summary of findings

shifts) where there had been one registered nurse and a healthcare assistant caring for the babies. This meant staffing levels on the unit were outside the recommended British Association of Perinatal Medicine guidance on Service Standards for Hospitals providing Neonatal Care (3rd edition 2010).

Following feedback to the trust we visited SCBU as part of the unannounced visit. We found escalation plans had been implemented and the manager was able to describe the process and what had been done to manage the risks. During periods of higher demand we found additional staff members were sourced or babies were transferred to other hospital's special care baby units.

We found the service routinely used Ketamine for sedation in children's for MRI scans. Within NICE clinical guideline 112 Sedation in children and young people, it stated that there should not be a routine use of ketamine or opioids for painless imaging procedures. We were provided with some information on clinical audits the service had undertaken.

We reviewed policies on the trust intranet and found there were a number which had not been reviewed since they were written in 2009. This meant up to date information on policies and guidance was not available to staff on the trusts intranet.

Throughout our inspection we saw that patients and relatives were treated with dignity, respect and compassion.

End of life care

Good



We rated end of life services as good for safe, effective, responsive and well-led. Caring was rated as outstanding.

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 in the top three in the same survey in 2013. The survey covers all 153 acute and specialist NHS Trusts in England that provide adult acute cancer services. 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

Summary of findings

contact with the cancer specialist nurse. Staff treated patients with dignity and respect and patients told us they felt well cared for. Staff supported patients and their families in a timely and appropriate way and involved patients and their families in planning care and treatment. Patients and their families were supported to cope emotionally with their care and treatment and there were systems in place to provide emotional support to staff when required.

Incident reporting was effective and embedded across the service. When things went wrong incidents were investigated, and lessons learned were shared. Staff responded appropriately to safeguarding concerns.

There were systems and processes for the monitoring of medication, infection control and they were regularly reviewed and improvements made. Staffing levels were monitored and reviewed to keep patients safe and meet their needs.

Documentation and care records were completed appropriately. Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed consistently. Equipment was available for patients and appropriate safety checks were in place. End of life care was evidence based and followed national guidance. There was a multi-disciplinary approach to care and treatment. Palliative care staff were appropriately qualified and competent to carry out their role.

Patients' needs and preferences were important in the planning and delivery of services. An end of life strategy was not in place but a steering group was established to develop a trust-wide strategy across acute and community services. Patients could access services in a way that suited them. Any complaints were dealt with appropriately and any lessons learnt were shared with staff. There were governance arrangements in place and the service monitored and audited the quality of the service. Clinical governance arrangements provided assurance that end of life care was being well managed and information about patient experience was collected, reviewed and acted upon.

Summary of findings

Outpatients and diagnostic imaging

Good



Overall, we rated outpatient and diagnostic services as good for being safe, caring, responsive and well-led.

The level of care and treatment delivered by the outpatient and imaging services was good. Arrangements were in place for managing radiation risks and incidents within the comprehensive local rules. Staffing levels were based on the knowledge and expertise of department managers and were flexible to meet the varied demands of clinics and patients.

Referral to treatment times met national targets but the rate for patients not attending appointments was slightly higher than the national average.

Outpatient clinics ran every day, including some evenings and occasionally at weekends. Imaging services for inpatients were available seven days a week and service availability was increasing and continuously improving.

During the inspection, we saw and were told by patients that the staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey and patients were given sufficient time for explanations about their care and were encouraged to ask questions

The Trust vision and strategy were well embedded and discussed at staff meetings. There were strong governance arrangements of which staff were aware and we observed good, positive and friendly interactions between staff and managers.

South Tyneside District Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

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Background to South Tyneside District Hospital

South Tyneside District Hospital provides acute services for South Tyneside NHS Foundation Trust.

The trust gained foundation status in January 2005. 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 has a workforce of approximately 5000 staff and serves a population of around 154,000 in South Tyneside, 275,700 in Sunderland and 191,000 in Gateshead. South Tyneside District Hospital provided medical services, surgical services, critical care services, maternity services, and children and young people's services and has 321 beds.

The Emergency Department (ED) at South Tyneside NHS Foundation Trust provided a 24-hour service, seven days a week and was part of the Emergency Care Directorate of the trust. As part of the department there was also a six bedded Ambulatory Care Unit. This was a service within the emergency department where either a GP (or other health care professional) may refer a patient for a specialist same-day review, assessment and treatment for specified conditions, managed by fixed protocols. The service offered rapid access to diagnostics and senior specialist review. The department had a separate children's emergency department which was managed through the Women and Children's Directorate. There were separate walk-in and ambulance entrances to the department. Within the main department there were 12

treatment rooms: a four-bed resuscitation area and a minor injuries/ treatment area. Overall attendances in the ED were 93,048 for the year April 2014 to March 2015 (Source: NHS England).

The hospital had nine medical wards including an emergency assessment unit (EAU), a stroke unit and an endoscopy unit. The care group included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine and stroke care. There had been 19,365 medical admissions to the hospital between July 2013 and June 2014. This is less than the England average and lies within the lower quartile range compared to other trusts. 57% of all admissions were emergencies, 1% had been elective and 42% were day cases.

The hospital provided acute emergency surgical care, outpatient consultations, specialist opinion and treatment for inpatient referrals, day surgery, advanced laparoscopic surgery, planned major bowel laparoscopic surgery and planned major hernia surgery.

The Intensive Therapy / High Dependency Unit provided care for both lower and higher dependency patients in a six-bedded area at South Tyneside District Hospital. Four beds were designated as Level 3 care and two beds as Level 2 care.

The maternity service at South Tyneside Hospital NHS Foundation Trust delivered 1,329 babies per year. The unit had nine delivery rooms on the labour ward,

Detailed findings

including one with a birthing pool, a 20 bedded antenatal/postnatal ward; ante-natal clinic and early pregnancy assessment unit. A team of 20 community midwives also provided antenatal and postnatal care generally outside of the hospital setting either at the GP surgery, local children's centres or in the woman's home.

Any child who has attended the hospital's accident and emergency department (A&E) who required longer assessment was admitted to the paediatric short stay unit which was adjacent to the A&E department. The PSSU provided care for children who required treatment and further assessment for up to 24 hours. Any child who required care for longer than that period was transferred out to a hospital which provided paediatric inpatient care.

Children's outpatient clinics were held to review and assess children following an episode of illness or injury or where the child had long term health problems which required ongoing monitoring. There were some specialist's clinics, for example, for urinary tract infections, diabetes and some general clinics where a variety of conditions were followed up. There was also a rapid review clinic where children were seen following an attendance at A&E to ensure their condition was improving. The clinics were held at Palmer Community Hospital.

The teams supporting the care of children and young people consisted of registered children's nurses, nursery nurse, auxiliary nurses, and Paediatric nurse practitioners, advanced Paediatric nurse practitioners, medical staff and consultant Paediatricians.

During our inspection the day case ward (Ward 12) had been closed the previous week and was due to be relocated next to the short stay unit and children's A&E. We saw works were being completed and the unit was due to open the following week.

The specialist palliative care services in South Tyneside were provided from Ward 20 which was a 16 bedded mixed sex palliative care/end of life ward for the older person. Palliative care was also provided on the main wards of the hospital with support from the palliative care specialist nurses.

The hospital had outpatient departments in 4 locations across the site. The trust offered outpatient appointments through a choose and book system and in the previous 12 months had seen 165,599 patients. Of these, 52,992 were new appointments and 99,359 were review appointments. There was a main outpatient department and three other outpatient departments where specialty-specific clinics (such as cardiology and oncology) were held. There was one main radiology and imaging department and a separate MRI (magnetic resonance imaging) department.

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 obstetrician and gynaecologist, a consultant anaesthetist, a consultant trauma and orthopaedic surgeon, a junior doctor, a clinical nurse specialist, senior nurses, 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?

Detailed findings

The inspection team always inspects the following core services at each inspection:

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew with us. These organisations included the clinical commissioning groups, local area team, Monitor, Health Education England and Healthwatch.

We held a listening event on 27th April 2015 in South Shields to hear people's views about care and treatment

received at the hospitals. 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 event.

We carried out the announced visit between 5 and 8 May 2015. During the visits we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, critical care, outpatients, maternity and A&E departments. We observed how people were being cared for, talked with carers and family members and reviewed patients' personal care or treatment records.

We completed an unannounced visit on 3rd June 2015.

Facts and data about South Tyneside District Hospital

South Tyneside Hospital 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 3084.59 WTE staff across acute and community services. The staff are split into the following broad groups:

- 212.23 WTE Medical
- 1541.17 WTE Nursing
- 1331.19 WTE Other

The trust inpatient activity (2013 -14) was 30,873 admissions. There were a total of 172,911 outpatient 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 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.

Detailed findings

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







Our ratings for this hospital

Our ratings for this hospital are:

	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	N/A	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at South Tyneside NHS Foundation Trust provided a 24-hour service, seven days a week and was part of the Emergency Care Directorate of the trust. The department was designated as a trauma unit with approximately 60,500 patients being seen every year. As part of the department there was also a six bedded Ambulatory Care Unit. This was a service within the emergency department where either a GP (or other health care professional) may refer a patient for a specialist same-day review, assessment and treatment for specified conditions, managed by fixed protocols. The service offered rapid access to diagnostics and senior specialist review.

The department had a separate children's emergency department which was managed through the Women and Children's Directorate. Any child who has attended the ED who required longer assessment was admitted to the paediatric short stay unit (PSSU) which was adjacent to the ED. The PSSU provided care for children who required treatment and further assessment for up to 24 hours. Any child who required care for longer than that period was transferred out to a hospital which provided paediatric inpatient care.

There were separate walk-in and ambulance entrances to the department. The main reception was staffed 24 hours a day. Within the main department there were 12 treatment rooms: a four-bed resuscitation area and a minor injuries/ treatment area. Overall attendances in the ED were 180,322 for the year April 2013 to March 2014.

We spoke with 11 patients, six relatives and 41 staff, including consultants, middle grade doctors, senior managers, nurses, ambulance staff, domestics, voluntary workers and security staff. We observed care and treatment and looked at 10 treatment records. We also reviewed samples of the trust's own quality monitoring information and data.

Urgent and emergency services

Summary of findings

We have rated urgent and emergency services as requiring improvement for safe, responsive and well-led and good for caring and effective.

Due to recent winter pressures, there were occasions when patients had to be accommodated in the ED for long periods because of a lack of beds in the hospital. It was customary practice to place patients staying over six hours in the department onto a bed and we were informed that this action in combination with the patient being nursed in the individual treatment rooms met the requirements of the Weekly Trust A&E Sitreps Guidance Version 1.04. Information on nursing care (such as evidence of when the patient had been transferred to a bed if required, received pressure area care and was offered nutrition and hydration), were inconsistently recorded. There was virtually no incident reporting of the occasions when patients had lodged in ED longer than 12 hours.

The ED used a number of evidence based protocols that followed National Institute for Health and Care Excellence (NICE) guidelines and the College for Emergency Medicine's (CEM's) clinical standards for emergency departments for the management of such conditions as sepsis and septic shock. A Sepsis 6 pathway was developed and introduced in 2014 and there was evidence that learning related to sepsis from mortality reviews was shared with staff during governance meetings and the daily huddle. The department took part in local and national audits and demonstrated sharing the learning from audit outcomes.

We observed positive interactions between staff, patients and /or their relatives. Staff consistently showed caring attitudes towards patients throughout the inspection. We spoke with 11 patients and five relatives. The majority spoke positively about their care and treatment. They felt that they had been treated with dignity and respect.

Are urgent and emergency services safe?

Requires improvement



We rated safe as requires improvement.

During recent winter pressures, there were occasions when patients had to be kept in the ED for long periods because of a lack of beds in the hospital. It was a standard practice to place patients staying over six hours in the department onto a bed, and we were informed that this action in combination with the patient being nursed in the individual treatment rooms met national requirements. Information on nursing care (such as evidence of when the patient had been transferred to a bed if required, received pressure area care and was offered nutrition and hydration) were inconsistently recorded. There was virtually no incident reporting of the occasions when patients had lodged in ED longer than 12 hours.

There were also omissions of recording times on the primary hard copy record. The discharge time was recorded on the electronic system only and in real time and the timing of the decision to admit was not always clearly recorded on the hard copy record.

Incidents

- No never events were reported in the Emergency Department (ED) within the previous 12 months.
- Between February 2014 and January 2015 the trust reported three serious incidents (SIs) relating to emergency care. We looked at the serious investigation reports for two of the most recent SIs reported and saw action plans had been developed to improve practice from lessons learned, with further follow-up actions agreed. The learning from the incident had been fed back to the ED team to prevent it happening again.
- For the period April 2014 to March 2015, there were a total of 196 incidents reported in the ED department with 98 resulting in no harm to the patients, 76 resulting in low harm, 21 resulting in moderate harm and one death.
- 75 incidents were reported about pressure ulcers from Grade 1 to Grade 4.
- There was minimal reporting about the impact of 2014/15 winter pressures by ED staff. One incident report

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reported the impact of long stay patients on workload and another on staffing levels. However staff did not report long stays in ED. 11 incidents between 1 October 2014 and 31 January 2015 related to falls in the ED; one of these reports included the statement that: “15 patients are on hospital beds in the department”. This was on the night of 6th January 2015.

- We saw minutes of the Emergency Care Group clinical governance meetings that showed that clinical incidents were reviewed and discussed. Feedback to operational staff was also given via daily staff huddles. An example of action taken in response following a patient's allergic reaction to a medication given in the ED included the trust implementing a campaign, 'Be Yellow, Be Bright, Think Allergies, Be Right' and introducing a yellow allergy wristband in July 2014.
- There were a number of complaints from patients about missed fractures in the ED over the reporting period, and we were told there were concerns in how missed fractures were reported back to the ED staff. We investigated the x-ray reporting and reviewing system and found it to be working well.
- The ED took part in regular mortality reviews. The reason for mortality reviews was to assess whether a patient's death could have been prevented and whether best practice had been demonstrated even though the patient had died.
- The last review demonstrated that of the seven patients who had died in January 2015, no deaths could have been prevented. The review also showed there were areas of good practice.
- Daily staff huddles took place at 09.15 hours each morning and were attended by all staff on duty that day. We observed one of these meetings which took place in the ED corridor where patients and visitors could pass by. Learning points were shared with the huddle and feedback was given (on this occasion from the previous day's Emergency Care Group meeting).
- The Duty of Candour requires staff to be open with patients when things go wrong. All staff interviewed understood the concept of Duty of Candour and were aware of the process to follow in the case of incidents and complaints. Evidence of disclosure to the patient was included in the Datix reports.

Safety Thermometer

- The Safety Thermometer provides a 'temperature check' on harm that can be used to measure local progress in

providing a care environment free of harm for patients. The trust used and recorded results for the Safety Thermometer for most clinical areas but Safety Thermometer audits were not carried out in ED. It was noted that falls do occur in ED and that four had been reported as incidents between April-December 2014.

Cleanliness, infection control and hygiene

- Compliance with standards for hand hygiene; the use of personal protective equipment and peripheral venous catheter insertion was reported to the Safer Care Panel in April 2015 and compliance with these standards was reported as 100%.
- The ED was clean and staff we spoke with were aware of the current infection prevention and control guidelines. We saw adequate hand washing facilities and alcohol hand gel available throughout the department. However there was no hand gel at the entrance to the ED waiting area. There was a hand gel dispenser at the reception desk but there were no signs asking patients or visitors to use the hand gels.
- During our inspection we saw that hand gel was not used frequently as staff and visitors moved about the department but staff did observe guidance on 'bare below the elbow'.
- Staff safely handled and disposed of clinical waste safely, including sharps.
- We saw clean equipment was identified with stickers 'I am clean' and we saw the department being cleaned as we inspected each day.

Environment and equipment

- The public areas and clinical environments were modern, well maintained and in a good state of repair. However, some chairs in the waiting area were split and needed replacing. A room was assigned as the 'safety room' for mental health patients.
- There were enough supplies of suitable equipment. Suitable life support and related monitoring and resuscitation equipment was to hand in the department. Equipment was checked and all were in date and stamped at the time of the inspection.
- Security arrangements were in place and CCTV was used in the department. Security staff told us they had training to look after patients or relatives who were abusive. Two security staff were on duty 24 hours a day to cover the ED and the rest of the hospital.

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- The overhead fans in the waiting area were loud and at times made it difficult to hear people speaking.
- Due to the layout in the children's A&E reception area we observed ambulance crews handing over patients to staff within close proximity to the waiting area. This meant there was a potential that confidential personal information may be overheard.

Medicines

- We saw drug cupboards were secure, well stocked and the sample of checked medications was in date.
- Patient Group Directions (PGDs) were used by nurses to administer specific medicines to patients without a doctor's prescription. Nurses used PGDs once they had completed their triage training. We were told not all nurses used these.
- We saw records to show the ED was carrying out an audit of prescribing practice but the results of this audit were not yet available.
- Of seven records reviewed from May and June 2015, three recorded medication allergies on the ED record.

Records

- The ED carried out an annual self-assessed integrated audit in 2014 which included the standard of record keeping and this showed 94% compliance with good record keeping standards. However, we looked at five sets of manual and electronic records in the ED which raised concerns about the completeness of record keeping.
- We were informed that the hard copy record was the primary record of the waiting times in ED. However it was noted that the discharge time was recorded on the electronic system only in real time and not on the hard copy. It was therefore difficult to track the timing of the patient's journey from ED to the ward by reviewing the case notes. It was also noted that the timing of the decision to admit was not clearly recorded on the hard copy record.
- Medical interventions were recorded during the patient's time in the ED but information on nursing care (such as evidence that the patient had been transferred to a bed), were inconsistently recorded. It was usual practice to place patients who were waiting for a hospital bed on a bed in the ED within six hours of

admission to increase their comfort while waiting and to provide pressure area care, and nutrition and hydration if required. However the timing and action were not consistently recorded.

- For example, a patient was admitted at 21:02 and no reference to nutrition or hydration was recorded until 08:15 the following morning when breakfast was given. Another patient was admitted at 17:41 and according to the nursing record had their first skin check for pressure areas at 05:30 the following morning.
- We looked at five sets of case notes on the Ambulatory Care Unit. While these were up to date and well documented the patients' ethnicity was not recorded in these records.
- The ED used a white board to track the patient journey through the department. This included: the patient's name, time of arrival in the ED, dependency score, pressure area score and the named nurse in charge of each patient.
- We reviewed those patients who were about to breach the four waiting target. At the time we were in the ED, there were four patients who breached the four hour waiting time by 25 minutes, 36 minutes, 45 minutes and 55 minutes. The following day we checked the reported breaches from the previous day. The trust had not reported the four breaches in their daily report. We checked this with the senior managers but they could give no reason for this difference.
- During the unannounced inspection (which took place on 3rd June 2015), we looked back at 11 sets of case notes of patients who were in the department during January and February 2015. We also reviewed seven ED records from May and June 2015 and found that there were omissions in recording the time of discharge from the department (7/7).
- Our findings supported the previous findings in that the quality of recording the time of decision to admit and nursing interventions was inconsistent and did not confirm the level of care that we were told was being provided during the time spent in ED. In response to these findings, the trust initiated a documentation audit to review the quality of documentation completed by all staff in ED.

Safeguarding

- Training records supplied by the trust indicated training levels for Level 2 child safeguarding were 58% for ED nursing staff and 28% for ED medical staff. Training

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levels for adult safeguarding were 35% for nursing staff and 4% for medical staff. However these figures were lower than reflected in the local records held by ED which were examined and showed that the training level for safeguarding adults for nursing staff was 96% and 74% for safeguarding children and young people training.

- Staff we spoke with knew how to report a safeguarding concern. Whilst we were carrying out the inspection we spoke with a locum doctor who told us he had reported a child protection concern onto the system whilst in the ED.
- It was evident from the record of incidents that child and adult safeguarding referrals were taking place as an incident report was being completed as part of the process of making the referral.

Mandatory Training

- We saw variable completion rates reported across all of the domains of mandatory training. There were low training levels recorded by the Trust for medical device training in ED: medical staff (20%) and nursing staff (23%) and for infection control training: medical staff (32%) and nursing staff (59%) but a higher level for Mental Capacity Act Level 1 training (60%).

Assessing and responding to patient risk

- Walk-in patients were registered at the main reception and asked to wait in the waiting area before being triaged by a nurse.
- For patients arriving by ambulance, the time for patients to be assessed was between four and six minutes with only 10 ambulances being delayed over a 30 minute period between November 2013 and March 2014.
- Systems and processes were in place to receive ambulance pre-alerts for major emergency cases. The ED had a Rapid Assessment and Treatment Unit (RATU) which provided early assessment of 'major' patients arriving in the ED by senior medical staff. This model of early assessment was introduced in July 2014 and consultant-led.
- We observed ambulance handovers with the RATU team where two nurses would take the patients from the ambulance crews. Nurses told us they did not take a second patient until all observations and assessments were completed and recorded from the first patient.

- There was no verbal handover of the patient from the RATU to the reviewing doctor. Doctors told us this could be difficult if the patient needed referring to another speciality as the reviewing doctor had to reassess the patient prior to referral.
- If a patient had to wait for more than one hour to see a specialist (or if there had been no decision made as to what would happen to the patient), staff told us how they followed the policy and would contact the site manager to inform them of this issue. Staff told us they felt this policy worked well in practice.
- The ED used an early warning score to assess deteriorating patients and we saw evidence of its use on the observation charts attached to ED records. We also saw evidence of medical staff being alerted according to the EWS policy.
- Children who deteriorated within the children's A&E department and who required inpatient care for longer than 24 hours were transferred to other hospitals. During our inspection we observed one patient (whose condition had deteriorated) who had been appropriately monitored and was transferred to another hospital by the ambulance service.

Nursing staffing

- During the past year the department had experienced a high level of absence including maternity leave and long term sickness. The nurse staffing establishment for the ED was 54.25 Whole Time Equivalents (WTE) and actual WTE was 51.57. The average monthly sickness rate for nursing staff was 4.70% between April 2014-January 2015 with a peak of 10.57% in November 2014. Substantive staff worked flexibly and worked overtime in order to maintain continuity and quality of care. Agency nurse use was a monthly average of 4.84% from April 2014-January 2015 and a peak at 6.92% in December 2014.
- The Ambulatory Care Unit was covered by 2.85 (WTE) Emergency Nurse Practitioners (ENP) and one Health Care Assistant (HCA). There was one new HCA due to start on the unit and one full time ENP post vacant. These staff did not rotate through into the ED. The Minor Injuries Unit had seven ENPs who covered the unit from 9 am to 10 pm Monday to Friday.
- Risks (in relation to the difficult challenge to recruit and retain staff (staff nurses and practitioners) with the

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necessary skill sets) was on the ED risk register. We saw from the register assurance that control measures were in place to manage the risk and these controls were reviewed monthly.

- The trust had recently completed the NICE safe staffing guidance audit on staffing levels. This determined whether the trust had the correct level of nurse staffing across the trust. The trust was awaiting the results of this audit.
- The children's A&E had four assessment rooms, one resuscitation bed (which could be increased to two beds if needed) and three beds in PSSU.
- We found staff between the children's A&E and PSSU worked as one team and provided care to patients in those areas. The planned numbers for qualified nursing staff was three on day shifts and two on a night shift.
- We saw the actual numbers of qualified staff on day shifts between 9th March to 3rd May 2015 in the Children's A&E. We found there were 12 occasions where there were two qualified nurses on duty for all or part of the day.
- Paediatric Nurse Practitioners (PNP) also worked within the A&E departments and were not included in the nurse staffing numbers. We found during the day there were two PNP's that supported the unit.

Medical staffing

- The medical staffing establishment for ED was 19 WTE and actual WTE was 16.05. The ED was staffed with five full time consultants, with two of the five consultants being registered on the specialist register. The main shortage was for middle grade doctors: there were five middle grade doctors in post and two vacant middle grade posts filled by locum doctors.
- There was a consultant present in the department from 9am to 9pm on weekdays and from 10am to 4pm at weekends. Consultant on-call cover was provided 24 hours, seven days a week. Middle grade doctors along with junior doctors covered the rota 24 hours a day.
- During the day time there was one consultant covering the Rapid Assessment Treatment Unit from 9am to 5pm and a second consultant covering the major cases and resuscitation bays from 9am to 5pm. After 5pm one consultant provided medical support in ED. At weekends there was one consultant on site from 10 am to 4 pm and then on call for the remainder of the time.

- There was middle grade cover for the Ambulatory Care Unit on Mondays to Friday from 9 am to 5 pm. Out-of-hours were covered by the on-call medical team.
- We observed a verbal handover by medical staff at 22.00 hours which was followed by a verbal handover with the senior nurse on duty. Cover overnight was supported by four doctors: one worked until midnight and another worked till 4.00 am which left two doctors to cover from 4.00 am until 9.00am.
- We were told medical staffing rotas were being reviewed to look at the possibility of providing consultant visibility and support over more hours. The emergency care clinical and management team were working closely together to provide consistent messages about what was expected from the middle grade doctors in terms of leadership for the junior doctors.

Major incident awareness and training

- The ED had a Business Continuity Plan but this was in a draft format.
- Staff were aware of the Major Incident Plan. We looked at the MAJAX store and checked the equipment which was in date. However, we were told that there was not a process in place for regular checking of the equipment

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We have rated effective as good.

The ED used a number of evidence based protocols that followed National Institute for Health and Care Excellence (NICE) guidelines and the College for Emergency Medicine's (CEM's) clinical standards for emergency departments for the management of such conditions as sepsis and septic shock. A Sepsis 6 pathway was developed and introduced in 2014 and there was evidence that learning related to sepsis from mortality reviews was shared with staff during governance meetings and the daily huddle. The department took part in local and national audits and showed the learning from audit outcomes was shared. Local audits included the initial management of chest pain, head injury and pneumonia in ED. A headache screening protocol in

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emergency care and subarachnoid haemorrhage protocol was being developed in conjunction with the findings of an audit of headache management. This was supported by an e-learning package.

Handovers between ambulance, medical and nursing staff were conducted sensitively. Relationships with the GP out of hours service was also effective and we were told how having the out of hours service within the unit resulted in improved relationships with GPs. There was evidence that appraisal rates were low for nursing staff.

Evidence-based care and treatment

- The ED used a number of evidence based protocols that followed National Institute for Health and Care Excellence (NICE) guidelines and the College for Emergency Medicine's (CEM's) clinical standards for emergency departments for the management of such conditions as severe sepsis and septic shock.
- Both the ED and Ambulatory Care Unit used pathways of care which were evidenced based. The Ambulatory Care Unit had a number of pathways including: the management of foot ulcers, headaches, high blood pressure and chest pain.

Pain relief

- Regular pain score monitoring audits were undertaken. For example, in March 2015, the ED was 97% compliant with the documentation of pain relief given to patients. This showed improvements from audits in previous months. The audits did not include monitoring the timeliness of patients receiving pain medication after admission to ED. However the trust performed about the same as other trusts for pain management in the CQC A&E patient survey 2014.
- Review of seven ED notes from May 2015 showed inconsistent location of the pain score on admission, with 2/7 recorded on the front of the ED card but routine recording of pain scores on a separate observation chart.

Nutrition and hydration

- There was a drinks machine in the patient waiting area and a Royal Voluntary Services shop which was open from 9.30 in the morning until 4.00 in the evening.

- Snack boxes were provided for patients. These contained a bag of crisps, a sandwich and a biscuit. If a patient was in the department for a long period of time, the housekeeper could order a hot meal from the canteen.
- The Ambulatory Care Unit did not have a kitchen but had a trolley with two flasks which could be used to give patients a drink if necessary. Hot meals could be provided from the canteen if necessary.
- Nursing documentation indicated that food and drink were offered to patients but there was inconsistent recording of how often and when this occurred during their stay in the department.

Patient outcomes

- Information was collected and monitored about patient outcomes. The trust participated in College of Emergency Medicine (CEM) audits so it could benchmark its practice and performance against best practice and other emergency departments.
- The CEM Severe Sepsis audit (2013) had 11 out of 13 indicators in the lower England quartile. A Sepsis 6 pathway was developed and introduced in 2014 and there was evidence that learning related to sepsis from mortality reviews was shared with staff during governance meetings and the daily huddles. The management of sepsis was reviewed as part of the mortality reviews where sepsis was involved. Areas to further improve were identified by the Emergency Care Mortality Review Group in May 2015 and included early use of antibiotics and increased awareness of potential indicators, such as hypothermia, hypoglycaemia and hypoactive delirium. An e-learning sepsis module was being developed for staff to support the pathway and learning identified in the mortality reviews.
- The ED also undertook CEM audits on: consultant sign off for senior ED clinician review for adults over 17 years of age with non-traumatic chest pain; senior ED clinician review for patients with unscheduled return visit to the ED within 72 hours with similar complaints and senior ED clinician review for the febrile (fitting) child.
- Data from the Trauma Audit and Research Network (TARN) was used to promote improvements in care through national clinical audit and to show performance comparison information on survival rates of patients with major injury who were admitted to hospital. The last TARN audit undertaken from July 2014 to January 2015 showed 27 patients attended as a

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trauma call and in all cases a trauma call was activated. A CT scan was needed for 18 of the patients with the time waiting for a scan ranging from 16 minutes to 132 minutes. A CT scan is a specialised X-ray test. It can give clear pictures of the inside of the body. In particular, it can give good pictures of soft tissues of the body which do not show on ordinary X-ray pictures. Overall the recommendations arising from the audit concluded there should be more opportunities for training and simulation.

- Local audits included the initial management of chest pain, head injury and pneumonia in ED. A headache screening protocol in emergency care and subarachnoid haemorrhage protocol was being developed in conjunction with the findings of an audit of headache management. This was supported by an e-learning package.
- Audits of paediatric outcomes included a re-audit of the use of Co-Amoxiclav in Paediatric A&E Discharges. Since the initial audit, a poster detailing antibiotic policy has been placed in the Children's A&E department, meetings between paediatrics and microbiology took place and training for local staff was performed. Compliance increased from 23% to 63% and antimicrobial prescribing education continued for regular staff in the department, as well as medical staff rotating through every 4 months.
- The number of patients who were seen in ED for 2014-15 Q4 was 14,730 of which 2,333 were majors. The number of admissions from ED attendances increased from 7.1% in 2013-14 to 12.2% in 2014-15. The unplanned re-attendance rate to the ED within seven days was worse than the national standard by approximately 2%.

Competent staff

- 48% of nursing staff attended the ALERT training. ALERT courses educate staff in recognising patient deterioration and how to act appropriately in treating the unwell patient.
- Training records for Alaris and Baxter pumps showed 22 out of 43 staff were trained to use the Alaris pump and 23 out of 43 staff were trained to use the Baxter pump. Eleven staff were trained to use the BiPaP (Bi level positive airway pressure) machines.
- 51% of nursing staff in the ED had received appraisals in 2013/14. 25% had received appraisals by January 2015 for 2014/15.

- Emergency Nurse Practitioners also carry out a self-assessment by peer review and had ten observed practices annually to ensure their practice was up to date.
- We were told there was regular in-house training for junior doctors and middle grades undertaken by the ED consultants.

Multidisciplinary working

- Communication between staff was effective. Shift handovers involved staff providing detailed information on the risks, treatment and care for each patient, the staffing requirements and patient flow through the department.
- Handovers between ambulance, medical and nursing staff were conducted sensitively. Relationships with the GP out of hours service was also effective and we were told how having the out of hours service within the unit resulted in improved relationships with GPs.
- We were told working with the Ambulatory Care Unit, the urgent care in the community team and the discharge liaison teams worked well.
- We were however told about some difficult relationships between other specialities when attempting to get a doctor to see a specific patient. Staff used the daily huddles to identify and action concerns. We observed this concern raised and the lead consultant was going to investigate.

Seven-day services

- There was a consultant present in the department from 9am to 9pm on weekdays and from 10am to 4pm at weekends. Consultant on-call cover was provided 24 hours, seven days a week. Middle grade doctors along with junior doctors covered the rota 24 hours a day.
- Radiology services were available seven days a week.

Access to information

- There was an IT system in place that enabled real-time tracking of patients through the department. We were informed that the ED record was regarded as the primary record but found that the decision to admit time was not clearly recorded and the discharge time not recorded on the 18 records examined.
- A discharge summary was sent to the GP when patients were discharged from the department.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act and Deprivation of Liberty training was provided by the trust.
- Patients and/or their relatives we spoke with confirmed that staff had provided clear explanations for them to make informed decisions.

Are urgent and emergency services caring?

Good



We observed positive interactions between staff, patients and /or their relatives. Staff consistently demonstrated caring attitudes towards patients throughout the inspection. We spoke with 11 patients and five relatives. The majority spoke positively about their care and treatment. They felt that they had been treated with dignity and respect.

Compassionate care

- The Family and Friends Test results for ED showed the scoring at 54.3 with a 30.8% response rate. Of the 846 responses received in March 2015, 87% would recommend the ED which would rate the service as four stars.
- We saw nursing and medical staff providing compassionate and empathetic care.
- Patients told us: “nursing staff are cheerful, helpful and caring and nothing is too much trouble.”
- We observed staff drawing curtains around each patient’s bed and individual cubicles to maintain their privacy and dignity. We heard staff using suitable speech and tone when talking with patients.

Understanding and involvement of patients and those close to them

- We spoke with three patients on the Ambulatory Care Unit. All said they knew the reason for their attendance and knew why they were waiting. They all felt they could ask questions and knew how to make a complaint if necessary.
- Patients waiting to be seen in the ED told us: “once we get to be seen it’s great but we have to wait a long time.”

- In the CQC A&E patient survey 2014, nine out of 10 patients felt staff explained their test results in a way they could understand, where these were given before they left A&E.

Emotional support

- The named nurse system was used in the ED. This meant that patients were allocated to one specific nurse who would ensure patients received continuity of care.
- We observed nurses supporting patients by linking arms to assist them to the assessment area.
- We were told the palliative care team would be brought in to the department to break bad news for any patient with a diagnosis of cancer.

Are urgent and emergency services responsive to people’s needs? (for example, to feedback?)

Requires improvement



During recent winter pressures, there were occasions when patients had to be kept in the Accident and Emergency department for long periods because of a lack of beds in the hospital. It was usual practice to place patients staying over six hours in the department onto a bed, and we were informed that this action in combination with being nursed in the individual treatment rooms, providing nutrition and hydration and access to toilet facilities, met the requirements of the Weekly Trust A&E Sitreps Guidance Version 1.04. One incident report refers to 15 patients being on beds in A&E on 6th January 2015. We found that 152 patients were in ED longer than 12 hours during January and February 2015. During this period, the longest lodging time after the decision to admit recorded by the trust was 32 hours 57 minutes. These patients were cared for in the ED. However the doctors from the speciality admitting the patient visited the patient in ED and started a treatment plan prior to admission.

Patients and relatives told us their care was good but they would often wait for long periods to be seen by a doctor. Staff reported the process for feeding back to staff around the learning arising from complaints was under review.

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Service planning and delivery to meet the needs of local people

- The need for an Urgent Care Hub to meet the urgent care demand of the local population was recognised by the trust and the local Clinical Commissioning Group (CCG). In 2014 a public consultation process was undertaken by the CCG to assess the views of local people on the proposed new Urgent Care Hub to be based at South Tyneside District Hospital. It would combine hospital A&E, urgent care assessment, GP services, minor injury care, and social and community care services. The plans are going ahead and the trust will be working with the council and CCG to improve travel and transport access to the new hub.
- Patients gave positive feedback on ambulatory care stating they preferred the Ambulatory Care Unit to having to be admitted to a specific ward.

Meeting people's individual needs

- Patients and relatives told us their care was good but they would often wait for long periods to be seen by a doctor.
- There was an electronic information board in the waiting area informing patients of the current waiting time to see a doctor. On two occasions we saw the information board showing a 20 minute wait to see a doctor but when we asked the nursing staff on duty about the wait, this was two hours. It was not clear whose responsibility it was to change the waiting time as the reception staff thought the nurses were changing the times and the nurses thought the reception staff were making the changes. This meant that information was poorly shared with the patients waiting to be seen and also added to the patients' frustration as we were told by some patients that no one came to inform them of the longer waiting times.
- There were a number of information leaflets for patients to access in all areas across the ED, Ambulatory Care Unit and Minor Injuries Unit. These leaflets were comprehensive and easy to read.
- Translation/interpreter services were available at the hospital for use when patients whose first language was not English entered the department.
- Patients with mental health needs had access to the mental health crisis team 24 hours a day, seven days a week and there was a designated safety room.

- Whilst the WRVS shop was a clean and welcoming area, it was not well sign posted and was situated on a corridor within the ED. Patients or relatives using the café had to walk past the triage area and other assessment cubicles to gain access. This was also on the route to the minor injuries area and the Ambulatory Care Unit.
- There was a bereavement room near the minor injuries area but there was no specific viewing area for patients who had died in the ED. We were told one of the 'major' rooms would be used for viewing patients who had died.

Access and flow

- The national ED waiting time performance indicator is for 95% of patients to be seen within four hours. The trust's four hour waiting time performance indicator dropped to 80.15% in January 2015 and the overall performance for Quarter 4 2014/15 was 84.2%. Performance since then improved and rose to 92.5% for Q1 2015/16 (Source NHS England).
- We reviewed the ED performance data supplied by the trust for January and February 2015. Following the decision to admit, 152 patients had a lodging time greater than 12 hours of which 20 lodged for more than 20hrs. During this period, the longest lodging time after the decision to admit was 32 hours 57 minutes. For example, on the 5th January 2015, there were 12 patients waiting over 12 hours (and a further four patients who had waited over 12 hours from the previous day were still in the ED). It was recorded on an ED incident report that 15 patients were being nursed on beds in ED on 6th January 2015.
- We raised this issue directly with the senior management team for the ED and staff confirmed this had happened and explained that any patient who was waiting over 6 hours would be transferred to a bed to meet the national A&E waiting time target guidance. We were not supplied with an escalation plan or policy for the department.
- We reviewed five medical records from January and February 2015 to establish whether transfers to a bed were documented. One record documented the patient had been transferred to a bed within a two hour period. One patient was transferred to a bed after 14 hours. Two patients were recorded as being nursed on a bed but no times were recorded as to when the patients were transferred onto the bed. One record did not

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document whether the patient had been transferred to a bed or not. This demonstrated an inconsistency in the standard of record keeping which could not support whether patients received adequate care whilst waiting in the ED.

- Whilst these patients may have been transferred to a bed, the definition of a ward was not met as there were no dedicated washing facilities for patients; nowhere their belongings could be stored securely; and there was a lack of privacy and dignity because patients wishing to go to a toilet would have to use the corridor to access the toilet in the department. However, senior staff did confirm hot meals and refreshments could be accessed from the canteen and brought to the ED. The percentage of patients leaving A&E before being seen was variable but overall was consistently better than the England average.
- A number of the patients we spoke with were concerned about the long waiting time. Staff reported that the frequent delays in patient flow through the department were due to beds not being available on the Emergency Assessment Unit or the wards.
- Time to triage for patients attending by ambulance should be 15 minutes and the ED was consistently meeting this target for walk-in and ambulance attendances.
- The Ambulatory Care Unit was open from 07.45 until 21.15 Monday to Friday and 09.45 to 16.00 Saturday and Sunday. The majority of patients were referred from their GP but also the ED or other clinics in the hospital and would be triaged before being transferred to the Ambulatory Care Unit.
- There were a number of pathways to follow such as: deep vein thrombosis, pulmonary embolism, cellulitis and vaginal bleeding in early pregnancy. However, patients would be seen with other conditions such as chest infections, diabetic ulcers and management of drains. All patients attending the Ambulatory Care Unit were followed up in clinic by a medical consultant.

Complaints handling and learning from feedback

- We were told formal complaints go to the Customer Services Divisional Directorate and then were given to senior nursing staff to investigate.

- Senior staff told us they were reviewing how they can learn from complaints as there was no formal process for feeding back to staff around learning arising from complaints. There were plans to develop a process to share themes and lessons learned from complaints

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as requiring improvement. There was no documented escalation process and the escalation process to prevent patients from staying in ED longer than 12 hours was ineffective. Also the quality of ED documentation to reflect the nursing care provided and minimal internal reporting of patients lodging over 12 hours was poor.

The ED had a strategy and vision for the service and this was understood by staff. There was a governance structure in place and an ED quality and safety information grid had been developed and was used at the monthly Safer Care Panel meetings. This included information about serious incidents, clinical incidents, complaints, staff sickness, infection control, pressure damage, medication issues, and professional issues, early warning score recording and open and honest care. The team were experiencing staff sickness at a senior level so senior staff were having to be more operational but there was a strong leadership culture within the ED. Staff were adaptable and flexible while ensuring the department was fully staffed and enthusiastic about delivering high quality care to their patients.

Vision and strategy for this service

- The ED had a strategy and vision for the service which was displayed in the waiting area in the department.
- We were told the future vision for the ED was determined by its Clinical Commissioning Group (CCG) as an Urgent Care Hub was being proposed and was being put out to tender. We were informed by senior staff the CCG would be looking at the new hub to be opened by October 2015.
- The new Urgent Care Hub would combine hospital ED, urgent care assessment, GP services, minor injury care, and social and community care services.

Urgent and emergency services

- Weekly clinical and operational leadership meetings were established and we heard their purpose was to monitor clinical and operational workforce governance.
- The ED worked together as a team reviewing and developing new ways of working in order to make the department more effective and safer for patients. Such as developing a Rapid Assessment and Treatment Unit, new pathways in the Ambulatory Care Unit and daily staff huddles.

Governance, risk management and quality measurement

- Virtually no incident reports were submitted to report patients being lodged in ED for longer than 12 hours. There was no documented escalation policy that stated how patients were managed when staying between four and twelve hours or longer in ED. The Safer Care Panel meeting minutes referred to pressures in ED but did not refer to the management of lodged patients.
- There was an Assurance Matron who was linked to the ED team and had responsibility for collating and presenting information to support governance and risk management. A monitoring tool had been developed and was used at the monthly Safer Care Panel meetings. This included information about: serious incidents, clinical incidents, complaints, staff sickness, infection control, pressure damage, medication issues, and professional issues, EWS recording and open and honest care.
- Clinical governance meetings had been set up to discuss issues within the department. However, these meetings had commenced in January 2015 and senior management staff recognised further work was needed to embed governance processes.
- There were two risks on the February 2015 corporate risk register for ED, one being about the nurse staffing levels and the second about the quality of data to support improvement.

Leadership of service

- There was a strong leadership culture within the ED even though maintaining a stable senior team had been challenging due to staff sickness at a senior level so that the remaining senior staff were having to be more operational.
- Senior leaders acknowledged that feeding back to staff needed to improve and staff told us they did not always receive feedback from complaints or incidents.

Culture within the department.

- We were told by nursing and medical staff that the ED was a: 'great place to work' and that: 'the atmosphere was great'. Staff told us they felt supported.
- We were told staff were always looking to improve systems and processes. They were adaptable and flexible while ensuring the department was fully staffed.







Public and staff engagement

- The new Urgent Care Hub had recently been discussed and as yet staff across the hospital had yet to be informed of the changes.
- To support problem solving the ED used the PERFORM methodology (Probe, Establish, React, Finalise, Optimise, Roll out and Maintain) which uses a bottom up approach. Where things could be done better Operational staff were given the opportunity to share their concerns.
- The Family and Friends Test results for ED showed the scoring at 54.3 with a 30.8% response rate. Of the 846 responses received in March 2015, 87% would recommend the ED which would rate the service as four stars.

Innovation, improvement and sustainability

- The department was recognised as a trauma unit and was part of the North East Regional Trauma Network.

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

Information about the service

At the time of our inspection South Tyneside Foundation Trust had nine medical wards including an emergency assessment unit (EAU), a stroke unit and an endoscopy unit. During our inspection we visited all of these areas. The care group included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine and stroke care. A community ward (Primrose Hill hospital) was temporarily based on ward 20 as part of the trust's winter pressures plan.

There had been 19,365 medical admissions to the hospital between July 2013 and June 2014. This is less than the England average and lies within the lower quartile range compared to other trusts. 57% of all admissions were emergencies, 1% had been elective and 42% were day cases.

We spoke with a wide range of staff, (47 in total) including registered nurses, auxiliary nurses (not called health care assistants on some wards at the trust), care support workers, domestic staff and housekeepers, discharge coordinators, doctors, medical and nursing students, allied health professionals (AHP's) and pharmacy staff. We spoke with 19 patients who were undergoing treatment and 14 relatives or family carers.

We observed care and treatment and looked at nine sets of patient care records, including medical notes, nursing notes and medicine charts. Before our inspection we reviewed performance information from, and about the trust.

Summary of findings

We have rated medical care services as requires improvement for safe, effective, responsive and well-led and good for caring.

The key risks related to: learning from incidents, medicines management, staffing levels, lack of equipment maintenance and insecure storage of chemical products and razors in the sluice areas. We observed inaccurate prescribing and medication errors including missed doses and delays in administration. There was difficulty in recruiting to registrar posts across medical services. Nurse staffing levels were affected by high sickness rates and vacancies and were regularly supported by use of bank and agency staff. We observed equipment ready for use with out-of-date portable appliance test dates including suction pumps on two resuscitation trollies and an electrocardiograph machine.

As a result of an audit of the use of the nutrition and hydration assessment tool, ward based training and competency assessments were introduced. The screening tool and dietetic referral forms were amended to enable an accurate audit to take place. Also monitoring by the nutrition and hydration steering group took place and there was development of individual ward based action plans. Patients we spoke with told us they had received good pain relief and nurses had asked them regularly if their pain was controlled.

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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 of over 90%.

We found that senior leaders in medicine and elderly care were not able to clearly communicate the five year plan or vision for the specialties. Governance systems were in place but staff reported there was a lack of sharing of the learning from incidents and complaints across the directorate. The role of assurance matron supported the patient safety and quality agenda but these were not based at South Tyneside District Hospital. Most staff we spoke with felt engaged and valued by ward managers, the clinical operations manager and clinical business manager. However they said more senior leaders were not visible. There were excellent examples of innovation in the endoscopy unit.

Are medical care services safe?

Requires improvement



We have rated safe in medical care services as requires improvement. The key risks related to: learning from incidents, medicines management, staffing levels, lack of equipment maintenance and insecure storage of chemical products and razors in the sluice areas. We observed inaccurate prescribing and medication errors including missed doses and delays in administration. There had been one locum consultant in place for the stroke service since January 2014 and there was difficulty in recruiting to registrar posts. Nurse staffing levels were affected by high sickness rates and vacancies and were regularly supported by use of bank and agency staff. We observed equipment ready for use with out-of-date portable appliance test dates including suction pumps on two resuscitation trollies and an electrocardiograph machine.

Wards were clean and tidy and we observed good infection prevention and control practices. There was good access to pressure relieving equipment such as heel protectors and mattresses for high risk patients. Wards used an Early Warning Score system to identify deteriorating patients. We were told the use of NEWS (National Early Warning Score) was due to be launched across the trust shortly after our inspection.

Incidents

- There were 259 Datix incidents reported on the care of elderly wards between October 1st 2014 and January 31st 2015. There were 346 incidents reported on the other medical wards in the same time period. The most commonly reported incidents in this timescale related to patient falls and pressure ulcers. Staff we spoke with knew how to report incidents on the Datix electronic system and told us that they were encouraged to do so by senior colleagues.
- There were 27 serious incidents which required investigation between February 2014 and January 2015. These included falls with harm, category 3 and 4 pressure ulcers, a patient assault and health care acquired infection.
- Tissue Viability Nurses (TVN) reviewed the incident reports for pressure ulcers. They validated the category and carried out root cause analysis (RCA). Senior staff

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told us the RCA has 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 TVN's could not always attribute the origin or category of pressure ulcers.

- Senior staff told us serious incidents were investigated by the safety team and the assurance matron and then ward managers shared the outcome and action plan with their team.
- 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.
- One incident involved a suicidal patient who absconded from a ward and put themselves at risk of life threatening harm. This was not reported as a serious incident. No harm came to the patient. The actions taken indicated a discussion took place with the patient, but it was not clear from the action plan if steps were taken to prevent this happening again.
- Ward 19 (care of the elderly) reported the highest number of falls with no or low harm in Medical Services. There were a number of tools in place to reduce the number of falls including the falls prevention service and a falls prevention risk assessment.
- Incidents regarding agency staff had been reported via the Datix system. On one ward, after a pattern of incidents were reported, this had resulted in the introduction of local induction information for agency staff.
- We were shown improvement plans (named as assurance project plans) on two wards. Some actions had been completed. Others were ongoing, such as the development of a well organised ward, the completion of personal development plans for staff, and the development of leadership in ward teams. We were told the wards involved have monthly meetings with senior staff to review progress.
- Senior staff told us their monthly meetings alternated between morbidity and mortality meetings one month and business meetings the next month.
- We were shown a 'problems record book' on the Endoscopy unit where day to day issues were recorded and action plans carried out to minimise recurrence.

- We saw documented evidence of the duty of candour being implemented following a fall.

Safety thermometer

- The NHS Safety Thermometer is a national initiative, providing a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
- Using this tool, performance against the four possible harms (falls, pressure ulcers, venous thromboembolism (VTE) and catheter associated urinary tract infections (UTIs) was monitored across medicine and elderly care on a monthly basis. Information regarding the results of the safety thermometer was routinely displayed on most of the wards.
- 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 to November 2014; this is compared to 88% for the whole trust and the England average of 93.82%.
- One ward manager reported their main safety concern as being pressure ulcers. We were told that there was no difficulty in ordering or obtaining pressure relieving equipment such as heel protectors and mattresses for high risk patients.
- There were 21 pressure ulcers recorded between December 2013 to December 2014, with no clear increase or reductions over this time.
- An assured process audit on Ward 6 showed the incidence of pressure ulcers had fallen from 13.79% in August 2014 to 0% in November 2014.
- There were 13 falls recorded in the same time period. While there had been a decrease in falls in March and July 2014, the incidence then rose again.
- Staff told us there had been a trend of falls on the Emergency Assessment Unit (EAU) but they worked with the assurance matron for the area and analysed the reasons for the falls. Their work resulted in them having a registered nurse added to their staffing establishment.
- There were 33 catheter associated UTI's in the same time period, and prevalence had been highest between January to April 2014.
- 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

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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”

Cleanliness, infection control and hygiene

- Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium difficile and MSSA Meticillin Sensitive Staphylococcus Aureus rates on the medical wards were lower than the England average. Only one episode of an MRSA infection was recorded in the trust between April 2014 and January 2015. There were seven cases of Clostridium difficile reported up to January 2015 but this was lower than the expected target of ten.
- We observed good infection prevention and control practices. Staff used alcohol hand rubs before entering side rooms and bays, they complied with ‘bare below the elbows’ policy and uniform standards. Doctors wearing ties had them tucked into their shirts.
- We saw isolation signs on side room doors and an adequate supply of personal protective equipment such as gloves and aprons. We observed a blood pressure cuff being cleaned with antiseptic wipes in between patient use.
- We were shown a water safety check booklet by a housekeeper. She was responsible for ensuring taps were run on a weekly basis to minimise the risk of Legionella. The booklet was up to date and correctly filled in.
- Waste disposal guidelines were clearly displayed in sluice areas, as were guidelines on the use of bags for soiled linen.
- The nurse allocated to each bay on EAU was responsible for cleaning in their area on a daily basis the medicine trolley and notes trolley. They completed a checklist which was verified by the ward coordinator of the day. All of the trolleys on EAU looked clean and dust free.
- There was no standard way to indicate equipment had been cleaned. Some wards used a written checklist; some used green tape, although the dates of cleaning were not always in date. The green tape on the bath lift on one ward indicated it had been last cleaned on 28th

April. We inspected that ward on 6th May. Staff could not recall if the bath lift had been used in that time. On one ward, four items of equipment were labelled as being clean, whereas four others were not labelled.

- One commode was found to be visibly soiled with faeces. This was raised with the Ward Manager. On a second visit to the same ward the next day, soiling was again seen on a commode. It was raised with the Ward Manager.
- Wards looked visibly clean and tidy. However we observed a full clinical waste bag left open on the floor in a corridor on one ward.
- We saw a trolley being taken around a ward and into bays stocked with linen, creams, and incontinence pads. Items should be stored in cupboards or in patient lockers for infection control purposes.

Environment and equipment

- There were large, varied amounts of equipment on the stroke ward. This included equipment used to move and transfer patients and specialist seating. Staff told us a lot of this was purchased by donations to the ward. There was a limited amount of storage space so most of the equipment was in the corridors on the ward which made the space cluttered and potentially a trip hazard.
- Resuscitation equipment was available on each ward although it was not always checked on a daily basis. On four wards there was a robust process for checking the equipment and the checks were up to date.
- Maintenance date stickers on two pieces of medical equipment on two wards indicated maintenance testing was out of date. The equipment was an oxygen saturation monitor and an electrocardiograph (ECG) machine. We saw a suction machine and 12 lead ECG machine on EAU had out of date maintenance dates. The ward manager took immediate action and a member of staff from medical physics arrived within five minutes to carry out the checks.
- On two wards the treatment room was not visible from the main ward area and was unlocked. Both treatment rooms contained needles and antiseptic liquids. This was raised with the ward managers who told us they would take immediate action.
- On two wards the sluice door was propped open. We found chlorine disinfectant chemicals, acetone and fly spray in unlocked cupboards and razors on shelves. This was raised with the ward managers who told us they would take immediate action. We visited one of these

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wards again the next day and found the cupboard had one locked door with the key in the lock and the second door unlocked. We pointed this out to the ward manager.

- The bathroom on the stroke ward had a height adjustable adapted bath and a ceiling track hoist so that dependent patients could be hoisted into the bath. The room was large enough for patients to be wheeled in on their bed.
- Staff told us the environment and layout of Ward 19 meant patients could not be easily observed.
- Ward 20 had mostly side rooms. We were told the area used to be part of maternity services and senior leaders acknowledge it was less than ideal for dependent elderly patients.
- There were good amounts of equipment, especially on the cardiology, respiratory and stroke wards. On all of the wards we saw falls alarms, low beds, and seating and mattresses used to minimise the risk of pressure ulcer development.
- The single rooms on the Emergency Assessment Unit (EAU) had piped oxygen and other medical gases, and a tympanic thermometer in each room. The nurse allocated to each bay on EAU was responsible for checking the oxygen, suction, and medicine trolley for their area. They completed a checklist which was verified by the ward coordinator of the day. All the checklists we saw were up to date.
- Each bay on the EAU had a computer on the nurses' station. This meant nurses could stay in the area allocated to them and be available for patients.
- The EAU had an electronic 'pod' system. This was used to send medication orders and receive them from pharmacy and to send samples to the labs. Use of the pod meant medications could be sent to EAU quickly when needed.

Medicines

- The pharmacy staff told us they replenished ward stock from an agreed list and checked dates of medications once per month.
- Medicines were stored securely on Ward 1 and pharmacy staff audited medicines security and the management of controlled drugs on a regular basis. We spoke with two pharmacy staff and nurses on Ward 1 and looked at medicine charts for seven patients.
- We found, on admission, some medicines were not accurately listed on the medicine administration chart.

We looked at records for seven people admitted to the wards on the weekend before our visit and found, because of errors, changes were made after review by the pharmacist.

- We noted the errors on medication charts to be as follows; a patient had been admitted on 2nd May and received a different dose of medication from the information the GP had given until the pharmacist checked the dose on 6th May. There was no evidence the patient had been harmed.
- One medication chart had gaps in the administration record without explanation.
- One chart showed a patient should have been receiving modified release drugs but was being given a standard dose.
- One patient had been prescribed a nasal spray on the 3rd of May but this was not ordered by the ward until the pharmacist checked the chart on 5th May.
- One patient was prescribed two inhalers which had been discontinued by their GP. It was not clear if discussion had taken place with the GP to restart the inhalers.
- The fridge temperature checklist had gaps on the 1st, 2nd and 3rd of May. On one check 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.
- We spoke with pharmacy staff and nurses on Ward 2 and looked at medication records for five patients.
- One medication chart had gaps in the administration of six drugs without explanation.
- Another chart had a dose crossed out and altered when it should have been discontinued and re-written as a new dose. The same chart had gaps in the administration of important medication without explanation or escalation. The same chart had medication with the wrong dose and one medication which should have been discontinued but was still being given.
- Another chart had the wrong dose which had been identified by a pharmacist.
- There were gaps in the temperature checks for the drugs fridge.
- We observed medicines for destruction were not locked away and stored in open boxes on the floor. We saw Temazepam syrup which expired in December 2014 (we

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were on the ward in early May 2015) and had not been returned to the pharmacy, and while it was kept in a locked cupboard, it was not the controlled drugs cupboard.

- We were shown Ward 10's medication audit report for the period of January to March 2015. There had been a reduction in the overall medication incidents reported over the last year. However, on average, there were still one or two reported incidents per month. The main reasons for these were missing medication, omitted or delayed medication, the wrong dose or strength prescribed, and a mismatch between patient and medication. On most of these occasions, no harm came to any patients.
- There had been two reported incidents of missed insulin on Ward 10 in June 2014 and November 2014. During our inspection we found a patient had missed a dose of insulin the night before. Limited action had been taken at the time the drug was omitted and the patient's blood sugar had been initially recorded as being at high levels but then not checked again overnight despite being raised. This was urgently pointed out to the ward manager and action was immediately taken to ensure the wellbeing of the patient. The incident was reported appropriately on the Datix system. We were concerned there was a lack of learning from previous incidents.
- The drugs fridges were checked twice a day on EAU and there was thorough medicine validation by pharmacy staff.
- When endoscopy staff were required to use controlled drugs for procedures carried out in a different part of the hospital, one staff member took the medications in a locked box and a second staff member took the keys.

Records

- We found variability in the standard of record keeping. We saw several sets of medical notes where doctors did not sign clearly nor print their name and designation. We checked 17 falls risk assessments; 15 of these were completed appropriately.
- Two new forms for a pilot related to falls prevention were reviewed, one was completed appropriately, and the other was not.
- We checked seven repositioning and intentional 'rounding' charts, five were completed appropriately.

- 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.
- We observed the use of 'extra-med' electronic care system; there were two screens available for display, and most wards had the non-confidential screen on display.
- We noted that a hospital social worker had written entries in two sets of notes; these were legible, signed and dated appropriately.

Safeguarding

- The medical and care of elderly wards showed an average of 60% compliance with safeguarding adults level 1 training. The trust target is 85%.
- There was only 8% compliance with safeguarding adults level 2 training. No one had undertaken level 3 training.
- There was 77 % compliance with safeguarding children level 1 training, and 50 % compliance with the level 2 training. 44 % of staff had completed safeguarding children level 3 training.
- The trust safeguarding process was displayed on four of the wards we visited. Staff we spoke with told us they were not all up to date with safeguarding training; however they had an awareness of safeguarding issues and were able to show us where the information was stored on the ward.
- One record regarding safeguarding was observed where a member of staff raised an alert with the local authority and documented it appropriately.

Mandatory training

- We were told that mandatory training has now moved to a two year cycle, with face to face learning one year and e-learning the next.
- We saw there were inaccuracies in electronic recording of mandatory training. We spoke with senior managers about this and were told they were unable to assure us of an understanding of the failing or an action plan to address this.
- There was a great variety in compliance with mandatory training. This ranged across wards and topics for training, for example from 8% compliance with safeguarding adults level 2 training to 100% compliance in Infection prevention and control. (These figures may be affected by the inaccuracies of recording by the trust).

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- Staff told us it was difficult to attend training due to staffing levels and the need to prioritise patient care. Some staff told us 'essential' face to face mandatory training such as resuscitation training took priority over other e-learning. One ward booked agency staff to release permanent ward staff for mandatory training. Nurses on EAU received an email and letter from the ward manager reminding them of booked training. The ward manager told us this helped them achieve 100% compliance with training.
- Mandatory training for doctors was recorded centrally and checked by the Medical Director as part of the medical staff appraisal process.
- The ward clerk and housekeeper on Ward 19 had received training in dementia awareness; they told us this helped them understand the needs of patients living with dementia.
- There were 10 cardiac telemetry beds in the ward block. Cardiac telemetry is continuous monitoring of a patient's heart rate and rhythm which takes place on one ward and the results are displayed in another area, in this case the cardiology ward. All registered nurses on the cardiology ward were trained to give advanced life support. One nurse on the cardiology ward carried a cardiac arrest bleep and attended cardiac arrests in other parts of the hospital.
- There was an Acute Respiratory Assessment Service (ARAS) which provided a specialist service for the assessment, management and treatment of patients with respiratory conditions.
- Staff on the respiratory ward cared for patients having biphasic positive airways pressure (BiPAP) or non-invasive ventilation. BiPAP is not included on the EWS, a separate BiPAP observation chart was in use.
- We reviewed the records of someone receiving BiPAP; the records were completed appropriately. The case notes of the patient were tracked and care had been delivered according to national and local guidance in a timely manner.

Assessing and responding to patient risk

- Wards used the 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 NEWS (National Early Warning Score) was due to be launched across the trust shortly after our inspection.
- We looked at eight EWS charts on a number of wards; they were all completed appropriately with the correct EWS and observation frequency. One ward completed weekly EWS chart audits showing 84%-100% compliance.
- We observed rapid attention given to a deteriorating patient on one of the care of elderly wards. Staff on several wards told us they felt confident in the management of deteriorating patients and had the support of the critical care outreach team 24 hours a day. Nursing staff reported good responses from medical staff when a patient's condition deteriorated.
- Auxiliary nurses on the stroke ward were not present at verbal handovers. Instead they were given a handover sheet and asked to care for patients. They told us this placed patients at some risk as there were individual aspects about patients that they were not told about.
- There were yellow stickers 'please call, don't fall' displayed behind the beds of patients who were at risk of falling. This method was used to identify the patients at risk and had been designed on EAU and shared across the trust. We were told this had led to a reduction in the incidence of falls.
- Staff told us BiPAP patients were nursed as Level 2 on the ward and that there was a maximum of 4 patients on BiPAP allowed on the ward.
- There was a small team who specialised in the care of frail older people; they carried out falls prevention work and gave advice regarding care of patients with Parkinson's disease and those living with dementia. The team were based in the Elderly Care Unit on the main hospital site.
- The situation, background, assessment and recommendation (SBAR) process was used for handover of patient care on EAU. This provided a comprehensive handover of care. A ward meeting took place every day at 7am on EAU in order that safety information could be given to staff on the day and night shifts.
- On the respiratory ward, a list was kept of patients who were not to be 'slept out' from the speciality area; this included patients with chest drains, brittle asthma conditions, and those having non-invasive ventilation.
- The EAU had 27 beds and was co-located with the Emergency department (ED). All emergency medical and surgical patients were admitted to EAU if a bed was not available on a 'downstream' ward. Emergency orthopaedic patients who needed care from the medical team were also admitted to EAU.

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Nursing staffing

- Senior staff told us the Safer Nursing Care Tool was used to determine the required levels of nurse staffing, and they worked to a ratio of 1:8, (one registered nurse to eight patients). We pointed out that staffing records on a particular ward indicated two nurses to 30 patients at night, a ratio of 1:15. Some ward nurses who spoke with us said they did not think nurse staffing was calculated using any dependency or acuity scores. Ward managers told us that acuity tools were being considered by the patient safety team.
- There were vacancies of all grades of nursing staff on several of the wards we visited. We were shown evidence that recruitment was underway but ward managers told us that recruitment was a challenge. Senior staff told us they would rather have vacancies filled with bank or agency staff rather than recruit someone without the necessary skills and attributes into a permanent post.
- Three ward managers who spoke with us reported that their own staff worked bank shifts to cover vacancies. One ward with the highest vacancy rate told us that they try and use the same agency staff on a regular basis for continuity. Senior Managers told us some agency staff were recruited on longer three month contracts and had an induction to the trust.
- Information on planned versus actual staffing numbers was displayed at the entrance to ward areas. The fill rate for shifts varied across all the wards, from 78% to 100%. 100% staffing was achieved on EAU, where their own staff covered extra shifts. Agency nurses were not needed to work on EAU.
- The use of nurse bank and agency staff varied across the wards. On Ward 1 the rate of agency staff use had fallen from 10.6% in October 2014 to 8.6% in January 2015. Nurses on this ward told us there were: "significant staffing problems". They cared for dependent patients who were undergoing alcohol detoxification, had encephalitis, (swelling of the brain), and gastric bleeding who needed a lot of nursing intervention. Staff told us their ward had not been recognised as a hotspot by leaders.
- On Ward 2 the rate had risen to 15.73% in the same timescale. Nursing staff on this ward told us they had raised concerns over low staffing levels with managers and had been encouraged to submit incident reports. We were told the ratio of registered nurse to patients

- had been 1:15, and the registered nurses were mentoring nursing students at this time. Nurses told us this affected patient safety but could not recall particular incidents during this time.
- On Ward 5 the rate had fallen from 17.3% to 2.34 % and on Ward 6 the rate had risen from 6.0% to 22 % in the same timescale.
 - Ward 19 had used 4.5 % agency staff in October 2014, this rose to 52.6% in December and then fell again, but no agency staff were used in January 2015.
 - Ward 20's use of agency staff fell from 17.2 % in December 2014 to none in January 2015.
 - Nurses who work extra hours through the nurse bank had their hours monitored informally by local managers and formally through the nurse bank.
 - One ward we visited had a cohort of night staff; we saw evidence of an action plan to rotate this group of staff in order to increase their knowledge and skills. The ward manager was awaiting feedback from human resources before proceeding with the plan.
 - Some nurses who worked 30 hours a week told us their contracted hours were worked out over the month, which resulted in them working between eight to ten days at a time which they believed was unsafe.
 - The average sickness rate across the trust was 5%. On Wards 1, 8, 10 and 20, this rate was between 11% -20%.
 - Some registered and non-registered nursing staff told us they felt demoralised that agency staff were paid more than them, and they felt: "they didn't get the credit they deserved". Other staff told us their managers tried to get extra staff, and understood recruitment was a significant issue.
 - For newly qualified nurses, we were shown evidence of supportive preceptorships.

Medical staffing

- The percentage of consultants in the skill mix for medicine and elderly care was 30%. This is slightly lower than the England average of 33%.
- 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 across Tyne and Wear with two other trusts with

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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.

- There was a higher than average percentage of junior staff in post, (40% compared to a national average of 22%).
- Senior managers told us that the number of specialist registrars was limited because of the limitation of specialities at the Trust. There was a plan in place to recruit more doctors, and locums were in use until recruitment was successful. There was acknowledgement that registrar levels need to be increased to reduce the pressure felt by doctors out of hours and on call.
- EAU had good medical staffing cover over 24 hours; this included both junior and specialist registrar cover during the night and at weekends and seven day consultant cover. Consultants were present on EAU until 9 pm on weekdays.
- Some junior doctors we spoke to raised concerns about the management of medical outliers which increased their workload. We spoke to senior managers about this and were told outliers were looked after by the responsible medical team, were on the medical list, discussed at huddles and teams were encouraged to review outliers first. We did not case track a medical outlier on this inspection.
- Senior leaders told us in order for them to manage the outliers during winter pressures, some junior doctors had been looking after patients outside of their speciality; this was based on short term advice of the Deanery.
- Medical staff reported good communication and handover of patients. Doctors participated in daily 'huddles' as part of the ward handover process.
- There was a clinical team which covered between the hours of 9pm and 9am. We were shown a comprehensive medical handover sheet which included responsibilities of doctors during the night.

Major incident awareness and training

- There was a major incident plan in place and three ward managers we spoke to had an awareness of this. Some junior staff were not able to describe what a major incident might entail, nor what their role might be.

Are medical care services effective?

Requires improvement



We have rated medical services as requires improvement for effective.

The Sentinel Stroke National Audit Programme (SSNAP) results rated the stroke service as 'D' for two quarters of 2014 and 'E' for the other two quarters (on a scale of A-E with E being the worst). An options analysis for the future of stroke services in South Tyneside was submitted to the trust board in January 2015 but no decision had been made at the time of our inspection in May. The Malnutrition Universal Screening Tool (MUST) audit of 2013 showed 58% of patients were screened on admission against a trust target of 100%. The MUST audit was previously undertaken in 2011 and 2008; we found this frequency of audit did not provide a basis for improvement in nutritional screening.

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 of over 90%. All of the doctors we spoke with had received an appraisal in the previous year. Trust records showed 100% of doctors in the care group had received an appraisal in line with the GMC revalidation process.

Results from the previous Heart Failure Audit of 2012/2013 showed the hospital achieved higher results than the England average for all four indicators relating to in-patient care. Results from the MINAP audit in 2013-2014 showed the hospital achieved higher than the England average for patients referred for or those who received an angiography. Patients we spoke with told us they had received good pain relief and nurses had asked them regularly if their pain was controlled. 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 rounds and daily huddles. We observed a discussion around DOLS during an MDT meeting and saw documented evidence of close work with the mental health team.

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Evidence-based care and treatment

- Policies based on National Institute for Health and Clinical Excellence (NICE) and the Royal College of Physicians (RCP) were available to staff and accessible on the trust intranet site. Some policies such as the Resuscitation policy included national guidance from the British Medical Association (BMA), the Resuscitation Council (UK) and the Royal College of Nursing (RCN). The guidance for staff around Deprivation of Liberty Safeguards (DOLS) was based on the Mental Capacity Act. The risk register for elderly care indicated that the falls policy did not meet national institute for health and care excellence (NICE) guidelines; this was due to be re-written by the end of May 2015.
- The endoscopy service had used evidence from research and clinical trials to implement a 'capsule endoscopy' service. We were told the procedure was completely non-invasive, did not require sedation and was well tolerated by patients.
- One consultant in the endoscopy unit told us evidence from the RCP and National Institute for Health Research (NIHR) had been used to develop other services for patients, such as trans- nasal endoscopy (which meant they did not require sedation) and could therefore have investigations in the evening. This also maximised clinic availability.

Pain Relief

- We were shown pain assessment charts which were used to determine how effective pain relief was for patients.
- We saw that regular pain relief was provided as prescribed and patients could request pain relief at other times. We observed nurses on the cardiology ward asking patients if they were experiencing pain.
- Patients we spoke with told us they had received good pain relief and nurses had asked them regularly if their pain was controlled.

Nutrition and Hydration

- Protected meal times were in place and we were told these were adhered to in most cases. Family carers were encouraged to be present at mealtimes if they wanted to support patients to eat and drink.

- We saw patients were assessed regarding their nutritional needs and care plans were in place. MUST (malnutrition universal screening tool) scores were used to assess nutritional needs.
- There were extra meals and drinks offered on the EAU; toast and drinks were given to patients at 3pm and soup was offered at 8pm.
- The Speech and Language Therapists assessed patients who had difficulty swallowing; guidelines for safe consistency food and drinks were provided to ward staff.

Patient outcomes

- During 2013 to 2014 the trust participated in several national and regional audits including the Sentinel Stroke National Audit Programme (SSNAP), the heart failure audit, the myocardial ischaemia national audit programme (MINAP) audit, the national diabetes audit and the British thoracic society non- invasive ventilation audit.
- The sentinel stroke national audit programme results from 2014 showed South Tyneside hospital achieved an overall rating of 'E' (on a scale of A-E with E being the worst) for two quarters of 2014, January to March and July to September; for the remaining two quarters a rating of 'D' was achieved.
- The stroke audit facilitator post had been vacant for some time prior to our inspection. The stroke specialist nurse worked Monday to Friday and had several responsibilities including staffing the transient ischaemic attack clinic (TIA), participating in ward rounds, undertaking visits to patients in the community and supporting junior medical staff.
- Senior staff told us a trust of this size would find it difficult to achieve a higher level in the SSNAP audit because of the size of the population they serve and additional standards which are required. An options analysis for the future of stroke services in South Tyneside was submitted to the trust board in January 2015 but no decision had been made during our inspection in May. Senior staff told us the current service is safe and works but is not sustainable.
- Senior staff accepted they had been a regular outlier with regard to the percentage of time spent on a dedicated stroke unit; however this was mitigated by patients having shorter length of stay due to support for an early discharge by the community stroke services.

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- There was a team of three cardiac rehabilitation nurses in post who supported patients for six weeks during their recovery from cardiovascular problems.
- British thoracic society non- invasive ventilation audit results for 2014 were in line with the national results.
- Results from the 2012-2013 national diabetes audit (published in 2015) showed South Tyneside was better than the England average for diabetic patients with a risk of angina. The results for complications of diabetes such as myocardial infarction (heart attack), heart failure, stroke, major and minor amputations and kidney replacement were in line with the national average. The mortality rates for patients with diabetes in South Tyneside were also in line with the national average. The report recommended the following: a review of heart failure risk reduction, glucose control, blood pressure control and cholesterol control according to NICE guidelines; the development of a foot disease prevention pathway and early identification of people at increased risk of diabetic kidney disease.
- Results from the previous Heart Failure Audit of 2012-2013 showed the hospital achieved higher results than the England average for all four indicators relating to in-patient care. The hospital scored higher than the England average for six out of seven indicators relating to care after discharge. (More updated results were not published by the time of our inspection).
- Results from the MINAP audit in 2013-2014 showed the hospital achieved higher than the England average for patients referred for (or those who received) an angiography, (88.7% compared to an England average of 77.9%). A higher result was also achieved for patients who were seen by a cardiologist or a member of the cardiology team, (99% compared to an England average of 94.3%).
- The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The Health and Social Care Information Centre reported in April 2015 that the trust had a 'higher than expected' SHMI for discharges in the reporting period October 2014 – September 2014. The standardised hospital mortality index (SHMI) for 2013-2014 predicted 951 deaths in the hospital; actual

results showed 1125 deaths. Various factors influence the reporting of these figures such as the number of palliative care beds at this trust and the management of coding.

- Internal clinical audits were carried out during this time frame as a way to find out if care is being provided in line with standards. The aim of audits is to enable low quality improvement to take place to improve outcomes for patients.
- A MUST audit (Malnutrition universal screening tool) was carried out on the medical and elderly care wards in 2014. The percentage of patients screened within 24 hours of admission was 58%. This is an improvement on the results of 2011 (47% were screened with 24 hours in 2011), but is less than the trust target of 100%.
- An action plan was in place as a result of the MUST audit. These included ward based training and competency assessments, the amendment of the screening tool and dietetic referral forms to enable an accurate audit to take place, the discussion of results at the nutrition and hydration steering group and the development of individual ward based action plans.
- The Endoscopy unit had been inspected by the Joint Advisory Group (JAG) and had consistently met the required standards. The unit had recently achieved accreditation levels 'A' and 'B' (out of a rating of A-D, where A is the highest).

Competent staff

- Senior managers were responsible for monitoring and auditing appraisals.
- 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 of over 90%.
- All of the doctors we spoke with had received an appraisal in the previous year. Trust records showed 100% of doctors in the care group had received an appraisal in line with the GMC revalidation process.
- Members of pharmacy staff who spoke with us told us they had not received appraisals in the last year.
- Staff told us clinical support workers were participating in an 'essential care' course and studying for the care certificate which was part of a national programme.

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- Student nurses told us they were supported by a university practice placement facilitator; they also told us they received good support from their ward based mentors and received a good balance of practical skills and theoretical knowledge.
 - Allied health professionals and support staff who spoke with us reported they were supported to participate in external training relevant to their role.
 - We were shown competency workbooks for nurses at band 5, 6 and 7 on the gastro ward. This meant staff were given support and training to gain skills and knowledge before being assessed as competent to carry out certain roles.
 - Junior doctors we spoke with felt supported through their induction programme. Doctors on the stroke ward received a week of theory and then shadowed an experienced doctor for a further week before working on the ward.
 - Some non-registered staff told us there was limited career progression for them. Some had an extended role but were unable to progress beyond Band 2 even if they had achieved NVQ level 3. Senior staff told us there was a working group looking at development of the Band 2 role.
 - Some non-registered staff told us they were not computer literate so had received support from the learning and development team before undertaking e-learning.
 - The ward with the highest vacancy rate had less experienced, underdeveloped staff on the ward as experienced staff had left. Senior managers were aware of this issue and had moved some experienced staff to this ward area.
 - 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.
 - Not all senior nursing staff we spoke to on the stroke ward were aware of the Sentinel Stroke National Audit Programme nor how they could contribute to improvement on the results.
- teams (MDT). We observed examples of good practice with MDT board rounds and daily 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.
- The only exception we found was on the stroke ward where nursing auxiliaries were excluded from 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; she carried out a variety of roles to support team working.
 - There were doctors' offices on most wards; other staff could use these rooms. The doctors' office on EAU had a designated desk for the discharge liaison nurses and pharmacist; this encouraged MDT working.
 - Therapy staff we spoke with said they felt a valued part of the MDT.
 - Two of the wards we visited carry out a weekly MDT meeting; we observed one of these meetings and saw evidence of collaborative working on this ward and across other medical wards.
 - We were told of good integrated working between the community integration team and Ward 20 staff.
 - There was a mental health liaison service provided on the wards. Following referral, mental health workers would come into hospital to assess and support care for patients with mental health needs.
 - The huddle on Ward 10 was very medically focused and not as inclusive as some other wards.
 - On one ward the therapists said they required referrals in only an electronic format; some nurses felt this process was time consuming and could be improved.

Seven-day services

- Consultant cover was available Monday to Friday on all the medical and care of elderly wards where daily ward rounds took place.
- Seven day cover was provided on the EAU, where consultants worked 7am to 7 pm. Specialist registrars provided overnight cover and consultants were available on an on call rota.
- Ward rounds took place several times a day on EAU.

Multidisciplinary working

- Staff on the wards and other clinical areas told us of very good working relationships within the multidisciplinary

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- Some therapy services were available seven days a week on the stroke ward where therapy assistants were trained generically to provide physiotherapy, occupational therapy and some speech and language services.
- Daytime weekend cover was provided by on call respiratory physiotherapists. We were told the night time service had not been used for two years so this had been withdrawn.
- Critical Care Outreach team provided 24 hour cover and this service had in part replaced the overnight weekend respiratory physiotherapy cover.
- The clinical team at night consisted of five staff: a nurse coordinator, a specialist registrar for medicine, a middle grade medical doctor, a middle grade surgical or orthopaedic doctor and a junior medical doctor.
- There was a hospital discharge team who worked in seven days a week in two teams. One was involved in the rapid discharge of patients from EAU, emergency department and ambulatory care; the other team were involved in supporting timely discharges from the downstream wards. The discharge team worked seven days a week until 8pm.

Access to information

- Doctors told us they received test results and information in a prompt timeframe.
- We were shown a folder on EAU with records of daily meetings; staff could refer back to this if they missed a meeting.
- Ward 6 had a communication folder; this was updated every three weeks.
- There were a range of patient information leaflets displayed on wards and clinical areas.
- There were staff guidelines displayed in ward offices. We were told the hospital intranet had many clinical guidelines which were easy to find such as Mental Capacity Act guidelines.
- We were shown handover sheets which had been generated by the Extra-med system; they contained detailed and thorough information.
- We were told electronic discharge summaries were sent to GP's within one hour of the patient leaving hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence of Deprivation of Liberty Safeguards (DOLS) urgent and standard authorisation forms which

had been completed to a high standard by a junior doctor. A capacity assessment had been undertaken appropriately, a best interest form completed and a referral made to the mental health team. The forms had been countersigned by a consultant. Band 6 or 7 nurses could complete DOLS forms; out of hours they were completed by the site manager.

- We observed a discussion around DOLS during an MDT meeting and saw documented evidence of close work with the mental health team.
- We were told that only Band 6 nurses and above received Mental Capacity Act (MCA) training. Senior staff told us training for Band 5 staff nurses had been withdrawn in 2014 and was due to be reinstated. Staff we spoke with had some awareness of MCA and DOLS.
- There were 'your voice' cards displayed on Ward 2; these cards referred to an advocacy service for patients.

Are medical care services caring?

Good



We rated medical care services as good for caring.

Staff were observed to demonstrate a caring attitude and treat patients and family members with respect and compassion. A patient and their family approached us in a corridor to tell us they had received an excellent service from a social worker. The NHS Friends and Family test results (FFT) between December 2013 and November 2014 indicated the response rate was higher than the England average (36.3% compared to an England average of 30.1%). The percentage of patients who would recommend the services was consistent with, or higher than, the national average during this time.

Staff showed understanding of patient and staff needs for emotional support. We were told that when a profoundly deaf person was on a ward for several weeks, some staff learned key words and phrases in British Sign Language (BSL) to involve the person in their care. The mental health liaison service provided support for patients with alcohol or substance misuse problems. Patients with anxiety and depression could also be referred to the team. A member of staff who returned to work following a family bereavement said they had been really well supported by their manager.

Compassionate care

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- We observed all staff talking about patients with care, respect and compassion during the huddles and MDT meetings.
- The NHS Friends and Family test results (FFT) results between December 2013 and November 2014 indicated the response rate was higher than the England average (36.3% compared to an England average of 30.1%). The percentage of patients who would recommend the services was consistent with, or higher than, the national average during this time.
- Senior Managers told us they found the FFT results useful because it helped them to make local improvements.
- Recent FFT results were displayed on wards we visited; real time patient feedback on one ward was 86% positive from January to March 2015.
- A patient and their family on Ward 20 told us the staff: "were very caring."
- Patients on Ward 6 told us the care was: "fabulous, the staff are lovely."
- A day case patient in endoscopy told us they had received: "top notch care, they treat you as a human, it's nice that they are so caring when doing these procedures."
- A patient and their family approached us in a corridor to tell us they had received an excellent service from a social worker.
- While we were visiting Ward 2 we noted that 10 nurse call buzzers went off during two hours; each buzzer was answered within two minutes. One patient told us someone always came quickly when they are needed.
- We looked at three care plans on one of the elderly care wards. It was documented that several patients had been given personal care very early in the morning by night staff before early staff arrived on shift. It was not clear if this was part of the ward routine.
- We were told the trust had carried out two dementia awareness events which focused on carers of people living with dementia.
- There were flexible visiting times on some of the wards we inspected; this meant patients could have family or friends with them more during the day.
- We heard of excellent understanding of patient needs; when a profoundly deaf person was on a ward for several weeks, some staff learned key words and phrases in British Sign Language (BSL) to involve the person in their care. Other examples were when staff used an online translation website to communicate with a non-English speaking patient when the interpreter was not available.
- Family carers told us they had been given exemption from car park fees because their relative was going to be in hospital for an extended time. They said they had been very well informed and supported.
- We were told about a carers group which met on the stroke ward. Carers were given practical advice and emotional support.
- A relative in the waiting area of the endoscopy unit told us their loved one had been well informed and involved in the preparation for their investigation.
- We observed an excellent example on the EAU. The housekeeper provided a 'meet and greet' service for families and friends during visiting times, telling them exactly where to find the patient; she also gave visitors information if the patient had been transferred to another ward. This prevented families from worrying if they couldn't find someone and freed up nursing staff to care for other patients.

Emotional support

- We were told there was a range of clinical nurse specialists in post who could provide support for patients during the acute stage of their illness and also in the community after discharge.
- The mental health liaison service provided support for patients with alcohol or substance misuse problems. Patients with anxiety and depression could also be referred to the team.
- A member of staff who returned to work following a family bereavement said they had been really well supported by their manager.

Understanding and involvement of patients and those close to them

- Patients on Ward 10 told us staff asked them their preferred name and said "they couldn't do any more than they do, care is excellent. They tell me things in a way I can understand."
- During the MDT meeting we observed we saw several occasions where staff discussed the involvement of family in patients' care.

Are medical care services responsive?

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Requires improvement



We rated medical care services as requires improvement for responsive.

There were high numbers of 'outlier' patients boarded outside of their speciality area. For example, a monthly average of 196 medical outliers in the surgical service between October 2014 and January 2015. Bed numbers were reduced through the refurbishment programme and a review of bed allocation in the hospital. As part of the winter contingency plans for winter 2014/15, the Trust and local authority agreed to increase the number of community beds. These remained in place during April and May 2015. In addition, the Trust also opened additional beds on Ward 20 (Primrose Unit) in January which remained open during April and May 2015.

We were told of examples to improve patient flow this winter such as the use of local authority funded 'time to think beds' for patients who may need more time (up to six weeks) to recover out of hospital. Planned or estimated dates for discharge were discussed at most of the ward huddles and board rounds we observed.

The extra-med electronic system was in use on all the wards. In EAU this meant live bed availability could be monitored in order to maintain flow of patients through the unit to downstream wards. There was a hospital discharge team who worked in two teams. One was involved in the rapid discharge of patients from EAU, emergency department and ambulatory care; the other team were involved in supporting timely discharges from the downstream wards. The discharge team worked seven days a week until 8pm.

We saw volunteers on some wards; they sat and spoke with patients, put curlers in female patients' hair and sang songs with them. We saw yellow 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 the patient could eat with them. Ward 20 had a small cinema for patients and their families; this was also used for reminiscence therapy.

Service planning and delivery to meet the needs of local people

- We were told by a consultant that the health needs of the local population meant a flexible cystoscopy service was needed; patients previously travelled to other hospitals, but now there were two lists a week at South Tyneside.
- As part of the winter contingency plans for winter 2014/15, the Trust and local authority agreed to increase the number of community beds. These remained in place during April and May 2015. In addition, the Trust also opened additional beds on Ward 20 (Primrose Unit) in January which remained open during April and May 2015.
- We were told of examples to improve patient flow this winter such as the use of local authority funded 'time to think beds' for patients who may need more time (up to six weeks) to recover out of hospital.

Access and flow

- Although contingency plans had been implemented to accommodate higher numbers of patients during the winter months, there were high numbers of 'outlier' patients boarded outside of their speciality area. For example, a monthly average of 196 medical outliers in the surgical service between October 2014 and January 2015.
- Ward staff told us medical and care of elderly patients could be cared for away from their speciality medical wards due to bed pressures. On the two days we visited the stroke ward, ten out of the 20 beds were occupied by medical patients from other specialties. This meant there was not a bed available in the relevant medical specialty for them, and if a stroke patient was admitted, the medical patient would need to move to another ward.
- We spoke with some allied health professionals who told us they were concerned about the number of medical outliers and the impact it had on patients' length of stay.
- The average length of stay for elective patients during the period between June 2013 and July 2014 was marginally less than the England average (3.7 days compared to 3.9 days).
- The length of stay for acute admissions was 7.9 days, compared to the England average of 6.8 days. The length of stay for stroke medicine was 14.4 days, compared to the England average of 12 days.
- Staff told us patients stay on the EAU between a few hours to one or two days. The longest stay on EAU had

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been three weeks. We were told that one Consultant started ward rounds at 6am on EAU in order to make beds available for patients from the emergency department. There were 27 beds in EAU and one chair used for patients awaiting discharge.

- The extra-med electronic system was in use on all the wards. In EAU this meant live bed availability could be monitored in order to maintain flow of patients through the unit to downstream wards. Planned or estimated dates for discharge were discussed at most of the ward huddles and board rounds we observed.
- Senior staff told us bed numbers had been reduced through refurbishment and a review of bed allocation in the hospital.
- Senior managers told us there were no themes identified in relation to delayed discharges; however NHS England reported the two main reasons for delayed discharge in the hospital were family /patient choice and patients awaiting a care home bed. South Tyneside reported 146 'lost bed days' from April 2014 to March 2015.
- A consultant told us families of older patients were given two weeks to find a care home before the hospital declared a delay.
- There was a hospital discharge team who worked in two teams. One was involved in the rapid discharge of patients from EAU, emergency department and ambulatory care; the other team were involved in supporting timely discharges from the downstream wards. The discharge team worked seven days a week until 8pm.

Referral to treatment times

- Between April 2013 to November 2014, the trust consistently met the 90% standard for percentage of patients referred and treated within 18 weeks except in July 2014 where the standard was not met.
- All specialties within medicine met the expected standard over this time period

Meeting people's individual needs

- Translation and interpreting facilities were available at the hospital and staff we spoke with knew how to access these services.
- Ward 20 had a small cinema for patients and their families; this was also used for reminiscence therapy.
- We observed 'personal care in progress' and 'please wait' signs on bedside curtains and side room doors on

Ward 2. This ward also provided non-slip socks for patients without slippers. We saw dignity and privacy being maintained; staff asked if they could 'come in' before entering behind curtains.

- We observed some older patients being wheeled to the toilet rather than having to use a commode at the bedside.
- We saw volunteers on some wards; they sat and spoke with patients, put curlers in female patients' hair, and sang songs with them.
- We saw yellow 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.
- We were shown a 'Wii' game console in the patients' gym on the stroke unit. This was used to help regain balance and coordination after a stroke.
- The bathroom on the stroke ward had a height adjustable adapted bath and a ceiling track hoist so that dependent patients could be hoisted into the bath. The room was large enough for patients to be wheeled in on their bed to maintain their dignity.
- We were told about a breakfast club and 'soup group' on the stroke ward. Patients were encouraged to participate and make meals as part of their ongoing rehabilitation.
- The therapy team on the stroke ward accompanied patients to the hospital paper shop or coffee shop as part of their rehabilitation; this helped some patients regain independence.
- Patients who were admitted to the medical wards with a tracheostomy are given a blue wristband and an emergency equipment box which went everywhere with the patient. Ward staff reported they felt supported to care for these patients by the Outreach Team.
- A family told us they had been offered the services of the chaplain and had appreciated the time to talk to someone who wasn't a nurse or doctor.
- There was an Acute Respiratory Assessment Service (ARAS) which provided a specialist service for the

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assessment, management and treatment of patients with respiratory conditions. The team worked both in the hospital and community and liaised with GPs, community matrons in preventing readmission to hospital.

- Families and carers had raised money to create a relatives room on the ward for patients with diabetes.
- The EAU and some other wards had link nurses for privacy and dignity, dementia and other key areas of focus. The link nurses had extra knowledge or an interest in the promotion of good experiences for patients.
- The hospital had carried out two dementia awareness days and employed a dementia lead nurse to support improvements in care for patients living with dementia.
- There was a mental health liaison service provided on the wards. Following referral, mental health workers would come into hospital to assess and support care for patients with mental health needs.
- There had been building work on EAU to provide a toilet and shower in each bay area; a bed space had been removed in each bay to enable this to happen.
- Staff in the endoscopy unit told us they had developed a trans-nasal method of endoscopy for some patients following feedback. This meant these patients could talk throughout the procedure and experienced less anxiety.
- The staff in the endoscopy unit made a video/ DVD for patients with a learning disability to watch before they had a procedure done. This was made with the support of the learning disability specialist nurse. The film showed a whole procedure from start to finish with explanations and terminology given in a way someone could understand. These patients were able to visit the unit beforehand if they wanted to in order to reduce their anxiety.
- Staff in the endoscopy unit told us they had changed the bowel preparation as a result of feedback from patients.
- There was some evidence of 'This is me' awareness. We saw posters on some of the wards however we saw little evidence of 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.

Learning from complaints and concerns

- We were shown improvement plans for two wards (named as assurance project plans). There were issues

on these plans related to informal and formal complaints. The themes for complaints (since April 2014) were around care, lack of communication and a professional investigation which had been undertaken.

- Ward managers told us they try resolve complaints at ward level by talking to patients and relatives.
- Two ward managers told us complaint themes were not shared between wards. Both cited communication and discharge plans as the most common complaints that were resolved at ward level.
- One ward manager told us they were involved in the investigation of a formal complaint and were expected to feedback to their staff and implement the action plan.

Are medical care services well-led?

Requires improvement

We rated the medical services to require improvement for well-led.

We found that senior leaders in medicine and elderly care were not able to clearly communicate the five year plan or vision for the specialties. Governance systems were in place but we were concerned about the safety issues identified relating to learning from incidents, medicines management, staffing levels, lack of equipment maintenance and insecure storage of chemical products. Nurse staffing levels were affected by high sickness rates and vacancies and were regularly supported by use of bank and agency staff. The role of assurance matron supported the patient safety and quality agenda but these were not based at South Tyneside District Hospital. Most staff we spoke with felt engaged and valued by ward managers, the clinical operations manager and clinical business manager; however they said more senior leaders were not visible. There were good examples of local leadership on EAU. There were excellent examples of innovation in the endoscopy unit.

Vision and strategy for this service

- When we spoke with senior leaders of medicine and elderly care, they were unable to clearly describe the five year plan or vision for the service. We were told of the building and estates plan to develop an integrated community hub on site.

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- We were aware that the future of stroke services was considered by the trust board in January 2015. We asked senior leaders of the plan and were told no decision had been made. We were told the current service was safe and works but is not sustainable.
- Senior leaders discussed how bed numbers in medicine had been reduced over recent months following refurbishment and a review of bed allocation at the hospital.
- Two of the ward staff we spoke with were aware of the trust aims to provide quality service for patients. They said the trust vision did not affect their day to day work as their purpose was "to deliver high quality care anyway".
- We saw evidence of improvement plans for two wards. These had been in place since 2014; local action plans had been put in place by ward managers to support the overall plan developed by the safety team and leaders.
- Concerns were raised with us on one ward of the potential of previous underreporting of incidents and safety thermometer.
- A ward with a high vacancy rate had submitted a plan for additional staffing to the patient safety team but had not received further information on it.
- Senior staff were aware of issues on the risk register and agreed they were representative of the risks they identified in the directorate.
- Senior staff told us assurance and operational managerial roles were split within the organisation. Assurance matrons were based off site so were not on the wards on a daily basis; they met with the ward management team weekly and were responsible for patient safety, the review of serious incidents, and practice development issues.
- Neither senior nursing staff on the stroke ward, nor their senior managers were aware of the Sentinel Stroke National Audit Programme (SSNAP) nor how they could contribute to improvement on the results. We found this concerning as SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence based standards, and national and local benchmarks. The managers told us they would have preferred to contribute to the options for the service.

Governance, risk management and quality measurement

- Governance systems were in place but we were concerned about the safety issues identified relating to learning from incidents, medicines management, staffing levels, lack of equipment maintenance and insecure storage of chemical products. Nurse staffing levels were affected by high sickness rates and vacancies and were regularly supported by use of bank and agency
- Senior staff told us there was a Clinical Incident Review Group, which was 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. Ward based staff who spoke with us said they were not aware of these meetings or communications from them.
- 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.
- Senior managers told us there was good team learning from Datix incidents, and governance was a standing agenda item on ward and department manager meetings.
- Ward managers told us they were in control of the ward budget and felt supported by senior leaders when they requested additional equipment or staffing, particularly if this was related to a Datix incident.

Leadership of service

- There was variability in leadership. One ward manager told us they felt supported by staff on the ward as senior staff were not always available. Other ward managers said they felt senior staff were approachable and felt valued by them.
- Some ward managers told us they acted as role models for their teams; they were proud of the ward and staff and had an open door policy.
- Some staff told us that continuity of management was a concern; one member of staff had worked on a ward for six years and had not had the same manager for longer than one year at a time.
- Some ward based staff told us the clinical operations manager and clinical business manager had a visible

Medical care (including older people's care)

presence on the wards. Staff felt they could pick up the phone and discuss concerns if they needed to; other ward based staff told us they: “never saw anyone more senior than that”.

- A variety of staff from different disciplines told us they felt excluded from a larger team; they said they received ‘cheer up emails’ from senior leaders and found these to be “patronising”. A number of staff told us they had been ‘coached’ on what to say to the CQC.
- We saw evidence of good local and senior leadership on the endoscopy unit. The senior manager had recently begun to attend a huddle there.
- We saw a lack of senior support for the ward manager on the stroke ward. There were plans to deploy a Band 6 to the ward in June.
- 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.
- Ward managers have one protected management/ leadership day per week; some of them told us they needed more time for this role.
- We were told the clinical business manager and assurance matron meet weekly, and the Director of Nursing meets with ward managers on a monthly basis.
- One member of staff told us they felt like they were ‘fighting fire’ and needed to provide a reactive service to patients rather than a proactive one. They said their manager didn’t fully appreciate the pressure they were under.
- Senior leaders told us they were proud of the way local interim leadership had ‘turned around’ Ward 2 after several problems on the ward.

Culture within the service

- Staff experience boards on some wards indicated around 75% of staff would like their relatives to be cared for on the wards. On average only 60% of staff were happy with the care they gave; they told us this was because they wanted to do more for patients but struggled to do so due to resources.
- Some non-registered staff told us they didn’t feel like part of a team and felt excluded on their own ward.
- Some staff from a variety of disciplines told us they had been told to attend the focus groups held during our inspection; they said they had not been given a choice to attend.

- Doctors told us the EAU was very forward looking. The ward managers had developed their own care targets.
- We were told about a positive team culture on one ward where the housekeeper had been involved in the development of the ward vision.
- Staff had completed the national NHS staff survey in 2014. The overall indicator for staff engagement was 3.7 (out of a score of 1-5 with 5 being the most engaged staff); this was slightly lower than other trusts of a similar type and less than the score for 2013 (both at 3.74). There had been a downward trend of staff feeling supported by their immediate managers and in being motivated at work. There had been an upward trend in staff reporting good communication between themselves and senior managers; at 35% this was slightly higher than the average score of 30% for acute trusts.
- Most staff we spoke with felt engaged and valued by ward managers, the clinical operations manager and clinical business manager, however they said more senior leaders were not visible, and the ‘cheer up’ emails from the chief executive did not make them feel engaged.
- We saw evidence on one ward of monthly team meetings that had been introduced from January 2015 as a way to engage staff and share information and learning from complaints and serious incidents.
- One member of staff told us they wanted to be listened to by leaders and recognised for the challenging work they felt they were faced with. They described their role as “empowering and firefighting” at the same time.
- Apart from the FFT, we did not see any other results of engagement with the public.

Innovation, improvement and sustainability

- We saw some very good examples of innovation from staff.
- 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.
- The SSKIN bundle (Surface, Skin inspection, Keep moving, Incontinence, and Nutrition), a five step model for pressure ulcer prevention, had been adapted from another trust for use by ward 10 staff and had been rolled out across the trust.







Medical care (including older people's care)

- We were told the 'care and comfort' hourly recording tool had been led by an auxiliary nurse.
- 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.
- There was an alcohol withdrawal programme in use on the gastro ward; the care pathway meant nurses could administer pre-prescribed medication when patients needed it, rather than waiting for it to be prescribed. This meant patient received the right medication and care at the right time and reduced risks to themselves and others.
- 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.
- Staff from the unit participated in a patient experience research programme and created a Patient Recorded Experience Measure tool (PREM) to provide a better understanding of the patient experience during and after an endoscopy procedure. This had the aim of improving future patient care. Staff told us that patient experience tools were usually designed by clinicians, rather than patients themselves. The staff felt what the patient regarded as important did not always align with what clinicians recognised as important.

Some of the work so far had resulted in:-

- an over 55's bowel screening programme where precancerous polyps could be removed;
 - trans-nasal endoscopy so patients could talk during a procedure and not feel choking sensations;
 - stents inserted for patients with bowel cancer 10 days pre-operatively to minimise the risk of the patient having to have a colostomy post-operatively;
 - wireless capsule endoscopy (known as 'pill cam' to patients), where a capsule was swallowed, and transmitted images to a screen for several hours so staff could remotely observe rather than some patients having to have an invasive procedure.
- 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.
 - We were told the IT department was working collaboratively with the community IT team to ensure both the acute and community electronic patient systems will be compatible.
 - The medical director told us sustainability of the current care of older people services was an issue and that community services for patients living with dementia and GP support to nursing homes were priorities for the service.

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

Information about the service

South Tyneside District Hospital provides a range of surgical services for the population of South Tyneside and the immediate surrounding area and is also servicing the population of the North East of England.

The hospital provided acute emergency surgical care, outpatient consultations, specialist opinion and treatment for inpatient referrals, day surgery, advanced laparoscopic surgery, planned major bowel laparoscopic surgery and planned major hernia surgery.

During this inspection we visited the following surgical wards: Ward 3 (general surgery), Ward 4 (general surgery), Ward 7 (trauma and orthopaedics) and Ward 9 (general surgery), as well as the Emergency Admissions Unit. We visited all theatres, day surgery and recovery areas on site and observed care being given and surgical procedures being undertaken.

We spoke with 33 patients and relatives and 41 members of staff. We observed care and treatment and looked at care records for 18 patients.

Summary of findings

The overall rating for the surgical division is 'requires improvement'. This is based on a range of issues identified within the safe, responsive and well led domains and summarised below.

Nursing staff said they did not have the experience or skills to give appropriate and safe care to ITU patients within the surgical recovery area. At the time of our visit the trust was unable to provide us with an approved policy and protocol for managing these patients. We were unable to find evidence surgical staff had been trained to look after the needs of ITU patients. Staff within the recovery area reported the impact of caring for high dependency patients from ITU meant long working hours on occasion and that they felt stressed through concerns for the safety of patients. We raised this issue with the division's management team. It was subsequently reported staff had been berated for sharing this concern with us.

There was no medical rota for the management of patients with gastrointestinal bleeds. Staff identified this as a major risk to the safety of patients. Although medical 'boarders' were under the care of medical clinicians, staff on surgical wards told us they did not feel able to provide the same level of care to medical patients.

Staff spoken with were able to repeat the trust vision and strategy. However, they raised concerns whether management within the division had put the vision into

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practice. Members of nursing and healthcare staff from theatres consistently told us that management within these areas was not appropriate and gave us specific examples where bullying and harassment had taken place. Staff said some of these incidents had been escalated through the department's management structure and human resources procedures were implemented but the issues were not fully resolved and difficult working conditions continued. They told us this situation had existed for a number of years. Staff said divisional managers were not always available, visible nor approachable; leadership of the service was remote and morale, particularly within theatres, was not good.

We had also been approached before and during the visit by medical staff from the trauma and orthopaedics department. They raised specific concerns with us about individual bullying and harassment leading to concerns about patient care. Individual and group discussions with medical staff from the trauma and orthopaedics department highlighted difficult working arrangements throughout the department. Although the trust medical director was dealing with these issues and the trust implemented human resource procedures to investigate and take action about these issues, individuals raised concerns about the effect on patient care.

The last available audit of compliance with the 'Five steps to Safer Surgery' World Health Organisation (WHO) process used data from patients who had a surgical procedure in the period June to July 2013.

Although Mental Capacity Act and Deprivation of Liberty Safeguards training had been planned, figures provided by the trust showed 8% of staff in surgery had attended Level 1 training and 2% had attended Level 2 training. Staff were aware of safeguarding policies and procedures but information provided by the trust showed low compliance with safeguarding training. Trust performance reports showed variable results across the surgical division for staff compliance with mandatory training.

We reviewed care records within surgical wards and saw these did not all contain a completed risk assessment for early warning scores for deteriorating patients.

We did find staff were aware and familiar with the process for reporting and investigating incidents, near misses and accidents using the trust's electronic reporting system. No never events had been reported within surgery at this trust between February 2014 and January 2015. Within surgery, 12 serious incidents had been reported in the last twelve months.

The Friends and Family response rate within surgery varied from 30% to 34% and scored similarly with the England average across all areas. The Care Quality Commission in-patient survey (2014) showed consistent performance in patients' believing that they were involved as much as they wanted to be in decisions about their care and treatment and they received answers they could understand when asking a nurse important questions.

We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital and saw that patients were spoken and listened to promptly. Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. The division's management team confirmed there was not a protected surgical list for trauma patients at a weekend and plans to introduce this had not been finalised.

There was information within care plans to highlight whether people had emotional or mental health problems and what support they required for this. Patients were able to access counselling services, psychologists and the mental health team. Assessments for anxiety and depression were done at the pre-assessment stage and extra emotional support was provided by nursing staff for patients both pre- and post-operatively.

There had been increased numbers of medical patients being placed on surgical wards during the Winter months. As a consequence 149 operations had been cancelled and then treated within the national target of 28 days.

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Are surgery services safe?

Requires improvement



Medicine fridge temperatures were not monitored in line with trust policy and missed medication was not always recorded on the trust incident reporting system. Not all care records reviewed within surgical wards contained completed risk assessments for venous thromboembolism and early warning scores for deteriorating patients. Although staff were aware of the safeguarding policies and procedures, information provided by the trust showed low compliance with safeguarding training. Trust performance reports showed variable results across the surgical division for staff compliance with mandatory training. The last available audit of compliance with the 'Five steps to Safer Surgery' World Health Organisation (WHO) process used data from patients who had a surgical procedure in the period June to July 2013.

Staff were aware and familiar with the process for reporting and investigating incidents, near misses and accidents using the trust's electronic reporting system. No never events had been reported within surgery at this trust between February 2014 and January 2015. Within surgery, 12 serious incidents had been reported in the last twelve months.

Incidents

- Staff were aware and familiar with the process for reporting and investigating incidents, near misses and accidents using the trust's electronic reporting system. Staff told us feedback on reported incidents was given and felt they were appropriately supported.
- No never events had been reported within surgery at this trust between February 2014 and January 2015. We saw the trust had a documented process for investigation of never events and the identification of root causes of errors, contributory factors, lessons learnt, arrangements for sharing learning and actions needed to stop reoccurrence.
- Within surgery, 12 serious incidents had been reported in the last twelve months; the reporting of serious incidents was in line with that expected for the size of the hospital. Three of these incidents related to Grade 3 pressure ulcers.

- We saw all incidents had been investigated in line with trust policy and actions identified where appropriate and resulting actions had been implemented.
- Mortality and morbidity meetings were held monthly in all relevant specialities within surgery. All relevant staff participated in mortality case note reviews and reflective practice.

Safety thermometer

- The trust used the NHS Safety Thermometer which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer information included information about all new harms, falls with harm, and new pressure ulcers. Information was displayed on boards on all wards and theatre areas visited.
- The hospital was performing within expected levels for these measures. In the twelve months to December 2014, eleven pressure ulcers were reported within surgery. Seven falls were reported and there were two incidents of catheter acquired urinary tract infection (C.UTI) during this time period. This was reflected in information displayed within ward areas.

Cleanliness, infection control and hygiene

- Wards and patient areas were clean and we saw staff wash their hands and use hand gel between patients, bare below the elbow policies were complied with.
- Infection control information was visible in all ward and patient areas.
- All elective patients undergoing surgery were screened for Methicillin Resistant Staphylococcus Aureus (MRSA) and procedures were in place to isolate patients when appropriate in accordance with infection control policies.
- There had been no incidences of MRSA and Clostridium difficile reported within surgery during 2014.
- Clinical waste bins were covered with foot opening controls and the appropriate signage was used for the disposal of clinical waste. Separate hand washing basins, hand wash and sanitizer was available on the wards, theatre and patient areas.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene. Recent audits (March 2015) showed compliance with hand hygiene protocols varied from 63% (theatres) to 100% on all surgical wards.

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- Nursing staff had received training in aseptic non-touch techniques. This covered the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- The division participated in the ongoing surgical site infection (SSI) audits run by Public Health England, for example, Surgical Site Infection Surveillance Service - Large bowel surgery (October-December 2014), and Surgical Site Infection Surveillance Service – Knee replacement (October-December 2014).
- For example in orthopaedics, information for 2013 showed 0.9% infections during initial inpatient spell (nationally 0.6%) and 1% infections during initial inpatient spell & re-admission (nationally 0.95%). Each case of SSI was identified, discussed at formal meetings and actions identified to avoid a repetition.
- Swab, pack surgical instrument and sharp count audits were completed within theatre and these were discussed at divisional meetings and actions identified if required.
- Pre-assessment of patients was in accordance with guidelines.

Environment and equipment

- We observed checks for emergency equipment, including equipment used for resuscitation. Resuscitation equipment in all areas had been checked daily.
- Records showed equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- All freestanding equipment in theatres was covered and had been dated when cleaned. Equipment was appropriately checked and cleaned regularly. There was adequate equipment in the wards to ensure safe care.

Medicines

- We observed medicines were managed safely. The preparation and administration of controlled drugs was subject to a second independent check and recorded in chronological order. After administration the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Pharmacy staff checked patients' medicines and ordered all medicines needed. Medicines were stored securely and controlled drugs were audited every three months by pharmacy staff and weekly by nursing staff.

- Medicine fridges on two out of three surgical wards were not fully monitored in line with trust policy and fridge temperatures were not recorded on a daily basis. Ward 7 records of fridge temperature had gaps and Ward 9 records of fridge temperature had been completed for only 20 of the 30 days prior to the inspection.
- Missed medication was not always recorded on the trust incident reporting system. We reviewed one patient's records that showed medications had not been prescribed until three days after admission to the hospital on 25 April 2015; this was identified by the pharmacist and an incident report completed.

Records

- Wards completed risk assessments for falls, pressure ulcers and malnutrition. Not all records we looked at were completed accurately.
- We reviewed twelve care records within surgical wards and saw all risk assessments were not completed in four records. This applied to risk assessments for venous thromboembolism (VTE) and early warning scores for deteriorating patients.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure patient confidentiality was maintained.
- Nursing documentation was kept at the end of the bed and centrally within the wards and was completed appropriately.

Safeguarding

- Although staff were aware of the safeguarding policies and procedures, information provided by the trust showed 56% of staff within the division had received safeguarding awareness training and 23% compliance with Level 1 safeguarding adults training.
- Staff we spoke with were able to describe action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.

Mandatory training

- Trust performance reports showed variable results across the surgical division for staff compliance with mandatory training.

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- For example 72% of staff had received slips, trips and falls training, 71% of staff had received record keeping training, 59% of staff had received Foundation Life Support training and 53% had received moving and handling training.
- Staff we spoke with confirmed they were up to date with mandatory training or had this planned.
- During group and individual meetings, staff confirmed they felt confident they had received the mandatory training necessary to enable them to perform their role effectively.

Assessing and responding to patient risk

- All wards used an early warning scoring system for the management of deteriorating patients. However, we reviewed eighteen care records within surgical wards and saw these did not all contain completed risk assessments for early warning scores for deteriorating patients.
- There were clear directions for escalation printed on the observation charts and staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected. We looked at completed charts and saw that staff had escalated correctly when appropriate, and repeat observations were taken within the necessary time frames.
- Theatre lists were updated in 'real time' to reflect changing priorities and timescales.
- We observed theatre staff practiced the 'Five steps to Safer Surgery' World Health Organisation (WHO) process. An audit in February 2015 used sample data from patients who had surgical procedures in the period June to July 2013. The sample consisted of 60 sets of notes (15 General Surgery, 15 Gynaecology, 15 Orthopaedics and 15 Day Surgery) and showed a compliance of 93%. As a result an action plan had been developed to ensure 100% compliance.
- Staff reported patients from the Intensive Therapy Unit (ITU) had received care within the surgical recovery area when beds had not been available in ITU; six patients had received critical care in the recovery area since January 2015. Nursing staff said they did not have the experience or skills to give appropriate and safe care to these patients.
- We raised this with the management team within surgery and were informed that additional support was

available for these patients from ITU staff and the critical care outreach team. The trust was unable to provide us with an approved policy and protocol for managing these patients.

- At the time of our unannounced inspection (3 June 2015), a further three patients from the Intensive Therapy Unit (ITU) had received care within the surgical recovery area since the original inspection. The trust provided us with an approved escalation policy for managing these patients and staff within surgery on the day. This had not yet been communicated to staff within surgery.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool. Work had been undertaken recently by the trust to ensure that staffing establishments reflected the acuity of patients.
- We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels were compliant with the required establishment and skill mix.
- There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster and acuity needs of patients. Staffing numbers on surgical wards had been adjusted flexibly between registered and unregistered staff to meet the needs of patients and in line with the protocol.
- Bank or agency staff were not routinely used and staff told us they were asked to cover staff shortages. Latest information (January 2015) confirmed the annual use of bank staff was between 6% and 19% on surgical wards.

Surgical medical staffing

- Surgical consultants from all specialities were on call for a 24-hour period and arrangements were in place for effective handovers. The general surgical on call team comprised of the consultant general surgeon.
- Patients that required unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant and the hospital published a rota for the provision of general surgical emergency provision.
- Consultants were available on-call out of hours and would attend when required to see patients at weekends. Medical staffing within the division was made

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up of 42% at consultant level (England average 40%), 5% registrar level (England average 37%), middle career 27% (England average 11%), and 27% junior doctors (England average 13%).

Major incident awareness and training

- Business continuity plans for surgery were in place and had been communicated to staff through staff meetings and training. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Good



Patients were treated based on national guidance. Local policies were written in line with national guidelines and updated every two years or if national guidance changed. The division had a formal clinical audit programme. Enhanced recovery pathways were used for patients where appropriate and pre-planned pain relief was administered for patients on recovery pathways. All patients we spoke with reported their pain management needs had been met. However there was no medical rota for the management of patients with gastrointestinal bleeds. Staff identified this as a major risk to the safety of patients.

Appraisals were undertaken annually and records for April 2013 to March 2014 showed that 50% of staff across all wards in surgery and theatres had received an appraisal. Patient-led Assessments of the Care Environment (PLACE) for 2014 scored the trust above the England average for food, privacy, dignity and wellbeing and facilities.

The Trust had developed the Orthopaedic Outreach Team, providing an enhanced rehabilitation program to patients

before admission and up to 30 days after discharge following elective joint surgery. This team also worked with AGE UK to ensure over 65's had support for continued support following discharge.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, Great Britain and Ireland and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients where appropriate.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and for perioperative management of antiplatelet and anticoagulants for elective general surgery and these were in line with best practice and NICE guidance.
- The surgery division took part in all the national clinical audits for which they were eligible, for example adherence to Department of Health, NICE and trust guidance for VTE assessment and the maintenance of normothermia during surgery.
- The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified, such as the audit of surgical readmissions over a six month period and general surgery handover.

Pain relief

- Pre-planned pain relief was administered for patients on recovery pathways.
- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- All patients we spoke with reported their pain management needs had been met. The trust had undertaken an audit of post-operative pain relief with patients. This showed 90% of patients received information about pain relief from their anaesthetist and 84% of patients recalled a visit from the acute pain nurse on how to manage their pain.

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- At a trust level the Cancer Patient Experience Survey (2013/14) showed a response of 87% of patients said: 'hospital staff did everything to help control pain all of the time' against a score of 88% for the top 20% of trusts.

Nutrition and hydration

- Patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary patients at risk of malnutrition were referred to the dietician.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on when the surgery was planned.
- Patient-led Assessments of the Care Environment (PLACE) for 2014 scored the trust above the England average for food (92, England average 90), privacy, dignity and wellbeing (91, England average 87) and facilities (93, England average 92). The trust scored the same as the England average for cleanliness (98).

Patient outcomes

- There were no current Care Quality Commission mortality outliers relevant to surgery at this trust. This indicated that there had been no more deaths than expected for patients undergoing surgery at this hospital.
- The division had introduced initiatives to improve adherence with national waiting list targets. Business cases and focus on additional weekend working and additional theatre sessions had been designed to reduce backlogs.
- Overall the Trust was matching the improvement seen nationally in Patient Reported Outcomes Measures (PROMs) and had a lower proportion of patients who reported an outcome worse than they expected compared to the national average.
- The trust had identified actions to improve PROMs performance through the increased reporting of outcomes by patients. This included changing the pre-assessment process to encourage increased numbers of responses.
- The Trust had developed the Orthopaedic Outreach Team, providing an enhanced rehabilitation program to patients before admission and up to 30 days after discharge following elective joint surgery. This team also worked with AGE UK to ensure over 65's had support to ensure continued support following discharge.

- Standardised relative readmission rates for elective surgical patients ran higher than the England average (100) for trauma and orthopaedics (112).
- The hospital had better than the standardised relative readmission rates England average (100) for elective surgical patients for general surgery (71) and oral surgery (78).
- The hospital had better than the standardised relative readmission rates England average (100) for non-elective surgical patients for general surgery (85).
- The trust contributed to all national surgical audits for which it was eligible.
- The National Bowel Cancer Audit (2014) showed better than England average results for clinical nurse specialist involvement (90%, England average 88%) and scans undertaken (100%, England average 89%) and the same for discussion at MDT (99%, England average 99%).
- A higher percentage (91%) of patients undergoing major surgery stayed in the hospital for an average of more than five days than the England average of 69%.
- Lung cancer audit results (2014) showed the percentage of patients receiving surgery was lower than the England average (15%) at 13%. The audit showed results better than the England average for multi-disciplinary team discussion (100%, England average 96%) and results for scans undertaken before bronchoscopy (98%, England average 91%).
- The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the hospital was better than the national average in areas such as: patients being admitted to an orthopaedic ward within 4 hours (67%, national average 48%); falls assessment performed (100%, national average 97%); senior geriatric review within 72 hours of admission (90%, national average 87%); abbreviated mental health test performed (100%, national average 97%) and bone health medication assessment (100%, national average 97%).
- The hospital was worse than the national average for surgery on the day of, or day after admission (68%, national average 74%) and the mean length of total trust stay (acute and post-acute) (26.5 days, national average 19 days).
- The absence of a medical rota for the management of patients with gastrointestinal bleeds was added to the surgical risk register in February 2014 and identified as a

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high risk. This had not been resolved at the time of our inspection and staff identified this as a major risk to the safety of patients. Since the inspection a plan has been in development.

Competent staff

- Staff told us that appraisals were undertaken annually and records for April 2013 to March 2014 showed that 50% of staff across all wards in surgery and theatres had received an appraisal.
- During the current appraisal period 69% of staff had received an annual appraisal up to January 2015. Remaining staff told us they had received an appraisal in the remaining months of the appraisal period.
- Nursing staff said they did not receive clinical supervision or formal one-to-one sessions; informal one to one meetings did take place. Monthly staff meetings had taken place and minutes were available to staff.
- Junior doctors we spoke with told us they attended teaching sessions and participated in clinical audits. They told us they had received ward-based teaching and were supported by the ward team and could approach their seniors if they had concerns.
- Training for surgical trainees had been developed and 'protected time' identified for completion.
- Revalidation of doctors outcomes were assessed and monitored by the Deanery.

Multidisciplinary working

- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists when needed.
- Daily handovers were carried out with members of the multidisciplinary team.
- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision for each ward was planned.
- Staff explained to us the wards worked with local authority services as part of discharge planning.

Seven-day services

- Daily ward rounds were arranged for all patients and patients were seen on admission at weekends.
- Access to diagnostic services was available seven days a week, for example, X-rays.

- There was an on-call pharmacist available out of hours and pharmacy staff were available on site during the week and on-call arrangements were in place.
- The division's management team confirmed there was not a protected surgical list for trauma patients at a weekend and plans to introduce this had not been finalised.

Access to information

- Care plans and test results were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements and these were started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that all patients had consented in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team.

Are surgery services caring?

Good



We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital and saw that patients were spoken and listened to promptly. Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received.

The Friends and Family response rate within surgery varied from 30% to 34% and scored similarly across all areas with the England average. The Care Quality Commission in-patient survey (2014) showed consistent scores in

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patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment and they received answers they could understand when asking important questions to a nurse.

There was information within care plans to highlight whether people had emotional or mental health problems and what support they required for this. Patients were able to access counselling services, psychologists and the mental health team. Assessments for anxiety and depression were done at the pre-assessment stage and extra emotional support was provided by nursing staff for patients both pre- and post-operatively.

Compassionate care

- We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw that patients were spoken and listened to promptly.
- Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment. We observed patients being kept informed throughout their time within the anaesthetic room and theatres.
- Patients told us staff kept them well informed, explained why tests and scans were being out and did their best to keep patients informed. Patients said they felt safe and confident in the nurses, doctors and support staff. Patients and relatives were positive about the care and treatment received.
- We saw staff were attentive to the comfort needs of patients. Doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- The Friends and Family response rate within surgery varied from 30% to 34% (trust average 27%) compared to the England average of 32%, between December 2013 and November 2014 and scored similarly across all areas with the England average during that period. Results showed 97% of patients recommended the trust.

Patient understanding and involvement

- All patients said they were made fully aware of the surgery that they were going to have and this had been explained to them. They felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- We saw ward managers and matrons were available on the wards so that relatives and patients could speak with them.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- The Care Quality Commission in-patient survey (2014) showed patients responded with a consistent score (7.7) in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment and (8.7) to say they received answers they could understand when asking important questions to a nurse in the last two years (2014 and 2013).

Emotional support

- Patients said they felt able to talk to ward staff about any concerns they had either about their care, or in general. Patients did not raise any concerns during our inspection.
- We saw information leaflets and posters available for patients explaining their procedure and after care arrangements, for example, hip replacement, or total knee replacement.
- The Care Quality Commission in-patient survey showed a consistent score (7.9) in patients believing they had received enough emotional support from hospital staff in 2014 and 2013.
- There was information within care plans to highlight whether people had emotional or mental health problems and what support they required for this.
- Patients were able to access counselling services and the mental health team.
- Assessments for anxiety and depression were done at the pre-assessment stage and extra emotional support was provided by nursing staff for patients both pre- and post-operatively.

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Are surgery services responsive?

Requires improvement



There had been increased numbers of medical patients being placed on surgical wards during the Winter months. As a consequence 149 operations had been cancelled and all patients were then treated within the national target of 28 days. Although medical 'boarders' were under the care of medical clinicians, surgical nursing staff told us they did not feel able to provide the same level of care to medical patients.

We were unable to find evidence surgical staff had been trained to look after the needs of ITU patients.

Nursing staff said they did not have the experience or skills to give appropriate and safe care to ITU patients within the surgical recovery area. At the time of our visit the trust was unable to provide us with an approved policy and protocol for managing these patients.

The division's management team confirmed there was not a protected surgical list for trauma patients at the weekend and plans to introduce this had not been finalised at the time of the inspection. Although Mental Capacity Act and Deprivation of Liberty Safeguards training had been planned, figures provided by the trust showed 8% of staff in surgery had attended Level 1 training and 2% had attended level 2 training.

We saw evidence the trust had identified and responded to complex medical problems and had developed protocols in accordance with NICE. The development of input from the Orthopaedic Outreach Team had shown an average reduction of patient length of stay across all specialities. All patients who responded to a trust survey reported they would recommend the team to friends and family if they needed similar care or treatment.

The trust was meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral. Between April 2011 and April 2015, all patients who had their operation cancelled were treated within 28 days.

Five formal complaints had been received on the hospital's surgical wards during 2014. The ward managers discussed these with us and we were assured these had been handled appropriately in line with trust processes.

Service planning and delivery to meet the needs of local people

- Capacity bed meetings were held to monitor bed availability in the hospital and managers were available for reviewing planned discharge data and assessing future bed availability. During high patient capacity and demand elective patients were reviewed in order of priority for cancellation to prevent urgent and cancer patients being cancelled.
- The hospital had an escalation and surge policy and procedure to deal with busy times. This had resulted in increased numbers of medical patients being placed on surgical wards during the winter months (average monthly number: 196 between October 2014 and January 2015). 149 operations were cancelled due to 'no bed available' between October 2014 and February 2015.
- Although the division had identified there was no medical rota for the management of patients with gastrointestinal bleeds, this had not been addressed. During discussion with the division's management team, plans were identified but these had not yet been put into practice.
- We reviewed patient records and saw medical patients had been placed on surgical wards ('boarders') when beds were not available on medical wards. Although medical 'boarders' were under the care of medical clinicians, surgical staff told us they did not feel able to provide the same level of care to medical patients.
- The division's management team confirmed there was not a protected surgical list for trauma patients at a weekend and plans to introduce this had not been finalised at the time of the inspection.
- Staff reported patients from the Intensive Therapy Unit (ITU) had received care within the surgical recovery area when beds had not been available in ITU; six patients had received critical care in the recovery area since January 2015. Nursing staff said they did not have the experience or skills to give appropriate and safe care to these patients.

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- We were unable to find evidence surgical staff had been trained to look after the needs of ITU patients. We were informed that plans had been developed to train Band 6 scrub nurses to look after the needs of ITU patients, but this had not been implemented.
- We raised this with the management team within surgery and were informed that additional support was available for these patients from ITU staff and the critical care outreach team. The trust was unable to provide us with an approved policy and protocol for managing these patients.
- We were told that ITU patients in recovery were visited by family and friends while surgical patients were also being treated and cared for in recovery affecting the privacy and dignity of all patients in recovery.
- At the time of our unannounced inspection (3 June 2015), a further three patients from the Intensive Therapy Unit (ITU) had received care within the surgical recovery area since the original inspection. The trust provided us with an approved escalation policy for managing these patients and staff within surgery on the day. This had not yet been communicated to staff within surgery.
- We saw evidence the trust had identified and responded to complex medical problems, for example, the frailty of elderly hip fracture patients. The trust had developed protocols in accordance with NICE guidance that identified correctable comorbidities for treatment within 36 hours of admission, beginning in Accident and Emergency, and continued on inpatient wards, preventing delay of surgery.
- The development of the Orthopaedic Outreach Team had shown an average reduction of patient length of stay across all specialities (7.7 days with team input, 15.7 days without team input). All patients who responded to a trust survey reported they would recommend input from the team to friends and family if they needed similar care or treatment.
- In response to increased demand for cancer treatment and diagnostics the trust had appointed an additional consultant general surgeon with an interest in colorectal surgery. This had resulted in further development of cancer pathways including advances in laparoscopic surgical techniques.

- Further business cases had been presented to the trust board within the last twelve months to support the appointment of an additional orthopaedic surgeon and the development and modernisation of a surgical centre environment.

Access and flow

- Pre-assessment was held with the patient before the date of surgery and identified issues concerning discharge planning or other patient needs. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed.
- The trust was meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral. RTTs were met (November 2014) within trauma and orthopaedics (95%), general surgery (99%), oral surgery (98%) and thoracic medicine (100%).
- There were 528 delays to patient discharge within the trust between April 2013 and November 2014. These were caused mainly by patient or family choice (53%, England average 14%), awaiting nursing home placement or availability (19%, England average 12%) and completion of assessment (11%, England average 19%).
- The average length of stay for elective patients was lower than the England average for general surgery (3 days, England average 3.5 days), and trauma and orthopaedics (3.4 days, England average 3.5 days).
- Average length of stay for non-elective patients was higher than the England average for general surgery (4.6 days, England average 4.3 days) and trauma and orthopaedics (13.3 days, England average 8.4 days).
- Between April 2011 and April 2015, all patients who had their operation cancelled were treated within 28 days.

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia leads that could provide advice and support with caring for people with these needs.
- We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect when undergoing surgery and post-operative care. We were told these were available in languages other than English.

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- We saw that the care of patients following surgery was particularly effective through the provision of ongoing physiotherapy services.
- Wards had access to interpreters as required, with requests for interpreter services identified at the pre-assessment meeting.
- There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- The trust had in place policies covering the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards'. A safeguarding training strategy was in place and the trust Safeguarding Assurance Group produced an Annual Report of Safeguarding Activity (latest 2015).
- Mental Capacity Act and Deprivation of Liberty Safeguards training had been planned. Figures provided by the trust showed 8% of staff in surgery had attended level 1 training and 2% had attended level 2 training.

Learning from complaints and concerns

- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint. Complaints were handled in line with the trust policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager and staff were able to explain this process.
- If patients or their relatives needed help or assistance with making a complaint the Independent Complaints Advocacy Services (ICAS) contact details were visible in the ward and throughout the hospital. We saw leaflets available throughout the hospital informing patients and relatives about this process.
- Five formal complaints had been received on the hospital's surgical wards during 2014. The ward managers discussed these with us and we were assured these had been handled appropriately in line with trust processes.
- Complaints and concerns were discussed at staff meetings where training needs and learning was identified as appropriate.

Are surgery services well-led?

Inadequate



Staff raised concerns about long-term difficult working relationships within theatres and the trauma and orthopaedics department. They told us this had existed for a number of years. The trust had investigated and taken action to address these concerns but the actions taken had not resolved the problems. Members of nursing and healthcare staff from theatres consistently told us that management within these areas was not appropriate and gave us specific examples where bullying and harassment had taken place. We were also approached before and during the visit by medical staff from the trauma and orthopaedics department. They raised specific concerns with us about individual bullying and harassment leading to concerns about patient care. We raised these issues with the trust medical director who assured us that action had been taken and was still progressing on these issues.

Staff confirmed that incidents had been raised through the department's management structure and through human resources procedures but difficult working conditions continued. Staff said divisional managers were not always available, visible nor approachable; leadership of the service was remote and morale, particularly within theatres, was not good.

Staff within the recovery area reported the impact of caring for high dependency patients from ITU meant long working hours on occasion and that they felt stressed through concerns for the safety of patients. We raised this issue with the division's management team. It was subsequently reported staff were berated for sharing this concern with us.

Vision and strategy for this service

- The trust vision and strategy was well embedded with staff and most staff were able to articulate to us the trust's values and objectives across the surgical wards and they were clearly displayed on ward areas.
- We met with senior managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division.
- Although staff spoken with were able to repeat this vision and discuss its meaning with us during individual interviews, some raised concerns whether management within the division had put the vision into practice.

Surgery

Governance, risk management and quality measurement

- Joint clinical governance meetings were held each month. Agendas and minutes showed audits, learning from complaints and PALS issues, learning from clinical risk management, peer review data, patient and public information involvement, infection control issues, alert notices, good practice, national service frameworks, clinical audits and research projects were discussed and action taken where required.
- Reports identified risks throughout the care group, actions taken to address risks and changes in performance. These monitored (amongst other indicators) MRSA and C.difficile rates, RTTs, pressure ulcer prevalence, complaints, never events, complaints and mortality ratios.
- We saw that action plans for never events were monitored across the division and sub-groups were tasked with implementing elements of action plans where appropriate, and the risk register reflected identified risks and the progress made in addressing them.
- Critical Care and Surgery Risk Management meetings were held every month to review and the relevance of risk management processes. We saw the departmental risk register had been reviewed and updated on a regular basis and action plans had been monitored and progressed.
- Incidents and complaints were reviewed to ensure appropriate follow-up action had been taken and learning and best practice had been shared throughout the department.
- Key performance indicators were reviewed regularly at the Critical Care and Surgery Risk Management and the Risk Management Operational Group, for example, statutory and mandatory training compliance, NICE guidance, infection control, medical devices alerts, safer care audits and safety thermometer.

Leadership of service

- During our visit we were asked to meet with eighteen members of nursing and healthcare staff from theatres who raised concerns with us. They consistently told us that management within these areas was not appropriate and gave us specific examples where bullying and harassment had taken place over a number of years. Although this was reported through

the department's management structure and the trust had investigated and taken action to address these concerns, the actions taken had not yet resolved the problems.

- Staff said divisional managers were not always available, visible nor approachable; leadership of the service was remote and morale particularly within theatres was not good.
- We were also approached before and during the visit by medical staff from the trauma and orthopaedics department. They raised specific concerns with us about individual bullying and harassment leading to concerns about patient care. We raised these issues with the trust medical director who assured us that action had been taken and was still progressing on these issues.
- However, staff spoke positively about the service they provided for patients and emphasised quality and patient experience was a priority and everyone's responsibility.

Culture within the service

- At ward level we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Concerns were raised about working within theatres by staff across a range of disciplines and all reported a difficult working environment. They told us this had existed for a number of years, and had been reported but not addressed.
- Staff within the recovery area reported the impact of caring for high dependency patients from ITU meant long working hours on occasion and that they felt stressed through concerns for the safety of patients. We raised this issue with the division's management team. It was subsequently reported staff had been berated for sharing this concern with us.
- Individual and group discussions with medical staff from the trauma and orthopaedics department highlighted difficult working arrangements throughout the department. Although the trust medical director was dealing with these issues, individuals raised concerns about the effect on patient care.

Public and staff engagement







Surgery

- The Friends and Family response rate within surgery varied from 30% to 34% (trust average 27%) compared to the England average of 32%, between December 2013 and November 2014 and scores similar across all areas with the England average during that period.
- The trust conducted a 'real time patient experience' survey (March 2015) within surgery. This showed 100% of patients were likely to recommend the service and were satisfied with the care and treatment they received within theatres. All patients said staff had been caring, considerate and compassionate and none identified any improvements.

Innovation, improvement and sustainability

- The development of the Orthopaedic Outreach Team had shown an average reduction of patient length of stay across all specialities. Patients reported they would recommend input from the team to friends and family if they needed similar care or treatment.
- In response to increased demand for cancer treatment and diagnostics the trust had appointed an additional consultant general surgeon with an interest in colorectal surgery. This had resulted in further development of cancer pathways including advances in laparoscopic surgical techniques.

Critical care

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

Information about the service

The Intensive Therapy / High Dependency Unit provided care for both lower and higher dependency patients in a six-bedded area at South Tyneside District Hospital. Four beds were designated as Level 3 care and two beds as Level 2 care. Level 2 care is for patients requiring more detailed observation or intervention, single failing organ system or post-operative care, and higher levels of care. Level 3 care is for patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure. There were four beds in the main area and two isolation rooms. The unit was well positioned within the hospital, being in close proximity to Accident & Emergency, Operating Theatres and the diagnostic departments.

An outreach service was provided by the critical care service 24 hours a day, seven days a week. This specialist nursing team provided advanced clinical advice and support to ward staff managing patients whose condition had deteriorated. They aimed to stabilise the patient and avoid their admission to a critical care bed. They also provided a follow-up service for those patients transferred from critical care to the general wards and departments in the hospital.

During two visits to the hospital, we visited the single intensive care and high dependency unit. We talked with one patient (all the remaining patients were too ill to interview), four relatives and 25 members of staff. These included nursing staff, junior and senior doctors (Critical Care, general physicians and surgeons) physiotherapists,

dietitians, housekeeping staff, technicians and managers. We observed care and treatment and looked at six care records. Before the inspection, we reviewed performance information including the most recent North of England Critical Care Network Peer Review (June 2013) and the Royal College of Anaesthetics Service Review (July 2013).

Critical care

Summary of findings

We rated critical care as good for caring and requires improvement for safe, effective, responsive and well-led.

There were known risks posed by the infrastructure and environment of the ITU and an outline business case had been approved by the Trust executive team to refurbish and expand the critical care services; however the final business case was not yet finalised or agreed and there was no evidence of a contingency plan should the final business case not be approved.

There were capacity issues regarding the number of available Level 2 beds and problems had been experienced with the flow of patients through the unit during periods of hospital-wide bed pressures. This posed potential risks to the safety and welfare of patients as, when demand exceeded capacity, it was necessary to care for a small number of patients within the Theatre Recovery area. Additionally patients could be discharged to ward areas during the night, which national data and guidance have associated with increased mortality. Patients were also remaining in critical care beds when they no longer needed them due to bed pressures on the wards, which could result in mixed-sex breaches and lack of privacy and dignity.

Staff reported a strong supportive working environment, which was led by the unit manager and lead clinicians; however, the unit manager spent most of her hours giving direct patient care and had little or no time for management or leadership activities. There was a culture of mutual support and respect, with staff willing to be flexible when they were short staffed. Innovative ideas and approaches to care were encouraged and supported but again time was limited to take these forward.

There were areas of good practice in the Intensive Therapy High Dependency Unit (ITU). These included fully and comprehensively completed care documentation, well maintained and serviced equipment, evidence in investment in new equipment, an increase in nursing, medical and outreach establishments and the introduction of a new renal

replacement therapy for patients with renal failure. Patients were followed up when they were discharged from intensive care to a ward by the recently expanded critical care outreach team.

The treatment and care provided followed current evidence-based guidelines. The critical care services participated in national and local audits and their clinical outcomes were comparable to units of similar size. Staff had effective mandatory training, supervision and appraisal systems in place but the unit lacked educational support. There was good multidisciplinary working to ensure that patients' needs were met. Clinical strategies were based on continuing to achieve positive outcomes for patients. Governance processes were focused on risk and quality and a risk register was maintained.

Critical care

Are critical care services safe?

Requires improvement



We rated safe as requires improvement.

There were concerns about the clinical environment which was cramped with less than the recommended space around each bed on the main unit. This was recognised in the Outline Business Case for the refurbishment and expansion of the Intensive Care / High Dependency Unit, June 2014. Health Building Note (HBN) 04-02 refers to allowing 25.5 square meters per bed space whereas the area per bed space in the ITU in the four bedded bay was 9.3 square metres. Additionally there were inadequate washing facilities for the patients and a significant shortage of storage space. For example, the relative interview room was used to house clinical fluids and equipment and the four bedded area had a wash basin at either end but HBN 04-02 requires each bed space to have its own wash basin. A male and female shower facility was in place but not used as they were not fit for purpose for a high dependency patient. The absence of dedicated pharmacy support to critical care was also noted. This was recorded in the North of England Critical Care Network appraisal report for South Tyneside District Hospital ITU in June 2013 and was still the case in May 2015 at the time of inspection.

No Never Events or Serious Incidents occurred in ITU between April 2014 and March 2015 and feedback was received on patient safety issues through team meetings and the monthly Clinical Governance Meetings. There was evidence of investment in equipment with replacement ventilators recently purchased along with renal replacement therapy machines. There was also evidence that both formal and informal consent were obtained and that best interest decision-making processes were taking place.

Incidents

- No Never Events or Serious Incidents occurred in ITU between April 2014 and March 2015.
- During the same period ITU reported 69 No Harm, 19 Low Harm and five Moderate Harm incidents.
- The Critical Outreach team reported four Moderate Harm and 11 No Harm incidents for the same period.

- Reported incidents included pressure ulcer development (up to Grade 2), either already present or developed on the unit and medication errors.
- All of the medical and nursing staff interviewed knew how to report an incident through the Datix system and feedback was received on patient safety issues through team meetings and the monthly Clinical Governance Meetings.
- All the staff interviewed understood the concept of Duty of Candour and were aware of the process to follow in the case of incidents and complaints. Evidence of disclosure to the patient was included in the Datix reports.
- The unit reviewed mortality and morbidity (M&M) as part of the first section of the monthly multi-disciplinary Clinical Governance meetings. These were peer reviews held in a structured forum for the open examination and review of cases that had led to illness or the death of a patient.
- The learning plans were discussed as a regular agenda item and highlighted discussions and actions to be taken. There was no cross disciplinary M&M meeting with other specialties as these were found difficult to timetable but cases were referred between specialties as required. The findings from individual cases were also discussed in a trust wide M&M meeting group and shared at the 'Uncle Ed' meetings.

Safety thermometer

- The trust used the NHS Safety Thermometer which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer information included information about all new harms, falls with harm, and new pressure ulcers. We noted that safety thermometer data was displayed in the relatives' waiting room.
- The monthly average for harm free care in ITU was 90.61% between January and November 2014 with six of these months recording 100% harm free care.
- There were zero falls recorded in the time period; this is as expected for Critical Care.
- There were five pressure ulcers recorded of which two were new and grade 2 or less.
- There was one catheter urinary tract infection recorded in the time period and no harm related to venous thromboembolism.

Cleanliness, infection control and hygiene

Critical care

- During the visit all areas were visibly clean, including storage areas and office facilities.
- There was only one access point to the unit which served as the entrance and exit and was used by patients, families and staff, as well as for stores deliveries and waste removal. The area near the entrance was also used for furniture storage, such as patient chairs and beds when not in use.
- There were no unit acquired C.Difficile, MRSA or MSSA infections in the past 12 months.
- The ITU infection control audits for the previous six months were reviewed and had in the majority of domains 100% compliance. The one domain with variable compliance was the Ventilation Acquired Pneumonia Care Bundle which, following a number of actions, had improved to 99% in March 2015.
- There were adequate staff hand washing facilities (two in the four bedded area; one in each isolation room, one in the medicines/clean utility room and one at the unit entrance). There were also adequate supplies of personal protective equipment and all staff were observed wearing it appropriately and following the 'bare below the elbow' policy.
- However, the clinical environment was cramped with less than the recommended space around each bed on the main unit. This was recognised in the trust Outline Business Case for the refurbishment and expansion of the Intensive Care / High Dependency Unit, June 2014. Health Building Note (HBN) 04-02 refers to allowing 25.5 square meters per bed space whereas the area per bed space in the ITU in the four bedded bay was 9.3 square metres.
- The ward domestic reported that daily cleaning was a challenge due to the increasing amount of equipment around each bed. The nurses also undertook a weekly cleaning programme which was recorded.
- There was also evidence of investment in equipment with replacement ventilators recently purchased along with renal replacement therapy machines.
- An emergency situation was not observed during the visit, but in discussion with staff it was acknowledged that during clinical emergencies there was a need to move equipment and furniture away from the bedside in order to allow adequate access.
- There was a significant shortage of storage space. For example, the relative interview room was used to house clinical fluids and equipment. The storage issue was also noted in the business case for the refurbishment of the unit.
- Equipment was stored on the corridors and at the main entrance to the unit which created a fire management risk and made moving beds and patients around the unit difficult and time consuming.
- On discussion with the Senior Team, whilst it was acknowledged that a number of risk assessments had been undertaken, there was a need to explore alternative solutions in regards to storage.

Medicines

- All medicines were kept in an access controlled room behind the nurses' station and were locked away appropriately.
- The control drug register was checked and was correctly completed with records of weekly accurate stock checks also noted.
- The drug fridge temperature was checked daily according to records for the last two months.
- The absence of dedicated pharmacy support to critical care had been noted in the North of England Critical Care Network appraisal report for South Tyneside District Hospital ITU in June 2013. The ITU risk register recorded the lack of a pharmacist assigned to ITU in February 2015 and this was still the case in May 2015 at the time of inspection. Standard 1.4.1 of the Core Standards for Intensive Care Units (2013) states that there should be at least 0.1 whole time equivalent (WTE) 8a specialist clinical pharmacist for each single Level 3 bed and for every two Level 2 beds. This would equate to 0.5 WTE for this unit.
- The Critical Care Action plan stated that there was a restructure of pharmacy underway and that the Director for this area had agreed dedicated pharmacy commitment for the unit as a priority. The target date was December 2015.

Environment and equipment

- Resuscitation and emergency equipment checks were observed and signed daily.
- During the inspection, 20 pieces of equipment were checked for Portable Appliance Testing (PAT), and testing and service records were all in date.
- The unit was well supported by the Biomedical Engineering Team and their presence was observed on the unit each day of the visit.

Critical care

Records

- Six patients care records were reviewed and were comprehensively completed, including signature, dates and times. The duration for the prescription of antibiotics was not recorded in four out of the six drug records; however there was a daily microbiology review of each patient and the medical staff were confident that antibiotics were only given as per protocols.
- Records were current and provided a clear record of patients' care and treatment. There was a daily review of treatment and care plan for all patients. Medical and nursing records were kept separately and nursing records were kept at the patients' bedside. Care plans were clearly structured and completed to identify patients' needs.
- Nursing records included risks to the patient of developing pressure ulcers, malnutrition, venous thromboembolism (blood clots) and specific risks that were associated with their clinical condition. When risks were identified, details were included in their care plan about the action needed to reduce the risk.
- There were clear records of decision-making processes and discussions with patients, relatives and other professionals such as physiotherapists, occupational therapists and social workers involved in the support of the patient.

Safeguarding

- All staff interviewed were aware of their role in managing a safeguarding concern and where to access information and assistance. There was an up to date safeguarding information folder at the nurses' station.
- Training levels for training were electronically recorded as 31% for Adult Safeguarding Level 1 and 65% for Child Safeguarding Level 2.
- Staff had a good understanding of the Mental Capacity Act 2005 and how it related to their working practices. There was evidence that both formal and informal consent were obtained and that best interest decision-making processes were taking place. One patient was subject to a Deprivation of Liberty order due to physiological confusion and the use of pharmacological restraint.

Mandatory Training

- All the nursing staff interviewed reported that they had received mandatory training in line with trust policy.

Documentary evidence of training attendance was available on the unit but incomplete. The unit manager reported issues with the electronic system used to record attendance and estimated training compliance at 86%.

- Electronic records indicated rates of over 70% for fire prevention, information governance, falls prevention, risk management and health and safety but less than 40% for conflict resolution and medical device training.
- Trust mandatory training attendance rates for medical staff were not accessible at the time of inspection.

Assessing and responding to patient risk

- On occasion, patients from the ITU had received care within the surgical recovery area when beds had not been available in ITU; these included Level 2 and Level 3 critical care patients. At the time of inspection, six patients had received critical care in the recovery area since January 2015. Recovery room nursing staff (including scrub nurses) said they did not have the experience or skills to give appropriate and safe care to these patients. The Core Standards for Intensive Care Units (2013) state that (critical care) nurse education programmes should follow the National Standards for Critical Care Nurse Education (2012) and include both academic and clinical competence assessment (section 1.2.8), and all staff must be appropriately trained, competent and familiar with the use of (critical care) equipment (section 3.3) We were told that following concerns raised in 2013 by recovery staff about managing Level 2 & 3 patients, an action plan was developed. We did not see the action plan and no evidence was supplied to demonstrate that the action plan had been carried out or achieved its aims.
- We raised this with the management team within critical care and were informed that additional support was available for these patients from ITU staff and the critical care outreach team. The trust was unable to provide us at the time of inspection with an approved policy and protocol outlining roles and responsibilities for managing ITU patients in the recovery area. We were unable to identify a completed training needs assessment and evidence of that training being attended by the surgical staff managing these patients.
- At the time of our unannounced inspection (3 June 2015), a further three patients from the ITU had received care within the surgical recovery area since the original

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inspection. The trust provided us with an approved escalation policy for managing these patients and staff within surgery on the day. This had not yet been communicated to the relevant surgical nursing staff.

- Risk assessments were completed for patients in the critical care unit. These included assessments for the risk of developing pressure ulcers, venous thromboembolism, malnutrition and falls. When a risk was identified, the action required to reduce or manage it was detailed.
- An Early Warning System was used on the general wards to monitor patients' health and identify deteriorating patients. Policies were in place that detailed when assistance should be sought from medical staff or the critical outreach team. The Trust was in the process of introducing the National Early Warning Score system (NEWS) and the critical outreach team were involved in the training and process of its implementation.
- Five critical outreach sisters covered all wards including A&E and maternity; they felt confident that they were contacted appropriately according to the early warning system risk assessments. Whilst the outreach team kept some paper records of referrals and activity, there was a lack of robust data in terms of interventions and outcomes for the critical outreach team.

Nursing staffing

- The qualified nurse establishment was 33 WTE, including two Band 7's and an equal number of Band 5 and 6 Critical Care trained nurses. These numbers and the skill mix corresponded to national guidance (BACCN and RCN) and could provide 1:1 care for Level 3 patients and 1:2 care for Level 2 patients.
- Standard 1.2.3 Intensive Care Society Core Standards (2013) recommends that there is a Band 8a designated as Lead Nurse to oversee the operational management and strategic direction of the unit; however there was no identified lead position with these formal responsibilities.
- The unit manager had 0.2 WTE built into the establishment for 'management' duties, but reported rarely having the opportunity to take this time away from clinical duties. During our inspection, we had the opportunity to interview her once for approximately 20 minutes due to her clinical commitments.
- The unit manager also had the responsibility, along with the part time Ward Clerk, for ICNARC and CCMDS data entry.

- Duty rosters were reviewed for the past month and there were between five and six registered nurses rostered per shift (minimum required was five). When additional staff were required either to accommodate a higher proportion of Level 3 patients or to cover short term absence, the ITU staff were utilised using additional hours / overtime. All the nurses interviewed said that this worked well and if required, the critical outreach nurses were also called upon to fill gaps at short notice.
- There was a small number of ex-ITU nursing staff on the internal bank which were used occasionally; no agency nursing staff were used.
- There were two WTE Health Care Assistant vacancies; these posts were under review with regards to roles and responsibilities prior to recruitment. As there were no Health Care Assistants in post, this meant that the nursing staff were responsible for additional cleaning, setting up bed spaces and other housekeeping duties. It also meant that there was less capacity to manage 1:1 supervision of patients or carry out moving and handling of patients.
- There was no supernumerary clinical education role for nursing (as recommended in Standard 1.2.4 Intensive Care Society Core Standards, 2013) and as a consequence the unit had not yet adopted the national critical care competencies covering the concept of 'novice to expert'. The unit manager did have plans to implement these in the near future. The Critical Care action plan included this area of need and planned a review of how this might be achieved once all nursing staff were in post.

Medical staffing

- There was a two tier medical rota (consultant and specialty doctor) that provided 24/7 resident cover and 24/7 consultant cover (on call out-of-hours). The consultant establishment was eight WTE of which six were in post. There was currently one consultant awaiting a start date and one vacancy which was being recruited to. There were also four vacant speciality doctor posts, which were being covered by experienced agency locum doctors who routinely provided cover for the unit.
- There was no formal competency assessment of specialty doctors, but local induction and shadowing was established for new appointments. Experienced doctors with appropriate airway and resuscitation skills were mostly employed into these posts.

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- Shortage of middle grade doctors was a chronic issue and there was difficulty in recruiting to these posts. This was managed by the presence of daytime cover by a CT2 doctor in medicine and Foundation Doctor as supernumerary doctors who carried out junior doctor duties effectively.
- Daytime gaps in ITU for middle grade doctors were observed in the weekly rotas.

Major incident awareness and training

- There was critical care unit Majax/escalation plan readily available on the unit and staff were aware of the plan.
- However, there was a lack of evidence of contingency planning should the final business case for expansion not be approved and whilst a number of risk assessments regarding the current environment, for instance, storage space and facilities for relatives, had been completed, there did not appear to be control measures in place to minimise those risks.

Are critical care services effective?

Requires improvement



We rated effective as requires improvement.

The senior management team, critical care outreach team and senior clinicians in critical care stated that they were confident that the patients were cared for safely in the theatre recovery area and that the theatre staff were trained and competent to care for ITU patients; however there were major concerns raised by the recovery nursing team to the CQC inspection team during our visit regarding lack of training and lack of confidence in caring for these patients safely. We were not provided with evidence of the scope and level of critical care training provided to the recovery room staff to assure us that they were assessed as competent for this task.

There was a lack of robust systems to facilitate nurse education and training in the ITU. Commitment to training and education was evident and 50% of nurses had a post-registration qualification in critical care nursing although some staff reported that they had undertaken certain job specific training in their own time. There was reduced access to education due to the lack of a dedicated nurse educator on the unit and protected time for

education which was limited to one staff member at a time. The responsibility for the development and training of staff was with the unit manager and her deputy. Due to capacity issues, there had been delays in the implementation of national competency frameworks. The unit manager reported that development for the Band 6 nurses was not formalised and there was no competency framework in place.

Multidisciplinary working was evident in the units. Patients were followed up when they were discharged from intensive care to the ward. Staff had a good understanding of the Mental Capacity Act 2005 and how it related to their working practices. There was evidence that both formal and informal consent were obtained and that best interest decision-making processes were taking place. One patient was subject to a Deprivation of Liberty order due to physiological confusion and the use of pharmacological restraint.

The treatment and care provided followed current evidence-based guidelines. The critical care services participated in national and local audits in order to measure their effectiveness. Data from audits showed there were good outcomes for patients being treated in the critical care services.

Evidence-based care and treatment

- Policies were accessible for staff and developed in line with national guidelines such as the trust Vital Signs Monitoring for Adult Changes Policy which provided clinical guidelines for managing the deteriorating patient based on national guidance including: NICE (2007) Acutely ill patients in hospital. However this policy was based on an Early Warning System, but not the National Early Warning System that was advocated by the Royal College of Physicians in 2012 to standardise the assessment of acute-illness severity in the NHS.
- The unit followed NHS guidance when monitoring sedated patients. Each patient who was sedated was subject to a sedation 'hold' each day using the Richmond Agitation Sedation Scale (RASS) scoring tool and had their response monitored. Sedation was then continued or adjusted depending on how the patient responded to the change.

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- However the score was not used to progress to the Confusion Assessment Method for the ICU (2001) as recommended in the Intensive Care Society standard, Detection, prevention and treatment of Delirium in Critically Ill Patients (2006).
- A tracheostomy pathway informed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines for managing patients with a tracheostomy was in use and all patients with a tracheostomy were discharged to the designated 'place of safety' in the hospital and followed up by the critical care outreach team.
- The nationally recognised care bundle to reduce the risk of ventilator-acquired pneumonia was in use and clinical guidelines on care of central venous catheter lines, arterial lines and managing sepsis were in place and referred to national guidance.
- The National Institute for Health and Care Excellence (NICE) guidelines for rehabilitation after critical illness were currently being reviewed with a plan for implementation and an outline business case was in development. The lack of compliance with this standard was recorded on the ITU risk register.
- Patient diaries were in use and the newly expanded critical care outreach team was exploring follow up clinics.
- Length of stay was measured by the Intensive Care National Audit and Research Centre (ICNARC). The mean length of stay for all admissions was 5.8 days which was slightly above similar units.
- There was one instance of tissue donation and no organ donation from potential organ donors in the ICNARC six month reporting period.

Pain relief

- Patients' pain and response to pain relief were monitored as part of the routine observations. During ward rounds, the pain-relieving needs of each patient were discussed and their pain-relieving medication adjusted accordingly and this was recorded in the daily care plans.
- There was a hospital-wide acute pain service. A nurse specialist in pain control was contactable by telephone for support and advice and would have patients referred to them where required.

Nutrition and hydration

- The patient records we reviewed were well completed and protocols were followed for nutrition and hydration. Fluid intake and output were measured, recorded and analysed for the appropriate balance and any adjustments necessary were recorded and delivered.
- All patients had a malnutrition universal screening tool (MUST) assessment completed about their nutritional and hydration needs, and their risk of malnutrition.
- Protocols and policies were in place regarding enteral and parenteral feeding practice. A dedicated dietician provided support to patients with nasogastric tubes and total parenteral nutrition feeding and there was evidence of nutritional assessment and advice recorded in the patients' records.

Patient outcomes

- The unit produced data to determine patient outcomes against recognised national indicators. It demonstrated regular patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards. This participation provided the unit with data benchmarked against other units in the programme and units similar in size and case mix. The data returned was adjusted for the health of the patient upon admission to allow the quality of the care provided to be identified from the results. The latest ICNARC Case Mix Programme data for the ITU covered 2nd July to 30th December 2014 and 163 admissions to ITU.
- One transfer out was made to another critical care unit for non-clinical reasons from July to December 2014.
- Post-unit hospital deaths were less than similar units at around 3.7%. These were patients who died before discharge from hospital excluding those discharged for palliative care.
- Patients were not discharged prematurely. Late readmissions (those readmitted later than 48 hours following discharge but within the same hospital stay) accounted for 2.5% of unit discharges to a hospital ward. The unplanned readmission rate to the unit within 48 hours was 3.3%. The unit was not an outlier in any of the patient outcome reports monitored by the ICNARC.
- The unit took part in a number of national audits to measure the effectiveness of care and treatment provided, for example, the National Cardiac Arrest Audit and data submitted to the Intensive Care National Audit and Research Centre (ICNARC).

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- Evidence of recent local audits, associated action plans and recommendations were also seen including: gentamycin monitoring, inadvertent hypothermia in the intensive care unit and an Early Warning Score re-audit of practice across 13 clinical areas.
- The ITU infection control audits for the previous six months were reviewed and had in the majority of domains achieved 100% compliance. The one domain with variable compliance was the Ventilation Acquired Pneumonia Care Bundle which, following a number of actions, had improved to 99% in March 2015.

Competent staff

Nursing Staff

- There was commitment to training and education but reduced access due to the lack of a dedicated nurse educator on the unit. The responsibility for the development and training of staff was with the unit manager and her deputy. Due to capacity issues, there had been delays in the implementation of national competency frameworks. The unit manager reported that development for the Band 6 nurses was not formalised and there was no competency framework in place.
- The nursing staff in the unit had mixed comments about the training opportunities and education packages for staff development. Whilst mandatory and equipment training were accessed fairly readily, some staff reported that they had undertaken certain job specific training in their own time.
- The unit has achieved the recommended 50% of staff having a qualification in critical care. The unit manager said that this was because only one staff member could be released at any one time and some individuals chose not to wait.
- Nursing staff confirmed that they received annual appraisals. However, the unit manager was unable to show evidence of the current percentage achieved. She verbally reported a rate of approximately 70%.
- The senior management team, critical care outreach team and senior clinicians in critical care stated that they were confident that the patients were cared for safely in the theatre recovery area and that the theatre staff were trained and competent to care for ITU patients; however there were major concerns raised by the recovery nursing team to the CQC inspection team during our visit regarding lack of training and lack of

confidence in caring for these patients safely. The critical care outreach team told us that recovery staff were not left with a patient that they were not comfortable caring for.

- We were not provided with evidence of the scope and level of critical care training provided to the recovery room staff to assure us that they were assessed as competent for this task.

Medical staff

- The trainee supernumerary doctors were closely supervised and had identified educational supervisors and an e-portfolio of learning. There was good access to mandatory training.
- There was a robust appraisal system in place as part of the revalidation process and undertaken by Consultants in other specialities.
- The Critical Care team was in the process of starting an in-house course on transfer of the critically ill patients accessible to both nursing and medical staff.

Multidisciplinary working

- There was evidence (both written in care plans and observed on ward rounds) of multidisciplinary working in the unit. This included physiotherapists, dieticians, occupational therapists and pharmacists; however there was no dedicated pharmacist attached to the unit.
- Dietetic support was provided by a dietician with dedicated responsibilities who visited the unit daily (week days only).

Seven Day Services

- There was a two tier medical rota (consultant and specialty doctor) that provided 24/7 resident cover and 24/7 consultant cover (on call out-of-hours).

Are critical care services caring?

Good



We rated caring as 'good'. Patients and their relatives were treated by staff with compassion, dignity and respect. Feedback from patients and their relatives showed that there was a caring and supportive, person-centred culture in the unit. Patients and their relatives were active partners in their care and patient diaries were in use where appropriate. The one patient we were able to have

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conversations with felt they were well informed and involved in the decision-making process regarding their treatment. Feedback from patients and their families in the form of thank-you cards was displayed in the units. Thank-you cards and letters praised the unit highly and spoke of “excellent” care and “wonderful” support.

Compassionate care

- There was no Friends and Family test data for ITU but feedback from patients and their relatives showed that there was a caring and supportive, person-centred culture in the unit. We observed patients and their relatives being treated by staff with compassion, dignity and respect. Patients and their relatives were active partners in their care and patient diaries were in use where appropriate. There was also a communication sheet that recorded discussions with patients and their families.
- People’s emotional and social needs were valued by staff and embedded in their care and treatment.
- The one patient who could be interviewed was very complimentary about the care and support they received. They were also positive about the staff approach to promoting their dignity.
- We observed staff speaking to patients and their relatives in a caring and compassionate manner, providing reassurance and support.
- Feedback from patients and their families in the form of thank-you cards was displayed in the units. Thank-you cards and letters praised the unit highly and spoke of “excellent” care and “wonderful” support.

Patient understanding and involvement

- The one patient who we were able to have conversations with felt they were well informed and involved in the decision-making process regarding their treatment.
- Relatives felt they were fully informed about their family member’s treatment and care. They said staff checked whether they wanted to be contacted during the night with any changes in the patient’s condition.
- We observed staff explaining to patients and their relatives the care and treatment that was being given.

Emotional support

- Staff reported that emotional support for patients and their families was available from the trust chaplaincy team who would provide support for patients of all faiths and those who did not have a faith.
- There was no funding for psychological follow-up for patients admitted to the Intensive Care / High Dependency Unit.

Are critical care services responsive?

Requires improvement



We rated responsive as requires improvement.

The trust recognised that the ITU did not meet the needs of local people in terms of capacity, facilities and premises being appropriate for the services that were being delivered. Level 2 beds were considered insufficient to meet the needs of the organisation. A business case had been reviewed by the executive team in 2014 but had not yet been approved by the Board at the time of the inspection. Bed occupancy levels resulted in delayed admissions, out-of-hours discharges and non-clinical transfers to other Level 2 areas such as theatre recovery area for management of ITU patients. The environment in the unit was not appropriate for discussing difficult news with relatives. Due to the constraints on space within the unit there was only one small waiting room outside of the main unit and no dedicated room for interviewing relatives. This was undertaken in the doctors’ office, which was not ideal. Delays in discharge from Level 2 beds meant that for Level 1 patients, there was the risk that they would be nursed in a mixed-sex area that did not effectively promote their privacy and dignity.

Service planning and delivery to meet the needs of local people

- The trust recognised that the ITU did not meet the needs of local people in terms of capacity, facilities and premises being appropriate for the services that were being delivered. Level 2 beds were considered insufficient to meet the needs of the organisation. A business case had been reviewed by the executive team in 2014 but had not yet been approved by the Board at the time of the inspection.
- Critical care beds booked for theatre patients are reviewed on a daily basis and capacity issues are

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escalated if a decision is required to cancel on the day of surgery due to lack of ITU beds. A business case for a surgical centre was being developed to manage major surgical patients post-operatively.

- Follow-up clinics after discharge from hospital are recommended by the Intensive Care Society to facilitate patients' ongoing treatment and emotional and psychological support. The critical care clinical team were in the process of planning for these clinics at the time of inspection and an outline business case to support this service was being written.

Access and Flow

- Bed occupancy rates for smaller units (less than 8 beds) are ideally expected to be at 70%, to manage the fluctuations in activity levels. The unit was found to be running at an average of 80% bed occupancy rate for the period 1st May 2013 – 31st December 2014. This was evident from the pattern of delayed admissions, out-of-hours discharges and non-clinical transfers to other Level 2 areas such as the theatre recovery area for management of ITU patients. We were told that one Level 2 bed was often ring-fenced at night to accommodate unexpected emergencies.
- ICNARC data 1st May 2013 – 31st December 2014 demonstrated that the demand for Level 2 beds (44.8%) was similar to the demand for Level 3 beds (54%) in the first 24 hours of care. The unmet need for additional Level 2 and 3 beds as experienced by the team was not reflected in the bed occupancy data collected by NHS England. No alternative local data tool was available to capture the virtual Level 2 or 3 beds that were being created during peak times with the support of the outreach service.
- Nationally agreed standards (Intensive Care Society Core Standards for Intensive Care Units 2013) state that discharges from critical care should occur between 7am and 9.59pm because discharges overnight have been historically associated with excess mortality. There were a total of 28 out-of-hours discharges from ITU of which 24 were to the ward (17.5% of all discharges) 1st July – 31st December 2014. These incidents were recorded on Datix whenever they occurred and were also included in the risk register. In discussions with the Senior Management Team, they reported that a proportion of

these were due to coding errors and some were reported as patients ready for discharge the next morning but who were being discharged to the ward during the night before because of bed pressures.

- 90.2% of admissions to the unit 1st May 2013 – 31st December 2014 were unplanned medical or surgical cases requiring Level 2 or 3 admissions. No incidents of cancelled operations due to lack of critical care beds were reported on Datix.
- The team was very aware of their limited capacity to manage the fluctuating demand for critical care beds. If a patient required a critical care bed and the unit was full, a risk assessment of each patient's clinical care needs within critical care was made and if possible a patient transferred to the ward. In the absence of a patient fit enough for ward care, a decision was made as to which patient to house in a Level 2 care area which included coronary care and the theatre recovery area. These areas were identified in the trust Guideline on Transfer of the Critically Ill Patient (2012). This could be the new patient or a suitable patient from the critical care unit.
- There was no formal monitoring of how often this occurred; however a manual review of the records by the inspection team revealed that there was a total of six (three Level 2 and three Level 3) patients cared for in the theatre recovery area between January 1st 2015 and the date of the inspection (May 2015).
- There were a higher number of patients discharged at night than in similar units. The Intensive Care Society core standards for intensive care units 2013 state that, historically, discharges from the critical care services overnight have been associated with excess mortality. However, there were regular out-of-hours discharges to the general wards. There were also a slightly higher number of discharges delayed over 4 hours compared with similar units. Although patients were well cared for, they were medically fit for discharge and a critical care unit was not the appropriate setting for them. This also had an impact on being able to admit new patients in a timely manner and sometimes resulted in the stable, ready for discharge patients being temporarily cared for in the Theatre Recovery area so that a more acute patient could occupy their critical care bed.

Meeting people's individual needs

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- Delays in discharge from Level 2 beds meant that for Level 1 patients, there was the risk that they would be nursed in a mixed-sex area that did not effectively promote their privacy and dignity.
- The lack of ITU bed capacity meant that patients requiring critical care skills were not always managed in the unit but in the recovery area where staff stated that they did not have the experience or skills to give appropriate and safe care to these patients.
- Information about ITU was available in a folder and on notice boards in the relatives' waiting room.
- The environment in the unit was not appropriate for discussing difficult news with relatives. Due to the constraints on space within the unit there was only one small waiting room outside of the main unit and no dedicated room for interviewing relatives as it was used to house clinical fluids and equipment. Interviews were undertaken in the doctors' office, which was not ideal.
- Additionally there were inadequate washing facilities for the patients. The four bedded area had a wash basin at either end but HBN 04-02 requires each bed space to have its own wash basin. A male and female shower facility was in place but not used as they were not fit for purpose for a high dependency patient.
- The staff reported that there was access to interpreters either by phone or face to face.

Learning from complaints and concerns

- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint. Complaints were handled in line with the trust policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the unit manager and staff were able to explain this process.
- The Clinical Operational Manager told us that the unit had not had a formal complaint for over 12 months. Notices on how to raise a concern/complaint were displayed in the relatives' waiting room and entrance. All the staff questioned knew how to advise patients and or relatives how to raise a concern.

Are critical care services well-led?

Requires improvement



We rated well-led as 'requiring improvement'. This was related to the lack of clarity as to the future strategy for critical care services in light of the pressure for Level 2 beds which resulted in the occasional but regular use of theatre recovery facilities for care of critical care patients. In addition, there were no clear plans to address the risks created by the lack of suitable infrastructure in the short term and these were not recognised on the local risk register. From a clinical care perspective, the unit had strong local clinical leadership with high visibility of both the unit manager and clinical lead. However, the unit manager was not afforded sufficient non-clinical time in which to undertake her management, education and leadership responsibilities.

Vision and strategy for this service

- Critical care services faced two main challenges: lack of capacity and an infrastructure and environment that did not meet the basic requirements of Health Building Note (HBN) 04-02 for providing critical care services. There was a Critical Care Delivery Group within the Trust that had representation from physicians and surgeons as well as critical care clinicians and an outline business case was approved by the Executive Board for refurbishment and an additional four beds (two Level 2 and two Level 3); however a final business case had not yet been drafted and there appeared to be a lack of alternative plans should this not be approved. It was also unclear how the plans for expansion were aligned with the trust five-year strategic plan for acute services. The expansion of critical care services was not referred to in the trust operational plan for 2014-16.
- In discussions with both managers and clinical staff there was concern about the pressures on the service and the impact on patient care and safety but there appeared to be an over reliance on the future development of the unit with a lack of focus on improving and managing current risks and pressures.
- There was strong local leadership in the unit. Within the service there was a culture of support and respect for

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each other and all the staff interviewed commented that it was a nice place to work and that all the team were 'fantastic'. The unit philosophy was displayed on the wall in the unit manager's office.

Governance, risk management and quality measurement

- The unit risk register had three main risks identified – (i) bed pressures in Medicine causing Level 1 patients to remain on ICU, (ii) insufficient Level 2 beds causing non-clinical transfers and out-of-hours transfers and (iii) lack of a critical care pharmacist. None were rated above 12 and therefore did not appear on the corporate risk register. Risks related to the clinical environment were not included on the ITU risk register.
- When asked about the risks detailed on the register, the divisional group management appeared unaware of what these were. Their response was that they planned to have a new expanded purpose built unit, which would resolve some of the issues. When asked what was being done at the present time to minimise risks, their response was unclear.
- There was an action plan in place for critical care dated April 2015. This was in response to the North of England Critical Care Network Unit Appraisal Report (June 2013) and incorporated actions that addressed the risks on the risk register. The action plan was monitored by the ITU Sub-Group which met on a monthly basis. The lack of a pharmacist was red rated on the action plan and was to be resolved through the restructure of Pharmacy by December 2015 but there was no reference to interim contingency arrangements. The lack of Level 2 beds was to be addressed by the business case to expand the unit and this work was stated to be on the capital plan for 2016/17. There was reference to the "regular" use of Recovery Room as a contingency arrangement for managing bed pressures. Management of bed pressures was also to be informed by an organisational bed base review and improved communication with the bed flow managers.
- There was a lack of documented guidance regarding the management of patients cared for in the theatre recovery area. Although an escalation policy for management of critically ill patients was in place it did not specify the roles, responsibilities and processes

around management of patients nursed in theatre recovery. A revised policy with these details documented was in draft format but had not been shared with the wider team at the time of inspection.

- Additionally we were unable to evidence that there were systems in place to provide assurance on the level of competency, skills and training of recovery area staff to manage ITU patients.
- Critical care governance meetings were attended by members of the multi-disciplinary team on a monthly basis. There were terms of reference available for the meetings and standard agenda items such as morbidity and mortality, incidents and audits. The meetings are chaired by the Clinical Lead for Anaesthetics and Critical Care. There were also bimonthly business meetings that dovetailed into the clinical governance meetings and picked up risk issues and action plans. The managers feed the discussions and actions from these meetings into ward and departmental meetings.

Leadership of service

- Leadership training was available to equip staff with the skills to lead teams. The unit manager had undertaken a number of management/leadership development programmes, for example, Leading an Empowered Organisation (LEO). However, current staffing levels meant that the manager was unable to adequately support the educational requirements of the nursing team or ring-fence sufficient management time to fulfil their leadership role.
- The unit had strong local clinical leadership with high visibility of both the unit manager and clinical lead. However, the unit manager was not afforded sufficient non-clinical time in which to undertake her management and leadership responsibilities.
- The staff spoke highly about and had confidence in their unit managers and lead consultants, but many of the nurses reported a lack of decision-making by some of the staff grade doctors and felt that might be in some part due to a lack of guidance from their seniors.
- Staff said that whilst they regularly saw middle managers on the unit they could not recall the executive team visiting the area.

Culture within the service

Critical care

- The staff spoke positively about the service they provided for patients. They said there was an open and transparent culture that focused on meeting patients' needs.
- Most of the staff said they felt valued as team members. They provided examples where local management had supported them with their professional and personal needs to enable them to work to their best ability. However, examples were given where staff felt that there was not enough support in undertaking professional development and that they had had to use their own time.
- Whilst they felt valued at a local level, a number of staff felt that they were not appreciated by middle or senior management.

Public and staff engagement







- Trust staff had taken part in the national NHS staff survey in 2014 although results were not available specifically for critical care services.

- The national staff survey showed that on a scale of one to five, with five being fully engaged and one being completely disengaged, the organisation scored 3.74. Staff from South Tyneside had a similar engagement score to other organisations of similar size.
- Staff meetings and handover sessions were used to keep them informed and involved in the running of the critical care service and the hospital.
- Feedback from the NHS Friends and Family Test and satisfaction surveys was displayed and there were actions highlighted from comments in the annual patient survey which had been implemented.

Innovation, improvement and sustainability

- There was some evidence of innovation, for example the development of 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).

Maternity and gynaecology

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

Information about the service

The maternity service at South Tyneside Hospital NHS Foundation Trust delivered 1,329 babies per year. The trust had a higher percentage of births to mothers aged 20-34 (82.5% compared to England average of 76.1%) as well as mothers aged 20 and under (6.2% compared to the England average of 4%).

The unit had nine delivery rooms on the labour ward, including one with a birthing pool, a 20 bedded antenatal/postnatal ward; ante-natal clinic and early pregnancy assessment unit. A team of 20 community midwives also provided antenatal and postnatal care generally outside of the hospital setting either at the GP surgery, local children's centres or in the woman's home.

We visited the antenatal clinic, labour ward, obstetric theatre, antenatal and post-natal ward and Ward 3 which admitted gynaecology inpatients. We spoke with 17 women and 34 staff including midwives, doctors, consultants and senior managers. We observed care and treatment and looked at 12 care records. We also reviewed the trust's performance data.

Summary of findings

Maternity and gynaecology care was rated 'good' for being safe, caring, responsive and effective and 'requiring improvement' for well-led.

The senior management team were aware of the challenges to the service and had a vision for the future of services. The head of midwifery told us a draft strategy for maternity and gynaecology services had been developed. This set out how the service was to achieve its priorities to ensure sustainability of the service and how staff understood their role in achieving the services objectives. However, this had not yet been formalised. The roles and profiles for clinical leadership in maternity were not clearly defined and clinical engagement at a corporate level was not always cohesive.

The service provided safe and effective care in accordance with recommended practices. Outcomes for women using the service were monitored and where improvements were required action was taken.

Care and treatment was planned and delivered in a way to ensure women's safety and welfare. Resources, including equipment and staffing, were sufficient to meet the needs of women. Staff had the correct skills, knowledge and experience to do their job.

The individual needs of women were taken into account in planning the level of support throughout their

Maternity and gynaecology

pregnancy. Women were treated with kindness, dignity and respect. The service took account of complaints and concerns and took action to improve the quality of care.

Senior managers were visible and approachable. A positive culture of openness and candour amongst staff was evident.

Are maternity and gynaecology services safe?

Good



Effective systems were in place for reporting, investigating and acting on adverse events. Information was routinely collected and reviewed around standards of safety and shared with staff.

Staffing levels were set and reviewed at ward level using nationally recognised tools and guidance. Medical and midwifery staffing was in line with national recommendations for the number of babies delivered on the unit each year.

Care and treatment was planned and delivered in a way to ensure women's safety and welfare. Recording of the 'five steps to safer surgery' procedures included in the World Health Organisation (WHO) surgical safety checklist was not being consistently completed in maternity services. Not all medical staff had completed mandatory training in line with trust targets.

Staff followed safety guidance for infection prevention and control. Medicines were managed safely. Records relating to the care of women were detailed enough to identify their individual needs and to inform staff of any risk and how these were to be managed.

Incidents

- The service used a specific data set for incident reporting as identified in the maternity adverse incident reporting trigger list. The list contained events that identified a trigger for routine reporting, for example, the incidence of category one caesarean sections and the department's response in managing this.
- There were no never events reported as having occurred in maternity services.
- Two serious incidents were reported during 2013/2014 which related to falls. We looked at one of the investigation reports which identified the care and service delivery problems, contributory factors and root causes. The action plan showed that recommendations and learning had been fully implemented.

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- We saw a list of other incidents that were classified as causing no harm, to minor or moderate harm. These incidents were reported through the incident reporting system and included details of the investigation of the incident and the follow up actions.
- All members of staff within maternity services were encouraged to report incidents (clinical or non-clinical). The incidents were logged onto the local maternity incident log spreadsheet by the clinical governance midwife. These were then triaged, graded and reviewed as appropriate within the designated maternity governance meetings.
- Any deficiencies were identified and actioned by the appropriate personnel including feedback which was given on an individual or departmental basis. This included face to face discussion, communication files, departmental meetings, letters and memos.
- Perinatal mortality and morbidity meetings were held. All serious cases, including stillbirths and neonatal deaths were reviewed by a peer group. Minutes for January, March and April 2015 showed that recommendations to improve practice had included changes to documentation, systems for review of test results and clinical guidelines.
- The trust had a policy in place to ensure that it met the statutory requirements with regards to Duty of Candour. The policy provided guidance for staff on the requirements of Duty of Candour and set out what should happen following a notifiable patient safety incident, prompting communication with patients and/or their representatives. We found staff had a good understanding of the Duty of Candour process.

Safety thermometer

- The service used the NHS Safety Thermometer for measuring, monitoring and analysing harm to patients and harm-free care. Monthly data was collected on pressure ulcers, falls, urinary tract infections for people with catheters, and venous thromboembolism (VTE or blood clots). Data showed women had received harm free care.
- Maternity had also commenced using the national maternity safety thermometer. This allows the maternity team to check on harm and record the proportion of mothers who had experienced harm free care. The

clinical areas reviewed included perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety.

Cleanliness, infection control and hygiene

- Ward areas appeared to be clean and we saw that staff regularly washed their hands between patient appointments and interventions. Staff were 'bare below the elbows', in line with trust policy and national guidelines for best hygiene practice.
- There were no methicillin-resistant staphylococcus aureus (MRSA) or Clostridium difficile infections within maternity or gynaecology over the last 12 months.
- All areas we visited had antibacterial gel dispensers at the entrances. Appropriate signage was on display regarding hand washing for staff and visitors.
- There were facilities for isolating patients with an infectious disease.
- Women were screened for MRSA before undergoing elective caesarean sections.
- Failsafe systems were in place to identify women for Hepatitis B and HIV at booking to ensure that they were managed on the correct care pathways. Trust data showed HIV coverage was 99% over the last six months. The timely referral of Hepatitis B women for specialist services was 100%.
- We noted that the backs of two shower curtains on ward 22 had black mould. We brought this to the attention of the ward manager who actioned this immediately.
- The CQC survey of women's experiences of maternity services 2013 showed the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.

Environment and equipment

- There was adequate equipment on the wards to ensure safe care (specifically cardio tocograph (CTG) and resuscitation equipment). Staff confirmed they had sufficient equipment to meet patients' needs.
- There was one obstetric theatre. Staff told us a second theatre could be set up in an emergency in one of the labour rooms using a mobile anaesthetic machine and theatre light. The anaesthetists told us it was rare that the second theatre was required and although this was not ideal, staff felt it was safe.

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- There were wall mounted resuscitaires in birthing rooms and one mobile freestanding resuscitaire. Records showed checks were carried out each day.
- There was a birthing pool in the unit to enable women to use water during labour.
- All delivery rooms had piped entonox and gases however it was not clear what control measures were in place to monitor exposure levels of nitrous oxide or how regularly checks were made on ventilation and scavenging systems to ensure they were still effective.
- The design of the unit was able to ensure women and babies were kept safe and could be transferred quickly in an emergency. The unit had its own separate entrance to enable 24 hour access and security control. There was easy access from the birthing rooms to one dedicated obstetric theatre. The theatre was in close proximity to the neonatal unit for ease of transfer of the baby.
- The service had made appropriate adjustments to ensure women with a disability had appropriate access to facilities. This included adaptations to bathroom and toilet areas. Specialist equipment for women with a high body mass index (BMI) could also be obtained when required.
- The existing inpatient facilities on Ward 22 were not designed to cater for partners to stay and were outdated. The service was aware of this and had put forward a business case to improve facilities and re-locate the ward.
- Clinical records were completed to a good standard. Each record we looked at contained a clear pathway of care that described what women should expect at each stage of their labour. When not in use, records were kept safe in line with the data protection policy.
- Risk assessments were completed at booking and repeated at every antenatal visit.
- Women carried their own records throughout their pregnancy and postnatal period of care. The personal child health record (also known as the PCHR or 'red' book) was given to parents before discharge and completed correctly.
- The maternity service used approved documentation for the process of ensuring all appropriate maternal screening tests were offered, undertaken and reported on during the antenatal period.
- Standard operating procedures and care pathways were included in records for care of women with diabetes, epilepsy, hypertension or a high body mass index (BMI) in pregnancy.

Safeguarding

- Staff demonstrated they had a good understanding of the need to ensure vulnerable people were safeguarded and understood their responsibilities for identifying and reporting any concerns.
- There was no formal safeguarding supervision in place. The safeguarding midwife told us they were looking to develop more structured supervision.
- Trust data showed 62% of staff in maternity had completed adult safeguarding awareness training. Children's safeguarding training showed 79% of staff had completed level 1, 49% level 2 and 41% level 3.
- The maternity unit used a security tag system for babies and an identity band. Strict procedures were followed to protect babies during their stay; alarms would activate should someone attempt to remove a baby from the ward. The tag was removed when the baby was being discharged home.
- Emergency procedures were in place for infant abduction incidents. An infant abduction exercise audit was completed on 15 January 2015. The annual test exercise showed only minor learning points were required and these were completed.
- Children aged 13 to 16 were asked about their sexual activity and referred to the appropriate agencies where required. Girls under 13 years of age were automatically referred to the safeguarding team.

Medicines

- Medicines were stored in locked cupboards and trolleys in all of the units.
- Medicines that required storage at a low temperature were stored within a specific medicines fridge. All of the fridge temperatures were checked and recorded daily. There were no gaps in recording.
- Records showed the administration of controlled drugs were subject to a second independent check. After administration the stock balance of an individual preparation was confirmed to be correct and the balance was recorded.
- In November 2014, an audit of inpatient omitted doses showed that all women had received their medicines and all controlled drug checks were correct on Ward 22.

Records

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- The service had recently developed processes for reporting cases of female genital mutilation in response to the Department of Health multi-agency guidance. The clinical business manager told us there was a plan to collect data for reporting and provide training for staff.
- There was information displayed relating to domestic violence which signposted women to appropriate agencies for further advice and support. Systems were in place to share information with the community midwives. Women were asked about any abuse at booking and when they were alone. Midwives tried to see women alone at least once in their pregnancy.

Mandatory training

- The maternity performance dashboard showed between April 2014 and March 2015 87% of midwives and 33% of medical staff had completed mandatory training against a trust target of 75%.
- All Band 7 nurses on the labour ward had attended advanced life support in obstetrics and the majority of staff had completed neonatal life support training.
- Staff attended the emergency skills and drills programme to maintain competence in managing complicated labour and delivery.
- Maternity support assistants received additional training to carry out post-operative observations and infant feeding support.

Assessing and responding to patient risk

- Midwifery staff used an early warning assessment tool known as the Maternity Early Obstetric Warning System (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support if required. The records we reviewed contained completed MEOWS tools for women who had been identified as at risk. An audit for January 2015 showed 100% MEOWS charts had been completed correctly.
- The 'five steps to safer surgery' (part of the WHO surgical safety checklist) was not being consistently completed. For example, we looked at 12 surgical safety checklists and found in 11 of these, areas such as the reason for a caesarean section and the stage three surgical checks had not been recorded. We discussed this with the clinical business manager who told us that these areas would be recorded in different sections of the clinical

records; however, they acknowledged that improvements were required in recording of the WHO checklist and that they would raise this with the clinical governance midwife for action.

- There was a clear escalation plan and handover to transfer women requiring high dependency care.
- The unit used the 'fresh eyes approach', a system which required two members of staff to review fetal heart tracings.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of one midwife to 23 births compared to the RCOG recommendation of one midwife to 28 births.
- The service was assessing staffing levels using the National Institute of Clinical Excellence (NICE) Guideline on Safe Midwifery Staffing for Maternity Settings released in February 2015. The guideline provided advice on how to make the right decisions about safe midwife staffing levels for women and their babies, wherever they choose to receive care.
- Staff were aware of the importance of NICE Safer staffing 'red flags' for women and hospital staff to identify when there was too few midwives on hand which impacted on care provided. These were discussed twice a day during handover of care.
- The unit used a recognised communication tool: Situation, Background, Assessment and Recommendation (SBAR). We observed a morning safety huddle which was attended by all relevant acute and community staff and provided a comprehensive overview of areas such as clinical risks, staffing levels and ward activity.
- Women told us they had received continuity of care and one-to-one support from a midwife during labour. The service reported the percentage of women given one-to-one support from a midwife was good.

Medical staffing

- There were five consultant obstetricians and gynaecologists providing elective and non-elective work

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across five weekdays. Consultants provided 40 hours of cover on the labour ward which was in line with the recommended RCOG safer staffing standards for a service delivering fewer than 2,500 births per year.

- Non-resident consultant cover 'out of hours' on-call was managed on a 1:5 basis from 5pm to 9am each weekday and 5pm Friday until 9am Monday.
- There were similar levels of consultant-level and junior-level staffing compared to England (31% consultants compared to the England average of 34% and 12% junior-level staff compared to the England average of 7%).
- There was a dedicated consultant anaesthetist for maternity. If the anaesthetist was busy in theatres during out of hours, there was back-up available from the ITU consultant and middle grade doctor.
- Adequate medical cover was provided for the gynaecology ward. Consultant ward rounds also took place at weekends.
- The General Medical Council National Training Scheme Survey 2013 showed there were no risks relating to junior doctors' workload for this trust.

Major incident awareness and training

- There were escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or beds shortages.
- Midwives and medical staff undertook training in obstetric and neonatal emergencies at least annually.
- The trust had major incident action cards to support the emergency planning and preparedness policy, which staff in maternity were aware of and understood their roles and responsibilities.

Are maternity and gynaecology services effective?

Good



The service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits. Information about patient outcomes was routinely monitored and action taken to make improvements.

Women were given sufficient information to help them in making decisions and choices about their care and the delivery of their babies.

Staff had the correct skills, knowledge and experience to do their job. Multi-disciplinary working was good between hospital and community services and support from allied health professionals and specialist expertise was available to women using maternity services.

Evidence-based care and treatment

- There was evidence to demonstrate women using maternity services were receiving care in line with NICE quality standards QS22 (antenatal care), QS32 (caesarean section) and clinical guideline CG37 (postnatal care).
- The service participated in national and local clinical audits and there was an annual audit programme. Audits were monitored and actions taken to improve clinical practice. For example, changes had been made to practice to reduce caesarean section rates to 17% with no increase in maternal morbidity and mortality rates.
- Trust data from the maternity audit in December 2014 showed good compliance against a number of areas such as care, record keeping, pain management and communication.
- Consultants participated in audits of their own practice. For example, for accreditation of the service, audit results were submitted regularly to national audit programmes such as The British Society for Colposcopy and Cervical Pathology and the British Society of Uro-gynaecologists.
- Minutes from the evidence based practice group meeting minutes (February 2015) showed that "change procedures" were communicated to the group, who reviewed existing evidence based guidelines and procedures to reflect changes in practice. Policies and procedures were available on the trust's intranet. The policies we reviewed (shoulder dystocia, pre-eclampsia and Group B Streptococcus infection in pregnancy) were all in date and in line with best practice.

Pain relief

- Women were provided with information to make them aware of the pain relief options available to them.

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- There was access to various types of pain relief for birthing women which included drug-free methods and complementary therapies. There was also access to a birthing pool. Trust data showed there was a 7% water birth rate in 2013/14.
- Clinical records showed pain assessment charts were completed appropriately following any pain related intervention.
- The service provided a 24 hour anaesthetic and epidural service.

Nutrition and hydration

- There was a specialist midwife with a lead role in supporting and improving infant feeding and nutrition across the service. There were also maternity support workers who visited and supported breastfeeding women following discharge.
- Data for April 2014 to March 2015 showed breast feeding initiation rates were 51% against a trust target of 60%.
- The service had a certificate of intention to work towards achieving UNICEF baby friendly initiative accreditation. This was a worldwide programme which encouraged maternity hospitals to support women with breastfeeding.
- A breast feeding support team pathway was in place. Actions to improve initiation rates included infant feeding training for maternity and children's centre staff, improved communication and documentation and monthly and quarterly audits for skin to skin and breastfeeding initiation rates. An audit showed 92% for skin to skin initiation rates against a trust target of 95%.

Patient outcomes

- During 2013/14 there were 1,329 babies delivered. The trust was in the lower quartile for number of deliveries compared to other trusts.
- There were no risks identified in maternal readmissions, emergency caesarean section rates, elective caesarean sections, neonatal readmissions or puerperal sepsis and other puerperal infections (Hospital Episode Statistics 2013/14).
- Emergency caesarean section rates were 10.5% which was better than the national average of 15%.
- For elective caesarean sections the service achieved 9.1% which was better than the national average of 10.8%.

- The service achieved a normal vaginal delivery rate of 67.7% which was better than the national average of 60.4%.
- Data showed 6.7% of deliveries were 'other forceps' deliveries compared to 3.4% nationally.
- The trust was better than the national average of 5% for third and fourth degree tears.
- The maternity performance dashboard showed that between April 2014 and March 2015 the total post-partum haemorrhage rate was 12.49%. At the same period last year there were a total of 9.79%. The dashboard indicated that this increase was due to the more robust reporting systems in place.
- The service participated in the UK National Screening Committee: antenatal and new-born screening education audit. Trust data showed that the rates of avoidable repeat tests for new-born blood spot sampling was in line with national targets of no more than 0.5% and 2%. The National Screening Committee had recently carried out an audit in maternity services. The screening midwife told us that initial feedback was positive.

Competent staff

- We found staff had the correct skills, knowledge and experience to do their job.
- New staff and those returning from a period of absence underwent an induction programme and on the job support to ensure their competence.
- To maintain clinical skills in different clinical areas midwives rotated between community, labour ward, antenatal and postnatal wards.
- Midwives said their preceptorship package was good. Staff spent four weeks working with a mentor and felt well supported. A student midwife spoke positively about their experience of working in different clinical areas.
- Trust data for April 2013 to March 2014 showed 53% of staff in maternity had received a yearly appraisal.
- All midwives had a named Supervisor of Midwives (SoM). The team of supervisors were experienced midwives from a variety of clinical and managerial backgrounds.
- SoMs were available seven days a week and on call out of hours. Supervisors were visible and had caseloads of 1:15 which was in line with the Local Supervising Authority (LSA) recommendations.

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- Midwives said they had received a supervisory review and were aware of how to contact their supervisor if required. The annual review also provides an opportunity to review the midwives practice standards and learning needs to ensure protection of women and babies. 97% of annual reviews were reported on the LSA database for 2014/15 as completed.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- The results of the General Medical Council National Training Scheme Survey 2013 showed educational and clinical supervision, induction and adequate experience for junior doctors was 'within expectations' for this trust.
- A member of the medical staff had attended a meeting for the launch of the confidential enquiries in maternal and child health (MBRRACE). Two presentations had been given to trust staff to emphasise the recommendations particularly those relating to pre-existing medical conditions in pregnant women.

Multidisciplinary working

- There was good integrated working between midwifery and medical staff ensuring women received care which met their needs.
- Midwives at the hospital and in the community worked closely with GPs, children's centres and social care services when dealing with concerns or risks to women.
- The service participated in multi-disciplinary working and peer reviews with tertiary centres and regional networks, for example, in areas such as gynaecological cancers and uro-gynaecology services (bladder and pelvic floor health).
- There was access to medical care for women who had other conditions; clinics were held for diabetes, ethnic minority groups and young adults.
- There were no transitional care cots on the post-natal ward for babies requiring additional support however staff worked closely with children's services to care for babies who required additional clinical interventions. Obstetric staff said they received good support from the neonatal unit and could obtain advice at any time.

Seven-day services

- There was an obstetric theatre team that was staffed and available at all times. A team was also on call out of

hours. A dedicated consultant anaesthetist was present on the labour ward for 10 sessions per week (Monday to Friday; 8am -6pm) and in addition there was a duty anaesthetist for maternity services 24 hours per day.

- There was medical staff presence on the labour ward 24 hours a day.
- The antenatal day unit was open five days a week 8am to 5pm. After this time the antenatal ward triaged all emergency admissions as well as assessment and management of early pregnancy problems.
- Access was available to pharmacy and diagnostic services.
- There was a designated physiotherapist for women's health who was present on the unit and provided advice and exercise programmes for women with pelvic pain and musculoskeletal problems during pregnancy.

Access to information

- During the transfer of women there were processes in place to ensure all appropriate documentation and case notes travelled with the woman, and the results of the appropriate investigations carried out.
- Communication between teams was verbal, written or an electronic print out was available, when required, using the SBAR tool.
- There were effective processes in place to ensure that the results of the antenatal screening tests were followed up and actioned in a timely way and in line with protocols. The screening coordinator worked closely with the laboratory to ensure investigations were actioned. Results were checked and all high-risk women were given an appointment to be seen in clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had been given sufficient information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were completed in line with Department of Health consent to treatment guidelines.
- Staff had a good understanding of mental capacity and described the process in place to care for women with special needs and in relation to 'Gillick' competence for girls less than 16 years of age. Arrangements were made at booking and women's care plans were arranged accordingly

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- Maternity dashboard data showed 66% of staff in maternity had received training in the Mental Capacity Act 2005 against a trust target of 75%.

Are maternity and gynaecology services caring?

Good



Maternity and family planning services were caring. Women spoke positively about their treatment by clinical staff and the standard of care they had received. Staff interacted with women in a respectful way and provided compassionate care. Women were involved in their birth plans and had a named midwife.

Compassionate care

- Feedback from the NHS Friends and Family Test showed 100% of women would recommend antenatal care in December 2014 and 98% in January 2015. The trust also scored better than the England average for the percentage of women who would recommend the trust for birth and postnatal care.
- Between March and November 2014 the scores for women who would recommend postnatal community provision was better than the England average with 100% against a target of 96%.
- Results from the Survey of Women's Experience of Maternity Care (CQC 2013), showed the service scored 'about the same' for questions relating to labour and birth and staff during labour and birth.
- Data for May 2015 showed 94% of patients would recommend the gynaecology service to family and friends.
- Most women spoke positively about the standard of care they had received. Women told us they had a named midwife and received good continuity of care by the community midwives. They felt well supported and cared for by staff, and that their care was delivered in a professional way.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful manner. There were arrangements in place to ensure privacy and dignity in all clinical areas.

- Patient-led assessments of the care environment (known as PLACE) for 2014 showed that the trust was better than the England average for privacy, dignity and wellbeing.
- The trust performed slightly better than the England average for the length of time taken to answer the call button (8.8 compared to the England average of 8.0, with 10 being the best).

Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth at booking and throughout the antenatal period. Most women we spoke with said they had felt involved in their care; they understood choices open to them and were given options of where to have their baby.
- Women were encouraged to visit the maternity unit for a tour before deciding where they wanted to give birth and to familiarise themselves with the facilities.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; this was facilitated by two midwives with a special interest in the care of the bereaved who worked closely with the chaplaincy service. There was a dedicated bereavement room available for parents.
- Guidance was available for the management of fetal loss under 24 weeks. Standard operating procedures were in place for the sensitive disposal of fetal and placental tissue.

Are maternity and gynaecology services responsive?

Good



The service was aware of risks to ensure services were planned and delivered to meet increasing demands.

Facilities in maternity were set up in a manner which enabled staff to be responsive to the needs of women and their families. There was access to investigation, assessment, treatment and care at all stages of the maternity pathway. Where women had additional

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healthcare related needs there was access to specialist support and expertise. Women using the service could raise a concern and be confident this would be investigated and responded to.

Service planning and delivery to meet the needs of local people

- Managers were aware of the risks associated with the increasing demands of the local and wider community and ensured that services were planned and delivered to meet these.
- Community based maternity services were provided from a number of locations within the area; these were pre-dominantly GP surgeries and children's centres. Care was also provided in the women's own home.
- The service was developing a business case to progress a revised pathway for maternity care and improved facilities from which to provide the service. The current maternity care facilities were specifically designed around a traditional service model with some out-dated facilities particularly on Ward 22. In order to address these factors the department was looking to develop services to support the principals of LDRP (labour-delivery-postnatal-recovery). A model where women were admitted in labour into a single room and remained there throughout their stay until discharge.
- South Tyneside had the highest number of deliveries in water when compared with other units in the South of Tyne and Wear area. The demands on the current single pool room often meant that women were not able to use the room when requested. There was a plan within the revised pathway for the conversion of an existing birth room in order to provide a second pool room to increase the opportunity for more women to labour and deliver in water.
- The service worked with community services and public health to improve the continuity of support for breast feeding women through development of pathways from initiation, establishment and continuation of feeding.

Access and flow

- Bed occupancy between April and September 2014 was low ranging between 25% and 29% each quarter (compared to England averages of between 55% - 60%).
- There were 1,329 deliveries between July 2013 and June 2014. The Trust was in the lower quartile for the number of deliveries compared to other trusts.

- The trust had a higher percentage of births to mothers aged 20-34 (82.5% compared to England average of 76.1%) as well as mothers aged 20 and under (6.2% compared to the England average of 4%).
- The maternity unit had not closed between July 2014 and December 2014.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests as required. The midwives were available on call 24 hours a day for advice. Community midwives were integrated within the service.
- There were appropriate triage facilities on the labour ward. Staff used a checklist to risk assess women and signpost them to the appropriate clinical areas. Access to medical input was available if required.
- There was good access to ultrasound services which provided flexible appointments for women. There were six radiographer sonographers and two midwives trained in sonography who provided 16 sessions a week but could add unplanned sessions if required. Targets were monitored; for example scanning within 48 hours for suspected small for gestational age of foetus.
- If the sonographer found a fetal abnormality, the ante-natal assessment unit contacted the lead consultant in fetal medicine who could carry out an urgent scan or make a decision to refer to a tertiary centre.
- Monthly referral to treatment waiting times for completed admitted pathways in gynaecology was 92.9% in April 2015 which was better than the England standard.
- There was no termination of pregnancy (TOP) service; this service was commissioned by another provider except TOP for fetal abnormality which was managed by the trust.
- The service was responsive to women admitted through A&E or ambulatory care with suspected miscarriages. The midwife visited the departments each day and gave priority to women requiring admission to the gynaecology ward.
- On discharge from the department, communication was sent to the GP, community midwife and health visitor electronically.. This detailed the reason for admission

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and any investigation results and treatment undertaken. The discharge summary was checked first with the woman who signed to say they were happy with the content.

Meeting people's individual needs

- The service responded to the needs of vulnerable women. There were a number of specialist midwives who provided support in areas such as young women's pregnancy services, substance misuse and ethnic minorities including the reporting of female genital mutilation.
- The services offered a holistic approach by developing an enhanced care pathway based on individual needs and that worked in partnership with community midwives and other agencies.
- Key workers were identified for women with learning disabilities. Care was tailored to the needs of the woman and included more frequent and longer appointment times, home visits and orientation visits to the unit.
- The labour ward had a birthing pool, which had a telemetric cardiotocography machine to monitor the baby's heartbeat during labour in the pool.
- There was active intervention to improve smoking cessation rates. A stop smoking advisor was present at each dating scan to provide support and advice and the service participated in the 'Baby Clear' initiative to reduce exposure to smoke among unborn babies. Trust data between April 2014 and January 2015 showed 22% of women were smoking during pregnancy which was better than the trust target of 24%.
- There was a proactive physiotherapy service for antenatal and postnatal women. A physiotherapist saw all women with back pain in pregnancy, incontinence, weight management or pelvic floor problems.
- A diabetic clinical pathway was in place. Women had access to weekly clinics run by specialist diabetic care staff.
- Midwives were trained to carry out new-born physical examinations. The service was achieving the national standard of new-born physical examinations within 72 hours.
- There were gynaecology cancer nurse specialists who acted as key workers in providing advice and support from pre-diagnosis, for example, tests and screening through to treatment and supportive care.

- Women using maternity services could access clinical nurse specialists for areas such as antenatal screening, diabetes and substance misuse.
- Women with mental health concerns were referred to the adult mental health team. There was no psychiatrist with a special interest in perinatal mental health. A letter was sent to the woman's GP and health visitor to inform them of the referral.
- There were a range of information leaflets in clinical areas including tests and screening, breastfeeding and other sources of support. The leaflets were available in different languages if required.
- A translation telephone service was available for patients who did not speak English as their first language.
- Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements. Women we spoke with said the quality of food was good.

Learning from complaints and concerns

- Complaints were handled in line with the trusts policy. Information was given to women about how to make a comment, compliment or complaint.
- All formal complaints were received by the clinical business manager and then forwarded to the clinical governance midwife to co-ordinate any actions identified. Lessons learnt from complaints and claims were disseminated to all staff through a six monthly summary report.
- Between January and March 2015 there were four formal complaints received for maternity services and three formal complaints received for gynaecology. One initiative that had been developed following a complaint was the introduction of a shift leader handover safety briefing form to enhance communication and escalate any clinical concern when a medical review was required.

Are maternity and gynaecology services well-led?

Requires improvement



Leadership in maternity and gynaecology services required improvement.

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Although the senior management team were aware of the challenges to the service and had a vision for the future, there was no formal clinical strategy for maternity or gynaecology services, which set out how the service was to achieve its priorities to ensure sustainability of the service or to ensure that staff understood their role in achieving the services objectives. There was no formal business continuity plan which included the risks specific to each clinical area and the actions and resources required to support recovery.

It was not clear how the roles and profiles of clinical leadership in maternity were aligned to the trusts corporate governance and clinical structures. The medical leadership engagement was not clearly defined or cohesive.

Although clinical staff were aware of the requirement to complete abortion notification forms and submitted these to the Department of Health (DOH) as required, there was no formal process for ensuring this happened and no record was kept to enable audit to confirm notification to the DOH.

There were good risk and governance processes in place. Risks were reported and monitored and action taken to improve quality. Senior managers were visible and approachable. A positive culture of openness and candour was evident.

The views of the public and stakeholders through participative engagement were actively sought, recognising the value and contributions they brought to the service. There was some evidence of innovative practice.

Vision and strategy for this service

- The senior management, midwives and consultants were all committed to their patients, staff and unit. The vision of the unit was to provide the best outcome for women through promoting normality and high quality care.
- Although the senior management team were aware of the challenges to the service and had a vision for the future there was no formal strategy for maternity or gynaecology services, which set out how the service was to achieve its priorities or to ensure that staff understood their role in achieving the services objectives.
- A business case had been put forward to progress the development of a revised pathway for maternity care and improve facilities from which to provide the service. The clinical business manager told us that maternity redevelopment was on the capital plan for 2015/16.
- Most staff were aware of the trust's vision and were committed to embedding the improvements both in maternity and gynaecology services and as part of the trust as a whole.

Governance, risk management and quality measurement

- The maternity risk management strategy set out guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure poor quality care was reported and improved.
- Clinical Incidents were reviewed by the local maternity clinical incident review group chaired by the lead consultant for risk management. The aim of the group was to look at any areas for concern in practice and to identify trends and determine what actions should be taken to avoid a similar incident in the future.
- Learning was encouraged through further discussion at local meetings and dissemination by memorandums and also one-to-one meetings where required.
- The service used the maternity dashboard recommended by the RCOG. The dashboard was a clinical performance and governance score card and helped to identify patient safety issues in advance.
- There was a clinical governance midwife who worked 30 hours per week and reviewed and responded to risks on a daily basis. A quarterly report was produced from incidents, data from the birth register and key performance measures that were monitored on the maternity services dashboard each month.
- Through the maternity risk management strategy and specifically through communication between the lead executive director and the trust's maternity services clinical governance structures, the board gained assurance that the risks to maternity services were being managed appropriately.
- A maternity risk register was in use and updated on a quarterly basis at the obstetric and gynaecology risk management meeting. Risks included cost pressure, recruitment to junior doctor trainee posts and environment.

Maternity and gynaecology

- Each morning staff attended an operational and safety huddle meeting. The service used PERFORM methodology which enabled staff to problem solve and review areas such as activity, staffing and clinical risks.
- There were systems and processes in place linking the statutory supervision of midwives to the local clinical governance and risk management strategy. Issues of risk and governance were discussed by the SOM team at their supervisors meetings.
- We found there was clear alignment of what staff had on their worry list with what was on the risk register.
- Governance documents identified the roles of the SoMs and the Local Supervising Authority. SoMs told us they attended in this capacity and not in a dual role. This was in line with recommendations by the Nursing and Midwifery Council.
- Most staff we spoke with had an awareness of the new regulations relating to 'duty of candour' and information was posted on wards and departments.
- Being open policies were already in use and an open culture was observed for reporting and responding to incidents and complaints.
- Although clinical staff were aware of the requirement to complete HSA4 (abortion notification) forms and submitted these to the Department of Health (DOH) as required, there was no formal process for ensuring this happened and no record was kept to enable audit to confirm notification to the DOH.

Leadership of service

- The service structure for obstetrics and gynaecology was led by the divisional director who was supported by the clinical business manager for maternity, health visiting and sexual health.
- We were informed that the clinical business manager combined their role with that of head of midwifery services. We asked whether this led to any conflicts of interest between clinical and business responsibilities. The clinical business manager felt there was no conflict and that they were able to influence care at a higher level and identify resources for maternity where required.
- The unit had a lead consultant obstetrician however it was not clear how the role linked to the trusts corporate governance and clinical structures. We were informed

that it was one of the consultant paediatricians who represented obstetrics as the clinical lead at trust board level; therefore the role profiles for clinical leadership were not clear.

- Staff said they received good support from managers and were able to escalate and discuss concerns. They felt the clinical business manager was visible and approachable and were aware of members of the senior management team.

Culture within the service

- We observed strong team working with medical staff and midwives working cooperatively and with respect for each other's roles. They told us that the trust was a 'good place to work'.
- Medical trainees came back to work in the service as consultants. For example 25% of consultants had worked at the trust as trainees.
- We saw commitment to patient care and treatment. Staff said they provided a safe service in maternity and this was confirmed by medical and anaesthetic staff we spoke with.
- Medical staff were flexible with their job planning to ensure patient needs were met. For example, a consultant said they had come in to do extra lists in gynaecology for two patients who were worried about their diagnosis.
- Managers operated an 'open door policy' for staff to raise any issues or concerns which staff felt confident would be acted on.
- Staff sickness levels in maternity between April 2014 and January 2015 was 8.45% against a trust target of 4.8%. Some of these related to long term sickness.

Public and staff engagement

- The service took account of the views of women and their families through the Maternity Services Liaison Committee (MSLC), a multidisciplinary forum where comments and experiences from women were used to improve standards of maternity care. The chair of the MSLC was a service user who told us they were able to put forward ideas and felt that these would be listened to.
- The service used a 'you said we did' board. We saw examples that changes had been made in areas such as the environment on Ward 22.







Maternity and gynaecology

- Staff were aware of the 'cheer up' weekly bulletin from the chief executive which celebrated good practice.

Innovation, improvement and sustainability

- The service 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.
- The Annual LSA audit 2014/15 showed that the supervisor of midwife's team demonstrated great commitment to their statutory role and were focused to achieve excellence in care for women through continuous improvement.
- The newborn and infant physical examination was midwifery led and met the target of all babies having the check within 72 hours of delivery. The service was introducing a bespoke IT screening management system designed to provide a robust and consistent means of capturing data from the newborn and infant physical examinations. The system supported staff in improving the quality, timeliness and consistency of the examinations and reduced the number of babies being diagnosed late with congenital medical conditions.
- The trust achieved Level 2 accreditation against national maternity clinical risk management standards (Clinical Negligence Scheme for Trusts) in February 2014. This showed a track record of delivery of care to a good standard and in line with evidence based practice.

Services for children and young people

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

Information about the service

Any child who has attended the hospital's accident and emergency department (A&E) who required longer assessment was admitted to the paediatric short stay unit (PSSU) which was adjacent to the A&E department. The PSSU provided care for children who required treatment and further assessment for up to 24 hours. Any child who required care for longer than that period was transferred out to a hospital which provided paediatric inpatient care.

Children's outpatient clinics were held to review and assess children following an episode of illness or injury or where the child had long term health problems which required ongoing monitoring. There were some specialist's clinics, for example, for urinary tract infections, diabetes and some general clinics where a variety of conditions were followed up. There was also a rapid review clinic where children were seen following an attendance at A&E to ensure their condition was improving. The clinics were held at Palmer Community hospital A&E department.

The teams supporting the care of children and young people consisted of registered children's nurses, nursery nurse, auxiliary nurses, and Paediatric nurse practitioners, advanced Paediatric nurse practitioners, medical staff and consultant Paediatricians.

During our inspection the day case ward (ward 12) had been closed the previous week and was due to be relocated next to the short stay unit and children's A&E. We saw works were being completed and the unit was due to open the following week.

The trust had a total of 1,817 spells between July 2013 and June 2014. This is within the lower quartile range compared to all England trusts in England. 85% of all spells were emergency, 15% were day case. Emergency spells were higher than the England average.

Services for children and young people

Summary of findings

Overall we rated children's services as requires improvement for safety, effective and well-led and good for services being caring and responsive.

We had serious concerns about the staffing levels on SCBU as there were occasions where one nurse was on duty which meant when the unit was full this did not comply with guidance on staffing levels. Following feedback to the trust at the announced visit we saw staffing levels had improved at the unannounced to ensure they complied with the guidance. During our inspection we found the ward environments on the PSSU and the SCBU had limitations in meeting patients' needs. Space between cots did not comply with relevant guidance. Staff we spoke with told us they had received safeguarding training at level 3. We checked trust records which showed that only 3% of staff on SCBU had received level 3 safeguarding children's training. The highest compliance rate was for children's day care unit which was 67%. It was difficult to determine from the information provided from children services and central trust records what specific training staff had received and the compliance rates.

We found the service routinely used Ketamine for sedation in children's for MRI scans. Within NICE clinical guideline 112 Sedation in children and young people, it stated that there should not be a routine use of ketamine or opioids for painless imaging procedures. We were provided with some information on clinical audits the service had undertaken. We reviewed policies on the trust intranet and found there were a number which had not been reviewed since they were written in 2009. This meant up to date information on policies and guidance was not available to staff on the trusts intranet. All staff we talked with told us that they undertook mandatory training and received an annual appraisal and they were supported to develop their skills and knowledge. However data submitted by the trust showed that the percentage of nursing staff that had had an appraisal between April 2014 and January 2015 ranged from 0% to 100%.

Throughout our inspection, we saw that patients and relatives were treated with dignity, respect and compassion. All of the patients and relatives we spoke

with all indicated how involved and supported they felt by staff within the services. We observed members of staff talking with children and young people. We heard them using language appropriate to their age and level of understanding.

Information provided by the trust showed the time to initial assessment was consistently under the 15 minute target. Over the week of our inspection the longest time a patient waited for assessment was 17 minutes. We saw over the last few months the four hour target within A&E was met 98% of the time. Within the children's diabetic clinic we saw specific patient information targeted at different age groups to help support the child or young person to self-manage their condition. Staff told us complaints were sent to divisional directors and through the communication teams. Lessons learnt were implemented through team meetings and action plans where service improvements were needed.

We were provided with the strategic business plan for children's services which detailed the service must do's to support the trust's strategic aims. When we spoke with staff and senior managers they were unable to describe the vision and strategy for children's services at the hospital. We had serious concerns over the arrangements for staffing and the number of babies cared for at certain times on the SCBU. We found from January 2015 to April 2015 there had been 10 occasions when there had been more than six babies cared for on the unit at one time. When we checked staffing on these days we found there were a number of occasions particularly on night shifts where there had been one registered nurse and a healthcare assistant caring for the babies. This meant staffing levels on the unit were outside the recommended BAPM guidance on Service Standards for Hospitals providing Neonatal care (3rd edition 2010). Following feedback to the trust we visited SCBU as part of the unannounced visit. We found escalation plans had been implemented and the manager was able to describe the process and what had been done to manage the risks. During periods of higher demand we found additional staff members were sourced or babies were transferred to other hospital's special care baby units. We found that there was a culture of openness among all the staff and teams we

Services for children and young people

met. Staff spoke positively about the services they provided to children and young people. We observed staff working well together and there were positive relationships within the multidisciplinary team.

Are services for children and young people safe?

Requires improvement



Overall we rated children's services as requires improvement for safety. We had serious concerns about the staffing levels on SCBU as there were occasions where one nurse was on duty which meant when the unit was full this did not comply with guidance on staffing levels. Following feedback to the trust at the announced visit we saw staffing levels had improved at the unannounced to ensure they complied with the guidance.

During our inspection we found the ward environments on the PSSU and the SCBU had limitations in meeting patients' needs. Space between cots did not comply with relevant guidance.

Staff we spoke with told us they had received safeguarding training at level 3. We checked trust records which showed that only 3% of staff on SCBU had received level 3 safeguarding children's training. The highest compliance rate was for children's day care unit which was 67%. It was difficult to determine from the information provided from children services and central trust records what specific training staff had received and the compliance rates.

Incidents

- There were systems in place to report incidents. Staff told us they knew how to report incidents, but did not always receive individual feedback from these.
- From 1 January to 31 December 2014 108 incidents were reported within children's services. The top three themes from incidents highlighted by the trust were ambulance delays, safeguarding issues and medication issues. There had been two reported serious incidents in the last 12 months.
- We received information from the trust prior to the inspection which showed 12 incidents had occurred between 1 October and 31 January 2015. Further information requested during the inspection showed that between 1 January 2015 to 30 April 2015 36 incidents had been recorded. However we found the number of incidents recorded for January was different

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in both documents. The first document highlighted there had been three incidents recorded in January whereas the second document had nine incidents recorded including the previous three.

- We saw there were a number of incidents related to issues regarding investigations, images and lab tests. For example, we saw in one incident a blood test on a baby needed repeating as the original samples had gone 'missing' and no results were available.
- Within the pre-inspection document April 2015 we found there had been no Never Events reported to have occurred between February 2014 and January 2015.
- There had also been no falls, Pressure Ulcers or catheter acquired urine infections reported from December 2013 to December 2014.
- Within trust records we found 14 staff had attended duty of candour training. Staff told us they were aware of the duty of candour regulation.

Cleanliness, infection control and hygiene

- Staff reported that they had received infection control training on an annual basis as part of the mandatory training. However we saw in information provided by the trust that between 24% and 86% of staff had received training on the control of infection. We saw that on SCBU only four out of 17 staff had received training which equated to 24%.
- The ward areas and clinics we visited were visibly clean. We observed staff observing hand hygiene appropriately and wearing appropriate protective equipment.
- We reviewed information on hand hygiene audits. We saw from April 2014-March 2015 both children's A&E and SCBU scored 100% compliance with hand hygiene audits.

Environment and equipment

- During our inspection we found the ward environments on the PSSU and the SCBU had limitations in meeting patients' needs. For example, we saw in PSSU the three bed spaces were very close together and this potentially impacted on the privacy and dignity of patients.
- On the SCBU we found there was limited space between cots in the main cot area. We measured the distance between 2 cots and found they were 1.5 metres apart. Within the British association of Perinatal medicine

(BAPM) Designing a Neonatal Unit guidance in 2004 they state: "There should be 3m between each cot centre. Including the central walkways, a special care room requires 9.5 square metres per cot."

- Further guidance in the Health Building Note 09-03: Neonatal units (2013) further confirmed the BAPM guidance and recommended the core clinical space envelope within a multi-cot environment was 9 square metres, including access space. This meant the space between two of the cots did not comply with the guidance.
- The space in the unit had been further comprised when on 23 January 2015, and 27 January 2015 there had been seven babies on the unit. Between 30 January 2015 to 6 February 2015 and 10 April 2015 there were between eight and nine babies on the unit. Staff told us additional cots had been 'borrowed' from the maternity units to accommodate the additional babies. This meant the distance between cots had been further reduced and babies may not have been in bed spaces with the correct equipment.
- We saw some of the equipment on the SCBU had 'PAT' test labels which showed the equipment had past the date they should have been re-tested. For example, one of the infusion pumps had a label which stated it should have been re-tested in September 2014. When we spoke with staff they told us when equipment had been re-tested the label would be updated.
- The trust provided information on their policy which stated that all high risk and life support equipment was fully maintained to manufacturer's specifications. This included infusion systems. The infusion pumps had a three year service however the pumps in SCBU had the wrong labels printed and the dates were not correct. The trust database had the correct service history and the trust during the inspection had changed the labels on the equipment in SCBU.
- We observed that SCBU had locks on the doors to ensure security however within children's A&E there was no security on the doors. Following the inspection the trust told us Children's A&E automatically locks down at 10pm until 8am – swipe access only during this time. During the day access is not restricted, but no security issues have occurred since the opening of the unit in November 2012.
- We found appropriate checks had been completed for resuscitation trolleys in all the areas we visited.

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- We were told there had been an incident in the paediatric diabetic clinic when the resuscitation trolley had been required for a patient but there was no specific paediatric equipment on it. We saw in the incident information this had happened in January 2015 and the resuscitation trolley had been stocked with equipment. We checked the trolley during our inspection and found the appropriate equipment for paediatrics was stocked on the trolley.

Medicines

- We reviewed a sample of treatment records in the children's inpatient areas and observed the administration of medications. We found that medicines had been appropriately stored, checked and administered within the ward areas where children received inpatient care.
- However on one occasion we observed medication being given to a child without the child's name band being checked to ensure medications were given to the correct patient.
- Through discussions with staff, they told us that some medications required checking by two registered nurses. On occasions in SCBU there had been one nurse on duty staff told us they would ask staff from children's A&E or the PSSU to come and check medications.
- We observed the trust medication charts and found for 'as and when medications', there were no spaces for the duration or a stop date of the medication to be written. As and when medications are prescribed when the patient requires them rather than a regular dose.
- For the 10 medication incidents reported during 2014 the trust told us feedback had been given to staff involved, and identification of any repeat issues, and clarification of systems and processes had occurred.

Records

- We found that all ten of the records we had reviewed had been completed appropriately which included entries being dated and signed and all the sections being completed fully.
- We saw that medical and nursing records were stored securely.
- We saw care records included the risk assessments and care plans needed to ensure children's care, treatment and support needs were being met.

- We saw trust records which showed that between 51% and 71% of staff had received training on information governance.

Safeguarding

- The trust had a single point of contact number for staff to contact the safeguarding children's team to get advice and support if they had concerns.
- The 'Safeguarding children and young people: roles and competencies for healthcare staff: Intercollegiate document', (March 2014) stated that all clinical staff working with children/young people and their parents and who contributed to assessing and planning to meet the child's needs, should undertake Level 3 safeguarding training.
- Staff we spoke with told us they had received safeguarding training at level 3. We checked trust records that showed that only 3% of staff on SCBU had received level 3 safeguarding children's training. The highest compliance rate was for the children's day care unit which was 67%.
- One of the band 6's told us they kept a paper copy of training staff had received and compliance rates were much higher than the trust records. We asked for information from the service and saw information on other core training but this did not include safeguarding information specifically so we were unable to determine an accurate picture of compliance rates.

Mandatory training

- Staff told us that they had received mandatory training which incorporated the required training such as resuscitation and moving and handling.
- We spoke with one of the band 6's who kept a paper training file which showed compliance with mandatory training. We saw information that showed for the 36 staff 32 had received mandatory training within the last 12 months. The remaining four members of staff had received mandatory training within the last 14 months. The information did not list all of the training staff had undertaken.
- The trust provided information on training which showed compliance rates were much lower than the rates within the paper training file. For example, we saw fire safety awareness training rates for children's services ranged between 18% and 100%.
- It was difficult to determine from the information provided from children services and central trust

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records what specific training staff had received and the compliance rates. This also meant the children's services management team would not have a clear picture as to what training the workforce had received.

Assessing and responding to patient risk

- The children's service utilised an early warning score system to detect a sick child, or infant, who may have required urgent or critical care. The system, known as the 'paediatric early warning score' (PEWS), allowed the paediatrician and children's nursing team to promptly identify when a child's clinical observations could be lying outside the normal range.
- We reviewed three records and found that the observations had been completed appropriately and within the required timescales.
- Children who deteriorated within the children's A&E department and who required inpatient care for longer than 24 hours were transferred to other hospitals. During our inspection we observed one patient whose condition had deteriorated had been appropriately monitored and was transferred to another hospital by the ambulance service.

Nursing staffing

- The children's A&E had four assessment rooms, one resuscitation bed though this could be increased to two if needed and three beds in PSSU.
- We found staff between the children's A&E and PSSU worked as one team and provided care to patients in those areas. The planned numbers for qualified nursing staff was three on day shifts and two on a night shift.
- We saw the actual numbers of qualified staff on day shifts between 9 March 2015 and 3 May 2015. We found there were 12 occasions where there were only two qualified nurses on duty for all or part of the day.
- Within the A&E Paediatric Nurse Practitioners (PNP) also worked within the departments and were not included in the nurse staffing numbers. We found during the day there was two PNP's that supported the unit.
- 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 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. SCBU had six cot spaces so could take up to six babies.
- We reviewed the off-duty for the SCBU from January to May 2015. We found consistently up to April 2015 there was one registered 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 had been 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 registered 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 expressed they had tried to get additional staff and this had been escalated to the director of nursing.
- During our unannounced inspection we found that during 27-30 May 2015 there had been five to six babies on the unit. We found on these occasions the nurse staffing had been increased to ensure there was at least two registered nurses for the six babies.
- Senior managers told us staffing had been increased during this period and was managed more flexibly to meet needs.
- However staff did raise concerns regarding capacity of qualified experienced nursing staff and that nurses were working over normal hours to ensure safe staffing levels on the unit.

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- The trust provided information on the sickness rate for nursing staff in the neonatal unit which was a monthly average of 10.67% between April 2014 – January 2015.
- We saw information in the paediatric business meeting minutes 24 April 2015 which indicated that staff sickness was 7% in children's services compared to the national target of 5%.

Medical staffing

- There were five consultants who covered the children inpatient services Monday to Friday between 9 am and 9pm. On the weekend there was ward rounds each day by the on-call consultant.
- Consultants were supported by advanced nurse practitioners and junior doctors however there was not always a registrar level doctor available through the day.
- We reviewed rotas and were told by staff that different locums were used virtually every night the month of our inspection. Staff told us locums had an induction with the Paediatric consultants.
- Due to the cover arrangements there were different consultant ward rounds on SCBU most days. This meant there was potentially an issue with continuity for babies on the unit. When we spoke with the clinical lead they told us they were working towards a consultant of the week rota but there was no timescale to implement this.
- In the children's management meeting the team highlighted one of their challenges was to recruit medical staff and maintain staff skills however when we reviewed the risk register we found this had not been identified as a risk.

Major incident awareness and training

- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response or additional services to meet the demands of a major incident or emergency.
- Staff told us they were aware of the trusts major incident plans. We asked for specific business continuity plans for children's services but the trust did not provide them.

Are services for children and young people effective?

Requires improvement

Overall we rated children's services as requiring improvement for being effective. We found the service routinely used Ketamine for sedation in children's for MRI scans. Within NICE clinical guideline 112 Sedation in children and young people it stated that there should not be a routine use of ketamine or opioids for painless imaging procedures. We were provided with some information on clinical audits the service had undertaken.

We reviewed policies on the trust intranet and found there were a number which had not been reviewed since they were written in 2009. This meant up to date information on policies and guidance was not available to staff on the trusts intranet.

South Tyneside Hospital had registered an intent to undertake the accreditation process for the UNICEF Baby Friendly Initiative at the time of the inspection.

All staff we talked with told us that they undertook mandatory training and received an annual appraisal and they were supported to develop their skills and knowledge. However data submitted by the trust showed that the percentage of nursing staff that had had an appraisal between April 2014 and January 2015 ranged from 0% to 100%.

Evidence-based care and treatment

- We found the service routinely used Ketamine for sedation in children's for MRI scans. When we asked the senior children's management team if this complied with NICE guidance they were not aware if this practice did comply.
- Within NICE clinical guideline 112 Sedation in children and young people it stated that there should not be a routine use of ketamine or opioids for painless imaging procedures.
- We saw an audit of CT following head injury in children in June 2014. We saw details of recommendations for change and a action plan.. However we were unable to determine from the information whether these actions had been implemented.
- Initiatives, such as the UNICEF Baby Friendly Initiative were not in full operation. The UK Baby Friendly Initiative was based on a global accreditation

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programme developed by UNICEF and the World Health Organisation. It was designed to support breastfeeding and parent/infant relationships, by working with public services to improve standards of care. South Tyneside Hospital had registered an intent to undertake the accreditation process at the time of the inspection.

- We reviewed policies on the trust intranet and found there were a number which had not been reviewed. For example, we found the Bronchiolitis protocol was written in 2009 and did not appear to have been reviewed. This meant up to date information on policies and guidance was not available to staff on the trusts intranet.
- When we spoke to the clinical lead they told us a number of pathways and clinical guidance had been reviewed by one of the consultants. We were provided with these following the inspection. For example, we saw clinical guidance on the treatment of anaphylaxis, acute management of asthma and the limping child. It was not clear from the information provided if the pathways were compliant with relevant NICE guidance or best practice. In addition the information was not available for staff to follow at the time of inspection.

Pain relief

- Children and young people had access to a range of pain relief should it be required, including oral analgesia's.
- In the records we reviewed, there was pain assessment tools utilised. Pain assessment tools enabled nurses to assess the level of pain the patient was reporting and the effectiveness of any analgesia given to relieve the pain.
- We saw the children's A&E department had developed a pain pathway which was based on the Royal College of Emergency Medicine Guidelines. The pathway utilised visual aids to support children and young people identify their level of pain.

Nutrition and hydration

- We saw children's or young person's nutrition and hydration were assessed and recorded in their records.
- Age appropriate snack boxes were available for children within the children's A&E and PSSU.
- We observed and staff told us within SCBU how they supported babies and parents with feeding. For

example, some babies needed additional enteral feeding support by naso-gastric tubes. We found appropriate documentation of feeding and nutrition within care records.

Patient outcomes

- The service participated in national audits such as diabetes. Information from the national paediatric diabetes audit 2014 showed the hospital was better than the England average for the HbA1c diabetic audit measure. Glycated haemoglobin (HbA1c) levels give clinicians an overall picture of what the patient's average blood sugar levels have been over a period of weeks or months. This, therefore, aids the clinician in the care and treatment of the patient.
- For children and young people who attended A&E with asthma staff utilised a guideline from the trust intranet. However, when we reviewed the guideline we found the information was limited and did not give staff specific information on when and how to escalate treatment.
- Hospital episode statistics (HES) between July 2013 and June 2014 showed the multiple admission rates for asthma patients aged 1-17 years old were worse than the England average (26.5% compared to the average of 16.8%).
- We saw the service had registered to participate in the North East Paediatric Pneumonia Survey 2014 which looked at comparing clinical features and management of patients following the introduction of the British Thoracic society (BTS) guidelines for the management of community acquired pneumonia in children 2011. We were not provided with the outcome of the audit results.

Competent staff

- There were formal processes in place to ensure staff had received training, supervision and an annual appraisal.
- All staff we talked with told us that they undertook mandatory training and received an annual appraisal and they were supported to develop their skills and knowledge.
- However data submitted by the trust showed that the percentage of nursing staff that had had an appraisal between April 2014 and January 2015 ranged from 0% to 100%. In the information there were no recorded appraisals for staff in the SCBU.

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- We found all of the paediatric nurse practitioners had received additional training in paediatric immediate life support (PILS), new-born life support (NLS) and undertook nurse prescribing.

Multidisciplinary working

- Staff we spoke with gave positive examples of multidisciplinary working. We were told that the paediatricians and nursing teams, along with other Allied Healthcare professionals worked closely together to support children and young people.
- In the children's diabetic clinic, there were examples of how the medical team worked closely with other professionals. For example, when a patient was due to transition to adult services joint appointments with consultants from adult services were held. This was an example of how the service worked with others to meet the needs of children and young people.
- Staff told us and we observed how they worked closely with neighbouring hospitals and the ambulance service when patients needed to be admitted to an inpatient bed for longer than 24 hours.

Seven-day services

- Within the children's department, there was consultant cover on site out of hours until 9pm and at the weekend. Staff told us that consultants would come in to review patients out of hours and there was a ward round each day at the weekend.
- The children's wards had access to diagnostic services, such as the x-ray department and laboratory during the weekend.

Access to information

- Staff reported that they had access to information for each patient, which included medical and nursing records and results from any investigations.

Consent

- Staff were aware of 'Gillick' competencies and 'Fraser' guidelines which were used for deciding whether a child is mature enough to make decisions and give consent. These guidelines refer to a legal case, which looked specifically at whether doctors should be able to give contraceptive advice or treatment to young people and children under 16 years old without parental consent.

Since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

- Patients and relatives we spoke with told us they felt involved in their care. Due to the day-case unit being closed at the time of inspection we were unable to check formal consent documentation.

Are services for children and young people caring?

Good



Overall we rated children's services as being good for caring. Throughout our inspection, we saw that patients and relatives were treated with dignity, respect and compassion. All of the patients and relatives we spoke with all indicated how involved and supported they felt by staff within the services. We observed members of staff talking with children and young people. We heard them using language appropriate to their age and level of understanding.

Compassionate care

- As part of our inspection, we observed care on the children's wards, clinic settings and observed staff speaking to patients and relatives on the telephone.
- In order to gain an understanding of people's experiences of care, we talked to twelve patients and their relatives who used services in children's and young people's services.
- Throughout our inspection, we saw that patients and relatives were treated with dignity, respect and compassion.
- We saw that the service gained feedback from patients and relatives through the "I want great care" paediatric questionnaires. We saw the results of one of these questionnaires in 2014. One person commented: "Such friendly staff. Lovely waiting area for families and toys for my child to play with. Honestly the nicest A & E I've ever visited."
- Another person stated: "Nurses were very friendly, helpful and thorough in their checks, ensuring my child was in as least pain as possible."

Services for children and young people

Understanding and involvement of patients and those close to them

- All of the patients and relatives we spoke with all indicated how involved and supported they felt by staff within the services.
- One relative told us: “I cannot fault the staff” another relative said: “I would be happy to take my child back to the department to receive care.”
- We observed staff explaining care and offering support and guidance to parents.
- We observed members of staff talking with children and young people. We heard them using language appropriate to their age and level of understanding.
- There was a range of information leaflets available about various treatments, as well as other care available within the hospital. We saw that the majority of leaflets available were written in English.

Emotional support

- Parents and children told us they had been well supported during their visits or stays on.
- We observed staff provide information to parents and updates on the care and treatment of their child.

Are services for children and young people responsive?

Good



Overall we rated children’s services as being good for responsive. Information provided by the trust showed the time to initial assessment was consistently under the 15 minute target. Over the week of our inspection the longest time one patient waited for assessment was 17 minutes.

Within the children’s diabetic clinic we saw specific patient information targeted at different age groups to help support the child or young person to self-manage their condition. Staff told us complaints were sent to divisional directors and through the communication teams. Lessons learnt were implemented through team meetings and action plans where service improvements were needed.

Service planning and delivery to meet the needs of local people

- Children who attended the A&E department who needed a period of inpatient care could be admitted into the short stay unit or if care was needed over a longer period of time were transferred to neighbouring hospitals.
- The diabetic specialist nurses told us they had supported some staff within the children’s A&E to become link nurses to enable the A&E department to have a better understanding of the care and treatment of these patients.
- Diabetic nurses also told us they undertook home visits and daily telephone calls for newly diagnosed children and young people with diabetes to support them and their families with their care. They also wrote care plans for children and young people to be used in schools.
- The trust had adapted the service to support the development of Paediatric nurse practitioners and advanced Paediatric nurse practitioners. A nurse practitioner is a registered nurse (RN) who has had additional education and training in a specialty area such as paediatrics.

Access and flow

- Access to A&E was via the children’s reception area where a receptionist collected demographic details and presenting complaints. Children were then assessed and triaged by nursing staff.
- The children’s A&E department saw between 50-70 children and young people in a 24 hour period. Information provided by the trust showed the time to initial assessment was consistently under the 15 minute target. Over the week of our inspection the longest time one patient waited for assessment was 17 minutes.
- We saw over the last three months the four hour target within A&E was met 98% of the time.
- Over the previous three months we saw there had been four breaches over 24 hours for patients staying in the short stay unit. Senior staff told us this was due to deteriorations in the patient’s condition and delayed ambulance transfers.
- We were told there were specific lists for children undergoing minor surgical procedures such as dental. We were unable to verify this at the time of inspection as the day-case unit had been closed the previous week.
- We saw information that on SCBU that on 23 January 2015, and between 27 January 2015 to 6 February 2015

Services for children and young people

and 10 April 2015 there had been between seven and nine babies on the unit. Senior staff told us there was a policy in place to manage demand in SCBU but this had not been implemented at the time.

Meeting people's individual needs

- Within the children's diabetic clinic we saw specific patient information targeted at different age groups to help support the child or young person to self-manage their condition.
- The children's diabetic team were involved with 'Type1Kidz' support group who supported children and young people with practical advice, skills and support to help them to 'live' with diabetes.
- The group met on a monthly basis and the nurses and doctors were involved with activities such as football and cooking food.
- The diabetic team also held annual education sessions for children and young people which were split into age specific groups. The patient was able to bring friends to the sessions to increase their understanding of the condition. A separate session was also held for parents and carers.
- Children and young people who attended the A&E department with deliberate self-harm were kept in the department and referred to the child and adolescent mental health service who were available seven days a week.
- Translation/interpreter services were available at the hospital for use when patients whose first language was not English visited the department.
- Due to the layout in the children's A&E reception area we observed ambulance crews handing over patients to staff within close proximity to the waiting area. This meant there was a potential that confidential personal information may be overheard.
- We visited two children's outpatient clinics, the children's eye clinic within the hospital and the paediatric diabetic clinic at Palmers community hospital. We found at the eye clinic there was no dedicated children's area and no toys/ play area available for children while they waited.
- At the diabetic clinic we found the waiting area was not child friendly and was in a main corridor which other patients passed through to get to clinics. We also found that the chairs were in close proximity to the consulting

rooms and while we visited voices from within the consulting rooms could be heard. This meant there was a risk that personal information could be overheard by other patients and visitors.

Learning from complaints and concerns

- We were told formal complaints go to the Customer Services Divisional Directorate which are then circulated to senior nursing staff to investigate.
- Staff told us complaints were sent to divisional directors and through the communication teams. Lessons learnt were implemented through team meetings and action plans where service improvements were needed.

Are services for children and young people well-led?

Requires improvement



Overall we rated children's services as requiring improvement for being well-led. We were provided with the strategic business plan for children's services which detailed the service must do's to support the trust's strategic aims. When we spoke with staff and senior managers they were unable to describe the vision and strategy for children's services at the hospital.

We had serious concerns over the arrangements for staffing and the number of babies cared for at certain times on the SCBU. We found from January 2015 to April 2015 there had been 10 occasions when there had been more than six babies cared for on the unit at one time. When we checked staffing on these days we found there were a number of occasions particularly on night shifts where there had been one registered nurse and a healthcare assistant caring for the babies. This meant staffing levels on the unit were outside the recommended BAPM guidance on Service Standards for Hospitals providing Neonatal care (3rd edition 2010).

Following feedback to the trust we visited SCBU as part of the unannounced visit. We found escalation plans had been implemented and the manager was able to describe the process and what had been done to manage the risks. During periods of higher demand we found additional staff members were sourced or babies were transferred to other hospital's special care baby units.

Services for children and young people

We found that there was a culture of openness among all the staff and teams we met. Staff spoke positively about the services they provided to children and young people. We observed staff working well together and there were positive relationships within the multidisciplinary team.

Vision and strategy for this service

- We met with the children's services management team who told us in 2012 services for children had changed at the hospital site. For children who required inpatient care for longer than 24 hours this was now provided at other hospitals in the region.
- We were provided with the strategic business plan for children's services which detailed the service must do's to support the trust's strategic aims. For example, one of the must do's was the implementation of the new paediatric pathway model where all emergency, short stay and day care children were managed through front of house. We noted that the strategic business plan did not have any timescales for completion or monitoring information to ensure the service had delivered what was expected.
- During our inspection the day case ward had been closed the previous week and was due to be relocated next to the short stay unit and children's A&E. We saw works were being completed and the unit was due to open the following week.
- When we spoke with staff and senior managers they were unable to describe the future vision and strategy for children's services at the hospital.
- When we spoke with the children's management team about this they stated they had tried to secure additional staff but were unable to confirm if this had happened.
- The management team were also unable to confirm whether the escalation plan had been implemented at this time. Matron told us the situation was monitored and throughout this period risk assessments had been undertaken but not documented.
- We asked the trust to provide a copy of the escalation plan and any documentation of the risks during this period but this had not been provided.
- The clinical lead told us on occasions for periods of time between 6-24 hours babies on SCBU may require non-invasive ventilation. It was unclear from our discussions with the management team whether non-invasive ventilation had been agreed by the neonatal network. The clinical lead told us they thought it had been agreed but the trust has been unable to provide us with information to confirm this.
- The use of non-invasive ventilation for babies would increase the acuity and dependency of the babies in the unit and according to the BAPM guidance this would require one nurse to two babies.
- One of the must do's from the strategic business plan was to ensure the Special Care Baby Unit is adequately staffed at all times due to the isolation of the unit. However during our announced inspection we found this was not always the case.
- Following feedback to the trust we visited SCBU as part of the unannounced visit. We found escalation plans had been implemented and the manager was able to describe the process and what had been done to manage the risks.
- During periods of higher demand we found additional staff members were sourced or babies were transferred to other hospital's special care baby units.
- We were told by staff and senior manager's that 80% of the workforce on SCBU was over 55. We asked for the workforce plan on how the service managed this and mitigated the risk but the trust has not been able to provide the information.
- We found a number of policies and guidelines on the trusts intranet were either out of date or did not follow Royal college of Paediatrics and Child Health (RCPCH)

Governance, risk management and quality measurement

- We had serious concerns over the arrangements for staffing and the number of babies cared for at certain times on the SCBU. We found from January 2015 to April 2015 there had been 10 occasions when there had been more than six babies cared for on the unit at one time.
- When we checked staffing on these days we found there were a number of occasions particularly on night shifts where there had been one registered nurse and a healthcare assistant caring for the babies. This meant staffing levels on the unit were outside the recommended BAPM guidance on Service Standards for Hospitals providing Neonatal care (3rd edition 2010).

Services for children and young people

guidelines for emergency departments. For example, we saw the paracetamol protocol on the intranet was developed in January 2009 however we saw no information on a review/ amended date.

Leadership of service

- Staff told us they felt well supported by the ward managers and the senior management team within the directorate. Staff also reported they felt listened to and their managers were approachable.
- We could not establish if children had a formal board level executive director to promote children's rights and views, as required by the 'National Service Framework for Children, Young People and Maternity Services' standard for hospital services.
- Staff and the children's management team were not aware of a children's lead at board level.

Culture within the service

- We found that there was a culture of openness among all the staff and teams we met. Staff spoke positively about the services they provided to children and young people.
- We observed staff working well together and there were positive relationships within the multidisciplinary team.
- Staff reported they felt valued as "thank you" cards and letters were shared via team meetings and on the staff notice board.

Public and staff engagement

- Trust staff had taken part in the national NHS staff survey in 2014 although results were not available specifically for children and young people's services.
- The national staff survey showed that on a scale of one to five (with five being fully engaged and one being completely disengaged), the organisation scored 3.74. Staff from South Tyneside had a similar engagement score to other organisations of similar size.
- We saw evidence that the service were actively seeking patient and relative feedback through 'I want great care' paediatric questionnaires. We saw the results from these and found the results were positive.
- The ward manager told us they had in the last 12 months met with focus groups for people with learning disabilities or ethnic minority groups to gain feedback on how services could be improved.
- The senior management team told us they had had engagement with the public through consultation processes on the change to children's services at the hospital.

Innovation, improvement and sustainability

- 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.
- Children's services were participating in 'project choice' to provide work experience for a person with learning disability.

End of life care

Safe	Good	●
Effective	Good	●
Caring	Outstanding	☆
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

South Tyneside NHS Foundation Trust provided acute end of life care services from Ward 20 South Tyneside District Hospital which was a 16 bedded mixed sex palliative care / end of life ward for the older person. Palliative care was also provided on the main wards of the hospital including Ward 10 (respiratory medicine), with support from the palliative care specialist nurses.

We spoke with 19 staff including palliative care consultants, specialist palliative care nurses, managers, ward staff and allied health professionals, 11 patients and their relatives and we looked at 6 patient records and 14 do not attempt cardio-pulmonary resuscitation (DNACPR) forms.

Summary of findings

We rated end of life services as good for safe, effective, responsive and well-led, with caring being outstanding. We rated the service as outstanding for responsive.

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 in the top three in the same survey in 2013. The survey covers all 153 acute and specialist NHS Trusts in England that provide adult acute cancer services. 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 treated patients with dignity and respect and patients told us they felt well cared for. Staff supported patients and their families in a timely and appropriate way and involved patients and their families in planning care and treatment. Patients and their families were supported to cope emotionally with their care and treatment and there were systems in place to provide emotional support to staff when required.

Incident reporting was effective and embedded across the service; incidents were investigated and lessons learned were shared. Staff responded appropriately to safeguarding concerns.

End of life care

There were systems and processes for the monitoring of medication, infection control and they were regularly reviewed and improvements made. Staffing levels were monitored and reviewed to keep patients safe and meet their needs. Documentation and care records were completed appropriately. Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed consistently. Equipment was available for patients and appropriate safety checks were in place.

End of life care was evidence based and followed national guidance. There was a multi-disciplinary approach to care and treatment. Palliative care staff were appropriately qualified and competent to carry out their role.

Patients' needs and preferences were important in the planning and delivery of services. An end of life strategy was not in place but a steering group was established to develop a trust-wide strategy across acute and community services. Patients could access services in a way that suited them. Any complaints were dealt with appropriately and any lessons learnt were cascaded to staff. There were governance arrangements in place and the service monitored and audited the quality of the service. Clinical governance arrangements provided assurance that end of life care was being well managed and information about patient experience was collected, reviewed and acted upon. There was evidence of outstanding responses to meet the patient's preference for their place of care.

Are end of life care services safe?

Good



Incident reporting was effective and embedded across the service. When things went wrong incidents were investigated, lessons learned were shared. Staff responded appropriately to safeguarding concerns.

here systems and processes for the monitoring of medication, infection control and they were regularly reviewed and improvements made. There were systems and processes for the monitoring of medication, infection control and they were regularly reviewed and improvements made. Staffing levels were monitored and reviewed to keep patients safe and meet their needs at all times of the day and night. Documentation and care records were completed appropriately. Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed consistently. Equipment was available for patients and appropriate safety checks were in place.

Incidents

- There were no serious incidents or Never Events reported for end of life care.
- Staff understood how to report incidents and feedback from incidents were discussed at team meetings. Patients and their families were informed of the incident and kept informed about the investigation.
- Staff were aware of their responsibilities in relation to duty of candour and being open with patients when incidents occurred.
- During 2014-2015 there were 175 incidents recorded and the top three themes were falls, pressure damage and medicine related.
- Incidents were reported into the trust risk management system via Datix, an electronic reporting system and staff were familiar with its use.
- The palliative care service held a forum to review incidents and share lessons learned. For example, staff told us they had discussed the importance of the timely completion of death certificates. All staff were invited to attend.

Safety Thermometer

End of life care

- Wards displayed safety thermometer information on the ward and reports were presented to the trust board. For example, in March 2015 Ward 20 scored 91.7% for harm free care and Ward 10 scored 96.6% for harm free care.

Cleanliness, infection control and hygiene

- The trust integrated audit for 2014 showed 100% of Elderly, End of Life & Specialist Palliative Care staff had completed infection control training within the last year.
- Staff adhered to 'bare below the elbow'. Personal Protective Equipment was available for all staff.
- The ward areas visited were visibly clean, bright and well maintained. Surfaces and flooring were covered in easy to clean materials allowing hygiene to be maintained at all times.
- The mortuary, waiting and viewing areas we visited were clean. The flooring in the mortuary was easy to clean allowing good hygiene to be maintained throughout the day.
- Guidance was available for staff in the Care of the Dying and Deceased Patient–Acute Services Policy to reduce the risk of infection when providing care to patients at end of life. There was also guidance for staff to follow when caring for a patient after death.

Environment and equipment

- The trust used a McKinley syringe driver across the trust for administration of end of life medications. Access to syringe drivers was available for patients needing continuous pain relief.
- Equipment was maintained and checked to ensure it was safe to use.
- The mortuary had secure access to prevent inappropriate admission to restricted areas and was being refurbished to include an increase in the number of fridges.
- The patient welfare officer shared an office with other general office staff. They told us that sometimes when they are speaking with families when on the telephone, it could be difficult to hear them due to the coin counting machines used by the parking staff being noisy. when on the telephone. We brought this to the attention of the medical director at the time of the inspection.

Medicines

- Medication for end of life care was available and medication was prescribed appropriately and in a timely manner by medical staff.
- There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management. Nursing staff told us that these were readily accessible along with regular access to pharmacist advice.
- Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Records were kept of the usage of controlled drugs so as to readily detect any loss.
- Arrangements were in place to ensure that medicine incidents were reported and fully investigated and we found there was an open culture around reporting medicine errors.
- We saw a system in place for managing national alerts about medicines such as safety issues.
- The Specialist Palliative Care Nurse was trained and assessed in the safe handling of medicines. Training was competency based and could be provided for specific identified needs.

Records

- Records were stored in lockable trollies.
- The trust was implementing new regional care of the dying documentation and was piloting the documentation on two wards in the hospital. The specialist palliative care nurse was facilitating the implementation on the wards.
- The specialist palliative care nurse had daily visits to the wards to review the use of the care of the dying documentation and she also completed weekly audits of the documentation.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed for patients if indicated and were kept with the care plans. We looked at 14 DNACPR forms. The forms were completed and signed appropriately and records of discussions with patients and their families were recorded in the patient's medical notes. These included the decisions made not to resuscitate. Entries made by medical staff included the detailed information on the conversations and discussions with the patient and their family.
- Care plans and DNACPR forms were kept in a yellow envelope on discharge and sent with the patient to

End of life care

ensure information was shared appropriately between all services including GPs and the ambulance service. Drug information was also shared via a green envelope system.

- In the mortuary there were systems in place to record the acceptance of deceased patients and for their release to the undertakers.

Safeguarding

- There were policies and procedures for safeguarding vulnerable adults and children.
- Staff were aware of the process for raising concerns for vulnerable adults and children. Staff could explain when they would escalate and refer concerns to safeguarding.
- Palliative care staff told us they received safeguarding training. We reviewed the safeguarding training for specialist palliative care nurses and found 100% of staff had completed safeguarding children level 1 training; and 20% had completed safeguarding children level 2 training. 67% of staff had completed safeguarding adult training.

Mandatory training

- Staff told us they had access to mandatory training which included medical devices training, slips trips and falls, infection control and fire safety.
- We looked at the mandatory training for specialist palliative nurse and training rates for staff was between 40% for medical devices training and 83% for slips trips and falls.

Assessing and responding to patient risk

- We looked at care records for patients receiving end of life care and we found risk assessments were completed and care plans contained information to enable staff to provide the care required to meet patient need.
- The specialist palliative care nurse reviewed patients on a Friday and if there were concerns the patient may deteriorate over the weekend, she developed a plan for the ward with contact details for the hospice and also informed the hospice staff about the patients she was concerned about.
- We looked at the integrated audits for 2014 completed by the medicine directorate. We found Ward 10 had scored 100% for evidence of regular assessment updates and any changes of care were discussed and documented with the people/carer.

Nursing staffing

- There was one Macmillan nurse specialist who supported staff on the wards. They saw patients with complex needs and provided education and training for staff.
- There were six discharge liaison nurses who worked across all wards, urgent care and the assessment units. They also worked with the ambulance service to facilitate patient discharges.
- There were four training and education staff, based at St Benedict's Hospice, who provided palliative care training across the trust.

Medical staffing

- The trust has recruited two palliative care consultants who are due to commence working with the trust in September. A third consultant was in the process of being recruited and interviews were scheduled for the week following the inspection.
- Medical cover on Ward 20 was provided by the medical director and he had two ward rounds a day.
- There was on call consultant telephone advice cover provided by St Benedict's Hospice out of hours and at weekends. In the South Tyneside locality the on call telephone advice was provided through St Clare's Hospice in the first instance who would contact St Benedict's if required.
- Junior doctors attended palliative care resource days run by the palliative care team. Doctors also spent time working with the palliative care team as part of their rotation.

Major incident awareness and training

- There was a contingency plan for the mortuary to use other NHS providers in the area if a major incident was declared.
- The trust had implemented a winter pressure project with the objective to avoid unnecessary hospital admissions and facilitate rapid discharge for patients with palliative/end of life care needs during the winter period.

End of life care

Are end of life care services effective?

Good



End of life care was evidence based and followed national guidance. Patients received care and support based on best available evidence and care was appropriately tailored to meet the needs of the patient and their families. There was a multi-disciplinary approach to care and treatment. Palliative care staff were appropriately qualified and competent to carry out their role.

Evidence-based care and treatment

- End of life care followed national guidance and information was available on the wards and on the trust intranet.
- End of life services followed National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care Guidance, 2011, updated 2013. There was a specialist palliative care team and an out of hours telephone service which provided support 24 hours a day.
- There was a policy for the care of the dying and deceased patient in acute services. The policy provided guidance for professionals involved in dealing with the death of a patient. It outlined the requirements staff adhere to by law, as well as the practical and sensitive issues which need to be addressed at a very distressing time for patients and their families.
- On ward 10 we found in the integrated audits for 2014 showed 100% of patient records demonstrated the use of regularly reviewed, evidence based policies/guidelines to inform patient's care planning.
- The trust contributed to the National Care of the Dying Audit (NCADH) 2013/14. The trust achieved the following organisational Key Performance Indicators (KPI)s which included access to information relating to death and dying; clinical protocols for the prescription of medications for the 5 key symptoms at the end of life and clinical provision/protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient.

- The trust did not achieve the five organisational KPIs which included access to specialist support of care in the last hours or days of life; care of the dying; and formal feedback processes regarding bereaved relatives/friends views of care delivery.
- The trust had reviewed their documentation in response to the national review of the Liverpool Care Pathway and had introduced regional care of the dying documentation and priorities of care in the last days of life.

Pain relief

- Patients who were identified as being at end of life were prescribed anticipatory medication. Anticipatory medications were prescribed in advance to manage changes in symptoms and pain.
- The medicine directorate completed an integrated audit 2014 into the care of patients which included the management of pain. For example, Ward 10 and Ward 5 scored 100% for the management and prevention of pain.

Nutrition and hydration

- The wards had protected meal times to allow staff to assist patients who needed help. Care plans included information on nutrition and hydration.
- Risk assessments and care plans showed how to support a patient who was at nutritional risk. In the care plans we looked at, we saw food and fluid charts were completed to monitor input and output effectively.

Patient outcomes

- The trust measured their performance: in 2014/2015 there were 197 hospital referrals with 79% from oncology services and 21% from other services. 24% of the caseload died in hospital.
- The out of hours service received 337 new referrals from South Tyneside District Hospital. There were 250 deaths and 249/250 patients died at home and one patient died in the hospice. There were no deaths in hospital.
- The trust contributed to the National Care of the Dying Audit (NCADH) 2013/14. The trust achieved the following organisational Key Performance Indicators (KPI)s which included access to information relating to death and dying; clinical protocols for the prescription of

End of life care

medications for the 5 key symptoms at the end of life and clinical provision/protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient.

Competent staff

- The palliative care team were specialist nurses who had access to specialist training and support.
- Training was offered to non-specialist staff by the palliative care education team and staff based at St Benedict's Hospice.
- 'Deciding Right' is a new north east initiative about making care decisions in advance. 'Deciding Right' training was available for staff to attend. Within the medicine directorate 88% of staff on Ward 10 had attended 'Deciding Right' training.
- However in the surgery directorate we found 10% of staff on Ward 7 and 50% of staff on Ward 9 had attended 'Deciding Right' training.
- There was a six week palliative care training course available for staff to attend. Within the Medicine directorate 81% of staff on Ward 10 had attended palliative care training courses either at St Benedict's Hospice or as part of a degree course.
- However in the surgery directorate 25% of staff on Ward 7 and 24% of staff on Ward 9 had attended palliative care training courses.
- Staff told us there were specialist palliative care nurses and services to support patients. We found 100% of staff on all wards were aware of the range of specialist palliative care services available to support patients and how to access them.
- The consultant at St Benedict's Hospice provided training to junior doctors.
- The trust had a process for annual appraisals and we found 100% of specialist palliative nurses and 75% of the discharge team had had an appraisal in 2013-2014. Staff told us they had a yearly appraisal and were able to discuss training requirements and any concerns.
- Staff told us they do not have formal supervision but can access support from managers informally.
- Porters and patient welfare staff told us they had not received any end of life or bereavement training.

Multidisciplinary working

- The 2014 trust integrated audit for Ward 10 in medicine scored 100% for evidence of an individualised comprehensive plan of care which reflected that

multi-agency working occurs where appropriate and the same score for staff being aware of the range of specialist palliative care services available to support patients

- The services (which included district nursing, equipment services, GP and Out of Hours specialist nurses) worked well together to co-ordinate and plan the care of the patient at the end of life. The service also included spiritual support from the chaplaincy team. Patient welfare staff also provided support after the death of the patient.
- The service also had access to a palliative care social worker who worked with the specialist palliative care team to support with discharges and support to patients and their families at the end of life.

Seven-day services

- The discharge nurses were available Monday to Friday 9am to 5pm.
- There was access to a specialist palliative care community team for staff and patients and their families.
- There was 24 hour access to the out of hours palliative care services via St Clare's Hospice who would contact St Benedict's Hospice as required and a palliative care advice line available to staff, patients and their families.

Access to information

- Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed for patients if indicated and were kept with the care plans.
- Care plans and 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. Also drug information was also shared via a green envelope system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- During our inspection we saw and heard staff sought the consent of patients before providing care. We observed that staff communicated sensitively with patients.
- The trust had a Mental Capacity Act policy and the priorities of care in the last few days of life

End of life care

documentation included information about advance decisions. Staff were reminded to involve patients and those important to them to be involved in any decisions about care and treatment.

- The integrated audit for 2014 showed 100% of Elderly, End of Life & Specialist Palliative Care staff were aware of and able to access the current 'Consent' Policy.

Are end of life care services caring?

Outstanding



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 in the top three in the same survey in 2013. The survey covers all 153 acute and specialist NHS Trusts in England that provide adult acute cancer services. 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 treated patients with dignity and respect and patients told us they felt well cared for. Staff supported patients and their families in a timely and appropriate way and involved patients and their families in planning care and treatment. Patients and their families were supported to cope emotionally with their care and treatment and there were systems in place to provide emotional support to staff when required.

Compassionate care

- The specialist palliative care team sent out Families and Friends Test questionnaires to families and these are reviewed quarterly. In January and March 2015, 100% of respondents would recommend the service to family and friends.
- Patients and their families were treated with dignity and respect. Staff ensured curtains were closed to protect patients' privacy and dignity when personal care was being given.
- Staff continued to treat patients with dignity and respect after their death. We observed deceased patients were shrouded and covered to maintain their dignity. Staff told us that patients were covered prior to and after a

post mortem examination whilst on the examination table to maintain dignity and we observed mortuary staff referring to the deceased patient in a respectful manner.

- A male patient was admitted to A&E; the patient did not wish to die in hospital and care was given to ensure he could return home to die. The service arranged for a bed to be delivered to his home with 1.5 hours by the out of hours service and increased his care package by arranging a carer for overnight to support the family. The patient was discharged within two hours of arrival in A&E with the care package in place.
- Another patient was admitted who did not want to die at home. The service arranged for end of life care to be given on the Emergency Admission Unit. The patient received end of life care and died peacefully and with dignity on the ward.

Patient understanding and involvement

- Patient records we reviewed showed detailed discussions with the patient and their families about their care and treatment. Discussions were recorded in a sensitive way.
- We observed staff approaching patients and speaking quietly and gently saying who they were and explaining what they were doing. They also used touch to alert the patient when approaching.
- Priorities for the last day of life care plans were developed with patients and their families.
- The trust provided a booklet to relatives for guidance on registering a death and organising a funeral. An information leaflet was available for patients and their relatives about the role of the specialist palliative care nurses and how to contact them.

Emotional support

- 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 in the top three in the same survey in 2013. The survey covers all 153 acute and specialist NHS Trusts in England that provide adult acute cancer services. 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.

End of life care

- Chaplaincy services were available to patients and their families., tThe trust employed two chaplains who were supported by volunteers. The chaplaincy service could access spiritual leaders from other faiths to ensure patients' religious beliefs were observed. The chaplaincy held a memorial service at the crematorium twice a year and would attend the wards to anoint patients with 'sacraments of the sick' and to undertake baptisms.
- The wards had bereavement link nurses and there was a bereavement midwife to provide support to patients and their relatives.
- Staff on Ward 10 had recently experienced a number of deaths. The ward manager had organised de-briefing sessions for the staff which included consultant feedback, chaplaincy support, reflective sessions and clinical psychology support for staff if desired.

Are end of life care services responsive?

Good



Patients' needs and preferences were important in the planning and delivery of services. The involvement of other organisations and the local community was important to how services were planned to ensure patients' needs were met. Patients could access services in a way that suited them. Any complaints were dealt with appropriately and any lessons learnt were cascaded to staff. The service would listen to the needs and concerns of individual patients and adapt the services to meet their need. We reviewed the care of patients with specific preferences about their preferred place of care; there was evidence of outstanding examples of responsive care.

Service planning and delivery to meet the needs of local people

- The trust met with commissioners, and other providers to review, design and deliver end of life care to meet the needs of patients.
- Services provided were person centred and discharge was planned to ensure patients were cared for in their preferred place of care.

Access and flow

- Patients were seen by the palliative care team within 24 hours of referral. When a patient was identified as near

the end of life, the palliative care team provided advice and support to ward staff on the care of the patient. The patient would remain under the care of local ward staff with continued support from the specialist palliative care team.

Discharge and transfer

- There was a discharge team which could fast track patients discharge to their preferred place of care. There was a rapid discharge process to enable patients to be discharged home from hospital in last hours/ days of life. One example was a patient who was admitted to A&E from home. She did not wish to die in hospital so staff arranged a fast track discharge home the same evening and the lady died at home the next morning.

Meeting people's individual needs

- The specialist palliative care nurse did daily visits to the wards to review patients who were on priorities of care in the last days of life and provided support and guidance to staff.
- The service would listen to the needs and concerns of individual patients and adapt the services to meet their need. We reviewed the care of patients with specific preferences about their place of care.: Outstanding examples included oOne patient who was at the end of her life and did not want to go to the mortuary after she died. The staff organised for the patient's body to be released straight to the funeral director so that she did not have to go to the mortuary.A male patient was admitted to A&E; the patient did not wish to die in hospital and care was given to ensure he could return home to die. The service arranged for a bed to be delivered to his home with 1.5 hours via the out of hours service and increased his care package by arranging a carer for overnight to support the family. The patient was discharged within two hours of arrival in A&E with the care package in place.Another patient was admitted who did not want to die at home. The service arranged for EOL care to be given on the Emergency Admission Unit. The patient received EOL care and died peacefully and with dignity on the ward.
- Patients were cared for in side rooms on the main wards of the hospital and there were 16 palliative care beds on Ward 20 so patients could be in quiet and calm surroundings. There were relative rooms available with sofa beds and chairs, microwave, fridge and kettle.

End of life care

- There was a single viewing room where families were able to spend time with their deceased relative.
- There was a chapel and multi-faith room available for patients and their relatives to use. The multi-faith room had equipment and resources for other faiths, for example the Qur'an and prayer mats were available. However the signage for the multi-faith room was only on the door to the room and it was difficult for people to find the room. We raised this with the medical director at the time of the inspection who told us they would review the signage for the multi-faith room.
- Information was available about services for patients and their families who were at end of life. For example, there was information about the hospice services in the area, and different types of nurses who may provide care such as district nurses, community matrons and the out of hours palliative care team.
- Families attending viewings at the mortuary were not provided with parking close to the mortuary and staff felt that this could be stressful for the families at the time of bereavement.
- The patient welfare office was small and did not have facilities to store patient belongings. We observed plastic bags containing patient belongings were stored in a pile in the corner of the room. We brought this to the attention of the medical director at the time of the inspection.
- Access to translation services was available. Signers were available for patients with a hearing impairment.

Learning from complaints and concerns

- The service told us they received low numbers of complaints. Staff told us they try to address any issues and concerns at a local level before they became complaints.
- The trust had a complaints policy. In Quarter 4, 2014-2015 palliative care services had received two formal complaints and no informal complaints. Complaints were discussed at the monthly governance meeting and any themes, trends and lessons learned were shared with staff.

Are end of life care services well-led?

Good



There were governance arrangements in place and the service monitored and audited the quality of the service. Clinical governance arrangements provided assurance that end of life care was being well managed. Information about patient experience was collected, reviewed and acted on. Staff felt supported, valued and respected by managers who were approachable.

Vision and strategy for this service

- The service had a strategic business plan for 2014 to 2019. The plan included actions for the service to support delivery related to the trust corporate objectives. For example, the service had identified a minimum of 5% cash releasing Cost Improvement Plans with any significant changes in income or expenditure, and any potential risks identified.
- There was not an end of life strategy in place. However, we saw the terms of reference for the Palliative, Supportive and End of Life Steering Group formed in 2015 whose objectives included to develop and deliver a strategic action plan for palliative, supportive and end of life care throughout the Trust, to identify and support the implementation of national and local policy, strategies and initiatives to meet locally determined needs and to oversee the delivery of the NHS England Actions for End of Life Care 2014-2016.

Governance, risk management and quality measurement

- Governance systems were in place to ensure learning and improvements were shared across the service.
- There was a palliative care risk register which was monitored and controls were in place and reviewed to reduce the impact of risk.
- There were systems in place to monitor and audit the quality of the palliative care service. These were discussed at monthly governance meetings.
- Staff understood how to raise and report incidents. Sharing of lessons learned was used to improve practice and quality across the service.

Leadership of service

End of life care

- Staff were supported by specialist nurses but there was limited medical support due to consultant vacancies which had been recruited to but there was a delay in start dates until September 2015. However, there was medical support from the medical director and consultants at St Benedict's Hospice.
- Ward staff felt supported by the palliative care nurses who visited the wards every day and described them as approachable and accessible to provide advice.
- Staff felt the service was committed to provide continuous improvement of care for patients receiving end of life care.

Culture within the service

- Palliative care staff worked collaboratively with staff on the wards to provide high quality care to patients. They worked to ensure patients had positive outcomes in their care and that it was provided in their preferred place of care.
- Staff told us there was a culture of sharing knowledge through formal and informal training.






Public and staff engagement

- 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.

Innovation, improvement and sustainability

- The service had introduced a card with prompts for staff on the priorities of care in the last few days of life.

Outpatients and diagnostic imaging

Safe	Good	
Effective		
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The South Tyneside NHS Foundation Trust had outpatient departments in 4 locations across the site at South Tyneside District Hospital as well as Palmer Community Hospital, Jarrow. The trust offered outpatient appointments using via a choose and book system and in the previous 12 months had seen 165,599 patients. Of these, 52,992 were new appointments and 99,359 were review appointments.

There was a main outpatient department and three other outpatient departments where specialty-specific clinics such as cardiology and oncology were held. There was one main radiology and imaging department and a separate MRI (magnetic resonance imaging) department.

The outpatient departments ran a wide range of clinics, some nurse-led, some led by allied healthcare professionals and some by doctors or Clinical Physiologists across a large number of specialties such as cardiology, oncology, diabetic medicine, gynaecology, orthopaedics, general surgery, ophthalmology, respiratory medicine, stroke and trauma.

Most imaging services were conducted from one location on the site. Diagnostic imaging services included plain x-rays (including mobile x-ray), CT, ultrasound and interventional procedures including fluoroscopy. MRI scanning services were delivered in a specially designed imaging department. The radiology service had carried out over 103,000 procedures in the year prior to our inspection. There was a Medical Physics Department on site but this was managed and staffed by a neighbouring Trust.

Palmer Community Hospital, Jarrow provided Children's outpatients, diabetes and gastro-intestinal outpatient services as well as a plain-x-ray radiology service. Data from those services is included in this report. However, the inspection team did not inspect the community hospital because levels of activity were low and no outpatient clinics were running when we planned to visit.

During the inspection we spoke with 35 patients and eight people close to them, six senior managers, five nurses, five doctors, four radiographers, four healthcare assistants and four administrative staff. We observed the radiology and outpatient environments, checked equipment and looked at patient information.

Outpatients and diagnostic imaging

Summary of findings

Overall, the care and treatment received by patients in the South Tyneside NHS Foundation Trust outpatients and imaging departments was safe, effective, caring, responsive and well-led. Patients were happy with the care they received and found it to be caring and compassionate. Senior staff understood their duty of candour and demonstrated an open and honest culture.

Clinical areas were clean and tidy. A volunteer service was active and effective in the main outpatients to provide extra support to patients. Food and drink was readily available and staff were keen to help all those they came into contact with. Staff were proud to work in the departments and were supported by managers and policies to reduce risks and work within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their health conditions.

We inspected the Radiology and MRI departments, Main Outpatients, Oncology, Cardiology and Moorlands day unit. We also visited the phlebotomy service and the plaster room. All departments had carried out service reviews and had taken positive action to reduce waste in terms of time, space and resources to provide improved patient experiences. Electronic records systems were used and were being increased. Service planning for the future took patient needs and demand into consideration. On the whole, the services offered were delivered in an innovative way to respond to patient needs and ensure that the departments work effectively and efficiently.

The main outpatients department was situated in the main hospital building with a separate entrance from other major departments. Outpatient services were available Monday to Friday from 8:45am to 5:30pm and some clinics were available on Saturdays. Diagnostic imaging services were in operation seven days a week with continuing improvements and expansion planned for the future. Several clinics and related services were organised so that patients were only required to make one visit for investigations and their consultation. Some patients' conditions were monitored remotely which reduced the need for some very frequent or urgent appointments.

Are outpatient and diagnostic imaging services safe?

Good



The level of care and treatment delivered by the outpatient and imaging services was good. Staffing levels were based on the knowledge and expertise of department managers and were flexible to meet the different demands of clinics and patients. There were some vacancies across the departments, however these were being recruited to and there were sufficient staff to make sure that patient care was not compromised.

Incidents were reported using the hospital's electronic reporting system. Incidents were investigated and lessons learned were shared with all staff. The cleanliness and hygiene in the departments was within acceptable standards. Personal protective equipment was readily available for staff and was disposed of appropriately after use.

Staff were aware of the various policies designed to protect vulnerable adults or those with additional support needs and we saw good examples of actions being taken to address them. Patients were asked for their consent before care and treatment was given. Staff were clear about who could make decisions on behalf of patients when they lacked or had fluctuating mental capacity. Patients were protected from receiving unsafe care because medical records were available for outpatient clinics, with very few exceptions and electronic records were available to supplement these if necessary. Staff in all departments were aware of the actions they should take in the case of a major incident.

There were some areas that needed improvement that the trust had identified for themselves such as the regular checking of resuscitation equipment in the outpatients department and some mandatory training for diagnostic imaging staff. There was no identified waiting area for children and no toys or other means of distraction and entertainment were available for their use in the main outpatients department at South Tyneside District Hospital. Some waiting areas such as in Phlebotomy experienced shortages in space and seating.

Incidents

Outpatients and diagnostic imaging

- The trust used an electronic system to record incidents and near misses. Staff we spoke with had a good working knowledge of the system and said they could access the system and knew how to report incidents. Staff were able to give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.
- The departments had robust systems to report and learn from incidents and to reduce the risk of harm to patients.
- There had been no never events reported and 6 serious incidents occurred between February 2014 and January 2015. Three other incidents occurred within outpatients, all between October and December 2014. They were due to missing patient notes, missing pathology results and verbal abuse from a relative.
- There had been no serious incidents reported in outpatients in the previous 12 months.
- There had been 7 radiological incidents reported under ionising radiation medical exposure (IR(ME)R) in the previous year. All of these were low level and included radiology staff failing to check the patient's previous imaging pathway fully which resulted in the patient receiving the incorrect imaging and 5 incidents of incorrect patients being referred for a procedure. Trusts are required to report any unnecessary exposure of radiation to patients. There was evidence that these had each been investigated, clear actions had been taken and appropriate action plans implemented as a result of learning.
- Staff told us that safety and security did not cause concerns for staff but the reception staff could access a "green dot" on their computers to summon help if needed.
- Staff were aware of their responsibilities in terms of the recently introduced Duty of Candour regulations and all staff described an open and honest culture.
- We observed a Radiological Reporting Discrepancy meeting where Radiologists took the opportunity to learn, work as a multidisciplinary team with referring clinicians and exercise the primary stage of duty of candour when agreeing that a patient should be informed of a reporting error.

Cleanliness, infection control and hygiene

- The outpatient sister was the infection control link nurse for the department and carried out regular

hand-washing audits. Compliance was consistently high and results were fed back to staff at group huddles and collated for Infection Control. The results were displayed on the department notice boards.

- Personal protective equipment (PPE) such as gloves and aprons were used appropriately and available for use throughout the departments and, once used, was disposed of safely and appropriately. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- A poster was displayed showing cleanliness expectations in clinics and hand gel was available for patients, visitors and the public to use. Dispensers were clean and well stocked.
- The imaging department, outpatient areas and clinic rooms were clean and tidy and we saw staff maintaining the hygiene of the areas by cleaning equipment in between patient use, reducing the risk of cross-infection or contamination.
- We saw that treatment rooms and equipment in outpatients were cleaned regularly. Imaging equipment was cleaned and checked regularly. Rooms used for diagnostic imaging were decontaminated and cleaned after use. Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly. The trust conducted cleaning audits to ensure that all areas had been checked and signed off clean.

Environment and equipment

- Cardiology and main outpatient department equipment was calibrated, maintained and replaced on an annual rolling programme, managed by the estates department. Ophthalmology equipment was managed and maintained by departmental staff. Equipment was new and of a high specification.
- All areas we inspected were clean, well maintained and most areas were spacious. Consulting, treatment and testing rooms were well stocked, and equipment labelled as clean was clean. The only infection control concern was a carpet that appeared to be dirty in the reception area.

Outpatients and diagnostic imaging

- Resuscitation trolleys and equipment including suction and oxygen lines were all checked and cleaned daily and checklists were signed and found to be up to date. Trolleys were locked and tagged and staff made weekly checks of contents and their expiry dates.
- A standard work compliance audit which measured resuscitation trolley and defibrillator checks was carried out weekly. Results were regularly 100% in radiology but had dipped to 50% on 4 weeks out of 7 in outpatients.
- During our observations we saw that there was clear and appropriate signage regarding hazards in the imaging department.
- Staff wore dosimeters in radiology. This was to ensure that they were not exposed to high levels of radiation.
- In diagnostic imaging, quality assurance checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protected patients against unnecessary exposure to harmful radiation.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging.
- PGDs (patient group directions) for drugs used commonly in the department were in place for adrenaline, saline and a new one was being developed for Omnipaque.
- Radiology staff administration of medication competencies were checked and training records were seen by the inspection team.

Records

- Records in the outpatient department were paper based. Within the imaging department, records were digitised and available to be viewed across the trust.
- Records contained patient-specific information relating to the patient's previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- There were examples of medical records not being stored securely. We saw some reception desks were not staffed at all times and patient notes were left closed but in view of passers-by. In one clinic reception area patient records for clinics were stored in a trolley. The trolley was used to prop the door to the reception desk open meaning that the records were available and in public view for anyone to take away. There were lockable cupboards inside reception areas which were left open. These contained patient records for that morning or afternoons clinics. We saw a number of staff walk in and out of reception to take the records from the cupboard. Any non-authorised person could have done the same.
- Patient notes were delivered to the department at 8am every day in sealed bags. Notes were then stored under the lips of desks to maintain confidentiality. Following clinics, nurses routinely stored notes in sealed trollies for transport to the secretaries. Notes for patients who did not attend (DNA) were returned to medical records in sealed bags.
- Information sent to us by the trust showed that patient notes unavailable at the time of an outpatient appointment were measured at less than 1%. When notes were not available information was available through the electronic PAS (patient administration system) to track them to their most recent location. Some letters and discharge summaries were stored electronically. The two systems complemented each other and provided back up on the rare occasions that patients' notes were unavailable. Staff were able to contact the patient's GP or other referrer to discuss the

Medicines

- We checked the storage and management of medicines and found effective systems in place. No controlled drugs were stored in the outpatients department. Small supplies of regularly prescribed medicines were stored in locked cupboards and, temperature-checked fridges. Outpatient nurses undertook monthly medication audits and each nurse was responsible for their own room. All medicines we checked were in date.
- Palmer Community Hospital outpatients department used FP10 for prescriptions and at the main site they used hospital prescription pads because there was an onsite pharmacy. All were kept securely and locked away at the end of every clinic.
- Pharmacy sent out drug alerts and these were discussed at monthly team meetings to make sure all members of the team received the information and took the required action.
- In the diagnostic imaging department some interventional procedures required sedation, and a consultant, nurse and allied health professional such as a physiologist or radiographer were present and observations were carried out and recorded.

Outpatients and diagnostic imaging

history if necessary and request copies of referral letters. Staff agreed that a patient would always be seen as long as there was some information about them available. Missing notes were reported as incidents using the Datix system.

- Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatient department. We observed these checks being undertaken during our inspection.
- Diagnostic imaging and reports were stored electronically and available to clinicians via PACS (Picture Archiving and Communications System).
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were stored electronically and were easily accessible to all diagnostic imaging staff.
- The diagnostic imaging department kept a list of approved referrers and practitioners. This ensured that only staff, both internal and external, could be vetted against protocol for the type of requests they were authorised to make.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation were recorded. An electronic radiology information system was used which ensured that the correct and most up to date information was kept on the system.

Safeguarding

- All staff we spoke to were aware of safeguarding policies and procedures and knew how to report a concern. They knew that support was available if they needed it or they had a query. There was a contact number displayed to contact the safeguarding team.
- According to information provided by the trust, 98% of applicable staff had undergone safeguarding children level two training. 97% of applicable staff had undergone safeguarding adults training.
- Patient details for those who do not attend appointments were checked by staff for any issues of concern. In the week previous to our inspection two patients were followed up after failing to attend and were found to have social issues of concern. The safeguarding team were contacted and staff informed them of their concerns. Staff had received feedback that one concern had identified a safeguarding need.

- Safeguarding adults level 2 compliance was only 13% for Radiology staff. We were told that more courses were planned in the near future and staff would book places as soon as they became available.

Mandatory training

- Mandatory training was well managed in both departments with dates of courses displayed in staff areas. Training delivery alternated annually between classroom based sessions and e-learning.
- The outpatient and imaging departments had systems and processes to ensure staff training was monitored.
- Training was accessed by via e-learning and classroom-based training sessions.
- All staff in the outpatient department were up to date with mandatory training.
- Mandatory training compliance for radiology varied and the rates were: for Fire Safety 99%; infection prevention and control 99%; Health and safety (including sharps and falls) 98%; patient handling 98%; mental capacity 61% and information governance 99%. We were told that the only course currently unavailable for bookings was Safeguarding children Level 3, for practitioners who worked directly with children. The staff development department were expected to release some more dates in the near future. The rates for other training identified as mandatory by the trust were low and these areas included: equality and diversity 30% and waste management 22%. However, we were not able to identify a trust standard for mandatory training compliance.
- The expected rate of compliance of the trust is 75%

Assessing and responding to patient risk

- There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms and imaging areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- Staff were aware of actions to take if a patient's condition deteriorated while in the department and explained how they could call for help, access the cardiac arrest team and the process for transferring a patient to the Accident and Emergency Department. There were also a number of resuscitation trolleys and defibrillators across outpatients and imaging departments which were available.

Outpatients and diagnostic imaging

- There were policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances was managed and minimised.
- The Radiation Protection Adviser report from March 2014 highlighted that all new equipment had been risk-assessed to ensure the safety of staff and patients.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. (IR(ME)R). Staff were able to contribute to and inform working practices. An example of this was that the CT policies had recently been updated by the senior radiographer and were awaiting authorisation by the trust protocols panel before being published on the intranet.
- There were named certified Radiation Protection Supervisors to give advice when needed and to ensure patient safety at all times. The trust had radiation protection supervisors (RPS) and liaised with the Radiation Protection Advisor (RPA).
- The senior radiologist was the Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holder for the Medical Physics elements of diagnostic imaging. Their role was to be available and contactable for consultation and provide advice on aspects relating to radiation protection concerning medical exposures in radiological procedures. They led on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. (IR(ME)R).
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and imaging work to national guidance and vary depending on setting. Policies and processes were in place to identify and deal with risks. This was in accordance with (IR(ME)R 2000).
- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks.
- Outpatients and diagnostic imaging used early warning scores to monitor and manage patient risk. Patients were assessed and given scores which indicate how the patient was then managed and treated.
- Some patients with pacemakers used telemedicine as a means of remote monitoring to record activity and a daily report was shown on a screen to alert staff to problems. Pacemakers used a Bluetooth receiver to signal any problem. Staff were able to carry out verbal checks with patients by telephone and some adjustments could be made by patients following verbal instructions. Other adjustments would need to be made in the department. Staff reported that the use of this technology had helped to increase clinic capacity as well as improving patient experience.
- CQC IR(ME)R information forwarded to the inspection team showed that the Radiology Department were compliant with safety regulations and the number of incidents reported gave no cause for concern.

Nursing and allied health professional staffing

- We looked at the staffing levels in each of the outpatient and diagnostic imaging departments. There were some vacancies; however, all department managers told us that staff were flexible to be able to ensure cover was available. There were no departments with significant vacancies that would affect the way they were able to function. Staff told us there were sufficient staff to meet service and patient needs and that they had time to give to patients.
- There was a skill mix review under way to identify best work force requirements to support effective working within the department.
- Managers told us they were able to adjust the number of staff covering clinics to accommodate those that were busy or where patients had greater needs. The managers in the outpatient departments were experienced staff who were very familiar with the clinics running in their departments as well as the dependencies of the patients attending them.
- Within the imaging departments, there were sufficient radiography and nursing staff to ensure that patients were treated safely. There were current vacancies; however, these were being recruited to. Radiology had 3 nurses who assisted with interventional procedures as well as running a nurse-led service for hysterosalpingograms; a procedure to show patency of the fallopian tubes.

Outpatients and diagnostic imaging

- Planned and actual numbers of staff on shift matched demand.
- Sickness was monitored and we were told that outpatient staff sickness rates were consistently very low. However, we did not receive evidence of sickness levels within the outpatient department.
- Sickness levels in diagnostic imaging had been higher than usual at 10% for the previous month, mainly due to long-term sickness. There were particular problems in the additional clinical services team (16.34% How many people?) with sickness. Occupational health and human resources had been supportive and 2 members of the team had recently returned to work.
- Recent sickness amongst the radiology team had depleted numbers but staff commitment was reported as being very high to ensure good service was maintained.
- Radiographers staffed the department over 3 shifts, including a night shift. There were sufficient staff on duty at all times to meet the needs of the service and the actual numbers of staff on duty matched the planned staffing for all requirements.
- Radiographers and radiography assistants were registered with the hospital bank and carried out additional shifts if needed.

Medical staffing

- Medical staffing was provided to the outpatient department by the various specialties which ran clinics. Medical staff undertaking clinics were of all grades; however we saw that there were always consultants available to support lower grade staff when clinics were running.
- Staff told us that locums were used within the outpatient clinics depending upon the staffing levels of the specialty.
- There was a national shortage of radiologists but at the time of our inspection there were sufficient staff to provide a safe and effective service. There were 4 full time consultant radiologists and 2 full time locum consultants. There were 2 Specialist Registrars and 1 Foundation level 2 doctor attached to the department on rotation.
- A full-time locum consultant radiologist had recently been appointed and had completed local induction and orientation, and was informed of the local rules for each

modality and piece of radiological equipment. The trust had gained assurance of their competence and skills through the agency and conducted peer review and supervision.

- One consultant radiologist who had previously held a substantive post had moved to an outsourcing company and was employed on a bank basis. The senior radiologist managed training needs analysis, appraisals and checked reports for discrepancies for both staff.

Major incident awareness and training

- A major incident policy and a folder was readily accessible to staff with information about what to do and who to contact in the case of a major emergency.
- Comprehensive business continuity plans were in place to make sure that each specific department was able to continue to provide the best and safest service in the case of a major incident. These also covered staffing shortages, electronic system failures and equipment breakdowns. We observed the plans being actioned in radiology when staff were requested to move from one speciality to another to cover staff absence and, on the day of our arrival, when the MRI scanner had broken down. These plans were put into practice with ease and efficiency and normal service was resumed quickly following the breakdown. The staffing problem did not affect the service to patients.
- The radiology interventional room had undergone a recent refurbishment which resulted in the Trust using a mobile catheterisation lab to facilitate service continuity. They had carried out a drill to check how staff managed a resuscitation incident in the new environment.
- Radiology managers had devised a full and detailed business continuity plan which was utilised twice during our inspection. On one occasion a major piece of equipment suffered a breakdown and staff absence in one area had to be managed. Both episodes were effectively managed following the plan and services were affected as minimally as possible. Normal service was resumed immediately following resolution of the problems.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Care and treatment was evidence-based and targets were met consistently. The staff in the departments were competent and there was evidence of multidisciplinary working across teams and local networks. Staff understood about consent and mental capacity ensuring that patients were protected from inappropriate decisions being made on their behalf, although some staff had not received Mental Capacity Act training updates.

Referral to treatment times met national targets but the rate for patients not attending appointments was slightly higher than the national average. Outpatient clinics ran every day, including some evenings and occasionally at weekends.

Imaging services for inpatients were available seven days a week and service availability was increasing and continuously improving.

Staff undertook regular departmental and clinical audits to check practice against national standards and action plans were put in place to make improvements when necessary.

Evidence-based care and treatment

- An integrated internal audit of procedures had been taking place for the past year.
- Speech and language therapists worked to Royal College policies and procedures for initial assessment of patients.
- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and trainings.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.
- The trust had radiation protection supervisors to lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. (IR(ME)R).

- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other guidance that affected their practice.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The imaging department carried out quality control checks on images to ensure that the service met expected standards.
- We had some concerns about the use of Ketamine for young people as this was not following agreed standard practice. We expressed these concerns to the team and were informed that the use of Ketamine in children had been risk assessed and agreed by the radiology team. However, NICE clinical guideline 112: Sedation for diagnostic and therapeutic procedures in children and young people (Issued December 2010) Section 1.6.1 states: "Do not routinely use ketamine or opioids for painless imaging procedures."

Pain relief

- Pain relief medication was not administered in the outpatients department but the doctors in clinic could prescribe medication for any patient needing pain relief.
- There was a pharmacy on site which patients could use to buy pain relieving medication.
- Patients we spoke with had not needed pain relief during their attendance at the outpatient departments.
- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures. Inpatients received pain relief on the ward prior to arriving in the department and outpatients were asked to bring their normal medication with them. Additional pain relief for procedures such as biopsies was prescribed by radiologists and administered safely as required.

Patient outcomes

- In the last 12 months, the outpatient department saw 165,599 patients. Of these, 52,992 were new appointments and 99,359 were review appointments.
- According to information supplied by the Trust, between April 2014 and end of March 2015, 15% of all clinics were cancelled, 4% of clinics were cancelled at short notice (less than 6 weeks) and 11% with more than 6 weeks' notice..

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- The trust's 'new to review' rate (the ratio of new appointments to follow-up) was 1:1.9. This was compared to the England average of 1:2.24 compared to the rates for other trusts.
- After receiving care and treatment, patients were either given another appointment or provided with information about the follow-up appointment process (for example six monthly or yearly reviews) when they would be sent an appointment letter. Consultants decided on whether a patient required a follow-up appointment. Staff were able to describe this process to us.
- All images were quality checked by radiographers before the patient left the department. National audits and quality standards were followed in relation to radiology activity.
- Audits carried out in Radiology included thermo luminescent dosimeter audits for every room, radiographers' sensitivity and specificity and referrer errors. Dosimeter audits showed all results were within the acceptable range and referrer errors were acted upon immediately, informing the referrers where incorrect information had been given.
- In the case of MRI scanning, claustrophobia audits were undertaken to establish how many scans were failed due to patient anxiety. The MRI lead radiographer had carried out research to improve the experience for patients and looked at replacement scanners with a view to reducing patient anxiety. Where requests for orbital images were requested, radiographers carried out a plain image first to rule out the presence of any metallic foreign body in the eye which could cause severe damage if it was present when the scanner was used.
- In cardiology, national audits were carried out by clinicians and combined across inpatients and outpatients. An outpatient audit was carried out for tissue viability and a patient was found to have developed a pressure ulcer underneath their plaster cast. A new care pathway was developed for plaster casts with input from orthopaedic staff and clinicians. This included recording the type of cast to be used and additional assurance checks to show what had been applied. A new patient information leaflet had been produced giving information on signs and symptoms, contacts in and out of hours, waterproof dressings and wheelchair services.

- Where audits had taken place, there were action plans to assist with service improvements. For example, another project was due to begin to produce an orthopaedic instruction leaflet for pin-site care and dressings.
- The diagnostic imaging department managers were processing an application to the Imaging Services Accreditation Scheme (ISAS). This was a patient-focussed assessment and accreditation programme, designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments.

Competent staff

- There were systems within departments to make sure that staff received an annual appraisal.
- In Radiology 84% of non-medical staff had taken part in appraisals with dates booked for those staff overdue an annual update. Supervisors and managers had attended appraiser training and refreshers. 100% of medical staff had received an appraisal. A training needs analysis was produced annually advanced practitioner and leadership strategy courses had been identified as a need for the year ahead.
- Radiographers undertook clinical peer support and one to one supervision meetings. Staff were rostered for one session per week to carry out continuous professional development activities, complete mandatory training, KSF, appraisal and specific modality training. One to one meetings were also used to sign off competencies, maintain Healthcare Professions Council (HCPC) continuous professional development (CPD) portfolios, carry out reflective practice and complete new medical devices training.
- Radiologists working in interventional roles were trained in specialist areas by the clinical leads, for example in fluoroscopy and angiography.
- All staff in outpatients had taken part in an annual appraisal and more staff were attending appraiser training to take responsibility and develop skills.
- In all departments staff were encouraged to discuss development needs at appraisal and as opportunities arose. Trust funds were made available for staff to attend external courses including postgraduate qualifications although some staff told us that there had been an informal block on accessing non-mandatory training due to time constraints.

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- Staff interested in gaining phlebotomy skills could access in-house training.
- Phlebotomy assistant competencies were checked by band five staff however Band 5 phlebotomists, although very experienced, did not have their competencies reviewed.
- Cardiology staff rotated around different testing areas to ensure competence across a range of skills and areas.
- A lunchtime journal club was held once a week and a bi-monthly meeting was held with the Sunderland cardiology team to share best practice and discuss unusual cases.
- Link nurse roles were identified and tissue viability and infection control link nurses provided advice and support to staff in outpatient clinics.
- Students were welcomed in all departments and staff described student placements as a chance for: “the rest of the team to step up their game. It results in everyone learning from each other.” Student roles included therapists, radiographers and nurses. Radiography students came for 12-month placements from Carlisle University and 2 radiographer students had recently applied for permanent posts within the department. A further 2 trainee sonographers were due to qualify and would be able to work independently, thus boosting the numbers of sonographers in the department.
- One consultant radiologist took the lead in reporting neonatal heads and hips. The children’s services inspection team had asked how they maintained their skills and competence in this area. This was met through radiology specialty training and additional training and mentoring by the regional children’s radiologist lead at James Cook Hospital, Middlesbrough.
- There were formal arrangements for induction of new staff. All staff completed full local induction and training before commencing in their role.
- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.
- There were no established models of regular clinical supervision in outpatients and staff received different types and frequency of supervision depending on their area of work. Nursing staff took part in informal group supervision activities. Therapists also took part in peer reviews. Clinical supervisions allow staff to reflect on and review their practice in a safe environment.
- There was evidence of multidisciplinary working in the outpatients and imaging department. For example, nurses and medical staff ran joint clinics and staff communicated with other departments such as radiology and community staff when this was in the interest of patients.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and holistic treatments.
- A range of clinical and non-clinical staff worked within the outpatients department and they told us they all worked well together as a team. Staff were observed working in partnership with a range of staff from other teams and disciplines, including radiographers, physiotherapists, nurses, booking staff, and consultant surgeons.
- Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.
- Outpatient clinics, run by other Trusts were hosted by the outpatients department and close links were maintained with the business managers from those services and hospitals. Staff were able to raise any issues directly with them.
- Plaster technicians told us that they organised meetings with technicians from other services and trusts to share best practice. This was an informal arrangement but they reported that it was effective.
- Managers in all outpatient and diagnostic imaging department held staff huddles at least once a day. All members of the multidisciplinary team attended and staff reported that they were a good method to communicate important information to the whole team.
- Cardiology MDT meetings were attended by staff from the cardiology outpatient department including nurses, physiologists, cardiology consultant leads, GP with special interest, Care of the Elderly lead consultant and a pharmacist. These meetings were held once a week and the team discussed new referrals and management plans as well as case reviews and sharing of best practice.
- There were 2 falls clinics; one was consultant led and the other was an MDT clinic, led by physiotherapists and nurses for patients with falls caused by multiple sclerosis or Parkinson’s disease.

Multidisciplinary working

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Seven-day services

- Diagnostic imaging provided services seven days a week. Outpatient services were available Monday to Friday although there were occasional Saturday clinics to ensure that the trust met their waiting list targets.
- The imaging department provided general radiography, CT, magnetic resonance imaging (MRI), ultrasound scanning and fluoroscopy services for outpatients and inpatients every day. There was a rota to cover evenings and weekends so that outpatients could access diagnostic radiology when they needed to.
- MRI was available at weekends and in the evenings. For times when the service was not staffed or in case of an equipment breakdown there was a reciprocal service level agreement with a neighbouring trust for urgent scans.

Access to information

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as imaging records and reports, medical records and physiotherapy records appropriately through electronic records.
- Diagnostic imaging departments used picture archive communication system (PACS) and radiology information system (RIS) to store images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. The systems also flagged outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met. There were no breaches of standards for reporting times.
- Diagnostic imaging departments outsourced reporting of out of hours urgent CT scanning to a private provider. There was a service level agreement (SLA) in place and quarterly meetings were held to discuss performance, concerns and discrepancies. Turnaround times for their reports were 60 minutes for general scans and 30 minutes for suspected stroke patients.
- Consultant cardiologists reported their own x-rays and orthopaedic surgeons used image intensifiers in theatres with automatic reporting facilities with protocol in place to support and monitor these.

- There were systems in place to flag up urgent unexpected findings to GPs and consultants. This was in accordance with the royal college of radiologist guidelines. This involved sending reports directly to the GP or consultant's secretary. A checking and alerting system was in place on the PACS to make sure that documents had been sent. This helped to minimise 'human error' when sending reports to consultants and GPs.
- Systems and processes were in place if patient records were not available at the time of appointment. Temporary notes would be created, referral and discharge letters were stored electronically meaning they could be printed off and added to the notes.
- There were processes in place for accessing patient files and information. Staff had an electronic patient record system which contained patient record details. This was supplemented by the use of patient notes where electronic patient records were not available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards competencies on induction and these were rechecked and discussed as part of the appraisal process.
- Information given to us by the trust showed that 61% of applicable staff in Radiology had attended mental capacity level two training. We were not able to obtain a figure for outpatient department staff but staff development information showed that an average of 10% of staff across the whole trust had completed this training.
- We observed patient consent being requested and given for personal care and procedures and staff confirmed that this took place in all areas and departments.
- Nursing, imaging, and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us that, in the outpatients department, consent was obtained verbally. This was the case for the majority of imaging procedures, although consent for any interventional radiology was obtained in writing on the ward prior to attending the imaging department. Staff told us that patient consent was confirmed before

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carrying out any personal care or interventional procedure. The majority of patients told us that staff had asked for consent before undertaking any examinations or procedures.

- Staff followed a formal process when patients lacked the capacity to consent which included an IMCA (Independent Mental Capacity Advocate) and, if necessary an interpreter to make best interest decisions.
- Staff we spoke with were aware of who could make decisions on behalf of patients who lacked or had fluctuating capacity. They were aware of when best interest decisions could be made and when a Lasting Power of Attorney could be used.
- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are outpatient and diagnostic imaging services caring?

Good



During the inspection, we saw and were told by patients, that the staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey and patients were given sufficient time for explanations about their care and were encouraged to ask questions.

People were treated respectfully and their privacy was maintained in person, in writing and through actions of staff to maintain confidentiality and dignity. There were services to emotionally support patients and their families. Patients were kept up to date and involved in discussing and planning their treatment and were able to make informed decisions about the treatment they received.

Compassionate care

- Staff in outpatients and diagnostic imaging were caring and compassionate to patients. We observed positive interactions with patients. Staff approached patients and introduced themselves, smiling putting patients at ease. Patients said that staff had received an “award for the Unit... best care in the country” and “there was no question that we would come back here”. One patient said that staff were: “very nice and couldn’t do enough to help”.

- There were good interactions between patients and reception staff.
- Clinic receptionists could access private areas to hold confidential conversations with patients if necessary and they informed staff quickly if patients had communication difficulties.
- Clinic names were not displayed in order to maintain privacy and confidentiality.
- New patients were asked to confirm that they had been resident in the UK for the previous 12 months to qualify for free NHS care. We observed this question being asked and a member of staff from medical records approached the patient to complete additional documentation. Although there was not a private room available they checked with the patient if it would be acceptable to ask them questions in the waiting area, which the patient agreed to. Unfortunately however the staff member was not discreet and the entire waiting room was able to overhear the patient being questioned. Although the patient was happy to answer the questions and complete the form, their dignity and right to privacy was not respected on this occasion.
- Patients’ privacy and dignity was respected by staff. Consultation and treatment rooms had solid doors and patients could get changed before seeing a clinician. Staff were observed to knock on doors before entering and doors were closed when patients were in treatment areas and a patient said that staff were “very good” at preserving their privacy and dignity.
- We spoke to 35 patients and 8 people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- We observed staff behaving in a caring manner towards patients they were treating and communicating with and respecting patients’ privacy and dignity throughout their visit to the department.
- Patients told us that they never felt rushed, staff gave sufficient information about treatment and conditions and they worked as a cohesive team to accommodate individual needs. For example, we observed a patient and their partner who had been at the Accident and Emergency department all morning. They had seen the consultant in clinic and went for an ultrasound scan at 3pm. Staff had noted that neither the patient nor their partner had had anything to eat so offered the partner a snack box and kept another for the patient to be given when they had finished their consultation.

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- Friends and family test survey results for 2014 were collected, interpreted and reported. Response rates ranged between different departments from 1% to 48% and scores ranged between 100 (the best possible) in cardiology, ear nose and throat and diabetes (non-consultant) clinics to 21 for the trauma and orthopaedics clinic. The outcomes were presented at the board of directors' meeting.

Understanding and involvement of patients and those close to them

- Patients told us that they saw the same staff at each appointment, staff recognised them and they were made to feel important. Staff were very good at explaining what was happening in a way they could understand and they checked patients' understanding.
- The team used non-verbal communication prompts for people unable to communicate or with children.
- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by nursing and medical staff. All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment and on some occasions those close to patients were encouraged or enabled to support patients.
- Patients were informed if clinics were running late. We saw staff inform patients, apologise and explain why clinics were running late.

Emotional support

- We observed staff helping a patient who was worried because they were late for their appointment but struggling to walk. They found a chair for her and reassured her that they could help.
- Patients told us that they felt supported by the staff in the departments. They reported that, if they had any concerns, they were given the time to ask questions. One patient told us that there was "plenty of emotional support" and "the specialist nurse shares my emotion".
- Staff made sure that people understood any information given to them before they left the departments.

- Patients told us they were able to change appointments if necessary or to request an outpatient appointment to discuss their concerns and anxieties.
- Emotional support for patients was available. For example, an oncology specialist nurse worked with the clinical teams and was present for extra support when patients received bad news.
- Healthcare assistants were able to support patients after receiving a diagnosis and told us they would feel confident to speak to clinicians on behalf of a patient if they had worries or concerns.

Are outpatient and diagnostic imaging services responsive?

Good



We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Extra clinics and scanning sessions were added to meet demand. Waiting times were within acceptable timescales, with outpatient clinic cancellations slightly higher than the average for Trusts in England. Patients were able to be seen quickly for urgent appointments if required.

Clinics and related services were organised so that patients were only required to make one visit for investigations and their consultation. Some patients' conditions were monitored remotely which reduced the need for some very frequent or urgent appointments.

There were mechanisms to ensure that services were able to meet the individual needs, such as for people living with dementia, a learning disability or physical disability, or those whose first language was not English. There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Service planning and delivery to meet the needs of local people

- The Did Not Attend (DNA) rate for the hospital was 8% which was worse than the England average of 7% and the percentage of patients cancelling appointments was less than 1% which was much better than the England average of 6%.

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- The department managers flexed capacity to meet demand. Extra clinics were added to ensure provision met demand. For example, an increased referral pattern was noticed for general surgery so two extra clinics had been scheduled.
- Clinics were organised to meet patients' needs. For instance, lung clinics were organised so that all investigations and consultations happened on the same day; Falls clinics were planned so that joint assessments and treatment could be carried out by clinicians, nurses and therapists.
- An evening clinic was scheduled between 5 and 9pm for fertility pre-assessment and a regular Saturday morning fracture clinic was scheduled. Unplanned Ad hoc Saturday clinics were arranged at the request of clinicians.
- If a patient's review appointment was planned for more than six weeks ahead, the department would send a reminder letter.
- The phlebotomy service manager told us an action plan was being drafted for the service to establish capacity and demand as well as commissioners' requirements. They had not been tasked to look at the environment in particular but would make recommendations for improvements if necessary.
- The phlebotomy department provided services from 8am to 11pm on weekdays for inpatients and between 8am and 5pm for GP referrals and outpatients. They processed tests for an average 1000 patients a week: up to 800 inpatients and 200 -300 through clinics and GPs. At weekends and bank holidays they provided an inpatient-only service for the same hours. Clinicians took bloods after 11pm. GP and routine outpatient samples were collected every two hours and were tested at a neighbouring hospital. Outpatient tests were ordered electronically through ICE (Integrated Clinical Environment) an electronic ordering and request system, which generated a bar code to be brought by the patient. Test details were kept on the system and the bar code was attached to the samples.
- The phlebotomy department provided services to adults and children. Children under the age of five and those having blood taken for the first time were treated in the children's day unit. Children over five who wished to, could access the phlebotomy department.
- The trust had a contract with four GP practices to provide phlebotomy services. Staff told us they were the only hospital in the North East to offer this service.

Patients were able to attend the main outpatients department or Palmer Hospital and this gave patients choice but provided a very variable workload and made planning for staffing more difficult.

- There were processes in place to facilitate rapid testing. For example, oncology staff carried out phlebotomy for their own patients and we observed that the samples were sent off in a pod and results were received within 15 minutes. A new blood analyser had been purchased to remove the need to send samples away for testing but staff training had not yet been completed. A risk assessment had been carried out to reconfigure the environment for the accommodation of a specialist phlebotomy chair.
- Demand for outpatient and radiology services was monitored and managed locally within the departments and centrally where other departments such as Estates, Facilities and Finance were included in planning and decision making. New equipment was considered with future needs and requirements in mind such as an increase in the number and size of patients requiring bariatric equipment.
- All departments had completed a service review to reduce waste in terms of time, space and administration. This had produced results in reducing the need for rooms and staff in some areas so that they could be deployed elsewhere to meet increasing demand. This was embedded in the culture and plans were in place to continue to carry out regular reviews and reassess future needs and demand.
- Demand for radiology services had been measured at 10% increase on the previous year's activity. Managers planned the service around demand on an ongoing basis and had already extended its opening hours but these were to increase further with an aspiration to provide a full seven-day service. As workloads had increased another consultant radiologist was recruited through an agency and had received local induction, support and guidance from the substantive team and their work was reviewed regularly and feedback provided.
- Staff huddles were held first thing in the morning to plan for the day ahead. They discussed each clinic taking place, previous performance in terms of appointment utilisation and over runs and highlighted concerns such as patient numbers or cancellations. They discussed the previous day's activity such as late starts and overruns and patient DNA's (did not attend).

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- The imaging department had good processes in place and the capacity to deal with urgent referrals and additional scanning sessions were arranged to meet patient need.
- Digital dictation had been introduced to enable a prioritised system for urgent and two-week wait letters. Diagnostic imaging reporting and record-keeping was transferring to electronic, paperless methods. However, systems were still in transition and staff reported occasional pressures. Support was given by managers and practical help offered by department staff in times of need.
- In radiology, there was a filing backlog at the time of our inspection. Clinical staff within the department supported the administrative team with practical help during quieter periods to address the backlog.
- Water fountains were provided for patients' use and there was a shop and café where people could purchase drinks, snacks and meals.
- Although a day room for infusion patients was clean with comfortable chairs, there was little for patients to do and the environment was drab and uninspiring.
- A review of the imaging departments by the Radiation Protection Advisor in March 2015 had identified no concerns about the imaging departments across the trust.
- The rates of patient non-attendance for the outpatients department (DNA rate) was 8%. This was worse than the national average of 7%. The trust had recently stopped sending out reminder text messages to patients. Work was underway to implement a new system however this was not in place at the time of the inspection. Managers were unsure if there would be a detrimental impact on the DNA rate without the reminder service.
- We saw there were policies in place for DNA's. Booking and reception staff was able to tell us the procedure for managing DNA's. Staff were aware of this policy and we observed it being followed through interactions between reception staff and consultants. There were no risks identified for referral to treatment times (RTT), diagnostic waiting times, cancer waiting or diagnosis times. All were well within national targets ranging between 98 and 100%. NHS England Operational standards are that 95% percent of Non-admitted should start consultant-led treatment within 18 weeks of referral.
- TV screens in clinic reception areas provided patient information and appointment waiting times that matched information given by reception staff.
- A free, direct-line telephone was provided for patients to book taxis. There were no review appointment waiting lists and no backlog of non-RTT patients. The information services department provided weekly reports on RTT statistics to the outpatients managers.
- Diagnostic imaging waiting times for all departments and from all urgent and non-urgent referrals met national targets except for a single breach where the target was exceeded by 2 weeks. This was related to a written complaint, was reported as an incident and investigated appropriately.
- Staff carried out a continuous review of planned imaging sessions in relation to demand and 7-day working arrangements. They organised additional evening sessions to accommodate urgent diagnostic imaging requests as necessary.
- Clinic staff tried to accommodate patients arriving by ambulance with flexible time slots and booked their return journey. There was a clean and comfortable area for ambulance patients to wait near the entrance to the department and volunteers checked patients were collected.
- Inpatient and urgent outpatient phlebotomy was prioritised and tested on-site with good turnaround times of around an hour. Patients regularly attended the

Access and flow

- The bookings team received an average of 200 referrals per day. These were checked and forwarded to consultants for triage. They then ordered tests and x-rays to be carried out on the same day. This ensured one trip per patient, was an efficient use of time and test results were up to date.
- The majority of patients used the "choose and book" system to make appointments.
- Staff were supported by colleagues within the wider department at busy times, or when there were absences. Between April 2014 and the end of March 2015 15% of all clinics were cancelled; 4% of clinics were cancelled at short (less than 6 weeks) notice and 11% with more than 6 weeks' notice. There was no trust target rate defined. The majority of cancellations were due to consultants being away or on holiday.
- The trust used the choose and book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

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phlebotomy department before their outpatient appointment. This ensured that blood test results were available to the clinician for the time of the appointment.

- Put in information about how often clinics were cancelled less than six weeks before the clinic was due to run.
- We observed staff announcing delays to patients in waiting areas. The longest wait during our inspection for phlebotomy patients was 1 hour and main outpatients was 2 hours. Outpatient Perform (a tool used to collate and report data collected about performance and utilisation of outpatients services within the Trust) – snapshot reports from 6 months ago and the week prior to our inspection showed that the number of appointments available had remained almost static and those used had increased from an average of 79% to 90% and time lost due to over runs had increased from an average of 35 minutes per clinic to 97 minutes per clinic.
- Waits in Radiology were much shorter and patients told us they waited no more than 10-15 minutes. Local audits showed that patients regularly waited less than an hour but during our inspection we noted much shorter waiting times.. We did see inpatients waiting for porters to return them to their ward following procedures.
- In radiology the 2014/15 annual report showed that 70% of patients waited less than 15 minutes and a further 28% were seen within an hour. 1% waited between 1 and 2 hours and 0.3% had to wait for over 2 hours.
- The arrival time of the patient was recorded and any unexpected delays were explained to individuals. Outpatient delays were displayed on a board in the reception area and explained to patients on their arrival.
- Guidelines say that 95% patients should start consultant-led treatment within 18 weeks of referral. The rate for this trust was consistently more than 98% of patients seen within 18 weeks of referral, for patients not admitted. This was consistently better than the standard of 95% and better than the England average.
- The average referral-to-treatment times for patients with incomplete episodes of care ranged from 94.5% (above the target of 92% in March 2014) to 95% (in August 2014). Over the six-month period from May to November 2014, an average of 94.5% met the target. This was slightly worse than with the national target of 95%.

- The trust was performing above and better than the England average for patients with all cancers being seen urgently within two weeks.
- The trust was performing better than the England average for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers. 90% of patients were seen within 62 days between January and March 2015.
- Department managers told us that they consistently monitored waiting times and were able to run additional clinics if there were concerns that patients would not be seen within the target waiting times.
- In the imaging department, reporting times for urgent and non-urgent procedures consistently met or were better than national and trust targets for all scans and x-rays for inpatients and outpatients.
- Patients who cancelled diagnostic imaging appointments were all booked to attend within the national target of 6 weeks of their original appointment date.

Meeting people's individual needs

- Some patients with pacemakers used telemedicine as a means of remote monitoring to record activity and a daily report was shown on a screen to alert staff to problems. Pacemakers used a Bluetooth receiver to signal any problem. Staff were able to carry out verbal checks with patients by telephone and some adjustments could be made by patients following verbal instructions.
- Double-slot appointments were given for some new and follow-up appointments for example some stroke patients required extra time with nurses and clinicians.
- Outpatient and imaging departments ran one-stop-shop clinics where patients were able to see several clinicians during one appointment. This meant that patients did not have separate appointments to see nurses, radiographers and consultants on separate days. Patients we spoke with liked this approach.
- The trust had a learning disabilities support team who could plan provision prior to admission or in an emergency.
- There were private rooms available for patients who had been given bad news to receive support or be talked through their condition. Patients and those close to them told us that they were given plenty of time and not rushed when given bad news.

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- Cardiology services for heart failure clinics also offered a one-stop-shop approach to appointments where all investigations and consultations are carried out on the same day and patients left with a diagnosis and treatment plan. They also offered open access ECG (electrocardiogram). An example of a patient timeline was given where a patient could attend for an ECG and the following day had a heart block and a pacemaker fitted. The service also offered treatments like angiography on the same day of a referral if required. This was corroborated by the consultant radiologists.
- Some home visits were organised for cardiology patients who could not attend outpatients.
- Vulnerable patients such as those with dementia or learning disabilities were identified as part of their referral and given longer appointment times. Their relatives, carers or social workers were accommodated to attend with them in consulting and treatment rooms. Often quiet areas of the department were used to help these patients feel safe. We observed a plaster technician caring for a child with learning disabilities. The child had heard a plaster saw being used and was anxious and upset by the noise. They were able to distract the patient and moved to another room. The patient was seen to be happy following their treatment.
- Patients who were required to be at the hospital for long periods of time, for example those with multiple appointments or waiting for ambulances, were offered food from the restaurant or a snack box and regular drinks by staff and volunteers. One patient told us they required a special diet and outpatient staff had prepared food especially for them.
- The Radiology department had a small area of the main waiting room orientated towards young patients with wall mounted toys which were regularly cleaned. There was also a separate waiting area which had been set aside for children waiting within the department and this was decorated with a jungle theme and signage took the form of a trail of animal footprints on the floor.
- The main outpatients department had no facilities for children. The children's outpatient department was on a different site at Palmer Hospital but we saw four children attending the main ophthalmology clinic during our inspection. There was nothing provided to distract or entertain waiting children. Staff told us that eight children were due to attend the clinic that morning.
- Prisoners with escorts used separate areas of the department for their dignity and to respect anxieties of others.
- Bariatric furniture and equipment was available and accessible.
- Patients for diagnostic imaging who met bariatric weight and size limits could be accommodated with some of the newer imaging tables and equipment but the current MRI scanner did not meet bariatric needs. Patients were offered the choice to access a different service or a private provider which had an open scanner that which was suitable for larger patients or those who suffered from claustrophobia. A replacement MRI scanner was being researched and both of these needs were being given consideration.
- Staff were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly. Staff had accessed the trust training programme called 'Barbara's story' in order to understand the condition and how to be able to help patients experiencing dementia.
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient space to move manoeuvre and position a person using a wheelchair in a safe and sociable manner.
- In the imaging department, MRI scanning staff had recognised the need for additional patient support during the scanning procedure. They had researched methods to allay fears of anxious patients and provided a calm waiting environment and practitioner approach.
- Patients had access to a wide range of information. Information was available on notice boards and leaflets. There was information that explained procedures such as x-rays. There was information about various illnesses and conditions including where to go to find additional support.
- Patient information leaflets were plentiful, of good quality and up to date and staff could print out large print versions or in a different language as necessary. There were posters displayed about falls prevention and general health advice. The bookings teams organised interpreter services for patients who did not speak or understand English. Staff told us that they experienced no difficulties in accessing interpreters. However booking staff had to rely on GPs and hospital referrers

Outpatients and diagnostic imaging

ensuring that the trust were aware of a patient's requirements. Staff told us that interpreters were preferable to friends and family to ensure that clinical messages were put across correctly and also to maintain patient confidentiality.

- There were separate toilets and waiting areas for patients who had received radioactive injections. This ensured that radioactive waste was managed appropriately and that other patients and visitors were protected from possible exposure to radioactive substances.
- Reception areas experienced busy periods. There was sufficient seating on most occasions but in some of the clinics we observed patients having to stand. Most seating was in good condition but we noticed that some chairs were very low and some patients found it difficult to stand up after sitting in them.
- The phlebotomy waiting area was crowded with insufficient seating at peak times. Staff felt the environment was restrictive and they could be more efficient with more space.

Learning from complaints and concerns

- Patients told us that parking charges sometimes caused anxiety when appointments were delayed. This had been addressed by the trust and reception staff were able to prevent additional charges being made. Notices were displayed throughout the department about how to avoid extra parking charges by giving the vehicle registration number to the receptionist.
- Staff in all departments told us that verbal complaints were few and far between and that the main issue was waiting times. There had been 15 formal complaints made between January and December 2014. They all fell into themes regarding verbal and written communications and misunderstandings, missed diagnoses, staff attitude and medical advice or guidance given. All patients were offered an explanation and an apology and actions taken as a result of complaints were recorded appropriately.
- Radiology had received one formal complaint when an appointment letter had not been received by a patient and they had missed their appointment. This was investigated within the department and followed up with the complaints team. A root cause analysis was carried out and the reason for the error was identified. Managers worked with staff to raise awareness and

included the outcome in the team meeting minutes. A letter of apology and an explanation was sent to the patient with a new appointment. The lessons learned were shared with the team and the referring service.

- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at huddles and local team meetings, where actions were agreed and any learning was shared. Staff huddles we observed did indeed include a section for discussion of concerns and complaints.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint. Some had raised concerns during their attendance. They told us that their concerns had been dealt with professionally and, where possible, action taken to address the concern. On the whole they were happy with the experience they received from the departments.
- Information was accessible on the Trust web site including the complaints policy. We saw posters displayed within the departments. Most patients we asked said they did not know how to make a complaint but when we discussed this they did know about the patient advice and liaison service (PALS) and were aware of the posters on display.

Are outpatient and diagnostic imaging services well-led?

Good



The outpatient and imaging departments of South Tyneside NHS Foundation Trust were well-led. Staff and managers had a vision for the future of the departments and were aware of the risks and challenges. Managers at all levels were active, available and approachable to staff. Business continuity plans had been developed to manage incidents, accidents and risks and these were simple to implement and effective.

Staff felt supported and were able to develop to improve their practice. Regular daily meetings took place where all staff participated and were confident to talk about ideas

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and sharing of good news as well as anticipated problems. There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed.

The department was supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments. Staff felt proud to work for the trust and felt they provided a good service to patients.

Vision and strategy for this service

- The Trust vision and strategy were well embedded and discussed at staff huddles. Clinical Business Managers and Divisional directors attended some huddles. Staff told us that senior managers were approachable to ask questions or discuss their concerns and that they felt able to feed into the vision and the direction the trust is going.
- The Clinical Business Manager was carrying out a full staffing workforce review to plan for future needs and identify any gaps. Succession planning was ongoing with human resource input.
- The trust had a strategy for the introduction of more efficient and effective working using information technology such as electronic records and digital dictation.
- There was a strategy in diagnostic imaging to transfer all patient records to an electronic system. This was underway and involved reviewing resources. A free mobile phone text service to remind patients to attend their appointments had closed the month before the inspection. Staff were expecting performance information to show a rise in DNAs. A replacement service was under consideration with the IT department but this would not be able to run for several weeks. Forward planning had not been carried out to ensure that the change was seamless.

Governance, risk management and quality measurement

- Serious incidents were discussed at clinical incident review and multidisciplinary clinical governance meetings, the management incident review group and the patient safety panel.
- Risk registers were held and controlled by Clinical Business Managers. Staff were able to influence what risks were included. Risks were discussed by the safer

care panel and learning was shared across the organisation. For example, patients at a high risk of falling were discussed at the senior clinical forum and the patient safety panel.

- We saw minutes of the Radiology risk management group where risk assessors from specialties within the department raised, discussed and actioned risks identified within the department and agreed higher level risks to be forwarded to the Clinical Business Manager.
- Department managers carried out investigations of incidents and reported back to teams. The higher risk management team monitored Datix reports, carried out trends analysis and sent out a trust-wide bulletin on incidents, trends and learning for all staff.
- Email aAlerts regarding drug or equipment information were sent out via email. Managers made checks to ensure staff had received the information and discussed it at huddles if they directly affected the team's work. Where necessary, policies and procedures were updated in line with guidance received.
- Radiographers had reported recurrent problems with space available and additional staff required for patients being transported for x-ray procedures on beds rather than trolleys. The director of nursing asked the Radiology Department to produce a paper which she shared with the ward staff to encourage the use of trolleys where possible and the radiology manager had drafted a standard operating procedure.
- Radiology had a separate risk management group consisting of modality (specialist Diagnostic imaging services for example CT and MRI) leads, radiology risk assessors and Radiology Protection Specialists. Radiology discrepancy incidents were discussed by case review with radiologists and referring clinicians.
- There were strong governance arrangements which staff were aware of and participated in. The departments had regular risk management meetings. For example, staff were given feedback about incidents and lessons learned and the trust communicate these via daily staff huddles.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging these included radiology related to head injury clinical guidance and stroke thrombolysis and non-thrombolysis imaging times.

Outpatients and diagnostic imaging

- Within the imaging department, there were examples of audits taking place to ensure that NICE and other guidance was being adhered to. For example, a national audit on the prevention of contrast induced acute kidney injury had been undertaken and the 2nd part of the audit cycle was in progress which was in relation to changing patient management.

Leadership of service

- Staff told us that the executive team were approachable, seen regularly on site and sent out regular communications to staff. Departmental managers were supportive in developing the service and practice, and the trust as a whole valued its staff. Staff felt that they could approach managers with concerns and would feel listened to. We observed good, positive and friendly interactions between staff and managers.
- The clinical business manager held monthly staff meetings where staff could discuss finance, departmental problems and pressures, complaints, recruitment and vacancies. Staff told us that they were encouraged to participate and give feedback at these meetings.
- Cardiology managers held regular one to one meetings with staff to discuss team developments.
- Staff found the managers of the service to be approachable and supportive. All the staff we spoke with told us they were content in their role and many staff we spoke with told us that they had worked at the hospital for many years.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development.
- Staff were able to access some training and development provided by the trust, although some staff told us this was not as easy as it had been in the past due to staffing level and time pressures.

Culture within the service

- Staff completed a chart each morning to show how they were feeling about the day ahead using a stress barometer. They could plot their feelings on a line between “relaxed” and “stressed” with “motivated” in

between. All staff completed the chart and responses varied depending on recent events and the activities planned for the day and most were realistic but very positive.

- Staff and managers told us that the trust had an open culture. They felt empowered to express their opinions and felt that they were listened to.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they felt well-supported by the organisation.
- Members of the board regularly visited the departments and took part in huddles and staff meetings.
- Staff were proud to work at the hospital. They were passionate about their patients and felt that they did a good job. Staff in all the outpatient departments said that they felt part of a team and empowered to do the job. Most staff we spoke to spoke of morale being good, being proud of their team and positive team working.
- At the staff huddle, managers asked the team to consider how children could be better accommodated within the outpatients department. Managers involved and consulted staff on their ideas for possible improvements.
- Radiology managers had made well-being contacts with staff on long-term absence.
- Staff told us that they felt there was a culture of staff development and support for each other.
- We were told by outpatients and diagnostic imaging staff that there was a good working relationship between all levels of staff. We saw that there was a positive, friendly but professional working relationship between consultants, nurses, healthcare and support staff.

Public engagement

- Volunteers worked as “greeters” for all patients and visitors entering the outpatients department. They provided two people all day to check that people were being cared for and had not been missed. They also helped to staff the 'League of Friends' shop and they told us that the League of Friends had raised over £53,000. Three new phlebotomy chairs had recently been purchased from these funds.

Staff engagement

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- Staff attended daily huddles where incidents, feedback to staff and lessons learned were discussed. All staff participated and were confident to talk about ideas and sharing of good news as well as issues occurring the previous day or anticipated problems for the day ahead. We observed this being carried out effectively in outpatients and the x-ray department during our inspection.
- Staff told us that they enjoyed working for the trust and we interviewed several people who had been employed for 20 years or more. Staff were proud of the service they provided and felt they worked in highly skilled teams. Several staff told us that they would be proud if members of their family were cared for by staff in the department.
- Policies and procedures were available to staff via the trust intranet as well as patient information leaflets that staff could print off to hand to patients and carers.
- Staff completed a chart each morning to show how they were feeling about the day ahead using a stress barometer. They could plot their feelings on a line between “relaxed” and “stressed” with “motivated” in between. All staff completed the chart and responses varied depending on recent events and the activities planned for the day and most were realistic but very positive.

Innovation, improvement and sustainability

- The cardiology department had started an outpatient valve clinic. 187 patients who came to clinic were checked by cardiology technicians with clinical support if required. This enabled review appointments to be released for cardiologists.
- An arrhythmia clinic was currently consultant led but plans were in place for this to be nurse led with consultant support. Staff would have to identify a select group of patients for this service.
- Staff were considering ways to improve effectiveness of the fracture clinics and to reduce the need for patients without fractures on x-rays to return to the department. They were planning to introduce a text or telephone service to inform patients they did not need to return.
- The lead radiographer for MRI had designed and delivered training to referrers for MRI safety and awareness. This had reduced the numbers of inappropriate referrals and fewer patients had to be turned away on the day of their scan due to contra-indications.

Outstanding practice and areas for improvement

Outstanding practice

- 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 by 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 is 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).

Areas for improvement

Action the hospital 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, e.g. 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.
- Ensure that when patients complain about their care, there is an effective process in place for staff to receive feedback and learning.

Outstanding practice and areas for improvement

- 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.
- Develop and 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.
- 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.

Action the hospital SHOULD take to improve

- Review the 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.

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	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>15(1)(a)(c)(e)</p> <ul style="list-style-type: none">• The trust must ensure that COSHH risk assessments are completed for all areas storing substances hazardous to health to ensure that these are stored securely.• 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.• 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	Regulation
Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>18(1)(2)a</p> <ul style="list-style-type: none">• 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.

Requirement notices

- The trust must ensure that all theatre staff caring for Level 2 and Level 3 ITU patients have received the appropriate training to do so 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.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17(1)

- 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
- Ensure all necessary patient risk assessments e.g. 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.
- 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.
- 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.

This section is primarily information for the provider

Requirement notices

- 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.
- Develop and 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 when patients complain about their care, there is an effective process in place for staff to receive feedback and learning.
- Ensure that all employees receive an annual appraisal.

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.