South Tyneside and Sunderland NHS FT

Inspection report

Sunderland Royal Hospital
Kayll Road
Sunderland
SR4 7TP
Tel: 01915656256

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

South Tyneside and Sunderland NHS Foundation Trust provides acute, community and specialist learning disability services for over 430,000 people across Sunderland and South Tyneside, as well as Gateshead and County Durham. The trust also provides specialist acute services for people across the North East and employs over 8,000 people.

The trust was formed in 2019 following the merger of City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust. The trust provides services from the following locations:

- Durham Diagnostic and Treatment Centre
- Intermediate Care Assessment and Rehabilitation (Houghton Primary Care Centre)
- Palmer Community Hospital
- South Tyneside District Hospital
- St Benedict's Hospice
- Sunderland Eye Infirmary
- Sunderland Royal Hospital

We inspected maternity services and medical wards at Sunderland Royal Hospital and South Tyneside District Hospital on 21-22 June 2022. We undertook further inspections of the trust's core services on 08 August 2022 and inspected the well-led key question for the trust overall on 9-11 August 2022. We carried out these unannounced inspections of services provided by this trust because we had concerns about the quality of services.

We identified concerns in relation to patient safety during the inspection of the trust's core service and we shared these concerns with the trust's senior leadership team. The trust provided details of the immediate action taken to address these concerns. During our inspection of the trust's leadership and governance we carried out a second inspection of the trust's core services to check whether the trust had addressed, sustained and embedded the improvements required.

Our findings

Our return visit found that the trust had not made significant improvement in some of the areas of concern identified in our June inspection which resulted in continued breaches of several regulations. We identified further breaches of regulation during our review of the trust's well-led.

Our rating of services went down. We rated them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good.
- The trust provides 30 services from seven locations which we inspect and rate. We rated 18 of these services as good, nine as requires improvement, and three as outstanding. We inspected the maternity services at South Tyneside District Hospital but did not re-rate this service at this inspection. In rating the trust, we took into account the services we inspected at this inspection as well as the current ratings of the 26 services we did not inspect this time.
- The trust did not have effective systems to ensure patient risk assessments were completed, and the care provided was in line with risk assessments.
- In medicine, we found did not always staff identify and escalate deteriorating patients for medical review. Staff did not consistently undertake intentional rounding or demonstrate adherence to the Mental Capacity Act. Medicines were not always stored appropriately. Patients with suspected sepsis did not always receive timely assessment and treatment. Patients with a learning disability were not consistently identified and assessed and they did not always receive care that met their needs.
- In maternity, the service could not consistently provide one to one care for patients in active labour. Staff did not consistently complete fresh eyes assessments of cardiotocographies, or the WHO safety checklist. Medicines were not always stored appropriately. The service had significant environmental risks and risks to infection prevention and control which had not been identified by the trust.
- The trust's systems for identifying, escalating and managing risks, issues and performance were not always effective and had resulted in significant unmitigated risks developing in frontline services. Leaders did not consistently identify, understand and manage the priorities and issues the trust faced. The trust had not taken effective action to address several areas of concern identified in previous inspections.
- The trust did not consistently operate effective governance processes to ensure all patients received high-quality care which met their needs. The trust did not have oversight of the quality and safety of care provided to patients with mental health needs. There were examples where failures in governance systems had resulted in unmitigated risks.
- The trust was slow to recognise and declare serious incidents which increased the risk of repeat incidents and reduced opportunities for learning, timely actions to reduce risk to patients and effective monitoring of quality and safety by external organisations. Unexpected deaths were not always appropriately and consistently screened.
- Not all staff felt respected, supported and valued. Staff were not clear about ways to raise concerns and did not know about the trust's Freedom to Speak Up Guardian.
- The trust had not maintained appropriate records to evidence adherence to the fit and proper persons regulation for directors.

However:

- Senior leaders had the necessary knowledge, skills and abilities to effectively lead the trust. Leaders including the board were visible and approachable in the trust for patients and staff. They supported staff to develop their skills and take on more senior roles.

Our findings

- The trust had a vision for what it wanted to achieve and had recently launched a new strategy to turn it into action, developed with all relevant stakeholders. The trust was committed to communicating effectively and plainly with all stakeholders including patients.
- The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.
- Information systems were integrated and secure. The trust's commitment to digital innovation had received national and international recognition.
- Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research. The trust had started to implement a quality improvement methodology to support and drive improvement in services.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements. This action related to three services across two locations and to the trust overall.

Trust wide

- The trust must ensure directors have an appropriate disclosure and barring service check and ensure this is repeated where required or the risks of not repeating checks are considered and assessed. (Regulation 5)
- The trust must maintain effective records to evidence adherence to the fit and proper persons regulation for directors. (Regulation 5)
- The trust must implement an effective system to assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service in line with the regulations (Regulation 17)
- The trust must ensure risks in services are appropriately recorded, assessed, escalated to the trust's board where required, and regularly reviewed. (Regulation 17)
- The trust must ensure risk assessments including clinical service risk assessments are up to date, thoroughly assessed and documented and benchmarked against national statutory and best practice guidance. The trust must ensure records of risk assessments are effectively maintained. (Regulation 17)
- The trust must implement an effective system to identify and report incidents including the severity of harm. The system must ensure incidents are appropriately reported to internal and external systems within appropriate timescales. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff. (Regulation 17)

Our findings

- The trust must implement an effective system to ensure that medical, nursing and midwifery staff have the skills, knowledge, and experience to care for and meet the needs of service users within their service area. Training must include but is not limited to cardiotocograph (CTG) interpretation, multidisciplinary skills and drills training including infant abduction, the needs of service users presenting with mental health needs and learning disability and the use of restraint. (Regulation 17)
- The trust must ensure there is effective oversight of the quality and safety of care provided to patients with mental health needs. (Regulation 17)
- The trust must ensure staff undertake assessments for patients who have a learning disability, care needs are assessed and planned to meet their individual needs. (Regulation 17)
- The trust must ensure any patient presenting and assessed by staff as having a learning disability regardless of whether this is identified on GP systems have their individual needs assessed and reviewed by specialist learning disability staff. (Regulation 17)
- The trust must implement an effective system to identify, report and learn from incidents involving the use of restrictive interventions including restraint and rapid tranquilisation. (Regulation 17)
- The trust must implement an effective system to ensure the assessment, prevention and management of infection prevention and control in the physical environment, this is recorded, monitored, and audited with actions taken to improve compliance. (Regulation 17)
- The trust must implement an effective system to learn from deaths which ensures deaths are appropriately and consistently screened, further review is undertaken where required and lessons learnt are effectively identified and shared with teams. (Regulation 17)
- The trust must ensure all staff have an appropriate disclosure and barring service check and ensure this is repeated where required or the risks of not repeating checks are considered and assessed. (Regulation 19)

Medicine (Sunderland Royal Hospital)

- The trust must ensure staff appropriately monitor, assess, and escalate when service users' physical health deteriorates in line with best practice, this should be monitored and audited with actions taken to improve compliance. (Regulation 12)
- The trust must ensure staff appropriately monitor, assess, and escalate when service users' mental health deteriorates. (Regulation 12)
- The trust must ensure staff undertake and appropriately record intentional rounding of all service users and ensure this is recorded, monitored, and audited with actions taken to improve compliance. (Regulation 12)
- The trust must implement an effective system to ensure patients receive timely medicines reconciliation. (Regulation 12)
- The trust must ensure staff understand and work within the requirements of the Mental Capacity Act 2005 whenever they work with people who may lack the mental capacity to make specific decisions. (Regulation 13)
- The trust must ensure staff appropriately record mental capacity assessments and decisions made in service users' best interests. (Regulation 13)
- The trust must ensure service user records are audited appropriately to evidence ongoing compliance with the requirements of the Mental Capacity Act 2005 and to identify missed opportunities to safeguard service users. (Regulation 13)

Our findings

- The trust must ensure staff undertake assessments for patients who have a learning disability, where care needs are assessed and planned to meet their individual needs. (Regulation 17)
- The trust must implement an effective system to assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service in line with the regulations (Regulation 17)
- The trust must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. (Regulation 18)

Medicine (South Tyneside District Hospital)

- The trust must ensure staff appropriately monitor, assess, and escalate when service users' physical health deteriorates in line with best practice, this should be monitored and audited with actions taken to improve compliance. (Regulation 12)
- The trust must ensure staff appropriately monitor, assess, and escalate when service users' mental health deteriorates. (Regulation 12)
- The trust must ensure staff undertake and appropriately record intentional rounding of all service users and ensure this is recorded, monitored, and audited with actions taken to improve compliance. (Regulation 12)
- The trust must ensure staff understand and work within the requirements of the Mental Capacity Act 2005 whenever they work with people who may lack the mental capacity to make specific decisions. (Regulation 13)
- The trust must ensure staff appropriately record mental capacity assessments and decisions made in service user's best interests. (Regulation 13)
- The trust must ensure service user records are audited appropriately to evidence ongoing compliance with the requirements of the Mental Capacity Act 2005 and to identify missed opportunities to safeguard service users. (Regulation 13)
- The trust must ensure staff undertake assessments for patients who have a learning disability, where care needs are assessed and planned to meet their individual needs. (Regulation 17)
- The trust must implement an effective system to assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service in line with the regulations (Regulation 17)
- The trust must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. (Regulation 18)

Maternity

- The trust must ensure staff undertake cardiotocographies (CTGs) and ensure this is recorded, assessed, monitored and escalated as appropriate with fresh eyes assessments. (Regulation 12)
- The trust must ensure staff complete the WHO safety checklist when required, and ensure this is recorded, monitored, and audited with actions taken to improve compliance. (Regulation 12)

Our findings

- The trust must ensure medicines are stored appropriately, and records of medication including controlled drugs, are maintained appropriately. (Regulation 12)
- The trust must implement systems to ensure that midwifery staff are suitably qualified, skilled and competent to care for and meet the needs of patients within all areas of the maternity services, including in the community. (Regulation 12)
- The trust must implement an effective system to assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service in line with the regulations (regulation 17)
- The trust must ensure risk assessments including clinical service risk assessments are up to date, thoroughly assessed and documented and benchmarked against national statutory and best practice guidance. The trust must ensure records of risk assessments are effectively maintained. (Regulation 17)
- The trust must implement an effective system to identify and report incidents including the severity of harm. The system must ensure incidents are appropriately reported to internal and external systems within appropriate timescales. The system must ensure incidents are effectively reviewed, lessons and actions are identified and shared with staff. (Regulation 17)
- The trust must implement an effective system to ensure the assessment, prevention and management of infection prevention and control in the physical environment, this is recorded, monitored, and audited with actions taken to improve compliance. (Regulation 17)
- The trust must implement an effective system to ensure service users in established labour receive one to one care in line with best practice. (Regulation 17)
- The trust must ensure effective risk and governance systems are implemented that supports safe, quality care. (Regulation 17)
- The trust must ensure audit information is up to date, accurate and properly analysed, areas for improvement are identified and action is taken to make improvements to the quality and safety of care (Regulation 17)

Action the trust SHOULD take to improve:

Medicine (Sunderland Royal Hospital)

- The trust should ensure patients living dementia have personalised plans of care which consider their individual needs and preferences.

Medicine (South Tyneside District Hospital)

- The trust should ensure patients living dementia have personalised plans of care which consider their individual needs and preferences.

Is this organisation well-led?

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

Our findings

Leadership

Senior leaders had the necessary knowledge, skills and abilities to effectively lead the trust. Leaders including the board were visible and approachable in the trust for patients and staff. They supported staff to develop their skills and take on more senior roles. However, leaders did not consistently identify, understand and manage the priorities and issues the trust faced.

The trust board had the appropriate range of skills, knowledge and experience to effectively lead the trust. The board was comprised of the executive and non-executive directors. There were six executive directors including the chief executive, medical director, the director of nursing, midwifery and allied health professionals, the director of human resources and organisational development, the director of planning and business development, and the executive director of finance. There were six non-executive directors in post including the chair who were voting members of the board, and one additional non-executive director who was a non-voting member of the board.

The trust's board was stable and well-established. The majority of the trust's executives had worked in their roles in either of the predecessor organisations prior to the merger. The newest appointee to the trust's executive team was the executive director of finance who had joined the trust in as deputy director of finance in 2020 and was appointed to the executive role in 2021.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. The trust's senior leadership team comprised of the six executive directors and six additional directors. The leadership team met weekly to discuss a range of issues. When senior leadership vacancies arose the trust reviewed capacity and capability needs. The trust reviewed leadership capacity and capability on an ongoing basis. Following our inspection, two new non-executive directors joined the trust's board of directors. The chief executive told us that the trust was exploring the opportunity to increase the number of executive directors whilst maintaining an appropriate balance in numbers between executive and non-executive directors. Succession planning was in place with examples including at board level of development of deputy leaders to take on more senior posts.

Each executive and non-executive director received an annual appraisal of their performance by either the chief executive or chair. The chair received an annual appraisal from the senior independent director supported by the lead governor.

The trust leadership team did not display a consistent comprehensive knowledge of current priorities and challenges across all sectors and there were examples where the action to address concerns had not been effective. There were examples where senior leaders had been slow to recognise issues in frontline services and shortfalls in governance. We found concerns in both maternity and in medical wards which had not been identified by the trust's internal systems, which meant senior leaders were not always sighted on issues in frontline services. When we raised concerns with senior leaders following our inspection, our revisits found the action taken to address these concerns did not always lead to improvements.

The trust had a board development programme in place which included a regular programme of workshops and other specialist training for board members. Three of the six board development sessions held between January 2022 and July 2022 had focussed on improving quality in maternity services which was seen as a priority for the trust.

There was a programme of board visits to services. The trust had established 'safety champion walkarounds' which included visits to services from executive and non-executive directors. The findings from the walkarounds were presented in board meetings. In July 2022, the board had undertaken two visits to maternity services. The walkarounds gave frontline staff the opportunity to meet and provide feedback to senior leaders.

Our findings

Leadership development opportunities were available, including opportunities for staff below board level. The trust had secured continuous professional development funding for staff which included access to specialist and inclusive leadership courses.

The trust had an associate medical director, supported by a deputy director of nursing, to lead on the quality of care provided to patients with mental health needs, learning disabilities and autism.

Fit and Proper Persons Regulation (Directors)

The fit and proper persons regulation ensures that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards are fit and proper to carry out this important role. During the inspection, the trust was required to provide evidence showing it had undertaken appropriate appointments of its board directors and had satisfied itself that at appointment, and subsequently, all directors were deemed to be fit and proper and of good character. During our review we found the trust did not complete the required checks on an ongoing basis to evidence compliance with the requirements of the regulation.

We reviewed the personnel files of eight executive and non-executive directors including the trust chair and chief executive. The majority of the trust's board had been in post for several years and had worked for the trust's predecessor organisations.

The trust did not regularly review or update checks with the disclosure and barring service (DBS) for all executive and non-executive directors. The trust had not undertaken a check with the disclosure and barring service for the majority of directors since 2017 and almost half of the board of directors had not had a check with the service since 2015.

The trust's employment checks policy required two employment references for all newly employed directors. Only two of the eight files we reviewed included two employment references for the appointed director.

All files included records of interviews and checks with professional bodies and national registers including the insolvency register. All directors had received an annual appraisal within the last 12 months.

Vision and Strategy

The trust had a vision for what it wanted to achieve and had recently launched a new strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Senior leaders knew the new strategy although there was further action needed to share the strategy with staff.

The trust had a clear vision and set of values with quality and sustainability as the top priorities. The trust's vision was 'excellence in all that we do'. The trust had refreshed the values of the organisation since the last inspection. The new values were:

- Compassion: we are kind and caring
- Teamwork: we work as a team
- Honesty: we are open and honest
- Respect: we treat people with respect

Our findings

Staff and people who used services had been involved in developing the strategy. The trust's refreshed vision and values were designed to be easier to understand, using more accessible language than the previous vision and values. The trust had established a behavioural framework to support the vision and values and to establish how staff should demonstrate the values in practice.

The new vision, values and strategic objectives were launched in Summer 2022 and this process was ongoing at the time of inspection. The trust embedded its vision, values and strategy in corporate information received by staff and by people who used services. The trust's website and social media spaces had been updated to reflect the new vision and values. We saw during our inspection there were posters focussing on the new vision and values located in staff and public areas.

The trust had developed and recently launched a new strategy for achieving the trust's priorities and developing good quality, sustainable care. The five-year strategic framework published in July 2022 set out the trust's five strategic objectives which were:

1. Safety and quality
2. Staff experience
3. Share and learn
4. Sustainability
5. Leadership

As part of this strategy, the trust had committed to developing an annual plan which would be refreshed for every year of strategy. The trust had established a framework for applying the vision, values and new strategy and how achievement of these would be reviewed and aligned on an annual basis to the work of their team and to staff members' individual objectives.

The trust had aligned its strategy to local plans in the wider health and social care economy and had committed to working in partnership with external stakeholders. Senior leaders actively contributed to the development of the integrated care system and were leading several workstreams. The trust's strategy included a commitment to working with other teams and partners to improve care pathways for patients.

The trust's quality strategy 2018-23 set the trust's five-year goals to reduce avoidable harm, provide the best patient experience, achieve the best clinical outcomes and support patients to be actively involved in their own care and treatment. The quality strategy established three domains which were patient safety, patient experience and clinical effectiveness to achieve the goals. Each domain had five priority workstreams to underpin the delivery of the strategy.

The trust had a strategy for meeting the needs of patients with a dementia diagnosis which was launched in 2018 and was set to run until 2023. The strategy had six strategic aims which included delivering person centred care, a competent and compassionate workforce, evidence-based pathways of care and assessment, strong partnerships and engagement, dementia friendly environments, and clear accountability and governance. However, the trust did not routinely identify milestones and monitor performance to demonstrate they were delivering on their strategic direction. For example, we saw the quality report presented to the trust board included performance data for dementia screening including a target of 90% 'screen all eligible patients, provide them with a conclusive assessment'. Data against this target was not available or not presented between January and June 2022.

Our findings

The trust did not have a specific mental health strategy or learning disabilities strategy. The trust's quality strategy included a priority work stream to which recognised the need to provide person-centred care for all patients with physical, mental health and learning disabilities. The trust could not provide examples of reports, dashboards or other performance monitoring measures to evidence oversight and show they were delivering the quality strategy in relation to mental health or learning disabilities or that this had an impact on improving patient experience.

None of the performance measures presented in the trust's May 2022 quality report explicitly related to the care of patients with mental health needs or a learning disability. The quality report did not show the trust's compliance with Mental Capacity Act which was a priority workstream in the trust's quality strategy.

The trust planned services to take into account the needs of the local population. Since 2018 the trust had worked alongside local clinical commissioning groups to develop and implement the 'Path to Excellence', which was a five-year healthcare transformation programme. This programme was paused during the COVID-19 pandemic and had restarted in February 2021. The programme had reached the second phase by 2021 and was focussed on improving emergency care and acute medicine, emergency surgery and planned operations, planned care and outpatients, and clinical support services.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. The trust board had established a sub-board strategy committee which was chaired by a non-executive director.

Culture

Not all staff felt respected, supported and valued. Some staff told us the trust did not have had an open culture where patients, their families and staff could raise concerns. However, staff were focused on the needs of patients receiving care. The trust mostly promoted equality and diversity in daily work, and provided opportunities for career development.

The trust's 2021 staff survey results were consistently below the national average in all questions related to compassionate culture and compassionate leadership. The trust results in relation to staff feeling valued, respected, and rewarded were also below the national average in every question except for satisfaction with levels of pay. The trust's results were lower than in 2020 and reflected a greater reduction than the national average.

Not all staff felt positive or proud about working for the trust and their team. The results showed 56% of staff would recommend the trust as a place to work and 65% of staff would recommend the trust as a place to receive care. Both results were slightly below the national average of 58% and 67% respectively. Most teams had positive relationships, worked well together and addressed any conflict appropriately although in maternity staff told us that there had been divides between staff and managers which were still being addressed.

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. The Trust Secretary who was also the Director of Corporate Affairs and Legal acted as the trust's Freedom to Speak Up Guardian. The trust had also appointed 10 Freedom to Speak Up Ambassadors to support the Freedom to Speak Up Guardian in their role. During our inspections of the trust's medicine and maternity core services, we found not all staff knew about the trust's Freedom to Speak Up Guardian.

The trust did not have a Freedom to Speak Up strategy, although the roles and responsibilities of the Freedom to Speak Up Guardian and Ambassadors were included within the trust's 'Freedom to Speak Up: Raising Concerns

Our findings

(Whistleblowing) Policy' which was in date and due for review in September 2022. The trust told us that a Freedom to Speak Up strategy would follow after the trust had concluded the 'Big Team Talk' which established the trust's future vision, values and strategic objectives. The trust had implemented mandatory training for staff to raise awareness of the right to raise concerns and compliance was above 80% for modules available to both staff and managers.

The trust board received an annual report and six-monthly update from the Freedom to Speak Up Guardian. The most recent report in May 2022 showed an increase in concerns raised via the Freedom to Speak Up Guardian. In 2021/22 there were 42 concerns raised, which was an increase of nine from the previous year. Of the 42 concerns raised, ten were raised by staff who did not wish to disclose their identity which was an increase from one the previous year.

The trust did not always ensure appropriate learning was identified or action taken because of concerns raised. The report noted that 22 concerns had been raised elsewhere prior to contact with the Freedom to Speak Up Guardian/ ambassadors however the staff member either felt no action had been taken or the issue was still a concern. Themes of concerns included patient and staff safety, allegations of bullying and harassment and concerns about leadership.

Staff survey results showed staff felt able to raise concerns. The trust's results were consistently above the national average for all questions related to raising concerns including whether staff would feel safe to speak up about anything that concerned them within the trust. Our inspection found some staff particularly in maternity services did not believe the trust had a culture where staff could raise concerns openly.

Staff did not always have the opportunity to discuss their learning and career development needs at appraisal. Appraisal rates in maternity services were significantly below the trust's target. The trust board considered data showing appraisal compliance rates across all services in private board meetings. Appraisal rates across the trust were consistently below the trust's target.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust had an occupational health and well-being team. This team also led on the trust's annual influenza vaccination programme. Sickness and absence performance in some services were significantly above the trust's target. Between March and June 2022, sickness rates were consistently above 8% against a trust target of 4%. In May 2022 the sickness rate for unregistered staff exceeded 20%. Total absence figures in maternity were consistently above 13% for registered midwives in the same period. Sickness rates across the trust were consistently above the trust's target between April 2021 and March 2022.

The trust addressed staff concerns and poor staff performance where needed. The trust monitored the number of cases of grievance and disciplinary. The trust's board report did not show how quickly cases were investigated and concluded which meant it was not possible to evidence whether the trust dealt with concerns and performance within appropriate timescales. Instead, the report included the numbers of employee relations cases carried forward from each quarter, the breakdown of the types of cases and protected characteristics of employees involved, and the number of cases still open at the end of each quarter.

The trust mostly applied the Duty of Candour appropriately. Staff in frontline services knew about the Duty of Candour and how to apply it in practice. Until June 2022, the trust had a target of responding to identified incidents in line with the Duty of Candour within ten working days. The trust did not consistently achieve this target and in June the target was extended to a response within twenty working days. Of the 28 incidents meeting the threshold for Duty of Candour in June 2022, the trust had responded to 22 (79%) in line with the requirements of Duty of Candour within twenty working days.

Our findings

The workforce race equality standards report approved in September 2021 showed that of the 8432 staff employed by trust, 11.2% of staff declared they were from a Black, Asian and Minority Ethnic (BAME) background which was slightly higher than the previous year (10.4%). The number of staff employed by the trust from a BAME background increased in 2021/22 to 12.6%. The trust's report in 2021 stated none were employed by the trust as very senior managers.

Of the 15 members of the trust's board, 13.3% were from BAME groups and 6.7% had not declared their ethnicity.. Staff from a BAME group were almost three times more likely than their white colleagues to enter into formal disciplinary processes.

The trust monitored diversity within the workforce although around one in three staff had chosen not to disclose their religion, sexuality, or whether they had a disability. The number of staff who chose not to disclose their ethnicity had increased from 2.9% in March 2021 to 3.7% in March 2022.

Staff networks were in place to promote the diversity of staff. The trust had established networks for staff from a BAME background (the BAME staff network), staff who identified as Lesbian Gay Bisexual and Transgender and allies (the LGBT+ staff network), and for staff who had a mental or physical health condition (Positive Health staff network). Each network had appointed a network chair and met between four and six times in 2021/22. The staff network chairs sat on the trust's Equality, Diversity and Inclusion steering group which reported to board of directors via the workforce committee.

The trust worked appropriately with trade unions. Trade union representatives were positive about relationships with the trust and told us that senior managers engaged well with unions. The trust recognised staff success by staff awards and through feedback. The trust supported staff to achieve national recognition and awards.

Governance

The trust did not consistently operate effective governance processes to ensure all patients received high-quality care which met their needs. There were examples where failures in governance systems had resulted in unmitigated risks. Staff at all levels were clear about their roles and accountabilities and although not all staff had opportunities to meet, discuss and learn from the performance of the trust.

The trust board had established eleven sub-committees with delegated authority in line with the sub-committee's terms of reference. The terms of reference for the board of directors detailed the matters which were reserved to the board for a collective decision. This included setting the values and strategic direction of the trust, approving the strategic direction, and approval of the annual report, accounts, and quality report.

The executive committee, governance committee and workforce sub-board committee each had a number of steering groups, assurance groups and other meetings which reported through to the board through their parent sub-board committee. The governance committee, supported by the clinical governance and corporate governance steering groups, held responsibility for the management of risk, and oversight of the quality of services and patient safety.

Leaders regularly reviewed these structures. The terms of reference for each board sub-committee were last reviewed in November 2021. Each sub-committee undertook a self-assessment of its effectiveness although the findings of this review were not presented to the trust's board of directors. The trust had amended this process for the next review in 2022.

Our findings

Non-executive directors were clear about their areas of responsibility. Each sub-committee was chaired by designated non-executive director with additional non-executive directors as committee members. Executive directors were clear about their areas of responsibility although there were examples where directors did not demonstrate shared accountability and ownership of key areas of performance or risk.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. The number of sub-committees and their diverse remit meant that there were examples of duplication where several sub-committees reviewed the same information. Complaints information was presented to the patient, carer and public experience committee, the governance committee and the board. Internal audits were presented to the governance committee and the audit committee. The trust's refreshed falls prevention policy and staff rostering policy had both been presented to the policy committee and the governance committee (falls prevention) and workforce committee (staff rostering).

The trust did not have a consistent framework which set out the structure of ward/service team meetings. Team meetings in maternity services did not take place due to operational pressures in most of the services we inspected. This reduced opportunities for managers to use meetings to share essential information such as learning from incidents and complaints and to take action as needed.

The trust had implemented a detailed and comprehensive monthly Maternity and Neonatal Quality and Safety Report which is received at Trust Board level. This includes the maternity dashboard to improve ward to board oversight of key areas of performance in maternity services as well as incidents, risks, complaints, litigation, patient feedback, training and appraisal compliance.

Divisional leaders met monthly and operational matrons met every two weeks. Staff in medicine were able to give examples of ward to board and the trust provided examples of emails reminding staff of highlighted issues in intentional rounding and NEWS escalation processes.

Staff at all levels of the organisation understood what to escalate to a more senior person although we found the trust's systems for reporting low staffing levels reduced opportunities for staff to escalate concerns to the most senior managers. Ward managers told us that they had previously had the option to report red flags due to low staffing levels. The number of red flags were reported monthly to the board. The trust had changed this system and now allowed only more senior managers to report red flags. Ward managers told us that this change was the result of staff escalating low staffing levels too frequently, senior leaders did not provide a rationale for why this change had been made.

The trust was working with third party providers effectively to promote good patient care. A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements. The liaison service was based at both South Tyneside District Hospital and Sunderland Royal Hospital and was available 24 hours a day, seven days a week. The service provided assessment, support and onward referral to specialist services.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The trust used an electronic system to report incidents and all staff had access to the system. Between September 2021 and August 2022, the trust declared 61 serious incidents (including one subsequently downgraded incident) to the Strategic Executive Information System (STEIS) and over 17,000 incidents of which less than 2% were categorised as moderate or severe harm or resulted in a patient's death. Of the 61 incidents declared by the trust, 51 were reported 15 days or more after the incident occurring and 25 were reported more than 90 days after the incident.

Our findings

Most serious incidents involved falls or delays in treatment resulting in significant harm or were maternity/obstetric incidents meeting the national definition of serious incidents. We reviewed five serious incidents reports. All had clear terms of reference although there was limited evidence in each showing that families had been involved. Investigation reports included recognition of good practice in incidents as well as identifying relevant areas for improvement.

The trust produced an annual safeguarding report in line with legislative requirements. The report showed the number of safeguarding referrals for adults made by the trust for adults had increased from 990 in 2020/21 to 1304 in 2021/22. The number of children's referrals had decreased by 10% in the same period and the trust's report attributed this to the models which had been designed to ensure early interventions in Sunderland and South Tyneside.

Appropriate governance arrangements were mostly in place in relation to the administration and compliance with the Mental Health Act. The trust monitored the use of the Mental Health Act with a quarterly report which was presented to the trust's safeguarding committee. The trust's Mental Health Act policy was overdue for review at the time of inspection.

The trust did not have a governance framework to address the need to meet people's mental health needs. The trust had established a mental health steering group in 2022 which had met three times prior to the inspection. The role and remit of the group were still being agreed at the time of inspection. The trust did not have effective systems to monitor whether staff were able to meet the needs of patients presenting with mental health problems. Staff received limited basic training in managing patients with mental health needs and compliance with this training was both low and was not mandatory. The trust did not routinely gather information or monitor incidents which involved the use of restrictive interventions such as restraint or rapid tranquilisation. Ward staff did not receive specialist training in the use of restraint and incident reports showed staff had been required to use restraint in patients' best interest. The trust did not audit whether patients presenting with mental health needs had received an appropriate risk assessment or whether risk management plans had been effectively implemented.

The trust had implemented systems to identify and learn from unanticipated deaths although these systems did not ensure all deaths were reviewed appropriately. The trust had a mortality review and learning from deaths policy which was in date and due for review in June 2026. The trust had established a mortality review group which met quarterly and had last met in March 2022. The trust did not undertake an initial screening of all deaths in line with the trust's Mortality Review and Learning from Deaths Policy. The purpose of the initial screening was to identify whether the death met the criteria for further investigation and a more detailed review by the trust's mortality review group. Data presented to the board showed that 77% of deaths occurring between July and September 2021 had an initial screening to identify if the death met the criteria for further review. This had increased to 82% by December 2021 but dropped to 74% by March 2022. In the same period since July 2021, the trust consistently undertook more detailed case record reviews of between 15-18% of deaths each quarter which was lower than the national nationally recommended sample size of 25%. During our 'well-led' inspection we looked at examples of the reviews undertaken in line with the trust's mortality review processes. The trust's approach to reviewing deaths did not fully identify opportunities for learning or correctly assess whether incidents and omissions in care provided evidence that the deaths were preventable.

Management of risk, issues and performance

The trust's systems for identifying, escalating and managing risks, issues and performance were not always effective and had resulted in significant unmitigated risks developing in frontline services. However, leaders had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Our findings

The trust's process for identifying, recording and managing risks, issues and mitigating actions relied on risk registers at directorate and corporate level, and a board assurance framework. The corporate risk register and board assurance framework were not used effectively to manage operational or strategic risks. Recorded risks did not align with what senior leaders said were on their 'worry list'. Directors repeatedly highlighted operational and strategic risks during the inspection which were not recorded on either the board assurance framework or the corporate risk register. Directors did not have a consistent view of risk, with some highlighting areas where the trust had improved, such as missed medications, that other directors described as an ongoing area of concern. Of the 327 risks on the trust's full corporate risk register, 50 had not been reviewed since 2021 and were overdue for review. Eight of risks overdue for review were rated as extreme risks. Staff had access to risk registers at divisional level although there were inconsistencies in how risks were escalated from divisional risk registers to the corporate risk register. This had resulted in instances were divisions were managing risks without senior oversight or support.

The trust board reviewed the board assurance framework twice a year. This was less often than recommended by national guidance which recommends a review of the board assurance framework quarterly or every two months. The trust's risk management policy stated that all risks must be reviewed on a quarterly basis. Our review of the trust's risk register identified risks which were overdue for review. Some risks were identified as requiring a review in 2023 which was contrary to the trust's risk management policy.

The trust failed to comply with previous CQC requirement actions and failed to make the required improvements by the time we reinspected services. We also identified breaches of regulation which showed a failure to act on past risks and a track record of repeated breaches within three years. Our previous inspection of the trust's maternity services in 2020 identified concerns and breaches of regulation related to baby abduction drills, hand hygiene audits, resuscitation trolleys, compliance with WHO checklists, compliance with the 'Fresh Eyes' approach to CTG assessments, appraisal rates, and the management of risks related to the second theatre. This inspection found the trust had not taken effective action to address the concerns found during the previous inspection. Our previous inspection of medicine in 2020 identified concerns and breaches of regulation related to sepsis care and compliance with the Mental Capacity Act 2005. This inspection also found the trust has not taken effective action to address these concerns.

Operational oversight

We found the trust board did not always have sight of the most significant risks facing the trust and mitigating actions were not always clear. Whilst leaders were satisfied that clinical and internal audits and governance systems were sufficiently robust to provide assurance, we found examples where these had failed to identify risks or where remedial action following poor audit results had been ineffective. Our first inspection in June 2022 found identified significant risks in frontline services which resulted in urgent requests for information and action from the trust. The information provided by the trust following our first inspection confirmed our findings and showed the issues found by the team were systemic and affected multiple wards and services. These issues had not been identified by internal governance systems prior to the inspection. Our second visit in August 2022 found the trust had addressed some but not all of the areas of the concern. Our well-led inspection found several concerns in the trust's governance systems which had not been identified by the trust. Throughout our inspections we identified a recurrent theme where the trust failed to demonstrate operational focus and oversight, or have effective systems to identify risks to enable them to implement timely action to mitigate the risks to patients receiving care in frontline services.

In maternity services, we found there were some clinical areas where care was being delivered which were not safe. The service had an operating theatre which was a repurposed patient bedroom. Although the theatre was infrequently used, it did not have the equipment necessary to provide safe care and treatment. The room did not meet standards to prevent and control the risk of infection. The risks of using this operating theatre had not been escalated to senior

leaders. The risk was recorded on the directorate risk register but was not assessed as sufficiently high-risk to be included on the corporate risk register. We escalated our concerns about the use of this theatre and senior leaders told us it would be closed with immediate effect. When we returned the next day, we found that the theatre had been reopened overnight without senior oversight or approval. This was escalated a second time to senior leaders who assured us that the theatre was closed with additional surgical capacity created elsewhere in the trust should it have been needed.

During our inspection of the trust's well-led, we undertook further inspection activity of the maternity services and found that, following some improvements to the environment, the theatre had been reopened and was available for use. This decision was made by the trust's executive directors and did not require the approval of the trust's full board of directors. This was because the reopening of the theatre was an operational decision and followed an options paper submitted to the trust's executive committee. The trust could not provide evidence that a full risk assessment of the theatre had been completed prior to reopening and they could not find the risk assessment on the day we asked for this. The next day the trust provided a risk assessment that had been completed the previous day as they could not find the original. Following the inspection CQC provided the trust with a second opportunity to provide evidence showing the trust had followed effective processes to assess and manage the risks in relation to the use of the theatre and had considered these risks alongside the risks of alternative options. In their response, the trust stated that the original options paper considered by the executive committee included a risk assessment of each option. The paper did not include evidence of a comprehensive risk assessment of each of the options available to the trust including reopening a theatre which potentially put patients at the risk of harm. The reopened theatre still did not meet standards to prevent and control the risk of infection or have all the equipment necessary to provide safe care and treatment. During the inspection, the trust told us it planned to replace the theatre in Autumn 2022. The trust later clarified during factual accuracy checks of the draft report that the theatre would be replaced in Winter 2022.

The trust had joined the Maternity incentive scheme which supports the delivery of safer maternity care through an incentive element to the contributions to the clinical negligence scheme for trusts (CNST). Trusts are rewarded when they meet ten safety actions which are designed to improve the delivery of best practice in maternity and neonatal services. The trust had originally identified they were compliant with all ten safety actions. However, following an internal review the trust resubmitted their assessment of compliance with year three safety actions and identified it was compliant in only two safety actions. This had resulted in the trust needing pay back over £1million to NHS Resolution. The trust faced a risk of further repayments pending the outcome of reviews looking at the trust's compliance in previous years. This risk was included on the local risk register for maternity services but not on the trust's highest-level corporate risk register. Despite the significant potential financial impact on the trust's ability to deliver on its strategy, this risk was not included on the trust's board assurance framework.

In medicine, we identified concerns in how the service managed deteriorating patients, intentional rounding, care for patients with sepsis, and how staff followed the requirements of the Mental Capacity Act in order to protect patients' rights.

The National Early Warning Score (NEWS2) is a system used to monitor a patient's physiological measurements. We found during our first visit that staff did not consistently score patients using NEWS2, or undertake routine observation or escalate for medical review when NEWS2 scores showed patients' physical health were deteriorating. Our findings differed significantly from the trust's own audit undertaken the month prior to our inspection which found 100% of NEWS2 charts were accurate with monitoring plans in place and appropriate escalation, and 70% had resulted in timely

escalation for medical review. The trust undertook a broad review in response to our inspection which found poor compliance in relation to the use of NEWS2 on most wards which meant the trust's audits prior to our inspection were not sufficiently robust to provide assurance. Our revisit in August 2022 found the trust had acted to make improvements in practice following our feedback.

The trust had not taken effective action to improve performance in the care of service users with sepsis. The trust had made limited progress with the 2021/22 quality target 'Improve the outcomes for patients [service users] with serious infection by ensuring timely identification and treatment of sepsis' which was rated as amber. The trust's performance was consistently poor since June 2021. Board papers showed performance with key performance indicators for 'Ensure timely treatment of patients [service users] with confirmed sepsis with antibiotic administration <1 hour' never achieved the 90% target between June 2021 and May 2022. The trust's performance was 77% in May 2022 for inpatient admissions. The trust's performance for emergency admissions was lower with 56% of service users admitted as an emergency had antibiotics administered within one hour of initial suspicion of sepsis. Board papers did not include details of actions taken to address the consistently poor compliance with trust targets.

Intentional rounding is a structured process carried out by nursing staff to check at regular intervals on patients' physical health and personal needs including whether patients are in pain or need any additional support. We found gaps in records of intentional rounding on all wards we visited during our first visit. The trust's review in response to our inspection identified this was an issue on most wards. Whilst our revisit in August 2022 found the trust had made and sustained improvements in practice, this risk had not been identified by internal audit prior to our inspection.

The Mental Capacity Act 2005 governs decision-making on behalf of adults who may not be able to make specific decisions. This could be because of, for example: a learning disability, an illness such as dementia or mental health problems. We found during our first visit that staff did consistently identify and assess patients who may lack capacity to make decisions about their care. Staff did not consistently record capacity assessments or decisions made in patients' best interests, including patients subject to Deprivation of Liberty Safeguards. The trust's review in response to our inspection identified this was an issue on most wards. Our return visit in August 2022 found this was still a concern on most wards we revisited which meant the trust had not taken effective action to embed and sustain improvements in adherence to the Mental Capacity Act across all wards. Following our inspection, the trust provided an action plan which included seven recommendations for improvements to improve compliance with the Mental Capacity Act. Four of the seven actions were not due for completion until November 2022. The trust's action plan did not provide assurance that the trust would take immediate action to make improvements.

The trust did not complete the required checks of senior leaders on an ongoing basis to evidence compliance with the requirements of the fit and proper persons' regulation. The trust did not have an effective process to ensure that all staff who were employed by the trust were regularly reviewed to ensure they continued to be of good character. Of the 6053 staff employed by the trust in August 2022, 73% (4441) had not had a recheck with the Disclosure and Barring Service (DBS) following their initial recruitment for more than three years. Over 50% had not been rechecked since 2016 and nearly one in every five staff had not been rechecked for more than ten years. The trust's DBS policy required staff to inform the Director of Human Resources and Organisational Development if they had contact with the criminal justice system including a conviction, warning, caution or were under police investigation. The trust's policy did not specify when staff needed to make this declaration to the trust. The trust had not undertaken a risk assessment of this approach prior to the inspection. Following our inspection feedback, the trust implemented a new policy to ensure all staff, including senior leaders, would have a recheck with the disclosure and barring service at least every three years and most directors had received their refreshed disclosure and barring service check by August 2022.

Our findings

Senior management committees and the board reviewed performance and quality reports covering a range of areas including accident and emergency care, referral to treatment standards, diagnostics, cancer waiting times and numbers of long-stay patients. The board received separate performance and quality reports for maternity services and for community health services including community child and adolescent mental health services. The board did not receive performance reports for the full range of services offered by the trust including dental services and community learning disability services.

There were plans in place for emergencies and other unexpected or expected events, for example adverse weather, a flu outbreak or a disruption to business continuity. The trust was asked to provide fire risk assessments for all sites including community locations. The trust did not provide fire risk assessments for all locations during the inspection, although did provide a sample of risk assessments including three community locations and all were in date. The trust provided fire risk assessments for each trust location following the trust's factual accuracy checks of our draft inspection report.

The trust had a process to assess the impact of cost improvement plans to ensure these plans did not compromise patient care. The trust's standard operating procedure for quality impact assessment had been reviewed in June 2022 and detailed the process for assessing the risk to the quality of healthcare in business plans, change projects, improvement plans and business cases or major consultations. The process included consideration of the impact of cost improvement plans on patient safety, clinical effectiveness and patient experience. The trust had a cost improvement target of 2% of operating expenses and was achieving more than planned by July 2022 as a result of non-recurrent pay savings.

Information Management

The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to the IT equipment and systems needed to do their work and the trust's IT systems had received international recognition for how they helped improve the quality of care.

The Healthcare Information Management Systems Society (HIMSS) is an international organisation which recognises seven stages of rollout of electronic medical records in healthcare providers. In January 2020, Sunderland Royal Hospital achieved HIMMS level six accreditation and by December 2020 the hospital had achieved level seven accreditation. The trust was the second NHS trust in the country to achieve level seven accreditation and remains one of only four in the country to have achieved this level of digital maturity. The trust explained that this meant services were '"paper free at the point of care". HIMMS accreditation was a requirement of NHS England's Global Digital Exemplar programme and the trust was one of 16 digitally advanced trusts originally selected to be part of this programme. The trust was the first in the country to achieve Global Digital Exemplar accreditation by completing all of the requirements of the programme. The trust had nominated South Tyneside District Hospital to be a 'fast follower' of this programme which provided the trust additional resources to support the hospital to rapidly accelerate the rollout of digital systems. By March 2022, the trust had achieved HIMMS level five at South Tyneside District Hospital.

The board mostly received comprehensive information on service quality and sustainability and the board and senior staff expressed confidence in the quality of the data. The trust was aware of its performance through the use of KPIs and other metrics. The board received a regular quality report which included details of key performance indicators including pressure ulcers, falls, nutrition and hydration, safeguarding, complaints, incidents, infection prevention and control and the management of deteriorating patients. Our inspection findings differed significantly from the data

presented to the board in relation to the management of deteriorating patients. The board did not receive data on compliance with the Mental Capacity Act or intentional rounding. These were areas of concern identified by the inspection. Some areas of performance including sepsis care, seven-day services, missed doses and medicines reconciliation routinely flagged in performance reports as achieving below trust targets. Most information was in an accessible format, timely, accurate and identified areas for improvement although there were areas including dementia care where performance data was not routinely presented. The action taken to improve these areas of performance was not always clearly documented in quality reports and the consistent poor performance in these areas showed the action was not effective. It was not possible to evidence that performance data fed into the board assurance framework or corporate risk registers.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Systems were in place to collect data from wards and teams. The trust had automated data collection systems which ensured monitoring performance was not over burdensome for front line staff.

Information governance systems were in place and ensured the confidentiality of patient records. The trust used a single electronic patient record system in most specialities which was password protected. The system recorded staff access to patient records. Community services and some specialities including radiology used separate electronic patient record systems which were also secure and password protected.

The trust had completed the Data Security and Protection Toolkit in June 2022. This assessed compliance with the National Data Guardian's 10 data security standards, compliance with the General Data Protection Regulation (GDPR) and ensuring cyber security within the organisation. The trust recognised that it had met all standards except for compliance with information governance training which was less than 1% below the required compliance rate (94.7% against a target of 95%). Compliance with all standards was achieved by the point of submission of the toolkit to external bodies with compliance in mandatory training rising above 95% by July 2022.

The trust learned from data security breaches. The trust had five information governance in the 12 months prior to inspection. Four of the five incidents involved the trust sending patient identifiable information to the wrong address. The trust had identified this theme from incident reports and had implemented a new standard operating procedure which included a checklist for staff to follow when sending patient identifiable information through external mail.

The trust had recognised and taken action to mitigate against the risk of cyberattack. This included phishing exercises where trust staff were sent false emails to test whether they would click on potentially dangerous links or give away login details to external websites. The latest test showed staff had reasonable awareness of cybersecurity with 85% of the 9166 emails addresses targeted taking no action to respond to the false email, although 14.6% (1573) of the recipient email addresses clicked at least once on the link within the email sent to them and 698 of these attempted to login to the phishing website. The trust had implemented an action plan which included additional training for staff to improve awareness of cybersecurity.

Leaders submitted notifications to external bodies as required although the trust was not always timely when submitting notifications. The trust had submitted two statutory notifications to CQC since registration and both were due to amendments to the trust's statement of purpose and locations. Between September 2021 and August 2022, the trust declared 60 serious incidents to the Strategic Executive Information System (STEIS) and over 17,000 incidents of which less than 2% were categorised as moderate or severe harm or resulted in a patient's death. Of the 60 incidents declared by the trust, 51 were reported 15 days or more after the incident occurring and 25 were reported more than 90 days after the incident.

Our findings

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had engaged with staff through the 'Big Team Talk'. Between July-September 2021 the trust had implemented monthly planning meetings with staff recruited as Team Talk champions. The champions supported the launch of the 'Big Team Talk' in October 2021. The project aimed to engage with staff using four questions:

1. What is most important to you when you come to work every day?
2. What do you believe is most important for our patients?
3. What do you think our priorities for the future should be?
4. How do you want us to involve and engage with staff better?

During the month-long project, staff were given the opportunity to complete a feedback form, write on a poster within their department, submit an online response via a virtual 'graffiti wall' or write on a poster in a communal area to answer the four questions. The trust received almost 9000 responses during this project with 70% of comments received via virtual or poster 'graffiti walls' and 30% via feedback forms posted into boxes in the Trust restaurants and main reception areas. The trust had sourced independent analysis of the feedback received by the project and had plans to share detailed feedback with staff in Autumn 2022.

Staff told us the chief executive was visible in the trust, although feedback about the visibility of other members of the board was less positive.

Communication systems including a public website, staff intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust's website allowed patients and carers to share their feedback directly through online forms. The website and posters on wards and in public areas provided details of how to contact the trust's advice and complaints service by email, freephone, or post. The trust had also established social media pages and allowed patients and carers to share feedback by direct messaging via social media.

The Friends and Family Test (FFT) gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment. The results of the June 2022 Friends and Family Test showed that 98% of the 256 patients who responded rated their experience as positive whilst receiving care as an inpatient. Patients receiving care in the trust's accident and emergency departments were less positive with eight of the 12 patients who responded to the Friends and Family Test rating their experience as poor or very poor.

The trust monitored both formal complaints and informal complaints received for each directorate. Senior leaders told us each directorate received a monthly report of feedback to enable them to make improvements, however the trust did not provide evidence of this. Between January and June 2022, the emergency care directorate consistently received the most formal complaints and informal concerns. The trust identified themes and trends from complaints. The most common themes from complaints received by the emergency care directorate related to clinical treatment or the values and behaviours of staff.

Our findings

We reviewed the records of four complaints. Each complaint was handled in accordance with the trust's policy and all were responded to within timescale set by the trust's policy. The Patient, Carer and Public Experience Committee (PCPEC) received a quarterly report on complaints which included details of the performance in handling complaints, and data showing the number of complaints, concerns and compliments for the trust as a whole, and complaints and concerns data broken down by directorate. The August 2022 report noted that the trust responded to 75% of complaints within 40 working days and responses completed beyond 40 working days related to coronial investigation, serious incident investigations and/or involved other organisations. The trust board received a regular highlight report from the Patient, Carer and Public Experience Committee which described in brief the key issues and decisions of the committee.

The trust had a structured and systematic approach to engaging with people who use services through the 'Path to Excellence' programme, which was a five-year healthcare transformation programme. The trust led this programme in partnership with the three clinical commissioning groups (now the North East and Cumbria Integrated Care Board) representing the areas of South Tyneside, Sunderland and County Durham. This programme had included opportunities for public and stakeholder engagement face to face events including public roadshows prior to the COVID-19 pandemic. Task and finish groups and advisory groups established to support the 'Path to Excellence' included representatives from Healthwatch. The trust enabled the public to engage virtually with the transformation of services and had offered eight virtual engagement sessions to enable the public to feedback and ask questions about the proposed new Sunderland Eye Hospital.

The trust sought to actively engage with people and staff in a range of equality groups. The trust attended the Sunderland Pride event in June 2022 taking part in the parade and hosting a stall to engage with the local community and discuss how to make services more inclusive for people who identify as LGBTQ+.

The trust engaged with stakeholders and ensured there was oversight and scrutiny from local authorities in key healthcare decisions affecting local people. Senior leaders and middle managers, on behalf of frontline staff, engaged with external stakeholders such as commissioners and Healthwatch. Trust representatives regularly attended the Health and Wellbeing Scrutiny Committees in Sunderland and South Tyneside. In September 2021, the trust presented details of the new integrated diagnostic centre in South Tyneside to the Health and Wellbeing Scrutiny Committee.

The trust was actively engaged in collaborative work with external partners and was involved with the newly established Integrated Care Board and Integrated Care System. The chief executive was leading two of the six workstreams established by the Integrated Care Board. These were 'Our People' which focussed on working as a system to build a strong and sustainable workforce and 'Optimising Services' which focussed on sustainable solutions for health services that are under the greatest of pressure.

The trust had 25 governors' roles including 15 governors elected from members of the public, six elected from staff working for the trust and four appointed from local authorities and universities. There was one vacancy as of July 2022 which was for a public governor to represent the 'rest of North East and Cumbria'. The trust offered public governors training to support them in their role after their appointment. Governors told us they were satisfied with the performance of the trust's board of directors and they felt actively involved in the operation of the trust. Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback. Governors' meetings were held in public four times a year and the trust held an Annual Members' meeting once a year. These had been held virtually in 2021 and 2020 to enable members to attend whilst managing the risk of COVID-19.

Our findings

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research. The trust had started to implement a quality improvement methodology to support and drive improvement in services.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning. The trust's Alcohol Care Team (ACT) had received national recognition winning the North East and Yorkshire NHS Parliamentary Award for Excellence in Healthcare.

The trust actively sought to participate in regional improvement and innovation projects. The trust's senior leaders were actively contributing and leading workstreams in the local integrated care system.

Staff had training in improvement methodologies and used standard tools and methods. The trust had trained 295 staff in quality improvement and subscribed to the Model for Improvement methodology advocated by the Institute for Health Care Improvement. There were examples where staff had time and support to consider opportunities for improvements and innovation and this had led to changes.

The trust had partnered with an external organisation to deliver additional support for children and young people including distraction products to improve their experience. The project included additional training for staff to support them to engage with children and young people with mental health needs.

Staff had established a project using quality improvement principles to reducing missed medicine doses on specific wards. The trust's wards for older people had received national recognition for virtual displays which demonstrated effective use of quality improvement methods.

The trust was actively participating in clinical research studies. In 2021/22 the trust recruited 3871 participants to 111 clinical trials; and launched 61 new clinical research studies across 18 clinical specialties. The trust produced an annual report to the board on performance in research and innovation. The report showed the trust had increased the number of research studies by 20% compared to the previous year.

There were organisational systems to support improvement and innovation work. The trust had separate lead directors for research and innovation and established a separate innovation team and research governance team.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Feb 2023	Requires Improvement ↓ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↓ Feb 2023

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Sunderland Royal Hospital	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023
Durham Diagnostics and Treatment Centre	Good Jun 2020	Not rated	Good Jun 2020	Requires improvement Jun 2020	Good Jun 2020	Good Jun 2020
South Tyneside District Hospital	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Good ➔➔ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023
St Benedict's Hospice	Good Jun 2020	Good Jun 2020	Good Jun 2020	Outstanding Jun 2020	Outstanding Jun 2020	Outstanding Jun 2020
Sunderland Eye Infirmary	Good Jun 2020	Good Jun 2020	Good Jun 2020	Outstanding Jun 2020	Good Jun 2020	Good Jun 2020
Overall trust	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023

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

Rating for Sunderland Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Feb 2023	Requires Improvement ↓ Feb 2023	Good →← Feb 2023	Requires Improvement ↓↓ Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↓ Feb 2023
Services for children & young people	Requires improvement Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Requires improvement Jun 2020	Requires improvement Jun 2020
Critical care	Requires improvement Jun 2020	Good Jun 2020	Outstanding Jun 2020	Good Jun 2020	Requires improvement Jun 2020	Requires improvement Jun 2020
End of life care	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Surgery	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Urgent and emergency services	Requires improvement Jun 2020	Good Jun 2020	Good Jun 2020	Requires improvement Jun 2020	Good Jun 2020	Requires improvement Jun 2020
Maternity	Requires Improvement →← Feb 2023	Requires Improvement ↓ Feb 2023	Good →← Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement →← Feb 2023	Requires Improvement →← Feb 2023
Outpatients	Good Jun 2020	Not rated	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Overall	Requires Improvement →← Feb 2023	Requires Improvement ↓ Feb 2023	Good →← Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement →← Feb 2023	Requires Improvement →← Feb 2023

Rating for Durham Diagnostics and Treatment Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good Jun 2020	Not rated	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Surgery	Good Jun 2020	Not rated	Not rated	Requires improvement Jun 2020	Good Jun 2020	Requires improvement Jun 2020
Overall	Good Jun 2020	Not rated	Good Jun 2020	Requires improvement Jun 2020	Good Jun 2020	Good Jun 2020

Rating for South Tyneside District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Feb 2023	Requires Improvement ↓ Feb 2023	Good → ← Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↓ Feb 2023
Services for children & young people	Requires improvement Dec 2015	Requires improvement Dec 2015	Good Dec 2015	Good Dec 2015	Requires improvement Dec 2015	Requires improvement Oct 2016
Critical care	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
End of life care	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Surgery	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Urgent and emergency services	Requires improvement Jun 2020	Good Jun 2020	Good Jun 2020	Requires improvement Jun 2020	Requires improvement Jun 2020	Requires improvement Jun 2020
Maternity	Not rated	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good → ← Feb 2023
Outpatients	Good Jun 2020	Not rated	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Overall	Requires Improvement ↓ Feb 2023	Good → ← Feb 2023	Good → ← Feb 2023	Good → ← Feb 2023	Requires Improvement ↓ Feb 2023	Requires Improvement ↓ Feb 2023

Rating for St Benedict's Hospice

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good Jun 2020	Good Jun 2020	Good Jun 2020	Outstanding Jun 2020	Outstanding Jun 2020	Outstanding Jun 2020
Overall	Good Jun 2020	Good Jun 2020	Good Jun 2020	Outstanding Jun 2020	Outstanding Jun 2020	Outstanding Jun 2020

Rating for Sunderland Eye Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Urgent and emergency services	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Outpatients	Good Jun 2020	Not rated	Good Jun 2020	Outstanding Jun 2020	Good Jun 2020	Good Jun 2020
Overall	Good Jun 2020	Good Jun 2020	Good Jun 2020	Outstanding Jun 2020	Good Jun 2020	Good Jun 2020

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with a learning disability or autism	Requires improvement Jun 2020	Requires improvement Jun 2020	Good Jun 2020	Good Jun 2020	Requires improvement Jun 2020	Requires improvement Jun 2020
Community mental health services for people with a learning disability or autism	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Requires improvement Jun 2020	Good Jun 2020

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

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2020	Good Jun 2020	Outstanding Jun 2020	Outstanding Jun 2020	Good Jun 2020	Outstanding Jun 2020
Community dental services	Good Jun 2020	Good Jun 2020	Good Jun 2020	Outstanding Jun 2020	Good Jun 2020	Good Jun 2020
Community end of life care	Good Jun 2020	Good Jun 2020	Outstanding Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Community health inpatient services	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Community health services for children and young people	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Community health sexual health services	Good Jun 2020	Outstanding Jun 2020	Good Jun 2020	Outstanding Jun 2020	Good Jun 2020	Outstanding Jun 2020
Community urgent care service	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020

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

Sunderland Royal Hospital

Kayll Road
Sunderland
SR4 7TP
Tel:

Description of this hospital

Sunderland Royal Hospital has 35 maternity beds. They are split across two wards including the antenatal/postnatal ward which has 13 beds and the delivery suite which has 22 beds in LDRP (labour, delivery, recovery and postnatal) rooms.

Medical specialties include renal medicine, oncology, haematology, rheumatology, gastroenterology, metabolic medicine and thoracic medicine. Rehabilitation and elderly medicine include care of the elderly, neurology, neurophysiology, neurorehabilitation and stroke services. There are 356 beds located within 13 wards.

Medical care (including older people's care)

Requires Improvement 

Is the service safe?

Requires Improvement 

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

Mandatory Training

The service provided mandatory training in key skills to all staff. However; not all staff had completed the training in line with trust guidance.

Mandatory training figures provided by the trust were not broken down by staff type or location so we could not differentiate between nursing and medical staff. However, all directorates of the medicine division were below the trust target for mandatory training. The current completion rates were between 84.97% and 88.94%.

Mandatory training figures were not broken down amongst staff group, so we were unable to ascertain compliance rates for nursing and medical staff.

Managers told us they monitored mandatory training and alerted staff when they needed to update their training.

Staff told us it was difficult to keep up with their mandatory training due to workload pressures. Leaders told us they were trying to combat this by moving as much training as possible to eLearning, however some training such as basic life support and manual handling needed to be face to face.

Recognising and responding to patients with mental health needs, learning disabilities, autism and dementia did not form part of the core mandatory training for staff.

New staff said they were given protected time to undertake mandatory training. However, other staff we spoke with told us they did not get protected time and some were completing training on days off.

Safeguarding training was included in the mandatory training platform. All staff were trained to level one and there was role specific training to level two and three.

Training in dementia and learning difficulties was part of the trusts safeguarding training compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding adults training rates across the division were 97% for level one and 94.9% for level two. Safeguarding level three was role specific and rates were at 95.04%.

Equality and diversity training rates across the division were at 97%.

Nursing staff received training specific for their role on how to recognise and report abuse.

Medical staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

All of the wards we visited spoke of a great support from the safeguarding team and the speciality safeguarding nurses were visible on the wards offering support and advice to staff.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE).

There was information displayed at ward entrances about appropriate PPE usage and an area for staff to don and doff PPE with supplies of surgical face masks and aprons and with access to a hand washing sink, hand wash and alcohol gel hand rub.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

IPC audits were not displayed on any of the wards we visited.

Wards had designated side rooms, which were easily identifiable with warning signs for staff.

All staff were ‘bare below elbows’ and compliant with uniform policy.

Managing and decontaminating reusable medical devices was done centrally and then returned and stored on ward.

Wards we visited had internal cleanliness ratings, all ratings were five stars.

The trust shared with us its environmental audit data. It showed that audits of each ward were undertaken quarterly and compliance across the division was good.

The trust shared hand hygiene data which overall showed some poor compliance for the last quarter across the division. However, audits in July and August showed improvements.

Medical care (including older people's care)

Patient Led Assessments of the Care Environments (PLACE) had been postponed due to the pandemic. The formal PLACE audit was due to recommence in September.

There was rapid testing available for COVID-19. Staff screened patients for COVID-19 throughout their admission on set days and if they presented with signs and symptoms. Staff cleaned equipment after patient contact.

The trust had oversight of infection rates, with processes in place to investigate any confirmed infections. Staff told us that patients identified as having a current or previous infection were isolated in side rooms and appropriate signage was used to indicate the potential for infection in order to protect staff and patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

All wards had a secure buzzer system to gain entry.

Patients could reach call bells and staff mostly responded quickly when called. However, we did observe instances of call bells persistently buzzing for prolonged periods of time on ward B20.

Staff carried out daily safety checks of specialist equipment. Resuscitation trollies and defibrillators were compliant with electrical testing and calibration.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

All sluice, storage and treatment room doors were locked on all wards we visited.

Suctioning equipment ready to use.

All substances that fall under COSHH, including Oxygen, were stored appropriately and locked.

Waste and sharps were managed in line with trust policy. One waste disposal on ward B20 was not working for some time, it was reported by staff but had not yet been fixed.

Assessing and responding to patient risk

Staff did not consistently assess and manage risks to patients. Staff did not always identify and act upon patients at risk of deterioration.

The National Early Warning Score (NEWS2) is a system used to monitor a patient's physiological measurements. Scores were inconsistently recorded on all wards we visited, and high scoring NEWS were not acted on in line with guidance. During our inspection in June, two patients that had NEWS scores of 5 did not have observations redone within one hour and no sepsis screening was done in line with guidance. Following the inspection, the trust undertook an immediate audit of five patients care on every medical ward on three separate days. They looked at NEWS scores, escalation

processes and intentional rounding. Results shared with us showed this issue was a significant concern across multiple wards and the trust implemented an improvement plan. When we revisited the service in August, we found they had made improvements and all patients that had high scoring NEWS were managed and escalated in line with best practice guidance.

During the inspection we found gaps in intentional rounding on all wards we visited. Following the inspection, the trust told us that as a matter of urgency, they had introduced some additional training supported by the Tissue Viability Team to the relevant clinical areas to support with staff understanding of intentional rounding documentation, specifically around pressure care assessments. When we revisited the service in August, we found there to be improvements in the recording and timeliness of the intentional rounding on all wards we visited.

The service had 24-hour access to mental health liaison and specialist mental health support. However, some staff we spoke with told us that it was often difficult to get psychiatric liaison team input as they would assess over the telephone and if they felt the patient did not warrant an assessment, they would reject the request. This meant that some patients were left with no assessment in the interim.

The trust did not have clear processes to ensure that all patients with a learning disability were identified clearly in their electronic systems (flagging systems). The trust relied on confirmation from primary care systems or other sources before a patient's record was flagged to indicate a learning disability. There was a risk that patients who had not been identified as having a learning disability in primary care would be missed and would therefore not receive the additional support needed. We were told in this instance, patients could be referred to the learning disability team for a cognitive assessment, but this would be done following discharge from hospital rather than when they were an inpatient.

Not all patients assessed as level three falls risk had 1:1 care provided, and patients assessed as level two falls risk had no staff member with them in their cohorted bays due to staffing pressures across the trust. In the previous three months, 37.5% of the divisions falls with harm were due to patients not receiving the correct level of enhanced care and observations.

The trust shared with us VTE audit results for March 2022. Audits showed that 100% of patients had a VTE risk assessment on admission. However, only 52% had prophylaxis prescribed and administered within 14 hours of admission.

The service shared with us NEWS audit results for May 2022. The audit results showed that medicine scored 100% in accuracy, monitoring plans in place and escalation. Timeliness was at 70%. The audit was of all the patients residing on the medical wards in May 2022. The trust's audit results differed significantly from the findings of our first visit in June 2022.

NEWS2 and sepsis training formed part of the trust's induction programme all clinical staff must complete. However, the figure shared with us from the trust did not show how many staff had not completed the training or the trust's target range.

The trust had a National Early Warning Score (NEWS2) and the monitoring and recording of vital signs policy. However, the policy was due for review in April 2022 so was not in date.

The trust had a clinical guidance to support staff with the recognition, diagnosis and early management of sepsis.

Medical care (including older people's care)

An audit for the administration of antibiotics within one hour for patients with sepsis showed that only 41% of patients received the medicine within the time frame.

Lying and standing blood pressures were done on admission and then routinely if there was a postural drop. The trust had developed a new falls risk assessment which recommended actions when there was a postural drop and advised for next steps to take. The pilot ward told us this was working very well and there were plans for this to be rolled out across the trust once the pilot had finished that month.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. However, assessments were not always redone when there was a clinical change in line with guidance.

Audit results for the division showed that 100% of patients with suspected sepsis were screened appropriately.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe

Staffing

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels. However, this did not always provide established levels of staffing.

The service did not have enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants did not match the planned numbers on the wards we visited during the inspection. The trust told us they used the safe care acuity tool to secure safe rosters and review skill mix.

Managers calculated and reviewed the number of nurses and healthcare assistants needed for each shift in accordance with national guidance. However, the planned numbers did not always manage the actual numbers of staff and shift. Managers told us that when they do have the correct number of staff on shift, they are then moved to work on other wards that do not have enough staff.

The trust shared with us planned vs actual staffing numbers for May 2022. This showed that actual nursing staff hours filled for day shifts were 24.58% lower than what the planned staffing should have been and for night shifts was 31% lower than planned staffing hours. Care staff actual staffing hours for day shifts were 12% lower than what planned staffing should be and for night shifts was 8% lower than it should be.

Staff told us that escalation of under establishment was reported as red flag incidents and discussed with senior management.

Red flag staffing incidents could only be reported by matrons due to the significant number of red flag incidents being reported. This approach prevented ward managers or staff from directly escalating and reporting low staffing levels

On the day of the inspection ward E53 had only one member of permanent staff on the ward for that shift.

Staff told us that it was very difficult to have enough staff to support with the additional needs of patients requiring level two and three care. Ward leaders said they would report this to matrons but on many occasions they were still not able to fill the gaps in staffing and patients would need to be cohorted in bays to maintain oversight even when they should have had 1:1 support.

Wards we visited did not have enough staff to support the 1:1 care needs of patients identified as needing enhanced monitoring. Staff told us that the low staffing contributed to patient falls and they said that wards regularly feel unsafe due to the staffing issues.

Managers told us that they escalate staffing issues to matrons, but gaps did not always get filled due to overall staffing issues across the trust. Ward leaders told us they often worked on the wards during their supernumerary management hours due to the staffing pressures.

Managers told us of the difficulty they face when trying to co-ordinate and manage a bay of their own patients due to staffing issues.

Staff on E53 told us that not having regular staff who know the ward impacted on patient care. They told us that a challenging patient who required 1:1 care due to behaviors could not have this fulfilled to low staffing and the patient was assaulting staff frequently.

The trust had a system in place which identified thresholds for safe staffing. This meant that matrons could have oversight of staffing issues across the service. The matrons met each morning and ring wards to get a picture of staffing issues and try to match staffing levels based on acuity needs. They then had further meetings at lunchtime and evening and staffing was re-assessed. They followed a process of green, amber, red and black staffing escalation levels to determine what staffing is required and where.

All wards we inspected on the day of inspection had staff sickness, some staff were absent with COVID 19 symptoms or were self-isolating and some staff were on long term sick.

The vacancy rate for registered nurses was 6.8%.

Some of the wards within the division showed high staff sickness rates. For example; E51 was 10.18%, B21 was 7.66%, E58 8.21% and E56 9.81%. Managers told us they tried to fill shifts with their own staff, bank staff or agency but this was not always possible.

Medical staffing

The service had medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Ward B20 is an emergency medical admissions unit. The ward had no base medical team. They had an allocated junior doctor 8am to 4pm on weekdays and an advanced nurse practitioner to support on weekends. Staff told us that there was often difficulty in getting doctors to review medical outliers on the ward. Medical outliers were medical patients who were being cared for on other wards that were outside of the speciality. Staff said there was a medical consultant on call after 4pm but told us it was very challenging to get them to come down to the ward.

There were low medical staff vacancies across the division.

Medical care (including older people's care)

The medical staff matched the planned numbers.

Sickness rates for medical staff was mostly low across the division. Medical staff sickness in thoracic medicine was 6.7%. Gaps in staffing were filled with locums.

Managers could access locums when they needed additional medical staff.

The service had a good skill mix of medical staff on each shift.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept records of patients' care and treatment. Records were mostly clear, up-to-date, stored securely and easily available to all staff providing care.

Staff could access patient notes easily; however, they were not always comprehensive. We looked at 11 full sets of patient notes. We saw gaps in recording in patient's records including skin and wound management, height and weight, malnutrition universal screening tools (MUST) scores, nutrition, and hydration charts and best interest decision making.

Complex needs such as learning difficulties or dementia were not always recorded in inpatient records. The trust relied on confirmation from primary care systems or other sources before a patient's record was flagged to indicate a learning disability.

Comprehensive medical histories were recorded in all records we looked at.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed.

Senior leaders told us that records are audited on a monthly basis and reports sent to senior teams and results were then shared with the matron and head of nursing. We requested audit data of records from the trust. However, at the time of writing the report these were not received and it was stated that there have been no recent clinical record keeping audits.

We saw allied health professionals documented comprehensive care and treatment plans within the paper nursing records that we reviewed. If notes had been made electronically there was a sticker in the paper notes to inform of this so staff knew where to look for the information about the patient.

Electronic whiteboards were used on all wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely on all wards we visited.

Medical care (including older people's care)

Medicines

Staff followed some systems and processes to prescribe and administer medicines safely. However, there were incidents where time critical medicines were not administered to patients as prescribed.

We checked the storage of medicines, fluids and gases on the wards we visited. We found these were stored safely and securely on all wards we visited.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff mostly completed medicines records accurately and kept them up-to-date. However, omissions in doses did not always include a recorded reason.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The pharmacy team were visible on the wards we visited and reviewed patients' medicines.

Oxygen was prescribed for all patients that used it.

Time critical medications were not always given on time and reasons for delays in administration were not recorded.

Two patients on ward B20 requiring pain relief at 8am did not have this administered until 11am with no reason for the delay recorded.

Two bottles of antibiotic suspension had been reconstituted for use and stored in a medicine fridge. However, the liquids did not have a date on for when this was done, and they are only suitable for use for seven days.

Daily controlled drug checks on ward E53 were not done daily.

Fridge temperatures that stored medicines were checked daily and logged in line with guidance.

Emergency hypoglycaemic kits were available on the wards we visited.

Staff stored and managed all medicines and prescribing documents safely.

National guidance recommends undertaking medicine reconciliation within 24 hours of admission. This allowed early action to be taken in relation to discrepancies and a complete an accurate list of medicines available. Audit data across the trust indicated an average rate of 64% completed within 24 hours for 21/2022.

Ward managers monitored medication missed doses by doing a monthly missed dose audit. The trust said that the introduction of weekly monitoring reports was enabling ward managers to clearly see where improvements were needed. The most recent trust wide audit showed missed doses were improving.

Medical care (including older people's care)

Incidents

The service managed patient safety incidents well. Most staff recognised and reported incidents and near misses. Managers investigated incidents.

Following inspection, the trust sent us details of investigations into serious incidents and shared with us lessons that were learned. The medicine division had 14 serious incidents declared in 2021/22. Six of these investigations were in progress, four had been approved for investigation and four had been completed.

The trust said they used a serious incident tracker to monitor timelines for investigations. This included dates for when an RCA was due and when the incident had been discussed at the Critical Incident Review Group (CIRG) Panel.

We spoke with staff of different grades and most could give examples of incidents they had recently reported. However, some staff we spoke with on two wards told us that only band 5 staff and above could report incidents, so not all staff were reporting their own.

Staff raised concerns and most staff told us they reported incidents and near misses in line with trust policy.

The service had one recent never event. Findings from the trust's shared incident report identified issues with staffing levels and skill mix. Learning from the incident was shared via the patient safety bulletin, ward handovers and staff huddles.

Managers shared learning about never events with their staff and across the trust.

Ward leaders that we spoke with all knew their wards most recurring top three incidents.

Staff we spoke with mostly understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There were systems and processes in place to identify changes to national guidelines and update policies appropriately

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Medical care (including older people's care)

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust's intranet, guidelines, policies and procedures relevant to their role.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

We observed mealtimes on various wards and noted that all staff were involved in getting meals to patients, including the more senior staff. Patients that needed support with eating their meals were given it. However, we did not observe any initiatives such as red trays to help staff identify which patients required support. Managers that we spoke with said that patients needing support were discussed at handover.

All patients' hands were cleaned with wipes prior to them being given their meals.

All patients that we spoke with were happy with the meals and said they were always given a choice of what they wanted.

Where modified diets were required, assessments of a patient's requirements were detailed above their beds and on a whiteboard at the nurse's station.

Fluid balance charts did not always capture fluid input and output where this was required.

We observed additional comfort rounds taking place with options for biscuits, tea and coffee.

Catering staff were observed adding prescribed thickeners to patients drinks if they needed it. Although they articulated they understood were to find details of how many scoops is required, the staff had not been appropriately trained to give a prescribed item.

Water jugs were in reach and patients said they were replenished frequently.

Mealtimes were protected; however, family members were allowed in to support with care if the patient wanted that.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. However, the speech and language team only worked Monday to Friday.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and mostly gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. However, we found instances of pain relief being administered later than prescribed.

Patients we spoke with told us they received pain relief soon after requesting it. However, two patients that were prescribed pain relief to be administered at 8am did not have this given until 11am with no reason for the delay recorded.

We observed that nurses administering controlled drug pain relief always had a second nurse with them to check the medicine in line with guidance.

We asked the trust to share with us audit data for pain management. However, at the time of writing the report this was not received.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. The service had been accredited under relevant clinical accreditation schemes.

The trust shared with an ongoing audit plan for 2022/23 for the medicine division. This showed participation in various national audits. The audit plan did not include details of ward level routine audits.

The endoscopy unit held full accreditation with the Joint Advisory Group (JAG). This meant that the service had demonstrated that is has the competence to deliver against criteria set out in the JAG standards.

The service participated in relevant national clinical audits including national falls audit, Sentinel Stroke National Audit Programme (SSNAP), lung cancer audit and national dementia audit which will restart in autumn 2022. Outcomes and action plans from the audits were discussed at clinical governance meetings and were assessed to monitor progress.

Mortality and morbidity reviews showed standards of care were looked at and actions for improvements identified. These were done frequently for all specialities within the division.

There have been no national pain audits within the last 12 months, and the trust did not complete local audits related to pain.

Leaders told us that matrons had a portfolio and they worked with ward managers and reviewed all audits. Wards were not given individual action plans but were given areas to focus on to help improve patient outcomes.

Managers told us they used information from audits to improve care and treatment. Ward level leaders shared with us weekly audits which had focus on falls reduction, nutrition and hydration and skin assessments.

Pressure ulcers graded category three and above were investigated with omissions of care identified action plans to mitigate risk were put in place.

Falls audits took place across the division and were discussed at a falls review panel. Audits identified immediate actions following a fall, issues relating to post fall management and actions taken.

The medicine division had 107 safeguarding referrals made in the previous 12 months, and the trust shared with us outcomes of the referrals.

Medical care (including older people's care)

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

Managers told us that supervision and appraisals had been continuing as required throughout the pandemic and that these had been of a good standard. However, this was not reflected in the appraisal completion rates for the division which were below trust target for nursing staff 72.43% and allied health professionals 72.59%.

Staff did not always have the experience skills and knowledge to meet the needs of patients. For example, on ward E53 during the inspection they had only one regular member of staff and the others were from other wards or bank/agency staff.

Staff said that education sessions had resumed, however the departments did not always work flexibly to accommodate these by offering protected time to complete them. Some staff told us that they would often have to complete these in their own time. Leaders told us they were trying to combat this by moving learning to electronic were possible.

Managers we spoke with told us they did not always get protected management time as they were too busy and would generally have to support on the ward.

Managers told us that they could identify any training needs their staff had, however giving them the time and opportunity to develop their skills and knowledge was not always possible due to staffing constraints.

Staff told us they had the opportunity to discuss training needs with their line manager and felt they would be supported to develop their skills and knowledge.

Leaders told us that at the start of the pandemic the challenge was that they did not have enough of a respiratory workforce. This was combatted by developing staff skills and additional training to increase the support on the respiratory wards.

Staff were given the opportunity to progress within their role. Multiple ward managers we spoke with had previously been band 5 nurses on the ward they now managed.

We spoke with a newly recruited international nurses who told us they were supernumerary in the rota, to give them time to become fully adjusted and inducted into the department.

Managers made sure staff received any specialist training for their role. For example, relevant staff received specific training in non-invasive ventilation (NIV) and the trust said they always have up to 50% of nurses on the ward competent in NIV.

The division benefited from Practice placement facilitators who sit within the workforce team. These help staff with development and competencies. There were two new posts for clinical educators to work with preceptor nurses.

International nurses told us they had good support from their mentors.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Medical care (including older people's care)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw different teams of healthcare professionals working with staff in the division as a multidisciplinary team (MDT).

We observed MDT board rounds which included consultant, pharmacist, physiotherapist and ward sister.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, including depression.

Patients had their care pathway reviewed by relevant consultants. For example, patients residing as medical outliers due to bed shortages, were reviewed by the appropriate consultant for their care needs. A medical outlier is a hospital inpatient classified as a medical patient but has a placement on a non-medical ward.

Seven-day services

Key services were not available seven days a week to support timely patient care.

Most wards had consultant led daily ward rounds on acute wards, including weekends. However, B20 did not have a base consultant and we were told this proved challenging, especially on weekends.

The trust had a learning disability team made up of two lead nurses with one based at each site. They would support staff with the management of patients with learning disabilities, however they could only support on Monday to Friday due to it not being a seven day service. The acute liaison learning disability nurses would also be required to work across site to cover each other's annual leave.

Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services.

Discharges were planned so they could still take place on a weekend to maintain flow out of the hospital.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

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Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always use measures that limit patients' liberty appropriately.

The trust had an up-to-date policy dealing with consent and mental capacity.

We reviewed nine records of patients subject to deprivation of liberty safeguards. Seven of the nine records showed staff had completed an assessment of the patients' mental capacity and had recorded decisions made in the patients' best interests in line with the requirements of the legislation. Two of the nine records did not evidence staff had followed the required process.

Following our inspection, the trust undertook an immediate review of all patients across the division that required mental capacity assessments, best interest decisions or a DoLS. The findings showed that there were delays in completing mental capacity assessments, no best interest decisions for some patients and delays in DoLS applications.

We revisited the service in August and found mental capacity assessments and best interest decisions were still not being completed in line with guidance. Four out of eight records we looked at on one ward did not have best interest decisions completed in line with requirements.

During the revisit in August, the safeguarding nurse told us that they were undertaking a daily audit of nursing documentation for patients that required a mental capacity assessment. They were reviewing patients from 16 wards and identifying gaps and trying to embed improvements.

On the return visit, we found that patients requiring a cognitive assessment did not always have this completed. For example, two patients with delirium on admission had no cognitive assessment completed.

During the inspection we escalated concerns relating to a patient who had refused medicines for eight days and for whom safeguarding documentation was incomplete. The trust took action to ensure the patient was safe and being adequately cared for and the patient was reviewed immediately. It was identified that the patient's DoLS and Mental capacity assessments had not been repeated when the patient's mental capacity had changed in line with guidance

Records showed that decisions around DNACPR (Do Not attempt cardiopulmonary resuscitation) were fully informed.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance.

Staff did not always clearly record consent in the patients' records.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The data was not divided by site or division but trust wide it showed that compliance rates for nursing staff was 95.2%, and health care assistants 95.3%.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.

When patients could not give consent, staff did not always make decisions in their best interest, considering patients' wishes, culture and traditions.

Medical care (including older people's care)

Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation.

Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Patients we spoke with told us they were receiving amazing care and that staff were excellent.

We observed varying examples of compassionate care including staff comforting a distressed patient immediately and appropriately.

We observed that all patients had access to their call bells.

There was a mixture of patients that were washed and fully dressed on the wards we visited. However, some patients remained in bed wearing hospital gowns.

Family and friends could visit patients on the ward, and it was organised with an appointment system.

We observed that there were some patients up and mobilising around the wards with support from staff.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We observed varying examples of emotional support including staff comforting a distressed patient immediately and appropriately.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

We observed staff supporting a patient with dementia whose comfort was to walk around the ward. The patient was never left unattended and staff were kind and caring in their conversations.

Wards we visited had quiet rooms available which could be used for delivering bad news to patients and their families.

Staff we spoke with said the trust had a multifaith chaplaincy that was very responsive to patient needs.

We saw that some wards had poster up promoting support from Macmillan cancer services and services that offered support and advice to carers.

The trust had in use carer passports which allowed carers to stay with their loved one if they wished.

Visiting had resumed on the wards with people being able to book time slots and visit for up to two hours, however, some visitors could stay longer at ward managers discretion.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

The trust participated in the Friends and Family Test (FFT). Survey results forwarded from the trust showed that the division had received 247 responses.

Staff mostly made sure patients and those close to them understood their care and treatment. However, some patients that we spoke with told us they did not know their treatment plans.

Patients said that relatives were involved where possible; on some wards, but not all. This included invitation to MDT if appropriate. This was also confirmed in discussion with relatives.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients mostly gave positive feedback about the service. Negative comments consistently related to food and lack of discharge information.

Some patients we spoke with were unaware of their proposed discharge date.

Medical care (including older people's care)

Staff talked with patients, families and carers in a way they could understand.

Patients we spoke with gave positive feedback about the service.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The trust had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems and dementia.

Staff knew about and understood the standards for mixed sex accommodation. There were no mixed sex breaches on any of the wards we visited.

The service had systems to help care for patients in need of additional support or specialist intervention. However, due to staffing shortages, additional one to one or specialised care was not always fulfilled.

Meeting people's individual needs

The service did not always consider patients' individual needs and preferences. They coordinated care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. On admission to the ward each patient received individual assessments, however these were mostly risk-based assessments, and they did not consider individual needs or preferences. The trust did not have policies or strategies for the management of patients with dementia, learning disabilities or mental health.

Staff did not supported patients living with dementia and learning disabilities by using 'This is me' documents or personalised care plans. However, they did use patient passports.

Medical care (including older people's care)

Ward E56 which was a dementia specialist ward, had a bus stop with routes for the local area. It also had pictures around the ward from 1930s to present day. Patient beds each had 'about me' boards above them to capture personalised information. The ward also had an activities trolley which included jigsaws, colouring books and board games.

E56 ward manager said that they are trying to make the area even more dementia friendly by moving a seating area near the nurse's station so patients can join them there if they wish.

Dementia and delirium outreach team take patients to the Alexandra suite. The suite provided additional care and support for patients with dementia and delirium. It also provided an outpatient follow up clinic for patients who have had delirium.

Staff did not undertake thorough assessments for patients who have a learning disability, care needs were not assessed and planned to meet their individual needs

Volunteers visited ward E56 to reminisce with patients who had dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

There was a chaplaincy service available at the hospital to facilitate any support patients and/or families may require.

Mortality and morbidity meetings took place across the medicine division with individual cases discussed and learning points identified.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, leaders told us that patients deemed medically optimised for discharge were not always suitable for discharge from the hospital due to ongoing issues in arranging the support they require in the community. They told us this was challenging and a lot of work goes into the discharge team trying to support the staff to be able to make the discharges happen, but it remained an ongoing challenge throughout the division.

Ward B20 was a short-term admissions unit. However, we observed some patients' length of stay had been extended due to access & flow issues throughout the trust. One patient had been on the unit for 20 days due to difficulties with social care arrangements.

The service benefited from the support of discharge team that could help with complex discharges and a discharge lounge. The discharge team liaised with social services, community, families and arrange care packages.

Wards had patient information available 'Getting you one step closer to home and helping you leave home safely'.

The service has two matrons that would job share across both sites. They told us that they had calls with community and social workers daily and would help to organise forty to fifty discharges across the medicine division daily.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. There was a dedicated discharge team to support with complex discharges.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. One ward had eight medical outliers and these were seen daily by the relevant consultant.

During a board round that we observed, staff identified patients that were medically fit to be discharged. This information was captured on the electronic whiteboard and the data would be used in bed meetings throughout the day to help staff plan patient movement.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The trust shared with us data relating to formal complaints received. The rehabilitation and elderly medicine directorate have seen a significant increase in this quarter from 10 formal complaints and 41 informal concerns in Q3, to 27 formal complaints and 48 informal concerns reported in Q4. The themes of the complaints received continue to reflect the organisational wide themes, with communication and patient care receiving the highest number in the directorate.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Medical care (including older people's care)

Managers shared with us some examples of positive feedback relating to their wards.

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and tried to manage the priorities and issues the service faced, although the action taken was not always effective. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The division of medicine was made up of four directorates; Medical specialities, general internal medicine, rehab and elderly medicine and cardiothoracic medicine. The senior leadership team worked across the trust and its two sites and the matrons were site specific. The head of nursing worked across all four directorates.

During the inspection we saw some excellent examples of leadership at location level. All staff we spoke with gave positive feedback about their ward managers and matrons. Staff told us they felt supported and the ward leaders told us that they felt supported by the senior leadership team.

Leaders understood the priorities and issues the service faced; however, actions were not always effective. For example, staffing pressures were evident throughout the medical division and the management of this was to move staff from fully staffed wards to wards that were short staffed. Staff told us this often impacted on patient care when managing high risk patients requiring 1:1 care and patients at risk of falls. Ward leaders we spoke with told us that this was very challenging for their wards and caused an impact on staff and patients.

We spoke with leaders at ward level. They showed great leadership and understood the challenges faced by their department. All managers across the division showed were very positive about their matron. They said that they all felt extremely well supported and their presence was very much recognised and appreciated.

Staff and ward managers told us that members of the senior leadership team were visible on their wards, especially during the pandemic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The medicine division followed the trust's overall vision and strategy. This was to deliver nationally recognised, high quality, cost effective, sustainable healthcare for the people it served, with staff who are proud to recommend the trust's services. The trust had an overall annual plan which included trust goals, divisional goals and individual goals.

The trust objectives were to provide safe and high quality care, to look after staff and be inclusive, to share what we learn and communicate well, to take action for a more sustainable future and to lead by example in their work.

Medical care (including older people's care)

Leaders of the division told us that their divisional challenges aligned with corporate challenges and whilst looking at getting back to business as usual, their vision had been adapted based on feedback and will relaunch in the summer. The division's strategies will align to the trust's overall vision and strategy.

The trust had values to support their vision. These were; Compassionate and dignified care, working together for the benefit of patients, their families and carers, openness and honesty in everything they do, respect and encouragement for staff and continuous improvement through research and innovation.

Progress of the trust's vision and strategy was monitored through various governance meetings at operational level. This was evidenced through meeting minutes the trust shared with us after the inspection.

The trust did not have a learning disability strategy. There was limited learning disability support within the service due to the working hours of the specialist nurses. Patients also did not receive support if they did not already have learning disabilities flagged on the system from the community. This meant that there was not a consistent approach to care for patients.

At ward level, some leaders shared with us ward improvement plans that identified targets and visions for improvements. For example, the leader of ward E56 told us of plans to further develop the dementia ward to make it even more suitable for patients.

Culture

Staff were focused on the needs of patients receiving care. However; they did not all feel respected, supported and valued. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers we spoke with reported a great working culture within their teams. However, all staff that we spoke with said that it was difficult to feel valued by leaders when they were working under immense pressure regularly and this was affecting staff morale.

Ward leaders and the senior leadership team spoke highly and with pride about their teams working on the wards, especially through the pandemic.

Leaders told us that staff wellbeing was of great importance to them and they had varying options for staff to help them maintain wellbeing. This included self-referrals to occupational health, Thrive service which was a counselling service that offered free sessions, psychology support for staff groups and all of this was available on the trust's intranet for staff to access if required.

The trust had recently set up a staff wellbeing hub in addition to the ICS funded wellbeing hub which was centrally funded and would allow staff to access training packages as well as support. A suggestion was made that the trust could look at staff training and possibly take a lead from mental health trusts and train staff to deal with violence and restraints, however this was not yet being actioned.

The trust also offered staff Schwartz rounds which were staff only group discussions that offered a space to share and reflect on the personal, emotional and social aspects of their work.

The trust benefited from an onsite gym that staff could access for a monthly membership fee.

Leaders told us they had a recent focus on supporting the financial wellbeing of staff, smoking cessation and menopause.

The trust had a designated freedom to speak up guardian, however staff we spoke with did not know who this was or how to contact them if needed.

Overall, we found staff morale to be low. The theme from staff we spoke with was they did not feel valued due to the ways they are made to work on each shift with low staffing numbers. Staff told us they had seen many colleagues leave the trust due to the pressures faced daily because of this. However, staff spoke proudly of their colleagues and the hard work they encountered during the pandemic, they said they felt valued by their peers.

Governance

Leaders did not operate effective governance processes. Governance systems did not consistently identify risks. However, staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The trust did not have an up to date dementia strategy, the one they had was dated 2018-2021.

Learning from incidents and complaints was cascaded to staff from ward leaders. Staff we spoke with told us the process for how this happens.

Leaders told us they meet as a division once a month and matrons have an operational forum every two weeks.

There was a formal meeting monthly with the executive nurses to share information and the head of nursing had informal meetings with ward managers monthly to discuss any issues and concerns

There was a weekly senior leadership team meeting which coincides with the clinical governance meetings. Consultants and junior doctors meet monthly.

The trust shared with us emails that had been sent in June to matrons and ward managers to remind staff how to complete intentional rounding documentation and the NEWS escalation process and clinical response requirement. The email requested it be cascaded to staff. During the inspection we identified that patients were not having high scoring NEWS escalated and monitored in line with guidance and there were gaps in intentional rounding. Following the inspection, the trust undertook an immediate audit of five patients per ward and results showed issues of significant concern across multiple wards relating to NEWS and intentional rounding. Improvements in practice had not been identified since the email to managers in June.

The trust shared with us meeting minutes for the division of medicine governance meetings. These occurred monthly and showed good attendance. They discussed ongoing issues such as staffing and discussed items for the risk register.

Governance meeting minutes showed discussions around lessons learned and improving practice. For example, following a patient death it was agreed that the case should be discussed at the Nutrition & Hydration Steering Group to discuss potential risks going forwards.

Managers meet monthly for quality assurance meetings, information from these is then cascaded amongst their teams

Medical care (including older people's care)

Management of risk, issues and performance

Leaders mostly used systems to manage performance effectively. They did not always escalate relevant risks and issues and did not always identify actions to reduce their impact.

Leaders told us that they could track timelines of incident investigations using an incident tracker.

Incidents were discussed in clinical governance meetings across the division and meeting minutes from the trust confirmed this. Leaders told us that lessons learned from incidents were shared with matrons who would then cascade this down to ward managers and their teams. They were also shared as part of patient safety bulletins.

The nursing metrics panel met monthly and looks at incidents including work force, pressure ulcers of grade three and above, falls, medication and IPC. Actions were discussed and lessons were shared with the wider teams.

Leaders told us that the trust used a 'Data Launchpad' which provided reports for MUST and NEWS compliance, which the matrons reviewed on monthly basis.

Ward level leaders had good oversight of their team's risks. All leaders that we spoke with talked about their ward's top risks.

The senior leadership team and ward level leaders were aware of risks and could explain actions in place to mitigate risks. Risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk and they were regularly reviewed.

However, items senior leaders told us that were the biggest risks for the division were not reflected in the risk register. Leaders told us the top risks of the division were workforce and environment, this was not reflected in the trusts risk register

The risk register was comprehensive and showed dates of when a risk was added, when it was due for review and any notes from reviews that had been undertaken previously.

Senior leaders told us patients who require enhanced care, were risk assessed and if there are not enough staff to support this the escalation process was followed at ward level. They said that matrons reviewed and helped mitigate any risks and they could move staff from other areas to support the additional need. If staff were not available, then escalation to the head of nursing was needed and the next step would be to move patients to another ward to facilitate the additional need. However, staff and managers at ward level did not describe this escalation process to us and they said they escalate the staffing concerns but they are often still not fulfilled and they are made to just manage with the staff they have. All wards we visited during the inspection had patients requiring 1:1 care that were not receiving it.

Clinical governance meeting minutes demonstrated that the lack of managing 1:1 needs was of concern and was on the radar of the trust's external stakeholders. It was discussed that any ward at any time would likely have patients requiring 1:1 care and not receiving it and it was deemed a problem at organisational level rather than just local level.

National guidance for safe staffing uses a red flag system. Red flags are used as a mechanism of monitoring a safe care system to highlight staffing concerns. Guidance states that hospitals need to have a system in place for nursing red flag events and be reported by any member of the nursing team, patients, relatives or carers to the registered nurse in charge of the ward or shift and will then be escalated by the nurse in charge. However, due to the number of red flags being raised by ward managers, only matrons are now able to raise red flags.

Medical care (including older people's care)

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training.

Staff could access information technology (IT) systems to record and view information such as test and x-ray results and patient records. Patient records were mostly electronic, and many assessments were integrated into the trust's electronic patient record system.

Staff we spoke with demonstrated they could locate and access relevant information and records to enable them to carry out their day-to-day roles.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training, and appraisals.

The service managed and used information appropriately to support its activities. The website contained detailed information about the differing wards, site maps and how to book an appointment.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Wards had staff engagement boards that included general information about their ward's performance in various areas.

Managers told us that wellbeing conversations were available for all staff wishing to have this conversation and there was an opportunity to access support and advice from colleagues/ managers/ mentors.

The head of nursing met with ward managers informally each month, providing a chance for ward managers to express concerns they had or ask for advice and support on issues they had been altered to.

Ward leaders spoke proudly of staff at ward level and recognised their hard work. Wards we visited did not have boards that recognised staff for excellence or hard work. However, the trust has an excellence reporting system where staff can nominate other staff members or teams for excellent work. Those recognised received a personalised letter from the CEO which can be used for appraisals and Clarity portfolios.

Ward managers shared with us various compliments received from patients, their loved ones and students that had worked on the words.

Family and friends test boxes and posters were displayed on each of the wards we visited, this gives patients and their families the chance to give open and honest feedback about their care.

Leaders said that feedback was important to them, and everyone was encouraged to complete staff surveys.

Medical care (including older people's care)

The trust shared with us its staff survey results. It showed there was a response rate of 47% for the 2021 staff survey and it was significantly worse on 34 questions than the previous year. Only 26% of staff said they had enough staff at the organisation to do their job properly

In response to the survey, the trust shared with us a staff survey action plan which identified themes, priorities and action plans.

Staff we spoke with said they felt valued by their peers but not always by more senior levels of staff due to the pressures of working short staffed so frequently.

Staff we spoke with did feel supported to professionally developed if they wished to do so, many of the ward managers had started out as band 5 nurses on the same wards they now managed. International students told us they were well supported by a mentor to help develop their skills and were supported to do their OSCE (objective structured clinical examination) which was used to assess clinical skill at pre-registration and postgraduate level.

As part of ongoing communications, the trust launched a trust wide engagement programme in October 2021. This was called the STSFT Big Team Talk. The ambition was to improve overall staff engagement and involve staff in resetting the vision and priorities of the future. The group had 70 team talk champions made up mostly of frontline staff and over 8700 comments were received from staff using graffiti boards, post boxes and virtual boards.

Leaders told us that they were most proud of all of the frontline staff during the pandemic.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Ward leaders were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Staff on ward E56 told us that dementia friendly activities trollies were available, and they had volunteers that visited the ward to reminisce with patients. This supported patient experience and engagement with activities.

We asked leaders for examples of innovation within the division, they told us that the dementia and delirium outreach team works hard to improve the outcomes for their patients by using therapeutic activity and offers an outreach service for cognitively

Leaders told us that the focus for the division was to get back to business as usual following the pandemic. They were working on improvements and pilots including a new falls risk assessment that we seen in use during the inspection. They also told us that the roll out of activities trollies was to take place on more wards.

The trust told us they had a rise and shine initiative to encourage patients to get out of bed and be up and dressed. On all of the wards we visited there were many patients in bed in pyjamas or hospital gowns.

Maternity

Requires Improvement 

Is the service safe?

Requires Improvement 

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

Mandatory training

The service provided mandatory training in key skills to all staff, however, not all staff had completed it.

Staff did not receive and keep up-to-date with their mandatory training. The completion rates for overall mandatory training at June 2022 were above the trust's target, however this was due to a decrease in the trust target from 90% to 85% from 1 April 2022. Prior to April 2022, the service consistently failed to meet the trust's previous target for mandatory training compliance.

The mandatory training was comprehensive and would have met the needs of women and staff when completed.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was a central system in place that alerted staff to training needs and we were told by staff they were allocated 2.5 days each year in a specific month for training to be completed. We also spoke with the specialist education midwife who shared training plans and additional training opportunities for staff.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. The training target for safeguarding was met by nursing and midwifery staff with 94% completion for May 2022 and 92.8% completion for June 2022 against the Trust target of 85%.

Medical staff received training specific for their role on how to recognise and report abuse. The training target for safeguarding was met by medical staff with 88.2% completion for June 2022 against the Trust target of 85%.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff training covers these areas as part of mandatory training and staff work with other agencies to ensure adults and children at risk of harm are referred as needed. There were good links in multi-disciplinary working across areas and information sharing was embedded for safeguarding.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff were able to make a safeguarding referral and there was an escalation policy in place where needed. The central safeguarding team for the Trust were available for support whenever needed.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and although we were told they undertook baby abduction drills, we did not see any evidence of this as requested. After our inspection, during our factual accuracy checks, the Trust shared of five baby abduction exercises carried out between July 2022 – September 2022. This was an area of concern in our previous inspection in 2019 and a requirement notice was issued to the trust. The trust had been told that it must ensure simulations of obstetric emergencies are undertaken on the hospital site (such as staff responding to an emergency buzzer or alert); and conduct a baby abduction drill). The trust had failed to act in accordance with this requirement.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Equipment and the premises were not kept visibly clean.

Ward areas were not clean and did not have suitable furnishings which were also not clean and not well-maintained. We saw dirty areas within individual rooms in the delivery suite when we carried out our inspection, this included rooms which had just been cleaned. During the second inspection visit, the head of midwifery gave our inspection team verbal assurances that this had changed but we were unable to corroborate this.

The service did not perform well for cleanliness. The maternity ward IPC audit achieved 78% compliance in May 2022. Issues in the audit included multiple dusty areas identified, splashes of bodily fluids on sink areas, and the linen trolley overloaded and not cleaned as it should be.

The maternity quality and safety reports April 2022 presented to the board in May 2022 identified hand hygiene audits were suspended between January and April 2022 due to operational pressures, however between October and December 2021 it was noted the service achieved 100% compliance.

Although cleaning records were up to date, areas were not cleaned up to standard and were visibly dusty.

Staff followed infection control principles for the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Labels were used on each piece of equipment with a date and signature to show it had been cleaned and was able to be used again.

Fridge temperature checks had not been recorded in rooms as they should have been, which is a risk to patients. There were gaps in checks when we visited on inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff did not always manage clinical waste well.

We were told there had been a recent baby abduction drill prior to our onsite inspection. However, when we asked for evidence, the Trust did not provide us with this.

Women could reach call bells and staff responded quickly when called.

Maternity

The design of the environment did not always follow national guidance, we found the second emergency theatre was not fit for purpose. We identified it was a converted labour delivery and postnatal delivery room, which had not been adequately modified to meet the requirements of Health Technical Memorandum 03-01 Specialised ventilation for healthcare premises and health building note 00-10 Part C: Sanitary assemblies. The second emergency theatre was not part of the daily cleaning schedule, which meant it was not kept clean for its purpose. We wrote to the trust formally to inform them of our concerns and we were told the second emergency theatre would be closed. We returned as part of the well led inspection and found the theatre was available for use, we saw improvements had been made in terms of environmental changes with the addition of a scrub sink being added and also the windows had been fixed. We were told it had been added to the daily cleaning schedule.

There was one fetal blood sampling machine, however, this was based in the postnatal area of the maternity unit. This meant there could be a delay if the analysing of fetal blood sampling in navigating the unit and the blood sample could clot and need to be collected again, this meant there may be a delay in obtaining results to enable prompt and timely treatment and also causing additional and prolonged discomfort for the woman.

Staff did not always carry out daily safety checks of specialist equipment, we saw there was no formal checking in place of the emergency trolley and during the inspection we saw staff members using this trolley for routine stocking and activities.

The service did not have enough suitable equipment to help them to safely care for women and babies. There was one emergency trolley in the maternity unit (antenatal clinic, maternity day assessment, delivery suite, and the ante and postnatal wards). This trolley was not easily identifiable as an emergency trolley, we saw it was disorganised and did not contain any flow charts to assist staff in the process of obstetric emergency. Staff told us if women required additional monitoring in their room this trolley would be based in their room, this meant there was no emergency equipment available to the rest of the maternity unit. Staff also told us of instances where two women were experiencing a post-partum haemorrhage and there was only one trolley available for use, therefore increasing the risk of harm to women and their babies. We escalated our concern to the trust and during our revisit to the service we saw that there were now three emergency trolleys in place which had arrived the week previously. However, these were not easily identifiable as emergency trolleys as they were not labelled as such nor was each drawer labelled as to which emergency it was to be used for. There were also no assurance checks in place to ensure they were ready for use.

Staff did not always dispose of clinical waste safely. We saw doors to the waste room were propped open which is against best practice guidelines. We also saw waste was not removed from the second emergency theatre in a timely manner, this meant it wasn't set up for surgery.

The quiet room in the antenatal clinic was located at the opposite end of the department from the scan machines, this meant women who were given news of a potential poor outcome would have to walk through the department in front of other women and their partners.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues and staff were able to tell us about examples of this on inspection.

The service had 24-hour access to mental health liaison and specialist mental health support. The mental health team provided mental health assessment and care to inpatients and people attending the department. The team was made up of mental health nurses, support workers, psychiatrists, social workers and administrative staff and is run by the local mental health service. Out of hours urgent ward issues could be discussed with the on-call SHO, Registrar and Consultant within the local mental health team, as required.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Staff shared key information to keep women safe when handing over their care to others.

Shift changes and handovers did not always include all necessary key information to keep women and babies safe. We observed both midwifery and medical staff handovers during the inspection. We found the midwifery handover on ante and postnatal ward areas included key high level information for each women on the delivery suite and then a more indepth handover between individual staff members was then completed. We saw key patient safety information such as the closure of the second emergency theatre was not discussed or handed over.

The medical handover was not conducted in line with best practice Ockenden guidance, there was no log of those in attendance, there was no introduction to identify the roles of each person in the room, there was no discussion or mention of fetal well-being when discussing those women in labour. In addition, there was no sharing of learning messages nor was there information offered in terms of key patient safety information such as the closure of the second emergency theatre. During the factual accuracy process of the inspection, the Trust shared with us information regarding an additional handover. This was an ‘SBAR’ handover for each patient on the labour ward and it occurs on the labour ward with the midwife looking after each woman in attendance. The full history, progress, and CTG is discussed on the second part of the handover.

The service used World Health Organisation (WHO) surgical safety checklists to ensure that patient safety was communicated by the team of operating room professionals. However, the maternity quality and safety report from April 2022 presented to the board in May 2022 illustrated that between July 2021 and April 2022 the 100% target had not been achieved at each step of the checklist and there has been an overall drop in compliance at 98.3%

Staff completed annual online training to assess staff competency to interpret cardiotocography (CTGs). Cardiotocography (CTG) measures a baby's heart rate and monitors the contractions in the womb (uterus). As of June 2022, 80% of midwives and 64% of medical staff had completed their CTG interpretation assessments. This was below the trust target of 90%.

We saw a CTG audit conducted in May 2021 which show poor compliance in the application of fresh eyes, which demonstrated the no area of assessment achieved 100%. Recommendations from this audit included:

- Raise awareness to colleagues
- Share report findings to raise awareness with all involved colleagues.
- Allocate designated midwife to perform reviews in place of coordinator on handover times

- Continue to re-audit

We saw a repeat CTG audit conducted in March 2022 which showed continued poor compliance in the application of fresh eyes, themes from this audit showed;

- No continuity in documenting “fresh eyes "reviews when required to be reviewed 2 hourly with some documented but delayed more than 15-30minutes.
- Co-ordinator reviews not completed on handover time.
- Very little/no documentation of assessments in the 2nd stage of labour, unless there were concerns.
- Required data missing from commencing and discontinuing CTG.
- Some ‘fresh eyes’ missed or done by the midwife who did the previous assessment with times missing on review.
- 1 circumstance where the CTG review had been missed completely by the midwife for whole labour.
- Documented in notes reviewed by senior team but full assessment not performed.

This repeat audit shows the Trust has made limited improvements to their CTG compliance between May 2021 and March 2022.

Midwifery staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers did not always review and adjust staffing levels and skill mix.

The service did not clearly display planned and actual staffing in all areas of the maternity unit. We saw this was only displayed on the delivery suite.

Since January 2022, services at the midwifery led birthing centre at South Tyneside Hospital had been suspended due to ensuring safe staffing levels were maintained.

The most accurate measure of midwifery staffing is highlighted when considering one to one care in labour. We saw red flag data which showed between November 2021 and April 2022 there were 53 occasions where midwives were unable to provide one to one care in labour. However, one to one care in labour figures were not included as a measure of quality in the maternity dashboard at the time of our inspection in June 2022, this was presented in the Maternity and Neonatal Quality and Safety Report. In maternity services, we found the trust did not have sufficient staff to consistently provide one to one care as recommended by national guidance. In June 2022, the trust provided one to one care in 72.5% of shifts according to the BirthRate Plus® acuity tool. Between December 2021 and June 2022, Staff reported 294 red flag incidents where a midwife was not able to provide continuous one-to-one care and support to a woman during established labour. The trust’s reports note the ‘decrease [in trust compliance for one to one care in labour] corresponds to the increased number of short-staffed shifts’

The midwife to birth ratio for between November 2021 and April 2022 was 1:27 and 1:39. This did not meet with national guidelines of 1:29 nor did it meet the trust target of 1:26. This ratio is calculated by dividing the total annual births by the total staff in post establishment for clinical midwives (excluding midwives in education, governance, management, specialist posts). We were advised that the service had a BirthRate Plus® implementation plan to deliver the improvements to meet the recommended birth to midwife ratio.

The service had a nursing and midwifery staffing escalation policy in place. The policy detailed how to address any shortfalls in staffing, for example, unexpected absence. However, the policy had not been updated to reflect the current service provision in terms of services at midwifery led birthing centre (MLBC) currently being suspended. The escalation policy detailed all of the action which should be carried out by the maternity team leader (MTL), however, there was no reference to when a significant midwifery problem remained unresolved; executive on call would be informed.

The escalation plan also identified one of the steps as "contact community teams for support from available community midwives", however, community midwives did not operate an on-call rota which meant that community midwifery teams would only be able to provide support during day time working hours.

The homebirth service was staffed by community midwives during between 09:00 to 17:00 and outside of these hours two midwives would be deployed from delivery suite. Dependant on the pressures in the maternity unit, women may not have been able to achieve a homebirth. There were not enough staff to consistently provide a safe home birth service at all times.

The total absence rate for registered midwifery staff, between January and April 2022 was between 24% and 14%.

The total absence rate for unregistered staff, between January and April 2022 was between 14% and 25%.

Managers used bank staff to try to support safe staffing, however, there continues to be shortfalls in staffing.

The service had a high number of staff leaving over the previous 12 months and also had a higher number of vacancies to fill. Sector 1 midwives at South Tyneside District Hospital had 41.38% LTR headcount between July 2021 and June 2022. Midwifery staff at Sunderland Royal Hospital had 12.15% LTR headcount between the same period. The vacancy rate is currently at 14% for midwifery staff at Sunderland Royal Hospital.

However, managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep women and babies safe. The vacancy rate for medical staffing in obstetrics and gynaecology was 22.95%.

The medical staff matched the planned number.

The service had a high number of staff leaving over the previous 12 months and also had a higher number of vacancies to fill. The LTR headcount for medical staffing in obstetrics and gynaecology was 43.90%.

Sickness rates for medical staff were low.

The service had low a rates of bank and locum staff.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of women's care and treatment. Records we reviewed were clear, up-to-date and were easily available to all staff providing care. However, the trust was unable to provide audit data which showed the service's performance over time and records were not always stored securely.

Women's notes were comprehensive and all staff could access them easily. We reviewed 10 full sets of patients records on site, both paper and electronic copies were held and these were fully completed and accessible. However, we asked the trust to provide the most recent records audit by location and for each speciality and we were advised there had been no recent records audits. This meant we could not be assured the service had implemented a robust audit plan to include record keeping which was a requirement following our 2020 inspection.

When women transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. When we carried out the second inspection visit, we found a number of patient records stored in an unlocked cupboard in the second theatre. This was a breach of confidential personal information and we raised this immediately with the Head of Midwifery, who then moved these records immediately.

Medicines

The service did not have effective systems and processes to safely prescribe, administer, record and store medicines.

We found emergency medicines which should be stored in a fridge on the emergency trolley, these medicines can be stored at room temperature, however, the half-life of these medicines is greatly reduced. There was no documentation on these medicines to identify when they had been removed from the fridge, and staff were also unable to articulate when they had been removed.

We found portable nitrous oxide and oxygen stored inappropriately on the floor, next to the designated storage space.

We saw an epidural pump with the epidural infusion still in place. This remained in the clean utility for over 6 hours without being dismantled and disposed of. This meant that the procedures of the trust were not being followed as it should have been removed immediately. It also meant that as a controlled drug, it had not been stored safely for the duration it was left in place.

Treatment rooms where medication was stored did not have thermometers to monitor maximum and minimum temperatures. The rooms were hot which meant we were not assured drugs were stored at the appropriate temperature.

We raised these issues during our inspection and had verbal assurances that changes would be made immediately regarding the concerns we had immediately.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date.

Staff followed national practice to check women had the correct medicines when they were admitted or they moved between services.

The controlled drug (CD) stock control book was not used as it should be. The book was not clearly defined as to who the drugs belonged to and when the remainder of drugs were destroyed or given to the patient upon leaving the ward. This meant that there was not a suitable control system in place for the management of controlled drugs. Staff did not use the book to record the dates and times of checks with attachments of paper to the back of a full book.

Incidents

Staff recognised and reported incidents and near misses. Managers did not always investigate incidents in a timely manner and did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. All staff spoken with throughout the inspection were able to describe how to report an incident and spoke about using the datix system.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

We found between July 2021 and August 2022 the service reported 658 incidents. Of these 14 were reported to strategic executive information systems (StEIS) which is a system for reporting serious incidents and included one never event. Never events are entirely preventable serious incidents (SIs) because guidance or safety recommendations providing strong systemic protective barriers are available at a national level. These should have been implemented by all healthcare providers.

The service reported 644 incidents to the national reporting and learning system (NRLS) with varying degrees of harm:

- 631 incidents were categorised as low or no harm.
- eight incidents were categorised as moderate harm,
- three incidents were categorised as severe harm
- two incidents were categorised as deaths however upon further review these incidents should have also been declared as serious incidents by the trust.

During our review of incidents reported in the 12 months prior to our inspection we saw the following recurrent themes:

- post-partum haemorrhage (n66) with two leading to emergency hysterectomies;
- unexpected transfers to the neonatal unit (n50)
- poor or pathological CTG traces (n28). Poor cord gases (n9)

Managers did not share learning about never events with their staff and across the trust. Staff repeatedly shared with us that they did not have follow up or learning following serious incidents or never events.

Staff understood the duty of candour. They were open and transparent, and gave women and families a full explanation if and when things went wrong.

Maternity

Staff did not receive feedback from investigation of incidents, both internal and external to the service. Often following investigations, staff described to us that they did not receive any follow up information.

Managers investigated incidents thoroughly, however, this was not always completed in a timely manner. We were told by leaders there was a backlog of 250 investigation reports waiting to be completed and some dated back to 2020. Women and their families were not always involved in these investigations.

Managers did not debrief nor did they support staff after any serious incident. Staff shared with us examples of serious incidents that they did not hear any more about after the initial event.

We did see the Patient Safety Bulletin is issued each month and includes a spotlight on trust wide incidents as well as national learning from incidents.

Within the Quality reports between April – June 2022, there was a total of 9 serious incidents related to maternity services reported.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

All policies were in place and available on the intranet for staff to follow. However, not all policies had been reviewed in line with the planned review date.

We found practice had been updated to reflect changes to the fresh eyes approach to fetal monitoring. Policies had been updated and these were available to staff. Staff also shared with us this was the case when we spoke with them.

We saw evidence that detailed the service was amber in its compliance of actions with the Saving Babies Lives Care Bundle Version 2 completed in July 2022. Staff also told us about this when we spoke with them.

The service undertook screening for gestational diabetes in line with national recommendations.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition such as diabetes and food was available to accommodate different cultural choices. We observed women receiving adequate nutrition and hydration during our inspection.

Staff fully and accurately completed women's fluid and nutrition charts where needed.

The service did not have specialist breast feeding midwives or support staff. Staff highlighted to us that this would be beneficial to have in the service to be most effective. Breastfeeding rate within the service is low in the first 48hours of life at 52.3%, compared to a regional target of 74.4%.

We saw that leaflets were available on promoting healthy pregnancy, post-natal exercise, infant feeding plans for parents as well as breastfeeding and formula feeding guidance.

Diabetes and pregnancy cards were available which provide guidance on managing diabetes when planning pregnancy and actions to take when pregnant for example liaising with the diabetic antenatal clinic.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed women’s pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Women received pain relief soon after requesting it and women we spoke to did not highlight any concerns with pain management.

Staff prescribed, administered and recorded pain relief accurately. We observed a midwife checking if a woman was in pain and prescribed medicines were explained before being given.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements although they did achieve good outcomes for women.

The service participated in relevant national clinical audits and had an audit programme in place.

Between April 2021 and March 2022, the number of caesarean sections (CS) for this period was equal to the regional threshold at an average of 26.6%. However, between April and May 2022 the number of CS had increased to 30.2% which was above the regional average. In July 2022, the total rate for CS was 24.7%, which is below the regional rate of 26.2%.

Between April 2021 and March 2022, the elective CS rate was 12.6% which was above the regional average of less than 11%, in addition to this, the position further deteriorated to 15.3%, between April and May 2022. In contrast the emergency CS rate remained better than the regional threshold of 15.2% between April 2021 and March 2022 at 14% and 14.9%.

We asked the service to provide the maternity dashboard, to include readmissions within 14 days, however we did not receive this, therefore we were not assured the service had oversight or monitored the numbers of women readmitted following birth. Without this oversight, the trust could not monitor re-admission themes or reduce risks of any themes identified from this monitoring.

Maternity

We were informed that all neonatal deaths were reviewed by a multidisciplinary group using the Perinatal Mortality Review Tool. We reviewed four sets of perinatal mortality tools, all minutes lacked detail and not all were complete with grading scores. As a result, we were not assured that there was a robust and embedded process in place.

Managers and staff carried out a programme of repeated audits to check improvement over time.

Competent staff

The service did not make sure staff were competent for their roles. Managers did not always appraise staff's work performance and did not always hold supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. In June 2022, 58% of staff had received an appraisal. With the exception of May 2022, the appraisal rate in the service has consistently decreased since October 2021.

Managers did not support nursing staff to develop through regular, constructive clinical supervision of their work. Midwifery staff shared with us they did not all receive clinical supervision in their role.

Managers did not make sure staff attended team meetings or had access to full notes when they could not attend. Midwifery staff shared with us they did not have regular team meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. A specialist training midwife has been appointed and was able to share with us training plans for staff and development opportunities.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff referred women for mental health assessments when they showed signs of mental ill health, or depression. Staff were able to describe this to us when we spoke with them during our inspection.

Seven-day services

Most services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women are reviewed by consultants depending on the care pathway

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. The homebirth service was staffed by community midwives during between 09:00 to 17:00 however outside of these hours two midwives would be deployed from delivery suite. Dependant on the pressures in the maternity unit women might not have been achieve a homebirth.

Maternity

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Staff showed us examples of this when we spoke with them on inspection.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle and we saw evidence of this within patient records.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle including public health initiatives such as obesity, and diabetes.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure women consented to treatment based on all the information available and clearly recorded consent in the woman's records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The current training compliance for mental capacity act level 2 and level 3 for registered nursing and midwifery staff was 95.2%

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good 

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

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Feedback from women and their families was very positive. We spoke to 6 service users, and they told us 'Excellent care, everyone went above and beyond', 'lovely, helpful staff, I cannot fault them at all', and 'the overall care and treatment was good'.

Maternity

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. We observed this when on inspection.

Women said staff treated them well and with kindness. We saw positive staff interactions with women and their families on our inspection.

Staff followed policy to keep women's care and treatment confidential.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

We observed that all patients had access to their call bells.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. The service had a bereavement suite for women and support from a bereavement specialist midwife. Staff undertook bereavement training, and this was part of mandatory training. Staff spoke very highly of the benefits of the training received and the leadership from the specialist midwife in this area.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Midwives were able to talk to us about this when we spoke with them. There was access to a private quiet room to help with breaking bad news to women and their partners.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with were able to share their understanding of this clearly through situations they described in their work.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. We saw good practice around informed consent.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary.

Maternity

Women and their families could give feedback on the service and their treatment and staff supported them to do this. There were feedback boxes throughout the services and the option for QR code readers to be used to encourage feedback to be captured from service users and their families.

Staff supported women to make informed decisions about their care.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service did not plan or provide care in a way that met the needs of local people and the communities served.

Managers did not plan or organise services so they met the needs of the local population. Four patients we spoke with were not happy with having to travel to Sunderland maternity unit when South Tyneside midwifery led unit was closed. The hours of the community midwifery team did not meet the needs of the local population as services transferred to hospital after 5pm on weekdays and at weekends.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia.

Managers monitored and took action to minimise missed appointments. We saw evidence of this when reviewing incidents and heard about this from midwives we spoke with during our inspection. Managers ensured that women who did not attend appointments were contacted.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Following two approved staffing papers in January 2021 and February 2022 there was 15 additional specialist posts were established for specialist midwives. At the time of our inspection, four of these specialist midwife positions were vacant.

The services midwifery led unit at South Tyneside District Hospital had been closed since January 2022 due to staffing concerns. This meant that women had the choice to birth at home or in hospital with MDT input. Community midwives did not operate an on call rota, which meant they would care for women requesting home birth during the daytime working hours, however, outside of these hours care was provided by the delivery suite team. This meant the delivery suite staffing could be reduced by two midwives attending a homebirth, which further increased concerns for staffing levels on the delivery suite. Staff told us they were concerned about this for patient safety and choice.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss.

We did not see a hearing loop available; we were told staff could get help from interpreters and signers when needed. We were told that the service had information leaflets available in languages spoken by the women and local community.

Staff could access emergency mental health support for women. Care was provided by an on-call crisis team.

Women were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were not always in line with national standards.

Managers monitored waiting times but did not always make sure women could access services when needed to receive treatment within agreed timeframes and national targets. There were delays to induction in labour for women.

Managers and staff worked to make sure women did not stay longer than they needed to.

When women had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Midwifery staff told us about this during our inspection.

Managers monitored that patient moves between wards/services were kept to a minimum.

The service moved women only when there was a clear medical reason or in their best interest.

Managers and staff started planning each woman's discharge as early as possible.

Staff supported women and babies when they were referred or transferred between services.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them although we did not see evidence of sharing lessons learned with all staff. The service said they included women in the investigation of their complaint. The response to investigation was not always timely.

There were 33 complaints recorded from obstetrics and community midwifery over the last 12 months. The themes from these complaints were around clinical treatment, patient care, values and behaviours of staff, communication, admission/ discharge/ transfer and clinical treatment.

Women, relatives and carers knew how to complain or raise concerns. There was information displayed on the Unit about how to complain within patient areas.

Maternity

Staff understood the policy on complaints and knew how to handle them. When speaking to staff they were able to share how they would handle complaints and understand their policy on this.

Managers investigated complaints and identified themes. We saw a record of these over the last 12 months. However, there were delays in responding to complaints and this was reflected in the maternity report to board.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

We were not assured all leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective in implementing meaningful changes that improved safety.

The service was experiencing midwifery staffing challenges and staff reported senior leaders had not recognised this, however we saw plans were in place to improve the staffing position. There was a lack of monitoring of risks in accordance with national guidance in relation to safe staffing of the service.

The service was led by an operations director, interim head of midwifery and clinical director. However, we found there had been an unstable leadership of the maternity unit in the 12 months prior to our inspection.

We found the previous long standing head of midwifery had retired. The newly appointed head of midwifery had handed in their notice after a short time in post and the service had an interim head of midwifery. When we went back to the service during the well led inspection, we found the interim head of midwifery had been appointed substantively to their post. The clinical director was also newly appointed.

The leadership recognised there had been significant challenges within the team, and were trying to take action to address this. They had recently recruited to a number of specialist midwifery posts to work to improve service provision and outcomes for women.

Some of the concerns identified during this inspection were identified in our previous inspection in 2020. This demonstrated leaders did not always act to make improvements.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, the new trust strategy had not been translated into action in this service.

There was not an effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. The strategy was in its infancy and had not been translated into action in maternity services at the point of our inspection.

Maternity

Culture

The service did not have a culture where staff could raise concerns without fear. We were not assured that staff concerns and incidents reports were considered and acted on in a timely manner, for example, regarding the unavailability of key equipment such as neonatal resuscitaires. We were not assured concerns were progressed appropriately. Not all staff felt respected, valued and supported. Staff were focused on the needs of the women receiving care.

It was evident during the inspection that the midwives and medical staff made every effort, under difficult circumstances, to meet the needs and care for women and babies.

However, we were told and saw the medical staff and midwifery did not always work well together. We heard there were challenges with engaging the medical team with the incident investigation process and also attending multidisciplinary risk meetings. The medical team identified they needed to come together to support each other, identify leads on key areas and to try and improve the culture for junior doctors. This was done without working alongside senior midwifery colleagues, which meant there was a missed opportunity for greater integration.

The trust was formed through the merger of two predecessor organisations. This had impacted on the service by creating a combined service across two hospital sites. All staff that we spoke with told us there had been persistent issues prior to, during and since the merger.

We were also informed of a further reconfiguration on the maternity unit in October / November 2021, where the service moved away from the labour, delivery and postnatal configuration of rooms to having a defined delivery suite area and antenatal and postnatal ward area. Leaders told us they consulted with staff regarding this change although we received mixed feedback from staff in all roles on whether they had been consulted regarding this change.

We found there was no integration of community midwifery services within the acute setting, as community midwives did not operate an on call rota nor did they rotate into the maternity unit to maintain their skills.

The staff survey results from 2021 showed that only 57.3% of staff in obstetrics and gynaecology feel safe to speak up about anything that concerns them in the organisation.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service.

We found there was limited oversight of maternity services by the trust board, however, these had improved over recent months. We also found there were unclear processes of how ward to board assurances were gained about the quality and safety of services. Staff including some senior leaders could not clearly articulate a governance framework for the directorate and how information flowed between directorate and the board.

We were not assured all levels of governance and management functioned effectively and interacted with each other appropriately. We saw there was no autonomy within the service to report incidents, we found all reported incidents were screened by the incident team and then taken to the critical incident review group (CIRG). CIRG then reviewed the detail of the incident, then identified the levels of harm and whether it required investigation and duty of candour, this was then handed back to the directorate to complete then present back the findings.

Maternity

During our review of the 658 incidents reported by the service between July 2021 and August 2022 to NRLS and StEIS, 41 of these incidents took over 90 days to report following the date of the incident and the longest delay in reporting was 382 days. We also saw 20 incidents where the time taken to report was 61 to 90 days and 186 incidents where the time take to report was between 31 and 60 days.

There was no delivery suite forum in place to discuss incidents in real time as a multidisciplinary team on a weekly basis and make immediate recommendations. We were told these were about to restart following our inspection, however, staff could not confirm when these had stopped in the first instance.

The trust audited 30 cardiotocography records from March 2022 representing 10% of the total deliveries that month. The results of the audit showed more than a third of CTGs had not had one hourly fresh eyes assessment by an allocated midwife, or two hourly Fresh Eyes Assessment in first stage labour by a second midwife or coordinator. Nine of the 14 service users who required 30-minute fresh eyes assessments by an allocated midwife and five of the ten who required 30-minute fresh eyes assessment by a co-ordinator during second stage labour had not received this.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. Plans were not always in place to cope with unexpected events.

We requested the risk assessment for the implementation of the second emergency maternity theatre during and following our onsite inspection, however, the trust were unable to provide this. Following our inspection we informed the trust of our concerns and we were informed they had closed the second emergency theatre.

We also found there was no restricted access to the second theatre, there was minimal signage on the door to state it was a theatre, this meant there was a risk people could enter and disturb equipment or enter during an operative procedure.

When we returned during the well led inspection we returned to the second theatre and found this was opened and able to be used, the service had improved the scrub sink area. Leaders informed us there was a risk assessment and the second theatre had been added to the directorate risk register. Again we requested the risk assessment and the trust were unable to locate this and provided a position paper. In addition we saw the signage on the door remained minimal and continued to pose a risk.

We have seen on the risk register, a previous entry identifying the second theatre as a risk to use when essential electrical works to the delivery suite emergency theatre were required in December 2021, although this work was then not carried out, no changes were then made to the second theatre to minimise risks identified to it.

Information Management

The service collected reliable data but not always analyse it. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions or to make improvements. The information systems were integrated and secure. Data or notifications were not consistently submitted to external organisations as required.

There was poor access to and challenge of performance by leaders and staff. There were significant failings in systems and processes for the management or sharing of data.

Inaccurate clinical data was identified to have been extracted from the electronic patient record system and utilised for reporting regionally and nationally in the Trusts risk register in February 2022. It was a requirement currently for clinicians to manually check data extracts prior to submitting and this is still an ongoing risk as there is not enough clinical staff available to check this data as needed, due to their clinical commitments. This meant there was a continual risk of inaccurate clinical data being recorded.

The service was signed up to the Maternity incentive scheme. The scheme supports the delivery of safer maternity care through an incentive element to the contributions to the clinical negligence scheme for trusts (CNST). Trusts are rewarded when they meet ten safety actions which were designed to improve the delivery of best practice in maternity and neonatal services. We saw evidence which showed the trust had originally identified they were compliant with all ten safety actions, however, following an internal review had resubmitted evidence to identify they were compliant in only two safety actions. This had resulted in the trust needing pay back an over £1million to NHS Resolution and repay further amounts based on their further reviews.

Engagement

Leaders and staff did not always actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. We saw limited evidence of this and staff we spoke with told us this did not always happen.

During our inspection we found the maternity area of the trust website did not reflect the current configuration of the maternity unit. It continued to offer women a labour delivery and postnatal provision at the Sunderland site, which, we found had not been available since October / November 2021. We also saw the midwifery led birthing unit (MLBU) was still offered as an option for women to deliver their babies, however, we were aware services at the MLBU had been suspended from January 2022 due to significant staffing concerns. We escalated this to staff during our inspection and saw the website had been updated to reflect the current service provision.

Staff had taken part in the Big Team Talk during October 2021 with the aim of helping the Trust with its vision and strategic priorities for the future.

Staff told us of concerns with staffing, and although senior leaders had plans in place, this had not been effectively communicated with staff.

Staff continually told us throughout The Path to Excellence and the merger of the two maternity units there was a lack of engagement with staff and staff reported they found information out through media outlets.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services, but raised they felt there was limited opportunity to do this. They did not have a good understanding of quality improvement methods.

We found some examples of quality improvement and innovation projects using a recognised methodology which were in progress at the time of inspection:

- MVP work submitted in June;
- Florence Telemedicine for diabetes introduced on August/preterm birth clinics commenced in 2021;
- Maternal mental health service commenced in March 2022;

Maternity

- Use of QUiPP app for preterm birth;
- Home telehealth for hypertension;
- Sfly plgt (blood test predictor) for pre-eclampsia;
- Enhanced recovery after CS; and Risk assessment tools in the electronic patient record system.

There was minimal evidence of learning and reflective practice. The impact of service changes on the quality and sustainability of care was not always understood.

Following the requirement notices issued following our inspection in 2020, there had been little improvement or no action taken to address the previously identified areas of concern. The trust had not started to implement the continuity of carer model of care which was recommended in Better Births (2016).

South Tyneside District Hospital

Harton Lane
South Shields
NE34 0PL
Tel:

Description of this hospital

Medical specialties include renal medicine, oncology, haematology, rheumatology, gastroenterology, metabolic medicine and thoracic medicine. Rehabilitation and elderly medicine include care of the elderly, neurology, neurophysiology, neurorehabilitation and stroke services. There are 200 beds located within seven wards.

The hospital had a Midwifery Led Birthing Centre although this was closed at the time of our inspection.

Medical care (including older people's care)

Requires Improvement 

Is the service safe?

Requires Improvement 

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

Mandatory Training

The service provided mandatory training in key skills to all staff. However; not all staff had completed the training in line with trust guidance.

Mandatory training figures provided by the trust were not broken down by staff type or location so we could not differentiate between nursing and medical staff. However, all directorates of the medicine division were below the trust target for mandatory training. The current completion rates were between 84.97% and 88.94%.

Managers told us they monitored mandatory training and alerted staff when they needed to update their training. However, staffing challenges meant that mandatory training was not always being completed.

Nursing staff mostly told us they were up to date with their mandatory training. One nurse said she had fell behind with training so was catching up during quieter periods such as night shifts.

Recognising and responding to patients with mental health needs, learning disabilities, autism and dementia did not form part of the core mandatory training for staff.

New staff said they were given protected time to undertake mandatory training.

Safeguarding training was included in the mandatory training platform. All staff were trained to level one and there was role specific training to level two and three.

Training in dementia and learning difficulties was part of the trusts safeguarding training compliance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding adults training rates across the division were 97% for level one and 94.9% for level two. Safeguarding level three was role specific and rates were at 95.04%.

Equality and diversity training rates across the division were at 97%.

Nursing staff received training specific for their role on how to recognise and report abuse.

Medical staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

All of the wards we visited spoke of a great support from the safeguarding team and the speciality safeguarding nurses were visible on the wards offering support and advice to staff.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Staff followed infection control principles including the use of personal protective equipment (PPE).

There was information displayed at ward entrances about appropriate PPE usage and an area for staff to don and doff PPE with supplies of surgical face masks and aprons and with access to a hand washing sink, hand wash and alcohol gel hand rub.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

IPC audits were not displayed on any of the wards we visited.

Wards had designated side rooms, which were easily identifiable with warning signs for staff.

All staff were 'bare below elbows' and compliant with uniform policy.

Managing and decontaminating reusable medical devices was done centrally and then returned and stored on ward.

Wards we visited had internal cleanliness ratings, all ratings were five stars except ward 3 which was four stars.

Patient Led Assessments of the Care Environments (PLACE) had been postponed due to the pandemic. The formal PLACE audit was due to recommence in September.

There was rapid testing available for COVID-19. Staff screened patients for COVID-19 throughout their admission on set days and if they presented with signs and symptoms. Staff cleaned equipment after patient contact.

The trust had oversight of infection rates, with processes in place to investigate any confirmed infections. Staff told us that patients identified as having a current or previous infection were isolated in side rooms and appropriate signage was used to indicate the potential for infection in order to protect staff and patients.

Medical care (including older people's care)

The trust shared hand hygiene data which overall showed some poor compliance for the last quarter across the division. However, audits in July and August showed improvements.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff managed clinical waste well.

An open staircase on ward 19 posed a health and safety to risk to patients. This was raised at the time of the inspection and the trust's estate team reviewed this immediately. It was agreed by them that the staircase would be enclosed immediately.

Patients could reach call bells and staff mostly responded quickly when called. However, we did observe instances of call bells persistently buzzing for prolonged periods of time on ward 3 even when nursing staff where in the bay.

Staff carried out daily safety checks of specialist equipment. Resuscitation trollies and defibrillators were mostly compliant with electrical testing and calibration. However, a defibrillator on ward 3 was due for calibration in March 2022. This was raised with the ward manager who told us the clinical engineering department had been made aware of it that day and calibration would be done with immediate effect.

The service had suitable facilities to meet the needs of patients' families.

The service mostly had enough suitable equipment to help them to safely care for patients. However, staff on ward 3 told us they only had one ECG machine for the whole floor and it was shared with the surgical assessment suite. This had been raised with managers and was being looked into.

Staff told us that bariatric equipment could be ordered in if required.

Staff disposed of clinical waste safely.

All sluice, storage and treatment room doors were locked on all wards we visited.

Suctioning equipment ready to use.

All substances that fall under COSHH, including Oxygen, were stored appropriately and locked.

Waste and sharps were managed in line with trust policy.

All wards had a secure buzzer system to gain entry.

Assessing and responding to patient risk

Staff did not consistently assess and manage risks to patients. Staff did not always identify and act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients. However, they did not always escalate them appropriately. For example, two patients on ward 2 with very high scoring NEWS should have warranted immediate medical assessment. However, their conditions were not escalated to the medical team until the inspection team

advised staff to do so. We raised this at the time of the inspection and requested assurances from leaders. They undertook an audit of patients on the medical wards which showed this issue was a significant concern across multiple wards. However, when we revisited the service in August, we found they had made improvements and all patients that had high scoring NEWS were managed and escalated in line with best practice guidance.

The National Early Warning Score (NEWS2) is a system used to monitor a patient's physiological measurements. Scores were inconsistently recorded, and high scoring NEWS were not acted on in line with guidance. Two patients on ward 10 did not have high scoring NEWS escalated and observations were overdue by one hour. This was escalated to the nurse in charge at the time of the inspection.

Following our inspection in June, the trust undertook an immediate audit of five patients care on every medical ward on three separate days. They looked at NEWS scores, escalation processes and intentional rounding. Results shared with us showed this issue was a significant concern across multiple wards.

During the inspection we found gaps in intentional rounding on all wards we visited. Following the inspection, the trust told us that as a matter of urgency, they have introduced some additional training supported by the Tissue Viability Team to the relevant clinical areas to support with staff understanding of intentional rounding documentation, specifically around pressure care assessments. When we revisited the service in August, we found there to be improvements in the recording and timeliness of the intentional rounding on all wards we visited.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool.

The service had 24-hour access to mental health liaison and specialist mental health support. However, some staff we spoke with told us that it was often difficult to get psychiatric liaison team input as they would assess over the telephone and if they felt the patient did not warrant an assessment, they would reject the request.

The trust did not have clear processes to ensure that all patients with a learning disability were identified clearly in their electronic systems (flagging systems). The trust relied on confirmation from primary care systems or other sources before a patient's record was flagged to indicate a learning disability. There was a risk that patients who had not been identified as having a learning disability in primary care would be missed and would therefore not receive the additional support needed. We were told in this instance, patients could be referred to the learning disability team for a cognitive assessment, but this would be done following discharge from hospital rather than when they were an inpatient.

Not all patients assessed as level three falls risk had 1:1 care provided, and patients' assessed as level two falls risk had no staff member with them in their cohorted bays due to staffing pressures across the trust. In the previous three months, 37.5% of the divisions falls with harm were due to patients not receiving the correct level of enhanced care and observations. Managers of all wards we visited told us of the difficulties around monitoring patients that required enhanced care.

One patient on ward 2 required 1:1 care. Staff told us the patient is aggressive and inappropriate towards female staff and said that they refused to be alone with the patient. The patient was left to walk around the ward unsupported which posed a risk to the patient and other patients in the ward.

The trust shared with us VTE audit results for March 2022. Audits showed that 100% of patients had a VTE risk assessment on admission. However, only 52% had prophylaxis prescribed and administered within 14 hours of admission.

Medical care (including older people's care)

The service shared with us NEWS audit results for May 2022. The audit results showed that medicine scored 100% in accuracy, monitoring plans in place and escalation. Timeliness was at 70%.

NEWS2 and sepsis training formed part of the trust's induction programme. All clinical staff must complete. However, figure shared with us from the trust did not show how many staff had not completed the training or the trust's target range.

The trust had a National Early Warning Score (NEWS2) and the monitoring and recording of vital signs policy. However, the policy was due for review in April 2022 so not in date.

The trust had a clinical guidance to support staff with the recognition, diagnosis and early management of sepsis.

An audit for the administration of antibiotics within one hour for patients with sepsis showed that only 41% of patients received the medicine within the time frame.

Lying and standing blood pressures are done on admission and then routinely if there is a postural drop. The trust had developed a new risk assessment which gives recommended actions when there is a postural drop and advise for next steps to take.

In response to a recent quality improvement project, ward 9 were piloting a new falls prevention assessment tool which gives a more detailed assessment than the current tool used within the trust.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.

The services audit results showed that 99.1% of patients with suspected sepsis were screened appropriately.

Staffing

Nurse staffing

The service did not have enough nursing and support staff with the right skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels. However, this did not always provide established levels of staffing.

The service did not have enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants did not match the planned numbers on the wards we visited during the inspection. The trust told us they used the safe care acuity tool to secure safe rosters and review skill mix.

The trust shared with us planned vs actual staffing numbers for May 2022. This showed that actual nursing staff hours filled for day shifts were 23.66% lower than what the actual staffing should have been and for night shifts was 16% lower than planned staffing hours. Care staff actual staffing hours for day shifts were 5% lower than what actual staffing should be and for night shifts was 9% lower than it should be.

Staff told us that escalation of under establishment was reported as red flag incidents and discussed with senior management.

Medical care (including older people's care)

Red flag staffing incidents could only be reported by matrons due to the significant number of red flag incidents being reported. This approach prevented ward managers from directly escalating and reporting low staffing levels

Staff told us that it is very difficult to have enough staff to support with the additional support needs of patients requiring level two and three care.

Wards we visited did not have enough staff to support the 1:1 care needs of patients identified as needing enhanced monitoring.

Managers told us that they escalate staffing issues to matrons, but gaps don't always get filled due to overall staffing issues across the trust.

Some managers told us of the difficulty they face when trying to co-ordinate and manage a bay of their own patients due to staffing issues.

Staff we spoke with told us that the wards regularly feel unsafe due to the staffing issues.

The matrons for the medicine division told us that they meet each morning; ring wards to get a picture of staffing issues and try to match staffing levels based on acuity needs. They then have further meetings at lunchtime and evening and staffing is re-assessed.

The trust has a process of green, amber, red and black staffing levels and there is an increase in frequency of meetings and escalation process depending on the level

Managers accurately calculated and reviewed the number nurses and healthcare assistants needed for each shift in accordance with national guidance. However, the planned numbers did not always manage the actual numbers of staff and shift. Managers told us that when they do have the correct number of staff on shift, they are then moved to work on other wards that do not have enough staff

All wards we inspected on the day of inspection had staff sickness, some staff were absent with COVID 19 symptoms or were self-isolating and some staff were on long term sick.

The vacancy rate for registered nurses was 6.8%.

Some of the wards within the division showed high staff sickness rates. For example; ward 2 was 10.23%, on ward 3 it was 12.85% and on ward 10 it was 17%. Managers told us they tried to fill shifts with their own staff, bank staff or agency but this wasn't always possible.

We spoke with a staff member who told us staffing on ward 10 often felt unsafe. They would have three nurses and two health care assistants for a 30 bedded ward including NIV patients requiring 2:1 care.

A safe staffing establishment review in November 2021 identified that ward 2 needed an immediate increase in staffing with further investment in April 2022. The suggested increase was to five registered nurses and three health care assistants on the day shift, at the time of the inspection there were four nurses and three health care assistants on shift. The impact of this was that staff were unable to safely monitor two patients that required 1:1 supervision. Data shared with us showed that in May actual nurse staffing on ward 2 was 27% lower than it needed to be for day shifts.

Medical care (including older people's care)

Medical staffing

The service had medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe.

There were medical staff vacancies across the division.

The medical staff matched the planned numbers.

Sickness rates for medical staff was mostly low across the division. However, the absence rate for medical staff within thoracic medicine was 6.47%.

Managers could access locums when they needed additional medical staff.

The service had a good skill mix of medical staff on each shift.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept records of patients' care and treatment. Records were mostly clear, up-to-date, stored securely and easily available to all staff providing care.

Staff could access patient notes easily; however, they were not always comprehensive. We looked at 10 full sets of patient notes. We saw gaps in recording in patient's records including skin and wound management, height and weight, malnutrition universal screening tools (MUST) scores, nutrition, and hydration charts and best interest decision making.

One patient on ward 9 had a MUST score of 2, reassessment was one day overdue, and the patients required food charts had not been completed for over one week.

Electronic whiteboards were used on all wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely on all wards we visited.

Complex needs such as learning difficulties or dementia were not always recorded in patient records. The trust relied on confirmation from primary care systems or other sources before a patient's record was flagged to indicate a learning disability.

Comprehensive medical histories were recorded in all records we looked at.

Medical care (including older people's care)

We saw allied health professionals documented comprehensive care and treatment plans within the paper nursing records that we reviewed. If notes had been made electronically there was a sticker in the paper notes to inform of this so staff knew where to look for the information about the patient.

Senior leaders told us that records are audited on a monthly basis and reports sent to senior teams and results are then shared with the matron and head of nursing. We requested audit data of records from the trust. However, at the time of writing the report these were not received and it was stated that there have been no recent clinical record keeping audits.

Medicines

Staff followed some systems and processes to prescribe and administer medicines safely. However, there were incidents where time critical medicines were not administered to patients as prescribed.

Insulin pens on ward 10 were left in the treatment room with no date of when the pen was removed from the fridge, this medicine will only last for four weeks once removed from the refrigerator.

We checked the storage of medicines, fluids and gases on the wards we visited. We found these were stored safely and securely on all wards we visited.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The pharmacy team were visible on the wards we visited and reviewed patients' medicines.

Oxygen was prescribed for all patients that used it.

Fridge temperatures that stored medicines were checked daily and logged in line with guidance.

Emergency hypoglycaemic kits were available on the wards we visited.

Staff stored and managed all medicines and prescribing documents safely. Intravenous potassium chloride was stored separate to other IV fluids in line with guidance.

National guidance recommends undertaking medicine reconciliation within 24 hours of admission. This allowed early action to be taken in relation to discrepancies and a complete and accurate list of medicines available. Audit data across the trust indicated an average rate of 64% completed within 24 hours for 21/2022.

Ward managers monitored medication missed doses by doing a monthly missed dose audit. The trust said that the introduction of weekly monitoring reports is enabling ward managers to clearly see where improvements are needed. The most recent trust wide audit showed missed doses were improving.

Medical care (including older people's care)

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The medicine division had 14 serious incidents declared in 2021/22. six of these investigations were in progress, four had been approved for investigation and four had been completed.

Following inspection, the trust sent us details of investigations that had been done into serious incidents and shared with us lessons that were learned.

The trust said they used a serious incident tracker to monitor timelines for investigations. This included dates for when an RCA was due and when the incident had been discussed at the Critical Incident Review Group (CIRG) Panel.

Staff we spoke with mostly told us they knew how to report incidents.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

The service had one recent never event. Findings from the trust's shared incident report identified issues with staffing levels and skill mix. Learning from the incident was shared via the patient safety bulletin, ward handovers and staff huddles.

Staff we spoke with could give examples of incidents they had recently reported.

Managers shared learning about never events with their staff and across the trust.

Ward leaders that we spoke with all knew their wards most recurring top three incidents.

Staff we spoke with mostly understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There were systems and processes in place to identify changes to national guidelines and update policies appropriately

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust's intranet, guidelines, policies and procedures relevant to their role.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

We observed mealtimes on various wards and noted that all staff were involved in getting meals to patients, including the more senior staff. Patients that needed support with eating their meals were given it. However, we did not observe any initiatives such as red trays to help staff identify which patients required support.

All patients' hands were cleaned with wipes prior to them being given their meals.

All patients that we spoke with were happy with the meals and said they were always given a choice of what they wanted.

Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds and on a whiteboard at the nurse's station.

We observed additional comfort rounds taking place with options for biscuits, tea and coffee.

Water jugs were in reach and patients said they were replenished frequently.

Mealtimes were protected; however, family members were allowed in to support with care if the patient wanted that and we did see family members supporting their loved ones at meal times on some wards.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition, however these risk assessments were not always completed for all patients that needed them.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. However, the speech and language team only worked Monday to Friday.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and mostly gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

All patients that we spoke with told us that they received pain relief in a timely way if they requested.

Patients told us they received pain relief soon after requesting it.

We observed that nurses administering controlled drug pain relief always had a second nurse with them to check the medicine in line with guidance.

We asked the trust to share with us audit data for pain management. However, at the time of writing the report this was not received.

Patient outcomes

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. However; the trust did not undertake any routine pain audits.

The trust shared with an ongoing audit plan for 2022/23 for the medicine division. This showed participation in various national audits. The audit plan did not include details of ward level routine audits.

The endoscopy unit held full accreditation with the Joint Advisory Group (JAG). This meant that the service had demonstrated that is has the competence to deliver against criteria set out in the JAG standards.

The service participated in relevant national clinical audits including national falls audit, Sentinel Stroke National Audit Programme (SSNAP), lung cancer audit and national dementia audit which will restart in autumn 2022. Outcomes and action plans from the audits are discussed at clinical governance meetings.

Mortality and morbidity reviews showed standards of care were looked at and actions for improvements identified. These were done frequently for all specialities within the division.

As there had been no national pain audits within the last 12 months, the trust did not complete any audits related to pain.

Managers used information from the audits to improve care and treatment.

Leaders told us that matrons have a portfolio and they work with ward managers and review all audits. Wards are not given individual action plans but are given areas to focus on to help improve patient outcomes.

Managers told us they used information from audits to improve care and treatment. Ward level leaders shared with us weekly audits which had focus on falls reduction, nutrition and hydration and skin assessments.

Pressure ulcers graded category three and above were investigated with omissions of care identified action plans to mitigate risk were put in place.

Falls audits took place across the division and were discussed at a falls review panel. Audits identified immediate actions following a fall, issues relating to post fall management and actions taken.

The medicine division had 107 safeguarding referrals made in the previous 12 months, the trust shared with us outcomes of the referrals.

Medical care (including older people's care)

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

Managers told us that supervision and appraisals had been continuing as required throughout the pandemic and that these had been of a good standard. However, this wasn't reflected in the appraisal completion rates for the division which were below trust target for nursing staff 72.43% and allied health professionals 72.59%.

Staff did not always have the experience skills and knowledge to meet the needs of patients. For example, we were told that ward 5 had recently had an agency staff member who had never worked in a hospital before.

Managers gave all new staff a full induction tailored to their role before they started work.

Staff said that education sessions had resumed, however the departments did not always work flexibly to accommodate these by offering protected time to complete them. Some staff told us that they would often have to complete these in their own time. Leaders told us they were trying to combat this by moving learning to electronic were possible.

Managers we spoke with told us they did not always get protected management time as they were too busy and would generally have to support on the ward.

International nurses told us they had good support from their mentors.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Managers told us that they could identify any training needs their staff had, however giving them the time and opportunity to develop their skills and knowledge was not always possible due to staffing constraints.

Staff told us they had the opportunity to discuss training needs with their line manager and felt they would be supported to develop their skills and knowledge.

Leaders told us that at the start of the pandemic the challenge was that they did not have enough of a respiratory workforce. This was combatted by developing staff skills and additional training to increase the support on the respiratory wards.

Staff were given the opportunity to progress within their role. Multiple ward managers we spoke with had previously been band 5 nurses on the ward they now managed.

We spoke with a newly recruited international nurses who told us they are supernumerary in the rota, to give them time to become fully adjusted and inducted into the department.

Managers made sure staff received any specialist training for their role. For example, relevant staff received specific training in non-invasive ventilation (NIV) and the trust said they always have up to 50% of nurses on the ward competent in NIV.

Medical care (including older people's care)

The division benefited from Practice Placement Facilitators who sit within the workforce team. These help staff with development and competencies. There were two new posts for clinical educators to work with preceptor nurses.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw different teams of healthcare professionals working with staff in the division as a multidisciplinary team (MDT).

We observed a morning huddle on ward 2 which was attended by consultant, junior doctors, nurse in charge and therapy staff. The staff discussed patients that were due for discharge, patients that had a DNACPR, alcohol liaison team referrals and also the social needs of a patient waiting for discharge.

We observed MDT board rounds which included consultant, pharmacist, physiotherapist and ward sister.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. One patient on ward 2 was discussed at the morning huddle and referred to the psychiatric liaison team for assessments.

Patients had their care pathway reviewed by relevant consultants. For example, patients residing as medical outliers due to bed shortages, were reviewed by the appropriate consultant for their care needs. A medical outlier is a hospital inpatient classified as a medical patient but has a placement on a non-medical ward.

Seven-day services

Key services were not available seven days a week to support timely patient care.

Wards we visited had consultant led daily ward rounds.

Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However, the SALT team were only available Monday to Friday. The acute liaison learning disability nurses would also be required to work across site to cover each other's annual leave.

The trust had a learning disability team made up of two lead nurses. They would support staff with the management of patients with learning disabilities, however they could only support on Monday to Friday due to it not being a seven day service.

Discharges were planned so they could still take place on a weekend to maintain flow out of the hospital.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always use measures that limit patients' liberty appropriately.

We reviewed five records of patients subject to deprivation of liberty safeguards. All of the records showed staff had completed an assessment of the patients' mental capacity and had recorded decisions made in the patients' best interests in line with the requirements of the legislation. In one additional record, staff told us the patient lacked capacity to consent to their admission although staff had not completed a mental capacity assessment or recorded a decision made in the patients' best interest.

Following the inspection, we requested immediate assurances around all patients subject to DoLS and best interest decisions. The trust undertook an immediate review which found there were 48 patients requiring further scrutiny regarding process, 11 patients were subject to DoLs, 22 were found to have no further concern regarding their capacity. There were four patients who required reassessment of their capacity and these were reviewed immediately.

Following our inspection, the trust undertook an immediate review of all 48 patients across the division that required mental capacity assessments, best interest decisions or a DoLS. The findings showed that there were delays in completing mental capacity assessments for 28 of the patients, no best interest decisions for 2 patients and delays in DoLS applications for 3 patients.

We revisited the service in August and found mental capacity assessments and best interest decisions were still not being completed in line with guidance. Six records we looked did not have best interest decisions completed in line with requirements.

During the revisit in August, the safeguarding nurse told us that they were undertaking a daily audit of nursing documentation for patients that required a mental capacity assessment. They were reviewing patients from 16 wards and identifying gaps and trying to embed improvements. However, we found in patient records that staff were not acting on recommendations made by the safeguarding nurses. For example, one patient who had confusion and delirium had no mental capacity assessment or DoLS. A note on the patient record stated the need for the assessments had been discussed with the ward sister on 26 July 2022, however on the day of the inspection 13 days later these assessments had still not been done. The same applied to another patient who was admitted with known dementia and did not understand the reason for their admission. The need for assessment was identified and discussed with staff on 5 August 2022, however the assessments were still not completed three days later. A third patient with known dementia could not provide a medical history due to cognitive impairment, no mental capacity assessment or DoLS were completed. We escalated these at the time of the inspection and requested an immediate review of these patients. The trust assured us that they would all receive an in depth review as a matter of urgency.

During the revisit in August, we reviewed one patient with a known learning disability. We found that they had been reviewed multiple times by the learning disability liason nurse and a reasonable adjustments form had been completed, however the patient also had known dementia and psychosis and staff told us that the patient did not understand their care and treatment and could not make decisions. The patient had no mental capacity assessment, best interest decisions or DoLS in place. We escalated this patient at the time of the inspection and requested an urgent review.

Records showed that decisions around DNACPR (Do Not attempt cardiopulmonary resuscitation) were fully informed.

Medical care (including older people's care)

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance.

Staff did not always clearly record consent in the patients' records.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The data was not divided by site or division but trust wide it showed that compliance rates for nursing staff was 95.2%, and health care assistants 95.3%.

Staff did not always understand how and when to assess whether a patient had the capacity to make decisions about their care.

When patients could not give consent, staff did not always make decisions in their best interest, considering patients' wishes, culture and traditions.

Staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation.

Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

We observed staff discussing the social and support needs of individual patients.

Patients we spoke with told us they were receiving amazing care and that staff were excellent.

We observed varying examples of compassionate care including staff comforting distressed patients.

A staff member on ward 9 encouraged a patient to eat who had refused a meal. She offered alternative meals until the patient agreed to try something.

We observed that all patients on all wards had access to their call bells.

There was a mixture of patients that were fully washed and dressed on the wards we visited. Whilst some patients remained in bed wearing hospital gowns.

Family and friends can visit patients on the ward, and it is organised with an appointment system.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

We observed staff having kind and compassionate conversations with patients, despite them all being extremely busy.

Wards we visited had quiet rooms available which could be used for delivering bad news to patients and their families.

Staff we spoke with said the trust had a multifaith chaplaincy that was very responsive to patient needs.

We saw that some wards had poster up promoting support from Macmillan cancer services and services that offered support and advice to carers.

The trust had in use carer passports which allowed carers to stay with their loved one if they wished.

Visiting had resumed on the wards with people being able to book time slots and visit for up to two hours, however, some visitors could stay longer at ward managers discretion.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

The trust participated in the Friends and Family Test (FFT). Survey results forwarded from the trust showed that the division had received 247 responses.

Staff mostly made sure patients and those close to them understood their care and treatment. However, some patients that we spoke with told us they did not know their treatment plans.

Patients said that relatives were involved where possible; on some wards, but not all. This included invitation to MDT if appropriate. This was also confirmed in discussion with relatives.

Medical care (including older people's care)

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients mostly gave positive feedback about the service. Responses shared with us from the trust showed that negative comments consistently related to food and lack of discharge information. However, during the inspection all patients that we spoke with said they were happy with the meals provided.

Some patients we spoke with were unaware of their proposed discharge date.

Staff talked with patients, families and carers in a way they could understand.

Patients we spoke with gave positive feedback about the service.

Is the service responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The trust had systems and processes in place to ensure that the needs of local people were considered when planning the service delivery.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Staff knew about and understood the standards for mixed sex accommodation. There were no mixed sex breaches on any of the wards we visited.

The service had systems to help care for patients in need of additional support or specialist intervention. However, due to staffing shortages, additional one to one or specialised care was not always fulfilled.

Meeting people's individual needs

The service did not always consider patients' individual needs and preferences. They coordinated care with other services and providers.

Medical care (including older people's care)

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. On admission to the ward each patient received individual assessments, however these were mostly risk-based assessments, and they did not consider individual needs or preferences.

Wards were designed to meet the needs of patients living with dementia.

Staff did not support patients living with dementia and learning disabilities by using 'This is me' documents. However, they did use patient passports.

Staff did not undertake thorough assessments for patients who have a learning disability, care needs were not assessed and planned to meet their individual needs

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

There was a chaplaincy service available to facilitate any support patients and/or families may require.

Mortality and morbidity meetings took place across the medicine division with individual cases discussed and learning points identified.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service benefited from the support of discharge team that could help with complex discharges and a discharge lounge. The discharge team liaise with social services, community, families and arrange care packages. There was also a discharge lounge to help with the flow out of the hospital.

Wards had patient information available 'Getting you one step closer to home and helping you leave home safely'.

The service had two matrons that job shared across both sites. They told us that they had calls with community and social workers daily and help to organise forty to fifty discharges daily.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, leaders told us that patients deemed medically optimised for discharge were not always suitable for discharge from the hospital due to ongoing issues in arranging the support they require in the community. They told us is this challenging and a lot of work goes into the discharge team trying to support the staff to be able to make the discharges happen, but it remains an ongoing challenge throughout the division.

Medical care (including older people's care)

Staff told us they do not move patients between wards at night. However, they told us this is not always possible to maintain and patients do sometimes get moved if needed.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

During a board round that we observed, staff identified patients that were medically fit to be discharged. This information was captured on the electronic whiteboard and the data would be used in bed meetings throughout the day to help staff plan patient movement.

Managers and staff worked hard to make sure patients did not stay in hospital longer than they needed to and we observed discharge arrangements being made during the inspection. However, staff told us that 'bed blocking' was a problem due to the difficulty with arranging ongoing care in the community.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The trust shared with us data relating to formal complaints received. The rehabilitation and elderly medicine directorate have seen a significant increase in this quarter from 10 formal complaints and 41 informal concerns in Q3, to 27 formal complaints and 48 informal concerns reported in Q4. The themes of the complaints received continued to reflect the organisational wide themes, with communication and patient care receiving the highest number in the directorate.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Managers shared with us some examples of positive feedback relating to their wards.

Medical care (including older people's care)

Is the service well-led?

Requires Improvement 

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The division of medicine was made up of four directorates; Medical specialities, general internal medicine, rehab and elderly medicine and cardiothoracic medicine. The senior leadership team worked across the trust and it's two sites and the matrons were site specific. The head of nursing worked across all four directorates.

During the inspection we saw some excellent examples of leadership at location level. All staff we spoke with gave positive feedback about their ward managers and matrons. Staff told us they felt supported and the ward leaders told us that they felt supported by the senior leadership team.

Leaders understood the priorities and issues the service faced; however, actions were not always effective. For example, staffing pressures were evident throughout the medical division and the management of this was to move staff from fully staffed wards to wards that were short staffed. Staff told us this often impacted on patient care when managing high risk patients requiring 1:1 care and patients at risk of falls. Ward leaders we spoke with told us that this was very challenging for their wards and caused an impact on staff and patients.

We spoke with leaders at ward level. They showed great leadership and understood the challenges faced by their department. All managers across the division showed very high acclaim for their matron. They said that they all felt extremely well supported and their presence was very much recognised and appreciated.

Staff and ward managers told us that members of the senior leadership team were visible on their wards, especially during the pandemic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The medicine division follows the trust's overall vision and strategy. This was to deliver nationally recognised, high quality, cost effective, sustainable healthcare for the people we serve, with staff who are proud to recommend our services. The trust had an overall annual plan which included trust goals, divisional goals and individual goals.

The trust objectives were to provide safe and high quality care, to look after staff and be inclusive, to share what we learn and communicate well, to take action for a more sustainable future and to lead by example in their work.

Medical care (including older people's care)

Leaders of the division told us that their divisional challenges aligned with corporate challenges and whilst looking at getting back to business as usual, their vision had been adapted based on feedback and will relaunch in the summer. The division's strategies will align to the trust's overall vision and strategy.

The trust did not have an up to date dementia strategy, the one they had was dated 2018-2021.

The trust did not have a learning disability strategy. There was limited learning disability support within the service due to the working hours of the specialist nurses. Patients also did not receive support if they did not already have learning disabilities flagged on the system from the community. This meant that there was not a consistent approach to care for patients.

The trust had values to support their vision. These were; Compassionate and dignified care, working together for the benefit of patients, their families and carers, openness and honesty in everything they do, respect and encouragement for staff and continuous improvement through research and innovation.

Progress of the trust's vision and strategy was monitored through various governance meetings at operational level.

The trust had a South Tyneside All Age Autism Strategy for 2022-2026. The aim of the strategy was to identify the needs of autistic patients earlier and improve their physical and mental health.

Culture

Staff were focused on the needs of patients receiving care. However; they did not all feel respected, supported and valued. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The trust had recently set up a staff wellbeing hub in addition to the ICS funded wellbeing hub which was centrally funded and would allow staff to access training packages as well as support. A suggestion was made that the Trust could look at staff training and possible take lead from Mental Health Trusts and train staff to deal with violence and restraints.

Managers we spoke with reported a great working culture within their teams. However, all staff that we spoke with said that it was difficult to feel valued when they were working under immense pressure regularly and this was affecting staff morale.

Ward leaders and the senior leadership team spoke highly and with pride about their teams working on the wards, especially through the pandemic.

Leaders told us that staff wellbeing was of great importance to them and they had varying options for staff to help them maintain wellbeing. This included self-referrals to occupational health, Thrive service which was a counselling service that offered free sessions, psychology support for staff groups and all of this was available on the trust's intranet for staff to access if required.

The trust also offered staff Schwartz rounds which are staff only group discussions that offer a space to share and reflect on the personal, emotional and social aspects of their work.

The trust benefited from an onsite gym that staff could access for a monthly membership fee.

The trust also had a recent focus on supporting the financial wellbeing of staff, smoking cessation and menopause.

The trust had a designated freedom to speak up guardian, however staff we spoke with did not know who this was or how to contact them if needed.

Overall, we found staff morale to be low. However, staff spoke proudly of their colleagues and the hard work they encountered during the pandemic, they said they felt valued by their peers.

Staff we spoke with did not who the trust's freedom to speak up guardian was.

Governance

Leaders did not operate effective governance processes. Governance systems did not consistently identify risks. However, staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The trust did not have an up to date dementia strategy, the one they had was dated 2018-2021.

Learning from incidents and complaints was cascaded to staff from ward leaders. Staff we spoke with told us the process for how this happens.

Leaders told us they meet as a division once a month and matrons have an operational forum every two weeks.

There is a formal meeting monthly with the executive nurses to share information and the head of nursing has informal meetings with ward managers monthly to discuss any issues and concerns

There is a weekly senior leadership team meeting which coincides with the clinical governance meetings. Consultants and junior doctors meet monthly.

The trust shared with us emails that had been sent in June to matrons and ward managers to remind staff how to complete intentional rounding documentation and the NEWS escalation process and clinical response requirement. The email requested it be cascaded to staff. During the inspection we identified that patients were not having high scoring NEWS escalated and monitored in line with guidance and there were gaps in intentional rounding. Following the inspection, the trust undertook an immediate audit of five patients per ward and results showed issues of significant concern across multiple wards relating to NEWS and intentional rounding. Improvements in practice had not been identified since the email to managers in June.

The trust told us that as a matter of urgency, they have introduced some additional training supported by the Tissue Viability Team to the relevant clinical areas to support with staff understanding of intentional rounding documentation, specifically around pressure care assessments.

The trust shared with us meeting minutes for the division of medicine governance meetings. These occurred monthly and showed good attendance. They discussed ongoing issues such as staffing and discussed items for the risk register.

Governance meeting minutes showed discussions around lessons learned and improving practice. For example, following a patient death it was agreed that the case should be discussed at the Nutrition & Hydration Steering Group to discuss potential risks going forwards.

Managers meet monthly for quality assurance meetings, information from these is then cascaded amongst their teams

Management of risk, issues and performance

Leaders mostly used systems to manage performance effectively. They did not always escalate relevant risks and issues and did not always identify actions to reduce their impact.

Leaders told us that they can track timelines of incident investigations using an incident tracker.

The nursing metrics panel meets monthly and looks at incidents including work force, pressure ulcers of grade three and above, falls, medication and IPC. Actions are discussed and lessons are shared with the wider teams.

Leaders told us that incidents are discussed in clinical governance meetings. We looked at meeting minutes which confirmed this.

Leaders told us that the trust used a 'Data Launchpad' which provides reports for MUST / NEWS compliance, the matrons review on monthly basis. However, minutes from the January 2022 deteriorating patient group stated there was no recent data for NEWS from the launch pad as the data is inaccurate and a meeting had been arranged to get the report fit for purpose.

Ward level leaders had good oversight of their team's risks and issues. All leaders that we spoke with talked about their ward's top risks.

The trust shared with us audits that showed some areas of poor compliance. For example, an audit for the administration of antibiotics within one hour for patients with sepsis showed that only 41% of patients received the medicine within the time frame. The trust did not share action plans to show how they would improve on low scoring audits.

The senior leadership team and ward level leaders were aware of risks and could explain actions in place to mitigate risks. Risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk and they were regularly reviewed.

However, items senior leaders told us that were the biggest risks for the division were not reflected in the risk register. Leaders told us the top risks of the division were workforce and environment, this was not reflected in the trusts risk register

The risk register was comprehensive and showed dates of when a risk was added, when it was due for review and any notes from reviews that had been undertaken previously.

Senior leaders told us patients who require enhanced care, are risk assessed and if there are not enough staff to support this the escalation process is followed at ward level. They said that matrons review and help mitigate any risks and they can move staff from other areas to support the additional need. If staff are not available, then escalation to the head of nursing is needed and the next step would be to move patients to another ward to facilitate the additional need. However, staff and managers at ward level did not describe this escalation process to us and they said they escalate the staffing concerns but they are often still not fulfilled and they are made to just manage with the staff they have. All wards we visited during the inspection had patients requiring 1:1 care that were not receiving it.

Clinical governance meeting minutes demonstrated that the lack of managing 1:1 needs was of concern and was on the radar of the coroner. It was discussed that any ward at any time would likely have patients requiring 1:1 care and not receiving it and it was deemed a problem at organisational level rather than just local level.

National guidance for safe staffing uses a red flag system. Red flags are used as a mechanism of monitoring a safe care system to highlight staffing concerns. Guidance states that hospitals need to have a system in place for nursing red flag events and be reported by any member of the nursing team, patients, relatives or carers to the registered nurse in charge of the ward or shift and will then be escalated by the nurse in charge. However, due to the number of red flags being raised by ward managers, only matrons are now able to raise red flags. Governance meeting minutes stated that staff felt the trust did not want staff putting in red flags.

The risk register shared with us included a risk that stated patients were at significant risk of harm or death when there are no staff daily to run the ward. This related to a staffing issue on ward 10 and 7, in which one set of staff were being used to run both wards. This was added to the register in October 2021 and had not been reviewed since. The risk was highlighted to us during the inspection by staff who told us the ward felt unsafe and actual staffing numbers on the day of the inspection were lower than the planned numbers. The lack of review of such a high risk showed there was no oversight of this risk.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training.

Staff could access information technology (IT) systems to record and view information such as test and x-ray results and patient records. Patient records were mostly electronic, and many assessments were integrated into the trust's electronic patient record system.

Staff we spoke with demonstrated they could locate and access relevant information and records to enable them to carry out their day-to-day roles.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training, and appraisals.

The service managed and used information appropriately to support its activities. The website contained detailed information about the differing wards, site maps and how to book an appointment.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Wards had staff engagement boards that included general information about their ward's performance in various areas.

Managers told us that wellbeing conversations were available for all staff wishing to have this conversation and there was an opportunity to access support and advice from colleagues/ managers/ mentors.

The head of nursing met with ward managers informally each month, providing a chance for ward managers to express concerns they had or ask for advice and support on issues they had been altered to.

Ward leaders spoke proudly of staff at ward level and recognised their hard work. Wards we visited did not have boards that recognised staff for excellence or hard work. However, the trust has an excellence reporting system where staff can nominate other staff members or teams for excellent work. Those recognised received a personalised letter from the CEO which can be used for appraisals and Clarity portfolios.

Ward managers shared with us various compliments received from patients, their loved ones and students that had worked on the words.

Family and friends test boxes and posters were displayed on each of the wards we visited, this gives patients and their families the chance to give open and honest feedback about their care.

Leaders said that feedback was important to them, and everyone was encouraged to complete staff surveys.

The trust shared with us its staff survey results. It showed there was a response rate of 47% for the 2021 staff survey and it was significantly worse on 34 questions than the previous year. Only 26% of staff said they had enough staff at the organisation to do their job properly

In response to the survey, the trust shared with us a staff survey action plan which identified themes, priorities and action plans.

Staff we spoke with said they felt valued by their peers but not always by more senior levels of staff due to the pressures of working short staffed so frequently.

Staff we spoke with did feel supported to professionally developed if they wished to do so, for example we were told about how international students were supported to do their OSCE (objective structured clinical examination) which is used to assess clinical skill at pre-registration and postgraduate level.

As part of ongoing communications, the trust launched a trust wide engagement programme in October 2021. This was called the STSFT Big Team Talk. The ambition was to improve overall staff engagement and involve staff in resetting the vision and priorities of the future. The group had 70 team talk champions made up mostly of frontline staff and over 8700 comments were received from staff using graffiti boards, post boxes and virtual boards.

Leaders told us that they were most proud of all of the frontline staff during the pandemic.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Ward leaders were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Medical care (including older people's care)

We asked leaders for examples of innovation within the division, they told us that the dementia and delirium outreach team works hard to improve the outcomes for their patients by using therapeutic activity and offers an outreach service for cognitively

Leaders told us that the focus for the division was to get back to business as usual following the pandemic. They were working on improvements and pilots including a new falls risk assessment that we seen in use during the inspection. They also told us that the roll out of activities trollies was to take place on more wards.

The trust told us they had a rise and shine initiative to encourage patients to get out of bed and be up and dressed. On all of the wards we visited there were many patients in bed in pyjamas or hospital gowns.

Maternity

Good ➔➔

Is the service safe?

Inspected but not rated

Mandatory training

The service provided mandatory training in key skills to all staff, however, not all staff had completed it.

Staff did not receive and keep up to date with their mandatory training. The completion rates for overall mandatory training at June 2022 were above the trust's target, however this was due to a decrease in the trust target from 90% to 85% from 1 April 2022. Prior to April 2022, the service consistently failed to meet the trust's previous target for mandatory training compliance.

The mandatory training was comprehensive and would have met the needs of women and staff when completed.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was a central system in place that alerted staff to training needs and we were told by staff they were allocated 2.5 days each year in a specific month for training to be completed. We also spoke with the specialist education midwife who shared training plans and additional training opportunities for staff.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. The training target for safeguarding was met by nursing and midwifery staff with 94% completion for May 2022 and 92.8% completion for June 2022 against the Trust target of 85%.

Medical staff received training specific for their role on how to recognise and report abuse. The training target for safeguarding was met by medical staff with 88.2% completion for June 2022 against the Trust target of 85%.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff training covers these areas as part of mandatory training and staff work with other agencies to ensure adults and children at risk of harm are referred as needed. There are good links in multi-disciplinary working across areas and information sharing is embedded for safeguarding.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff are able to make a safeguarding referral and there is an escalation policy in place where needed. The central safeguarding team for the Trust are available for support whenever needed.

Staff followed the baby abduction policy and although we were told they undertook baby abduction drills, we did not see any evidence of this as requested. After our inspection, during our factual accuracy checks, the Trust shared of five baby abduction exercises carried out between July 2022 – September 2022.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Women could reach call bells and staff responded quickly when called.

The design of the environment was appropriate and worked well for staff and women using the services.

Staff carried out daily safety checks of specialist equipment. We checked the resus trolley on site and this was well managed and checked daily. The equipment was all in date and organised in the trolley.

The service had enough suitable equipment to help them to safely care for women and babies. Computers were in each of the rooms and rooms were well stocked.

Staff disposed of clinical waste safely.

There was a specialist quiet room available and this was a calm, clean and appropriate space for women and their families to be spoken too for any difficult conversations or bad news.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. There was a robust acceptance criteria in place and women were usually triaged via telephone in advance of arrival.

Maternity

Women were transferred to Sunderland if they deteriorated or if it was decided during their appointment that they were higher risk based on the criteria. An exercise had not been completed to transfer women which would have been good practice to ensure all staff have had experience of this training.

Staff completed risk assessments for each woman on arrival, using a recognised tool, and reviewed this regularly, including after any incident.

The service had 24-hour access to mental health liaison and specialist mental health support.

Staff shared key information to keep women safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep women and babies safe.

Midwifery staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and midwifery staff to keep women and babies safe at South Tyneside. Staffing was shared between South Tyneside and Sunderland and midwifery staff told us they spent so much time each month working at Sunderland.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of women.

The number of midwives and healthcare assistants matched the planned numbers.

The service had low and/or reducing vacancy rates.

The service had low and/or reducing turnover rates.

The service had low and/or reducing sickness rates.

The service had low and/or reducing rates of bank and agency nurses.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

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Women's notes were comprehensive and all staff could access them easily.

When women transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check women had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured women's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

The service had no never events on any wards.

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave women and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Maternity

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.