Sunderland Royal Hospital

Evidence appendix

Kayll Road

Sunderland

SR4 7TP

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Date of inspection visit:

17 April to 17 May 2018

Date of publication:

23 August 2018

This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

City Hospitals Sunderland was established as an NHS trust in April 1994 and became the first NHS Foundation Trust in the North East in July 2004.

The trust provides hospital services to a local community of around 350,000 along with a range of more specialised services to a population of around 860,000. The trust also provides a substantial range of community based services particularly within family care and therapy services.

The trust operates from Sunderland Royal Hospital, Sunderland Eye Infirmary, Pallion Urgent Care Centre and The Children's Centre and provides outreach services at a range of satellite locations.

(*Source: Routine Provider Information Request (RPIR) – Context Acute)*

A list of all hospitals at the trust is below:

Name of hospital site	Address
Sunderland Royal Hospital	Kayll Road, Sunderland, Tyne and Wear, SR4 7TP
Sunderland Eye Infirmary	Queen Alexandra Road, Sunderland, Tyne and Wear, SR2 9HP
Pallion Urgent Care Centre	Kayll Road, Sunderland, Tyne and Wear, SR4 7TP
The Children's Centre	Durham Road, Sunderland, Tyne and Wear, SR3 4AG

(Source: Routine Provider Information Request (RPIR) – Sites)

There are two main hospital locations, Sunderland Royal Hospital, and Sunderland Eye Infirmary. The trust has an annual income of around £358m and employs around 4,800 people.

Sunderland Royal Hospital has 814 inpatient beds across 35 wards; there are 34 maternity beds and 25 critical care beds. In 2017-2018, there were over 156,500 attendances in the emergency department. The outpatient department saw around 96,600 patients for their first appointment, and there were 197,512 follow up appointments provided.

City Hospitals Sunderland formed an alliance with South Tyneside NHS Foundation trust in March 2016 and established the South Tyneside and Sunderland Healthcare Group. A single executive and management team has been in place across both trusts since November 2016, and in January 2018, both boards began to explore a formal merger between the trusts. There is one executive leadership team working across both organisations, led by Ken Bremner the chief executive.

Services are commissioned by Sunderland Clinical Commissioning Group (CCG), South Tyneside CCG, Durham Dales, Easington and Sedgefield CCG, and North Durham CCG. The trust works in partnership with the local authority and the local mental health trust.

Is this organisation well-led?

Leadership

The trust was led by the board of directors who were responsible for the day to day running and management of the trust. Since our previous inspection in September and October 2014 there had been changes to the membership of the board. The director of nursing was appointed in January 2016; the director of finance commenced in post in July 2008 and the director of corporate services was appointed in 2017. The chief executive had been in post at the hospital since 2004, and became chief executive of the both hospital trusts in 2016.

The board structure comprised of the chair, the chief executive, and the deputy chief executive who also was the director of corporate services. There were also four executive directors, these were the director of nursing and patient experience, the director of finance, the medical director and the director of planning and business performance. There were six non-executive directors; one of these was a non-voting medical advisor who had been appointed to provide clinical challenge.

Board Members

Of the executive board members at the trust, none were from a British Minority Ethnic (BME) background and 40% were female. Of the non-executive board members none were from a BME background and 16.6% were female. This meant that BME and females were under represented at board level. The chair told us they were concerned there was no BME representation on the board; they were considering adding a non-voting BME representative to the board, although it was not clear when this might take place.

Staff group	BME %	Female %
Executive directors	0.0%	40.0%
Non-executive directors	0.0%	16.6%
All board members	0.0%	27.3%

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

We found the trust executive leadership team had an appropriate range of skills, knowledge and experience both when they were appointed and on an ongoing basis. Our checks of formal documentation included fit and proper person reviews and recruitment processes for both executive and non-executive leaders. We found leaders were visible and approachable and worked well together.

We saw a clear distinction between the executive and non-executive roles and functions of the board which meant there was appropriate support to the executive directors and also scrutiny and challenge around performance and goals. The non-executive directors chaired ten committees; each committee had an executive lead. The committees included the patient, carer and public experience committee, the strategy committee, governance committee, audit committee and the workforce committee. Each of the non-executives had 'champion' roles, for example in falls prevention, safeguarding, or research.

The executive directors understood the challenges to quality and sustainability. Some of the executive directors had a number of roles and a broad portfolio. For example, the director of nursing also held the positions of safeguarding lead, complaints lead, joint head of governance, and was also executive lead for mental health. The director of corporate affairs and deputy chief executive was also the equality and diversity lead. The non-executives had asked for capacity of the executives to be placed on the risk register and board assurance framework in 2017. The chief executive was mindful of the volume of work this generated for individual roles. The board had shared out some responsibilities in order to mitigate the risk around capacity.

Senior leaders told us it provided oversight and collective leadership and responsibility.

The non-executives told us they had confidence in the executive leadership and were kept up to date and felt well informed.

There were actions in place to ensure sustainable leadership. In February 2018, the board reviewed the age profile of directors, their skills, and any pressure points. Non executives rotated across committees so that experience was shared across areas.

The trust's leadership and talent development strategy was approved in 2017; the organisational development team were leading on the delivery plan for this.

Priorities for the next 12 months related to addressing equality gaps in the leadership and talent development strategy included development of competency and behavioural standards framework for consultants and the introduction of assessment centre based consultant recruitment process. A new talent management appraisal policy, framework, documentation, and training would be introduced to support succession planning and increase management diversity. There were plans to develop a behavioural standards framework for all staff which would be used in recruitment, appraisal, and performance management. A further priority was to analyse workforce reports to identify specific departments and job roles where black and minority ethnic (BME) staff were poorly represented. Plans were to be developed to identify the underlying reasons, potential solutions, and likely blockages to senior management positions.

There were a range of leadership programmes which employees at all levels could access. The trust was also using the new 'apprenticeship levy' to develop current and future leaders via leadership apprenticeships at level 3 (team leader level) and level 5 (departmental manager level).

- In 2017, leadership programmes were undertaken by 399 employees.
- Nine staff undertook North East leadership academy courses.
- From October to December 2017, 42 staff undertook an introduction to leadership programme.
- There were 47 attendees at the leading empowered teams training.
- Introduction to leadership programme had 42 attendees.
- Leadership apprenticeships; a chartered manager degree was taken by eight staff. Nine staff did an operational manager apprenticeship and five staff undertook team leader apprenticeships.

Source: PIR Leadership tab (63)

The board had not had an externally facilitated well led review. There is no requirement to have external reviews; instead the trust undertook an annual review of the board using the NHS Improvement framework.

The chief executive carried out formal appraisals of the executive directors each year. The chairman undertook annual appraisals of the non-executives and the chief executive. Each of the non-executive's appraisals was reviewed by the nomination, appointments and review committee which was a subcommittee pf the council of governors. Annual appraisals of the chairman were undertaken by the senior independent director supported by the lead governor. There was a council of 16 governors who held the non-executives to account for the performance of the board. Any performance enhancement awarded (or penalty) for achievement was published in the trust annual report.

The trust had three principal groups of clinical activity; acute, specialist and community. The community facing activities were a small number of services. There were five divisions; clinical support, family care, medicine, surgery, and theatres. Each division was led by a divisional general manager; the four clinical divisions were led by a triumvirate of a clinical director, a directorate manager and a matron or matrons. The matrons provided front line leadership. The four clinical divisions also had a matron or matrons to provide front line leadership.

Vision and strategy

There was a clear vision and set of values, and we saw quality and sustainability of care were priorities within the vision. In 2016, the trust formed an alliance with South Tyneside hospitals trust. Both trusts were collaborating to ensure local communities received high quality, safe and sustainable hospital and community health services in the future. The vision of City hospitals Sunderland was to deliver nationally recognised, high quality cost effective, sustainable healthcare for the people it served with staff who would be proud to recommend their services. Staff at all levels were aware of the values, and although the values were described differently by different groups of staff, all staff told us high quality patient care was their priority.

In order to measure delivery of the vison and values, there was a process known as 'objectives, goals, strategies, and measures'. Work began in January 2018 to engage staff in developing a set of behaviours intended to increase confidence in challenging poor behaviour. Value based behaviours was part of human resource (HR) processes and formed part of induction to the trust.

In order to achieve the vision, an organisational strategy, made up of a number of core strategies had been developed. The seven core strategies were clinical transformation, quality, workforce

and organisational development, estates, finance, communication and engagement, and information management and technology.

Front line staff were able to articulate the overall strategy to us, and on the whole, could describe how they contributed towards achieving it. The quality strategy focussed on shared learning and quality improvement. Senior leaders told us this was meaningful to front line staff as they were involved in measurement of real time patient experience, and hence could see change for the benefit of patients.

The clinical transformation was known as 'the path to excellence' and it focussed on three core areas; care and quality and the need to close gaps by reducing variance in care and patient outcomes: System efficiency, to remove boundaries and so develop person centred care: Health and well-being was an area intended to focus on prevention and health promotion for local people. A series of clinical services reviews had been undertaken, and were in two phases;

Phase 1: included stroke services, maternity and gynaecology, and acute paediatrics. Following a period of staff and public consultations, the clinical commissioning groups (CCGs) announced their recommendations in February 2018. Those recommendations were;

- Stroke services to move to Sunderland Royal hospital
- South Tyneside district hospital to have a midwifery-led unit and Sunderland to have a medically-led obstetric unit.
- South Tyneside to have a nurse-led paediatric minor injury and illness unit (open from 8am-10pm); there will be a 24 hour paediatric emergency department at Sunderland.

Phase 2: all other services (acute medicine and emergency care, acute surgery and critical care, elective (planned) care and specialist services and clinical support services) were subject to the same clinical service review process at the time of our inspection.

Non-executive directors were clear about their involvement in development of the strategy and were focussed on achieving it. They spoke with us about how it would benefit patients and address recruitment challenges in the local area. Non executives also told us there was accountability for achieving the strategy; it was on the agenda of a number of committees and sub groups, and that executive directors challenged each other at the board on how areas of the strategy could be best achieved.

The overall strategy had been developed in a structured way and there had been consultation with the public, governors, and stakeholders such as the clinical commissioners.

There was no mental health strategy although there were mental health policies. The equality and diversity strategy was in draft form, but it was not clear when this would be ratified by the board.

Culture

Leaders encouraged supportive relationships among staff to that people felt respected, valued and supported. There were processes in place to support most staff and to promote their well-being. Staff we spoke with told us they felt valued and respected. We saw that leaders' promoted the vision and values and made high quality compassionate care a priority.

Action was taken in a timely way to address performances and behaviours which were not consistent with the trust values, regardless of the seniority of the person concerned. There was a 'maintaining high professional standards' panel, which was a forum where inappropriate or unacceptable behaviours among medical staff could be addressed.

There was an open and honest culture, and senior leaders empowered front line staff to make improvements and raise concerns when something wasn't right. There was a strong reporting culture and the trust supported and applied a 'fair blame' culture. Senior leaders told us when things went wrong they were mainly due to system weaknesses rather than to a failing on the part of any individual. Lessons were learned, acted upon, and shared, however we found occasions where relevant staff had not been aware of never events in their local area.

The trust had a process known as 'excellence reporting'; staff could submit a report through the incident reporting framework. This meant there were opportunities to learn from what had gone well. The excellence reports were all seen by the chief executive who responded personally to each reporter. An annual reward and recognition event took place where long service was celebrated and staff awards were presented. The trust was a gold medal winner at an NHS Employers event in May 2018. Work had been done to support the armed forces community who worked within the trust. Several events were held throughout the year to promote and support reservists. The trust attended military organisation's employment fairs to help service leavers with NHS applications and mock interview sessions. The trust was committed to Armed Forces Covenant, and guaranteed interviews for veterans meeting minimum employment requirements.

There were processes for providing staff with development and for career progression, and 'taster sessions' as part of talent management. Staff at all levels were invited to be part of consultant and senior manager recruitment. The process included meet and greet with staff from other staff groups, psychometric testing and a clinical event to get to a position to recruit the right people, with the right attitude as well as the right clinical skills. Candidates were scored after the meet and greet sessions; senior leaders told us this was a way to engage with staff and also to recruit the right people.

There was a freedom to speak up guardian who was the director of workforce and human resources (HR). We asked if there was any conflict for them as guardian when they were also involved in staff performance and HR investigations. We were told there was assurance as the guardian had access to other sources of data which enabled them to triangulate speaking up issues to proactively identify potential concerns.

There were nine speak up 'ambassadors' or champions within the trust, some of the champions had been appointed based on them having a quiet area available to speak with staff. They had not all volunteered for the role, which gave us some concern around the motivation to manage concerns and whether staff would be comfortable raising concerns. Eight freedom to speak up concerns had been raised and generated into reports within the last year; senior leaders told us a report wasn't always produced, rather that concerns were handled on an informal basis. Whilst this meant some individuals may just want advice, there was no formal record of what had been raised or how it had been addressed. The freedom to speak up guardian reported formally to the board twice a year about the number and nature of concerns which had been raised with them. We found it would be difficult for the board to take action to improve culture if they were not fully aware of potential patient safety concerns or staff experience issues. Following our inspection, the trust told us there were a number of other ways that staff raised concerns; the board had access to a quarterly workforce report including staff sickness, turnover, grievances, disciplinary information, and staff survey reports which gave the board a picture of staff experience and patient safety.

NHS Staff Survey 2017 – results which were better than average of acute trusts

The trust took part in the NHS staff survey in 2017. The trust had five key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

Key Finding	Trust Score	National Average
KF13. Quality of non-mandatory training, learning or development	4.10	4.05
KF8. Staff satisfaction with level of responsibility and involvement	3.99	3.91
KF16. Percentage of staff working extra hours	64%	71%
KF2. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	4%	4%
KF17. Percentage of staff suffering work related stress in last 12 months	33%	37%

(Source: NHS Staff Survey 2017)

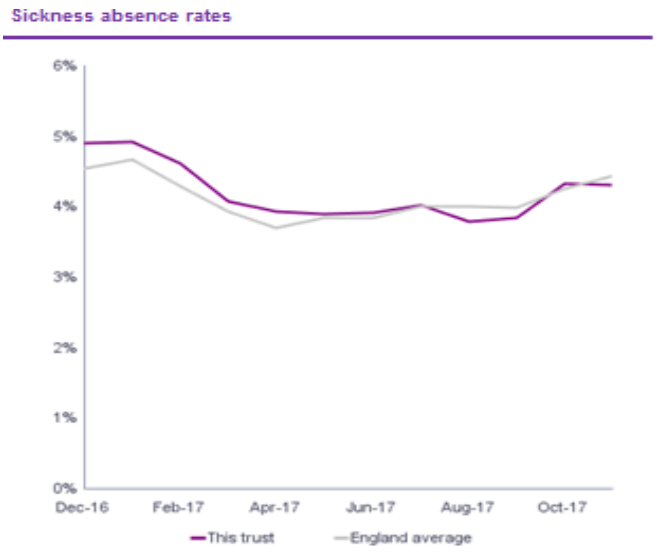
NHS Staff Survey 2017 – results worse than average of acute trusts

The trust had no key findings that were worse than the average for similar trusts in the 2017 NHS Staff Survey.

(Source: NHS Staff Survey 2017)

Sickness absence rates

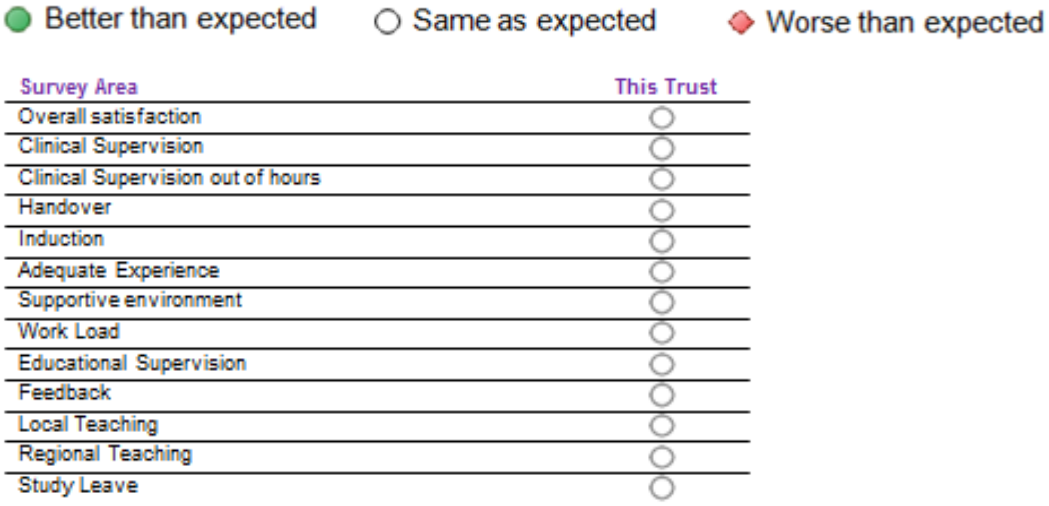
The trust's sickness absence levels from December 2016 to June 2017 were slightly above the England average. From July to November 2017, sickness levels were below or similar to the England average, following a similar pattern over the period.



(Source: NHS Digital)

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council National Training Scheme Survey, the trust's performance was the same as expected for all indicators.



(Source: General Medical Council National Training Scheme Survey 2018)

Staff Diversity

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by ethnic group:

Ethnic Origin	Medical and dental staff %	Qualified nursing and midwifery staff %
White – British	5.11%	25.94%
White – Irish	0.19%	0.12%
Any other white background	0.41%	0.29%
Mixed White and Black Caribbean	n/a	0.02%
Mixed White and Black African	0.02%	0.04%
Mixed White and Asian	0.12%	0.12%
Any other mixed background	0.08%	0.02%
Asian or Asian British – Indian	1.49%	2.09%
Asian or Asian British – Pakistani	0.17%	0.02%
Any other Asian background	0.12%	3.87%
Black or Black British – Caribbean	0.02%	0.02%
Black or Black British – African	0.08%	0.31%
Any other Black background	n/a	0.08%
Chinese	0.06%	0.08%
Any other ethnic group	0.25%	0.68%
Not stated	0.35%	0.52%

(Source: Routine Provider Information Request (RPIR) – Diversity P6)

This table shows the majority of medical and dental staff (5.1%) were white British; the majority (25.9%) of registered nurses and midwives were also white British. The ethnic origin of other groups of staff is not included in this table.

Equality and diversity

There was no ratified equality and diversity policy. Equality and diversity information fed into the patient experience subcommittee of the board. Senior leaders told us the equality and diversity priorities were to target bullying and harassment, and violence from public and staff. Human resources teams carried out targeted work focus groups which highlighted that a number of incidents mentioned in the groups hadn't been reported as incidents.

Staff satisfaction was mixed; there were no staff networks. There was an equality group which was aimed at patients equality needs. It was an informal group, where minutes of meetings were not taken. However the trust celebrated the international day against homophobia each year with an event to raise awareness around the rights of lesbian, gay, bisexual, and transgender people.

Senior leaders told us there was a low Black and minority ethnic population in the workforce; however this meant there was no network for those staff to be belong to. There were other employees with protected characteristics such as disabled staff or LGBT and no network for those groups of employees. Some targeted work had been done to consider why staff who had been recruited from the Philippines were not moving up through the hierarchy.

Senior leaders told us there was a need to promote equality and diversity going forward. They told us it was clear from the staff survey that the trust needed to take some cultural steps and address some behaviour and culture issues particularly with middle managers who were key to ensuring implementation of policies.

There was positive work around employment of people with disabilities. Work placement s were used for young people with disabilities who found it hard to get into employment.

NHS Workforce race equality standard

There is a requirement for NHS healthcare providers to implement and report on Workforce Race Equality Standard (WRES) in the NHS standard contract. WRES is in place to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

Alongside WRES, NHS organisations use the Equality and Diversity Systems (EDS2) to help in discussion with local partners including local populations, to review and improve their performance for people with characteristics protected by the Equality Act (2010). By using the EDS2 and the WRES, NHS organisations can be helped to deliver on the Public Sector Equality Duty.

There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BME representation on Boards. Average response from BME staff was 6.4% compared to the England average of 16.2%. this can indicate how engaged BME staff feel.

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of "Yes" responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	28%	27%	29%
		BME	35%	28%	28%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	20%	25%	19%
		BME	32%	27%	26%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	89%	87%	89%
		BME	74%	75%	74%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	6%	7%	4%
		BME	19%	15%	14%

Of the four questions above, three questions showed a statistically significant difference in score between White and BME staff:

- KF26: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
- KF21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
- Q17b: In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

The table above shows the percentage of white staff who experienced and reported bullying and harassment or abuse from the public in 2017 had gone down from 2016; whereas the percentage increased for BME staff.

The percentage of staff who experienced bullying harassment or abuse by staff went up by 1% for white staff and by 6% for BME staff.

The percentage of staff who believed the organisation provided equal opportunities did not change for either staff group; however a less BME staff felt there were equal opportunities.

The percentage of white staff who experienced discrimination from a manager or other colleagues went up from 4% to 6%; however, there was a greater increase for BME staff, from 14% to 19%.

The trust had an action plan related to their 2017 staff survey; however staff side representatives (unions) we spoke with were not aware of it, and told us they had never heard of WRES, or any culture issues and action plan for the trust. Staff side representatives told us they had never considered gender or race equality of the board. We were concerned that culture issues were not high enough on the trust agenda.

Gender pay gap

Gender pay gap information regulations introduced in April 2017 require employers to report their gender pay gap on an annual basis from March 2018, using data from March 2017.

In March 2017, women accounted for 82% of the workforce at the trust and men were 18% of the workforce board papers from March 2018 indicated women's hourly rate of pay at the trust was on average 37.4% lower than men's pay. After our inspection, the trust told us this was significantly affected by the high number of male consultants; if that staff group was removed, the result would be 9.4% (although the trust did not provide data to corroborate their statement).

It is noted that the gender pay gap is different to equal pay (which looks at pay differences between men and women who do the same job). The gender pay gap report shows whether there is a defence in the average pay between men and women.

The trust did not have an action plan as to how it would address the pay gap.

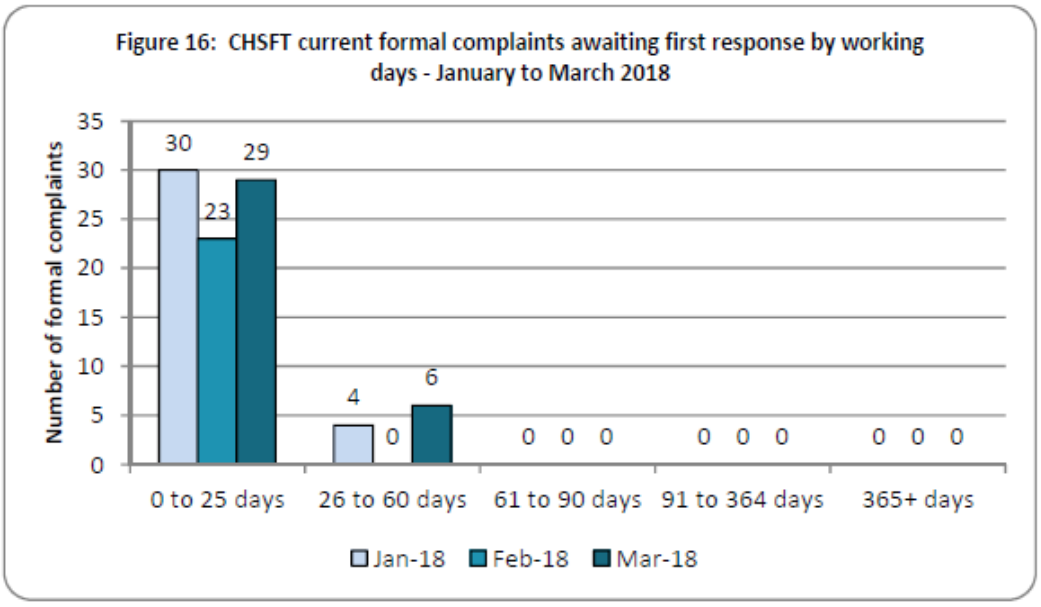
Accessible information standard

From 1st August 2016 onwards, all organisations which provide NHS care have been legally required to follow the Accessible Information Standard (AIS). The standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

We found not all areas of the trust were compliant with the accessible information standard. There was no standard approach to ensure each of the five steps were in place across the trust for all groups of people who had additional needs. This meant the trust overall were not compliant.

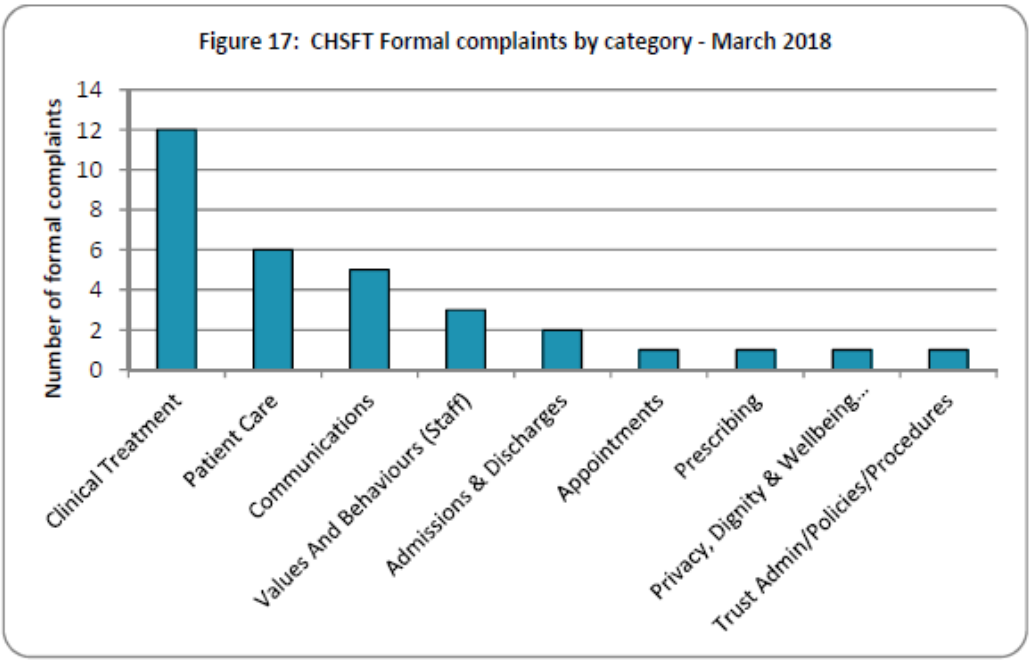
Complaints

When something went wrong, people received an apology and were told about actions being taken to prevent the same things happening again. The trust complaints policy indicated formal complaints should be acknowledged within three working days of receipt of the complaint. Data for March 2018 showed 100% of complaints were acknowledged within that timeframe. There were 33 complaints received in March 2018, with a year to date average of 36 per month. In March 2018 there were 35 formal complaints awaiting a first written response (by working days), compared to 23 in February 2018. There were no complaints awaiting a first response for more than 60 days. Performance around complaints was monitored through weekly meetings.



(Source - quality risk and assurance report May 2018)

The majority of complaints received by the trust were around themes of clinical treatment, care, and communication as seen in the table below.



(Source- quality risk and assurance report May 2018)

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Number of complaints made to the trust

The trust received 446 complaints from January 2017 to December 2017; 429 of these complaints were about Sunderland Royal Hospital and 17 complaints were about the Eye Infirmary.

Surgical care core service received the most complaints with 185. The biggest complaint subject was patient care with 215 complaints, followed by communications with 90 complaints.

Question	In days	Current performance
What is your internal target for responding to complaints?	Three working days	99%
What is your target for completing a complaint	25 working days	83%
If you have a slightly longer target for complex complaints please indicate what that is here	40 working days	N/A – One case within target
Number of complaints resolved without formal process in the last 12 months?	1,808	N/A

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Core Service	Number of complaints	Percentage of total
Surgery	185	41.5%
Medical care (including older people's care)	92	20.6%
Urgent and emergency services	69	15.5%
Gynaecology	25	5.6%
Other	24	5.4%
Diagnostics	13	2.9%
Other – ASC service	11	2.5%
Maternity	11	2.5%
Outpatients	8	1.8%
Services for children and young people	6	1.3%
Critical Care	2	0.4%
End of life care	0	0.0%
Provider wide	446	100%

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From January 2017 to December 2017 Sunderland Royal Hospital received 703 compliments and Sunderland Eye Infirmary received 44 compliments. A breakdown of core services is in the table below:

Sunderland Royal Hospital	Total number of compliments
AC - Medical care (including older people's care)	197
AC - Surgery	150
AC - Urgent and emergency services	95
Other	71
AC - Outpatients	51
Other - ASC service	40
AC - Services for children and young people	31
AC - Maternity	30
AC - Gynaecology	18
AC - Diagnostics	12
AC - Critical care	8
Total	**703**

Medical care received the most compliments across both sites. Sunderland Royal Hospital had 197 and Sunderland Eye Infirmary had 20.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Ombudsman Investigations

16 complaints were investigated by the Ombudsman, of which 7 were partially upheld and 9 not upheld during 2017.

Key outcomes and learning points included:

1. Awarded £1500 compensation for delay in further investigations for cancer and an apology for the failing identified.
2. Letter to address manner of doctor and ward cleanliness
3. Complaints handling action plan and what we are doing about discussions about DNACPR with families. See attached action plan.
4. Letter of apology to patient's daughter
5. Action plan regarding medical staff being proactive in deteriorating patient/Sepsis investigations
6. Complaints handling action plan due to delays which are now resolved. Compensation of £100
7. Delays in complaints handling (response and arranging meeting)

(Source-PIR (P70)).

Governance

Governance in an NHS trust is about the systems, processes and lines of accountability used to ensure the trust run themselves efficiently and effectively in order to provide safe high quality care.

The board and other levels of governance at the trust functioned effectively and interacted with each other appropriately. The role of the board was to set the strategic direction, monitor and manage performance and accountability, promote trust values and shape the culture for the board and the organisation.

Following the development of the strategic alliance with South Tyneside NHS foundation trust and the single executive management team being formed, the trust undertook a review of some of the committee and sub-committee structure during 2017. Some joint committees were established to enhance the oversight of issues and to avoid duplication. The revised committee structure has been in place since April 2017.

Reporting directly to the trust board were the following committees;

- Audit
- Charitable funds
- Competitive tendering
- Executive committee
- Finance and performance
- Governance
- Patient, carer, public experience - joint
- Policy - joint
- Remunerations and appointments
- Strategy - joint
- Workforce - joint

Some steering groups reported through the governance committee, these were the clinical governance steering group and the corporate governance steering group. Some of the groups had cross working arrangements and there was a range of subgroups, such as falls and mortality. The sub groups reported upwards so information reached the board. Executives and non-executives all described the same frameworks and processes to us. Joint working arrangements were clearly set out and the teams were clear about their roles and accountabilities.

There were monthly clinical governance meetings in the directorates. These meetings reported to the clinical governance steering group. Each directorate had a governance lead which was often a consultant. There were weekly 'rapid review' meetings which fed into the clinical governance steering group; information from serious incidents and root cause analysis or other investigations were heard at the rapid review meeting at the initial stage of investigation. The director of nursing and medical director heard the case reviews along with staff from the risk teams, and key messages were shared by weekly electronic briefings to staff, and at team meetings.

The trust had established processes from board to ward to board in order to gain assurance, identify gaps, set priorities and put in place plans to address these gaps. A 'quality, risk, and assurance' report was produced each month. This contained dashboard information around performance and patient experience such as falls, pressure ulcers, infection control and staffing.

However, we saw there had not always been correlation between patient harm and reduced nurse staffing levels. For example three wards had from 44% to 63% unfilled nursing shifts from October 2017 to March 2018; there had been increased rates of falls with harm in these areas during those times but this had not been picked up in the quality risk and assurance report. Furthermore, there had been a ward with consistently low staffing levels since January 2017, fill rates were in the 70% range. We looked at serious incidents for this ward and found there had been grade 3 and grade 4 pressure ulcers, falls resulting in patent harm such as fractures. Senior leaders were not able to tell us whether they had identified any concerns in these wards, or if there had been any senior nurse support or intervention.

The trust produced a quality report (also known as a quality account) each year. This gave detail on progress and achievement against the trusts quality and safety priorities. The report contained statements of assurance from the board around the participation in national and clinical audits and how the trust benchmarked itself against national comparators.

There was joint working with other organisations such as the local authority designated officer for safeguarding issues; collaboration with the police and MAPPA (multi-agency public protection arrangements) to ensure the successful management of violent and sexual offenders; the trust actively participated in MARACs (multi agency risk assessment conference) which is a victim focused information sharing and risk management meeting attended by key agencies. There was also in reach from mental health services to enhance the care of people with mental health needs. There was a service level agreement for 24-hour access to mental health liaison teams both in the emergency department and on the wards.

Board Assurance framework

The board assurance framework (BAF) was the structure used by the board to identify the principal risks to the organisation in meeting its objectives. The BAF identified the main risks to quality and safety across the organisation based on a range of information including governance reports, the risk register and performance data. It was reviewed twice a year to inform the board of significant risk exposure. The BAF outlined the controls in place to address these issues and any potential gaps in compliance; these gaps were then included in the assurance programme for further checks and then reported to the governance committee.

The 2017/2018 BAF was the one in use at the trust; the 2018/19 BAF was progressing through the governance committee at the time of our inspection.

The BAF was sub divided into highest safety, best quality, shortest lead time and cost leadership.

Highest safety had five objectives/aims and 18 associated principal risks

Best quality had five objectives/aims and 17 associated principle risks

Shortest lead time had one objective/aim and one associated principle risk

Cost leadership had one objective/aim and eight associated principle risks

(Source: Trust Board Assurance Framework – P113)

There were 13 objectives or aims which were aligned to principle risks to the trust achieving its strategic objectives. There principle risks on the BAF are set out in the table below:

Operational pressures due to activity pressures of demand V capacity	Pressures in the emergency department relating to increased attendances	Ability to recruit senior medical staff in key specialties
Inability to recruit sufficient registered nurses	The variable ability to recruit and manage junior doctors	The ability to replace equipment in a timely manner
Non recognition of deteriorating patients	Number of incidents relating to falls resulting in serious harm	Number of hospital acquired pressure ulcers
Failure to recognise remediable factors which could prevent deaths	The ability to deliver the objectives of being a 'third centre' of key specialties	Functionality of the patient information system
Poor communications with patients and relatives, discharge communication, attitude and approach around face to face communication, impacting on patient understanding incidents/ claims and the requirement of duty of candour.	Slow turnaround of incidents, complaints and root cause analysis	NHSI Compliance with conditions and financial risks
NHSI compliance around quality governance frameworks	NHSI compliance- performance governance risks for A&E	Compliance with CQC fundamental standards
Compliance with all relevant health and safety requirements	Lack of achievement of clinical standards to maintain accreditation (e.g. in endoscopy)	Claims increasing which increase NHSLA premiums

Risk that the executive team were spread too thinly as part of the group working	Failure of a number of key performance metrics impacting on patient care	Failure of some key performance metrics related to capacity and demand in orthopaedics
Harm to patients, staff and trust reputation because of increasingly complex safeguarding cases	Not achieving transformation change to meet the demands of users of services	Failure to secure income
Failure to deliver on the cost improvement programme	Failure to deliver all criteria associated with the sustainability fund	Joint working with South Tyneside doesn't deliver the financial benefits envisaged
Proposes service changes impact detrimentally on one of the two organisations	Failure to maintain cash flow through the year impacted by the alliance	

(Source RPIR and board papers)

Each of the risks above had an assigned lead and controls in place to manage the risks. Gaps in controls and assurance were highlighted and reviewed on a quarterly basis.

The Ulysses integrated risk management system was used to report incidents such as safety or quality issues. These were investigated by ward managers to address the issues and learn from incidents. Any incidents rated moderate or above were addressed by the rapid review group to look for systemic safety problems and commission root cause analysis.

Incidents were reported by impact; the table below indicates from April 2017 to March 2018 the percentage of no harm and minor harm incidents as a proportion of all incidents reported at the trust was 95% in March. Six incidents were reported as having caused major or extreme harm in March 2018.

Data for Figure 24: CHSFT Incidents reported by category April 2017 to March 2018

	Apr 17	May 17	June 17	July 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Near miss	22	21	35	22	33	26	30	26	21	24	15	19
No harm	714	763	667	607	627	632	703	680	595	788	634	667
Minor harm	335	358	410	321	458	369	405	433	481	469	424	388
Moderate harm	5	13	19	10	23	42	23	27	33	21	24	32
Major harm	2	1	2	2	3	6	5	2	3	2	4	3
Extreme harm	0	0	1	1	0	2	0	1	3	4	1	3
Total	1078	1156	1134	963	1189	1077	1166	1171	1136	1308	1102	1112

A number of strategies and policies were in draft form at the time of our inspection, for example, the workforce strategy (2017-2020), and the equality policy. Senior leaders we spoke with could not tell us when these would be ratified.

Management of risk, issues and performance

Risk

When we inspected the trust in 2014 we found risk was generally well managed, although the trust faced challenges over the recruitment of medical and nursing staff particularly in the medical wards. During our 2018 inspection we found that the challenges around recruitment remained.

The risk management strategy (2018- 2021) provided a structured approach for identifying and managing risk. The strategy included objectives for managing risk, and the goals which must be met to achieve those objectives. It defined individual and organisational responsibilities. It described the trust's organisational arrangements for risk management, and the systems and processes by which the trust's aims would be achieved. Progress against the risk strategy was monitored by the governance committee, through the provision of interim reports and an annual report.

Trust corporate risk register

The trust provided 15 separate documents detailing their health and care risk register for the following services:

- Diagnostic imaging
- Emergency care
- General internal medicine
- General surgery
- Head and neck
- Medical specialties
- Obstetrics and gynaecology
- Ophthalmology
- Paediatrics
- Pharmacy
- Rehabilitation and elderly medicine
- Theatres
- Therapy services
- Trauma and orthopaedics
- Urology

(Source: Trust Risk Register – P113)

The local risk registers in the directorates which were overseen by directorate managers; when a local risk was scored at 15 or more using the risk matrix, the risk was escalated into corporate work streams via the clinical governance steering group for further monitoring and mitigation. Recommendations to add risks to the corporate risk register were made by the corporate risk register group and considered by corporate governance steering group or clinical governance steering group, dependent on whether the risk was non-clinical or clinical. Recommendations to add risks to the risk register were made by either steering group to the governance committee.

We found the trust had a low appetite for risk, given the nature of healthcare. Senior leaders told us certain risks were accepted particularly in respect of the trust pursing it business objectives.

Nurse staffing

All of the senior leaders we spoke with told us nurse staffing was among the top three risks. The board papers of March 2018 indicated a reduction in registered nurse vacancies and an increasing the availability of registered nurses, up to 90% across the trust.

	Jan 18	Feb 18	March 18
Maternity leave	2.64%	2.63%	2.81%
Sickness	5.08%	3.91%	3.60%
RN vacancies	5.17%	3.91%	2.63%*
Available RNs	87.11%	89.55%	90.96%
Starters	6	5	17
Leavers	17	6	8

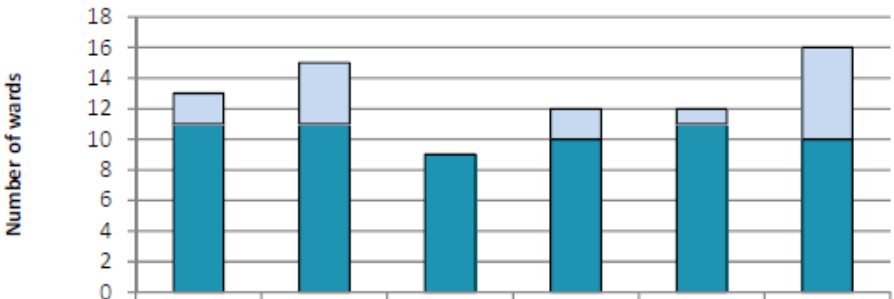
(*Source- board papers March 2018)*

However the number of hours provided by NHS professionals (nurse bank) increased from over 20,000 hours in February, to over 25,000 hours in March 2018.

The trust did not use a safer staffing tool to align nurse staffing to patient acuity and dependency; instead a standardised ratio of aiming for one registered nurse to eight (1:8) patients in the day time, and one nurse to ten patients (1:10) at night was used.

The graph below from the quality risk and assurance report of May 2018 showed there were 12 wards that exceeded 1:8 (day duty) nurse to patient ratios, and 16 wards that exceeded 1:10 (night duty).

Figure 21: CHSFT Nurse to patient ratios showing 2 month trend January to March 2018



	Exceed 1:8	Exceed 1:10	Exceed 1:8	Exceed 1:10	Exceed 1:8	Exceed 1:10
	Jan 18		Feb 18		March 18	
Theatres	0	0	0	0	0	0
Family Care	0	0	0	0	0	0
Surgery	2	4	0	2	1	6
Medicine	11	11	9	10	11	10

(Source- board papers May 2018)

All of the care of elderly wards had significant vacancies, and the trust had struggled to recruit to those areas. The trust was in the process of rolling out electronic rostering and 'safe care' to all wards and departments. Until a formal process was in place, a local system was used where ward managers entered daily staffing numbers onto a database, measured against budgeted and 'safe' staffing numbers using a traffic light system. Matrons moved staff around to ensure all areas were staffed on a shift by shift basis.

There were 75 incident forms submitted in March 2018 relating to nursing and midwifery staffing, a small decrease from February (78 reports). There were 32 incidents forms submitted by wards or matrons when registered nurse staffing was below minimum numbers, a decrease from February (45), with the division of medicine submitting 14 of those incident reports.

Infection prevention and control

There was an infection, prevention, and control (IPC) committee which met every month and reported to the clinical governance group, which reported into the governance sub- committee of the board. There were quarterly meetings with the commissioners and public health England for a wider strategic view of risk.

We found poor standards of infection prevention and control (IPC) in the emergency department and during the well led review, a senior manager told us the trusts own measure of 100% compliance had not been accurate. After our unannounced inspection, the trust carried out audits to ascertain compliance with 'bare below the elbow'. The first audit showed 66% compliance, the second audit showed 75% compliance, and the third audit showed 92% compliance. It was acknowledged that standards had fallen and intervention was needed to attain compliance with standards

There had been 71 hospital acquired cases in 2017/18 up to March 2018. The rate per 100,000 bed days for the past 12 months up to March 2018 for the trust was 30.4 cases. The national rate up to January 2018 was 22.4.

The trust aimed to reduce case of E. coli bacteraemia by 50% by the year 2021. Reduction on cases of bacteraemia (the presence of bacteria in the blood) in 2017 was 8.6% against the target of 10%. This meant the trust was in the top 50% of trust performance in England.

Four cases of C. difficile infection were reported in March 2018 which was one above the monthly trajectory. At the end of March there had been 22 cases against an annual target of 34.

The C. diff rate per 100,000 bed days for the previous 12 months up to March 2018 remained within target, at 9.4. By comparison, the national rate for the latest 12 month period available

(up to January 2018) was 13.3 per 100,000 bed days. The Trust's target rate was 15.4.

Mortality

There was a mortality review group which looked at all in-patient deaths; it reported through the clinical governance steering group. There was a well-established process and the trust had been engaging in mortality reviews for four years. A process was being developed to move all information related to deaths onto a new electronic system, rather than keeping on the patient care record. This would enable information to be obtained more effectively and reduce the chance of transcribing errors.

The mortality review panel (MRP) did not measure unexpected deaths. The panel measured 'Hogan avoidability' (looking at the scale and scope of preventable deaths), Hogan quality, and national confidential enquiry into patient outcome and death (NCEPOD). The panel met on a weekly basis and comprised of senior doctors and other clinical staff who critically reviewed all in-hospital deaths. The meeting excluded child and maternal deaths as they had their own statutory process; it included deaths of patient with learning disabilities. At the conclusion of each case review, the MRP provided a judgement using the review outcomes. Where there were any unexplained variations in care the reviews were referred for speciality reviews. Quarterly reports on the outcomes from the MRP reviews were presented to the mortality review group and to the clinical governance steering group. The report included articles on any death reviews where there was evidence of preventability, poor care, or clinical room for improvement, for example in death certification.

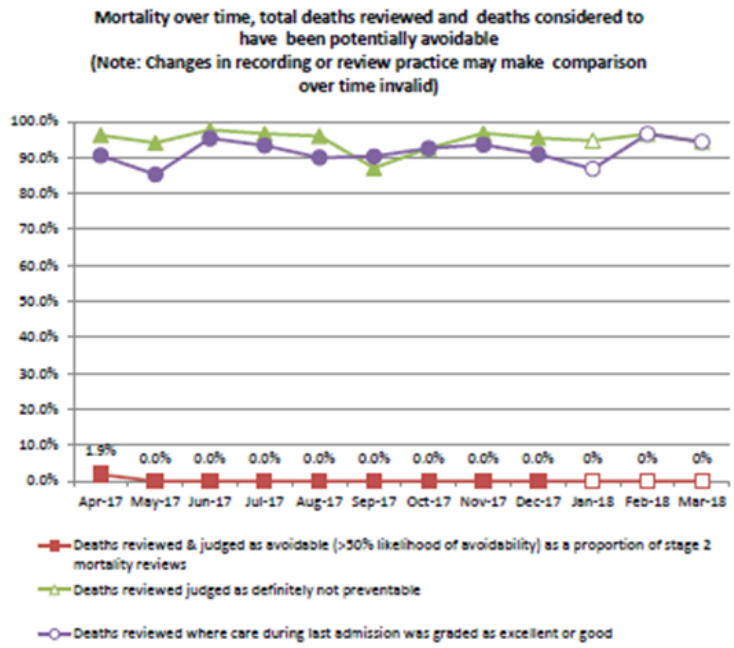
The MRP process incorporated a separate end of life review. In this process, all patients who had received either specialist palliative care or general end of life care were subject to a structured review of their death which enabled the trust to assess the quality of end of life care. The specific reviews were based on the five core elements of care from the national implementation of care of the dying patient documentation. The outcomes of the reviews were used to target staff awareness and training sessions in care of the dying. The outcomes of these reviews were fed back to wards on a quarterly basis.

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths; a lower score means less deaths. The trust's HSMR for the period of October 16 to September 17 was 110. (Source- RPIR). Following our inspection, the trust told us their overall HSMR for the full previous year (2017) was 96, but they did not supply us with data to corroborate their statement.

The Standardised Hospitals Mortality Index (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI for the period July 16 - June 17 was 101.

The SHMI remain in band 2, which was the expected range. The HSMR was above the index of 100. The trust told us there had been an issue with how end of life patients (expected deaths) has previously been included in coding of other deaths. In April 2017 the documentation and coding process was changed and was then monitored by the coding manager and the mortality review group to ensure it reflected the trust's activity and followed coding principles.

The chart below shows there were no avoidable deaths since May 2017.



(Source- Quality Risk and Assurance report May 2018)

There were 80 open inquest cases at the time of our inspection. This was a 16% increase from the previous quarter, with 34 new cases were received in March 2018. The trust told us there had been an increase in both volume and complexity of caseload with a decrease in the number of cases closing at enquiry and an increase in the number of cases progressing to inquest rather than closing at investigation.

(Source- Quality Risk and Assurance report May 2018)

Audit

There was a comprehensive programme of clinical and internal audit. The trust participated in wide range of national clinical audits as a way of benchmarking itself against national standards. Key actions were developed as a result and quality standards and action plans developed with the aim of improving the safety and quality of care, for example in the reduction of avoidable cardiac arrests. There was also wide participation in local audit where results were used to make improvements in care or update clinical guidelines.

Performance

The trust submitted data to NHS England as required so performance against targets could be measured. Metrics or standards included four hour waits in emergency department, cancelled operation, cancer waiting times, consultant-led referral to treatment (RTT) waiting times and

delayed transfers of care. During our unannounced core service inspections we found areas for improvement in emergency department, medicine, and surgery.

In the emergency department, from January to December 2017, the trust's unplanned re-attendance rate ED within seven days was generally worse than the national standard of 5% and generally worse than the England average. There was poor performance in Royal College of Emergency medicine audits (RCEM) including severe asthma, consultant sign off, vital signs, and procedural sedation. Performance for April 2018 in the four hour target improved slightly to 88.4% but continued to underperform against the 95% target and annual plan published trajectory. The trust was visited by NHS Improvement Emergency Care Improvement Programme (ECIP) in April 2018, and a review of recommendations was due to take place. The trust were ranked 54th out of 139 acute trusts for four hour performance in April 2018.

In medicine; the heart failure audit identified input from consultant cardiologists was lower than the England and Wales average. The lung cancer audit identified the proportion of patients seen by a cancer nurse specialist was 83%, which was worse than the audit minimum standard of 90%. (After our inspection, the trust told us a number of patients with lung cancer were admitted for palliative care, and as such would not be seen by the specialist nurse). The trust took an average of 28 days to investigate and close complaints; this was slightly worse than what the trust complaints policy stipulated, that this should occur within 25 days. National performance for referral to treatment times in March 2018 reduced slightly to 87.2% and continued to fail the national standard. National performance for the 62-day standard improved in March 2018 but remained below target at 84.5%.

In surgery, we found over the last two years, the percentage of cancelled operations at the trust was generally higher than the England average. In the latest period, Quarter two of 2017/18, the trust cancelled 83 surgeries. Of the 83 cancellations 14% of those were not treated within 28 days.

Further work was needed to make improvements in those areas. We asked senior leaders about recovery plans form poor performance but did not receive consistent answers, for example on how the numbers of hospital developed pressure ulcers could be reduced. One of the executives told us cancer waiting times were not under their 'umbrella'; as a board member they should have collective responsibility for performance. We found there had been no patient tracking to give assurance that patient outcomes were not affected by cancer waiting times. Senior leaders told us there had been struggles to manage performance in urology and for some cancers. Action plans were developed however, depending on the severity of the issues.

Information management

There was an information management and technology strategy in place and the trust was working to become paper free by 2021.the strategy was aligned with the objectives of the strategic alliance with South Tyneside and formed part of the clinical review process.

The trust had invested in information systems to improve the quality of patient care. As one of the 16 Global Digital Exemplar NHS trusts in England, (GDE) there had been much investment in up to date and advanced digital solutions. (NHS England was supporting 16 digitally advanced acute trusts, through funding and international partnership opportunities, to become Global Digital Exemplars over the next two to three and a half years).

There was an ongoing development programme for medical information technology (Meditech) which was a fully integrated software system for health care organisations.

The trust had received £10million from NHS Digital some years ago and had invested this into the digital programme. We found the information management team were enthusiastic and had innovative ideas. The trust had access to EMIS (a database for GPs) and that information fed into Meditech. This meant the IT systems enabled the smooth transfer of information into and out of the trust. We saw the IT systems had been designed to be user friendly for front line staff. Examples of how the IT systems worked for the benefit of patients included staff being able to see how many patients were in the urgent care centre, so staff were allocated to that area rather than patients having to move to another part of the hospital. In the endoscopy unit, staff could see which areas patients were in and which areas were free to use. Patient prescribing, medicine reconciliation and administration, and clinical records were all electronic.

In order to ensure high quality data there had been an investment programme for a number of projects including a recent transition from paper records to a single electronic patient record (EPR) as part of the paperless digital footprint. The areas where EPR is in place Emergency department and endoscopy) had found a significant improvement in data quality. In addition, there was a robust governance structure in place where changes were needed to the Meditech system as a result of developing national standards. Those changes were implemented through specialist module teams led by operational and clinical staff and technical co-ordinators.

There was evidence of integrated reporting which was used to support decision-making at board level. There was a holistic understanding of performance and performance information was generally used to hold senior leaders and staff to account. We saw that information used in reporting, performance management and delivering quality care was usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

However, our inspection in the emergency department found IPC standards were not at the 100% which had been reported, so there had been gaps in challenging that data. Performance information was produced on a variety of dashboards, senior leaders told us this was used as measures for improvement, not just for assurance.

There was a data assurance manager in post, who led the data assurance team. The team was responsible for ensuring complete and accurate data across the organisation. We saw there were systems in place to ensure data was accurate such as data quality dashboards and the use of data benchmarking tools. IT systems were used effectively for the purpose of monitoring and improving patient care.

The IT project told us they planned to attain for level 7 accreditation or above (level 5 is the minimum) which meant the trust would need to be 97% paper free.

The trust was compliant with assessment for the Information Governance (IG) toolkit and scored itself at level two. (The toolkit is an online system which allows organisations to assess themselves or be assessed against IG policies and standards). Overall compliance with IG training at the trust was 98% in 2017.

The trust carried out planned shut downs of the IT systems to ensure patient care would not be affected if the systems failed. The data was backed up on a second server which gave a level of assurance. The trust had not carried out unplanned shut downs to ensure patient care and safety was unaffected.

There were however, delays in uploading data information onto the National Reporting and Learning System (NRLS); this is a central database of patient safety incident reports. Senior leaders told us this was due to the trust using a Ulysses system rather than datix.

The medical director was the trust's Caldicott guardian. (A Caldicott guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing). There were good working relationships with the Senior Information Risk Owner (SIRO) who was accountable for managing information risks and incidents. There had not been any reported information governance breaches in 2017.

The trust was not affected by the NHS 2017 cyber-attack.

Engagement

People's views and experiences had been gathered and acted upon in order to change services. There had been comprehensive engagement with staff, the public and key stakeholders around the strategic alliance with South Tyneside hospital. The trust were involved in a 'path to excellence' which was a five year plan for transformation of health services in the region. Public engagement began with a listening phase in October 2016. This was aimed at understanding people's views and experiences related to stroke, maternity, gynaecology and paediatric services.

Senior leaders met with local people, the commissioners, local authority, and other health providers on a number of occasions since 2016. Market research, social media, and other methods have been used to gather views which fed into the quality risk and assurance reports.

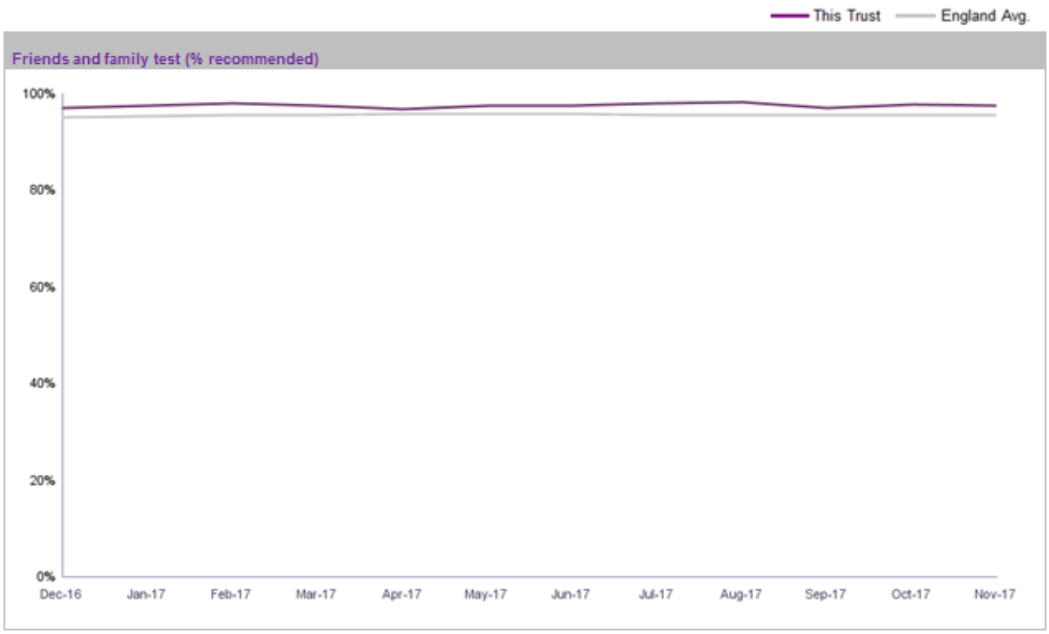
There had been positive feedback from Healthwatch about how the trust had engaged with the public around the strategic alliance.

We saw positive examples of how the trust had engaged with certain groups for the benefit of patients; for example, there was a young person's group, close working with learning disability services and good collaboration with domestic abuse agencies, and mental health services.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment. Survey results were displayed in areas that had carried out a survey with an action plan detailing any improvements. Response rates for FFT were low in many areas across the trust, so there had been work to collect feedback by other means such as social media. The trust also used 'real time' feedback in order to obtain views of friends and family.

From December 2016 to November 2017, the trust scored better than the England average, recommending the trust as a place to receive care. However, the response rate at the trust was 12.7%, compared to the England rate of 25.1%. The graph below shows the percentage rates for those who would recommend the trust.



Staff engagement

The trust had gathered the views of staff in the design and planning of the new emergency department which opened in June 2017 in order to make the department work for them as well as in the patients' interest. Yes. The design of the refurbished endoscopy unit was influenced by staff and feedback for example with use of privacy glass.

Each year NHS staff are invited to take part in the NHS Staff Survey. It gathers views on staff experience at work around key areas, including appraisal and development, health and wellbeing, staff engagement and involvement, and raising concerns. The chart below shows the trust results for the 2017 survey.

NHS Staff Survey Performance

The trust has 18 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

Key Finding	Trust score	National average
KF13. Quality of non-mandatory training, learning or development	4.10	4.05
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	10%	12%
KF21. Percentage of staff believing the organisation provides equal opportunities for career progression / promotion	87%	85%
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	28%	31%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.82	3.73
KF31. Staff confidence and security in reporting unsafe clinical practice	3.78	3.65
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	33%	36%

KF18. Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure	50%	52%
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns	55%	51%
KF16. Percentage of staff working extra hours	64%	72%
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.81	3.75
KF8. Staff satisfaction with level of responsibility and involvement	3.99	3.91
KF14. Staff satisfaction with resourcing and support	3.41	3.31
KF6. Percentage of staff reporting good communication between senior management and staff	37%	33%
KF2. Staff satisfaction with the quality of work and care they are able to deliver	4.06	3.91
KF24. Percentage of staff reporting most recent experience of violence	72%	66%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	21%	25%
KF27. Percentage of staff reporting most recent experience of harassment, bullying or abuse	46%	45%

NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has three key findings that were worse than the average for similar trusts in the 2017 NHS Staff Survey:

Key Finding	**Trust score**	**National average**
KF11. Percentage of staff appraised in the last 12 months	84%	86%
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last 12 months	89%	90%
KF4. Staff motivation at work	3.89	3.92

(Source: NHS Staff Survey 2017)

The trust overall engagement score was 3.8 out of 5, which was average for NHS trusts in England.

From the survey, the trust identified five areas which needed improvement; staff health and wellbeing, bullying and harassment, management behaviours, communication and personal development and support. Staff were invited to attend focus groups in summer 2017, there were 185 staff at the focus groups. The feedback was reviewed and led to targeted areas of work.

There was limited engagement and involvement with all groups of staff, for example those with protected characteristic recognised under the equality act; this meant that the voices of all staff were not heard or acted on to shape services and culture. There were limited changing facilities for staff with disabilities and no staff networks which would be a source of information and

guidance to the board, offer individual, and peer group support and demonstrate the organisational commitment to equality and diversity through positive investment in people.

Workforce race equality standard

The total response rate was higher than the England average but did not meet the minimum recommended response rate of 50%, the trust response rate was 44.7%. Average response from BME staff was 6.4% compared to the England average of 16.2% and the trust response rate of 93% from white staff. This demonstrated a lower level of engagement from BME staff.

NHS Staff Survey Indicator		Proportion of respondents answering "Yes"		% difference between BME and white staff	
		BME staff	White staff		
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	39.1%	26.6%	○	-12.5%
	England	27.4%	26.5%		-0.9%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff the last 12 months	Trust	20.0%	19.8%	○	-0.2%
	England	28.2%	24.1%		-4.1%
KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	Trust	88.9%	90.1%	○	1.2%
	England	72.7%	88.0%		15.4%
Q17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?	Trust	15.9%	5.1%	○	-10.8%
	England	14.8%	6.1%		-8.7%

Key for % difference between BME and white staff	
●	Statistically significant
◆	Not statistically significant
○	Statistical analysis of results was not undertaken due to the low number of BME respondents (<50)

		Previous	Latest
Sampling method	Trust	Basic sample	Basic
Total number of recipients *(ineligible staff removed)	Trust	835	1,228
Response rate from total recipients	Trust	44.7%	60.7%
	England	42.0%	43.7%

		BME		White		Total
Average number of respondents across the 4 WRES questions	Trust	43	(6.4%)	628	(93.6%)	671
	England	40,880	(16.2%)	210,966	(83.8%)	251,846

We held focus groups with a range of staff from all backgrounds before our inspection. Some junior members of staff from a variety of disciplines told us they did not feel as though they had been engaged with in the past.

Learning, continuous improvement and innovation

There was a strong focus on learning and improvement throughout the organisation; the trust participated in research and clinical trials to seek improvements to patient care and outcomes. There was participation and learning from internal and external reviews including learning from end of life care deaths. Learning was shared to make improvements after serious incidents had been reported.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

There was only one service which had received an external accreditation; the Sunderland MacMillan centre received the MacMillan Quality Environment Award and the Macmillan Quality Information Standards award in 2016. (Pathology services were outsourced so have not been counted). There was no accreditation for end of life care of anaesthetic services. A submission for joint advisory group (JAG) accreditation was applied for during our well led review. The trust had

not had JAG accreditation in the past due to the environment of the endoscopy department which had been recently refurbished.

The table below shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	Service accredited
Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189	CHS outsource pathology services to a third party – the service specification stipulates that they achieve accreditation (and currently they have it).
MacMillan Quality Environment Award (MQEM)	The Sunderland MacMillan Centre received the MQEM in 2016 and also the Macmillan Quality Information Standards in March 2016.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)

There were innovations in the HR and workforce team; 'stay' interviews were due to commence in September 2018, in addition to exit interviews which already took place (when someone left the organisation). The stay interview was to be held after someone had worked in the trust for a year, to ascertain if the job was as they expected and how it could be improved to retain the staff member.

Improvements had been made in how the trust supported families during times of bereavement, including in the emergency department.

There was positive and innovative practice for patients living with dementia. The Alexandra centre within the hospital was a base for the trusts dementia and delirium outreach team (DDOT). The team supported patients with, or at risk of cognitive difficulties. The service supported carers and staff within the trust by providing information, education, and specialist input to the wards. Therapeutic activates were provided in the centre, and the DDOT team visited wards to support cognitively frail in-patients who could not leave the acute areas. A follow up outpatient clinic was provided for patients who had experienced delirium.

The trust carried out excellence reporting; staff could submit a report through the incident reporting framework. This meant there were opportunities to learn from what had gone well. The excellence reports were all seen by the chief executive who responded personally to each reporter. The process had been nominated for a health service journal patient safety and innovation award.

The tables below show how many reports had been submitted during 2017/2018, and the directorates which had submitted them.

	CHS
Excellence Reports submitted (up to the end of March)	608
Excellence Reports submitted in March	74

Top 5 directorates reporting (cumulative)	CHS
Theatres	76
Emergency Medicine	71
Rehabilitation & Elderly Medicine	60
General Internal Medicine	53
Paediatrics & Child Health	43

(Source - quality, risk and assurance report May 2018)

There was an innovation department at the trust which was supported by a director for research and innovation and deputy directors. There were also innovation ‘scouts’ who represented nursing, medical, allied health professionals and support services; each scout fed the respective areas ideas into the bright ideas pathway. The pathway, developed by the innovation team supported ideas for service improvement, research, or continuous improvement. The innovation department was funded through the academic health and sciences network and ideas from other health providers were brought back through the trust.

There had been innovation in the out patients department; one of the senior sisters had developed a ‘room to breathe’ programme working with homeless people who had respiratory disorders, to help them manage their condition and avoid hospital admission.

The emergency department hosted an independent domestic violence advocate service (IDVA) who worked in partnership with an agency to provide support to women.

The trust was in partnership with an international cancer support charity which helps women and teenagers manage the visible side effects of cancer treatment, in the form of ‘look good, feel better’ workshops.

Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services

City Hospitals Sunderland (CHS) urgent and emergency care service are mainly based at Sunderland Royal Hospital (SRH) however there are also services provided at Sunderland Eye Infirmary and Pallion Health Centre. On the SRH site, departments include acute medicine, adult emergency department, cardiology, children's emergency department, emergency ambulatory care unit (EACU) and integrated assessment unit (IAU).

The Trust has a dedicated Urgent Care Centre based at Pallion Health Centre (on Sunderland Royal Hospital site) to support emergency care services. Sunderland Eye Infirmary's emergency department (ED) provides emergency ophthalmic services 24/7 for approximately 33,000+ patients per year both adults and children. These include trauma and non-trauma patients.

For the purposes of this inspection, we visited the adult emergency department (ED), the paediatric ED and the emergency ambulatory care unit. Colleagues from another team inspected cardiology and the integrated assessment unit. Neither Pallion Urgent Care Centre nor Sunderland Eye Infirmary were included in this inspection.

Care is provided for the population of Sunderland and the surrounding districts of North Durham, Hartlepool and South Tyneside.

(Source: Trust Routine Provider Information Request – Context Acute)

CHS adult and paediatric EDs are located in a new purpose-built building on the SRH site.

The paediatric department has its own waiting room divided into sections for children and young people and its own entrance. There are toys for children to play with and a television screen playing child friendly programmes. The entrance to the department is locked at night and only accessible by buzzer for safety and security reasons.

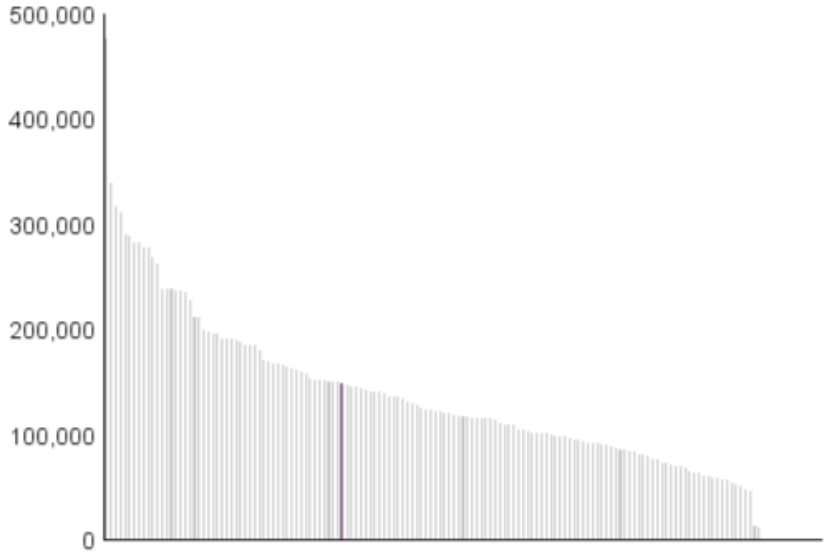
There is one dedicated paediatric resuscitation room, three high dependency rooms with full observation equipment, three high acuity rooms, six treatment rooms and an eight-bedded children’s assessment and observation unit. The rooms in the paediatric department are in the process of being decorated with child and young person friendly décor. There is direct access via a lift to one of the paediatric wards on the floor above.

The adult department has a large waiting room with reception and initial assessment desk, two triage rooms and three large patient areas, see and manage for less serious conditions, high acuity for more poorly patients and the emergency ambulatory care unit for patients with certain specific medical conditions. There is also a four-bedded resuscitation bay.

Both departments were trauma centres. This means that they can treat patients who arrive by ambulance or on foot with serious illness or injury. Patients very seriously injured in major incidents are taken to the nearest major trauma unit not at this hospital.

Activity and patient throughput

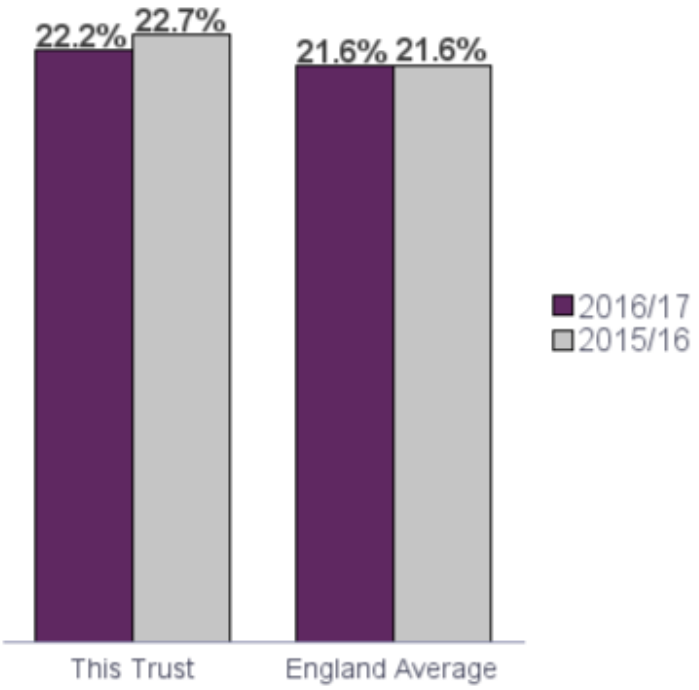
Total number of urgent and emergency care attendances at City Hospitals Sunderland NHS Foundation Trust compared to all acute trusts in England.



There were 147,657 attendances from April 2016 to March 2017 at City Hospitals Sunderland NHS Foundation Trust as indicated in the chart above.

(Source: NHS England)

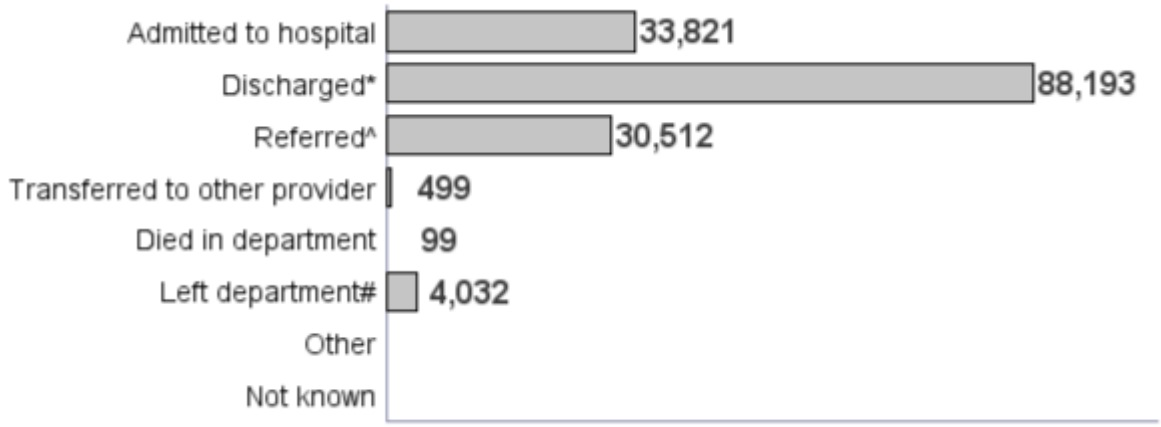
Urgent and Emergency Care attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission stayed about the same from 2015/16 to 2016/17. In 2016/17, rates were similar to the England average.

(Source: NHS England)

Urgent and Emergency Care attendances by 'disposal' method



* Admitted to hospital includes: no follow-up needed and follow-up treatment by GP

^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional

Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2017 to December 2017 for medical/dental and nursing staff in urgent and emergency care is shown below. We have requested the most up to date training information from the trust.

Mandatory Training Completion by module – Medical and Dental Staff

Name of course	Number of eligible staff this year	Number of staff trained (YTD)	Completion Rate	Met (Yes/No)
Slips, Trips and Falls - Patient Falls	43	43	100%	Yes
Venous Thromboembolism	3	3	100%	Yes
Consent	3	3	100%	Yes
Moving & Handling for People Handlers	27	26	96%	Yes
Equality, Diversity and Human Rights	45	42	97%	Yes

Resuscitation	30	28	93%	Yes
Blood Prescribing: Blood Components and Indications for Use	26	24	92%	Yes
Blood Prescribing: Safe Transfusion Practice	26	24	96%	Yes
Fire Safety	45	38	89%	No
Fire Safety Classroom	45	37	96%	Yes
Information Governance	45	37	82%	No
Infection Control - Level 2	27	22	81%	No
Inoculation Incident	12	8	67%	No
Infection Control - Level 1	45	26	58%	No
Grand Total	**422**	**361**	**86%**	

The 90% target was met for nine of the 14 selected mandatory training modules shown above for medical staff. Infection control level one had the lowest completion rate with 58%.

Mandatory Training Completion by module – Nursing Staff

Name of course	**Number of eligible staff this year**	**Number of staff trained (YTD)**	**Completion Rate**	**Met (Yes/No)**
Moving and Handling - Level 1	2	2	100%	Yes
Consent	9	9	100%	Yes
Slips, Trips and Falls - Patient Falls|	257	252	98%	Yes
Baxter Colleague Infusion Pump	223	212	95%	Yes
Conflict Resolution - Dealing with Violence and Aggression	182	169	93%	Yes
Fire Safety Classroom	296	285	97%	Yes
Equality, Diversity and Human Rights	279	259	97%	Yes
Fire Safety	296	262	89%	No
Alaris GH Syringe Drive	203	188	93%	Yes
Infection Control - Level 2	279	254	91%	Yes
Information Governance	280	251	90%	Yes
Blood Administration Annual Refresher	215	187	87%	No
Infection Control - Level 1	296	267	90%	Yes
Moving & Handling for People Handlers	278	229	82%	No
Alaris CC Syringe Driver	31	26	84%	No

Medical Devices: Alaris Signature Infusion Pump	33	27	82%	No
Resuscitation	279	227	82%	No
Inoculation Incident	36	26	72%	No
Grand Total	**3495**	**3132**	**90%**	

The 90% target was met for 11 of the 18 selected mandatory training modules shown above for registered nursing staff. Inoculation incident training module had the lowest completion rate with 78%.

Only two of the compliance rates for either medical or nursing staff were so low as to be a concern. These were infection control and inoculation incidents both for medical staff.

(Source: Routine Provider Information Request (RPIR) –Mandatory and Statutory Training tab)

Managers in the department closely monitored training compliance and training sessions were booked for staff to make sure compliance improved.

We spoke with staff about access to training. They told us that on the whole there were very few problems accessing any training. There were training sessions run every week covering a variety of different topics to improve staff knowledge and skills.

Training was accessed in different ways. Some could be done on line via e-learning and some was more practical hands on training. None of the staff we spoke with expressed any concerns about the standard of training or ease of access either online or in person.

Staff of all different disciplines and grades told us they were encouraged to learn and gain new skills and experience. They also told us that training compliance was monitored by managers to ensure they attended.

Safeguarding

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to December 2017 for medical/dental and nursing staff in urgent and emergency care is shown below:

Safeguarding Training Completion by module – Medical and Dental Staff

Name of course	Number of eligible staff (YTD)	Number of staff trained (YTD)	Completion Rate	Met (Yes / No)
Safeguarding Children (Version 2) - Level 2	18	18	100%	Yes
Safeguarding Children (Version 2) - Level 3	12	11	92%	Yes
Safeguarding Adults - Level 2	30	22	73%	No
Grand Total	**60**	**51**	**85%**	

The 90% target was met for two of the three safeguarding training modules for which medical staff in urgent and emergency care were eligible. Safeguarding adults level two had not met the completion rate with 73%.

Safeguarding Training Completion by module – Nursing Staff

Name of course	Number of eligible staff (YTD)	Number of staff trained (YTD)	Completion Rate	Met (Yes / No)
Safeguarding Adults - Level 1	1	1	100%	Yes
Safeguarding Children (Version 2) - Level 1	10	10	100%	Yes
Safeguarding Children (Version 2) - Level 2	148	143	97%	Yes
Safeguarding Adults - Level 2	276	252	91%	Yes
Safeguarding Children (Version 2) - Level 3	130	107	82%	No
Grand Total	**565**	**513**	**91%**	

The 90% target was met for four of the five safeguarding training modules for which registered nursing staff in urgent and emergency care were eligible. Safeguarding children level three had not met the completion target with 82%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The department had robust processes in place to gather information about patients relating to safeguarding and were linked to a national database of information about children who were at risk of harm or abuse. The electronic record keeping system made it mandatory for staff to ask parents, guardians or carers specific information about children and young people and who was responsible for their care and treatment decisions. This made sure that everyone was treated the same with respect to safeguarding information.

There was a process in place for identifying children at risk and each child had a CWILTED (condition, witness, incident, location, time, escort, description) assessment carried out. This again was a mandatory field on the electronic patient record.

The IT system linked patients together and raised a flag to identify whether anybody within the wider family circle posed a risk to patients such as from alcohol or drug abuse.

The record system in the department routinely showed how many times a child had attended the trust ED services in the last 12 months and in their lifetime.

Safeguarding training included specific training about safeguarding topics such as child sexual exploitation, people trafficking and female genital mutilation (FGM). These topics were discussed regularly at additional ad hoc teaching sessions and also at safeguarding supervision sessions.

Staff from the paediatric ED met every two months for safeguarding supervision. These sessions were interactive and staff and the supervisor shared and discussed recent safeguarding cases,

concerns they had and any learning and feedback from previous cases. During the inspection, we attended a session as an observer and found it to be very informative and supportive for staff.

We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients, both adults and children. They demonstrated knowledge of the reporting process and were able to describe the signs to look for and the action they would take.

The hospital had a paediatric liaison nurse who visited the department regularly to check paediatric records to ensure that any safeguarding concerns had been recognised and reported appropriately. This ensured that no children or incidents were missed.

The department had systems and processes in place to ensure that people who may need extra support were identified. For example, there was an independent domestic violence advocate in the department every Friday and Saturday night to support patients who may be victims of domestic violence.

Cleanliness, infection control and hygiene

When we visited the department, we found it to be visibly very clean. Patient rooms were cleaned between patients and waiting area floors and seating were in excellent order. Patient toilets were clean. We found that the environment was compliant with infection prevention and control guidelines and there was no dust below, or on top of surfaces. The cleaning staff were very thorough.

There were cleaning schedules in place and we saw completed paperwork confirming that cleaning had been carried out. They were signed and dated. We saw staff completing the required tasks in line with schedules. However, we did find that sluice checks in the high acuity area had not been completed every day at every designated checking time and there were gaps in the documentation. There was also dirty linen on the floor of the sluice.

Staff could call cleaners to the department ‘out of hours’ if required. Health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.

There was sufficient personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this, latex gloves and other equipment and disposing of it correctly during our inspection.

We noted not all staff were bare below the elbow and some staff, both medical and nursing had false nails or were wearing nail varnish. This was not in line with infection prevention and control policies.

In the paediatric waiting area, toys met infection control standards and had been cleaned regularly. The cubicles in the paediatric area were well stocked, tidy and uncluttered.

Neither medical nor nursing staff were meeting the trust’s training target of 90% for infection prevention and control. Nursing staff were at 84% and medical staff at 58% compliance.

The department had solid walled cubicles with en suite facilities for patients who required isolation for the prevention and management of actual or potential infection.

We looked at the areas where equipment was cleaned and these were visibly clean and there were cleaning schedules in place for all equipment. The majority of equipment in this area was

clean however we did find one commode that still had bodily fluids on it. This was brought to the attention of staff who cleaned it immediately.

Mattresses we checked were in good condition and met infection prevention and control standards.

Environment and equipment

Both the adult and paediatric EDs were located in a purpose-built building that had only been in use for 10 months. It was clean, light and airy, with natural light and wide spacious corridors.

Consulting and treatment cubicles were a generous size and contained the necessary patient equipment. All cubicles had solid walls and solid doors to maintain privacy.

The department had a room that could be used in the event of chemical, biological, radiation or nuclear (CBRN) contamination. When we checked it, it had discarded towels inside and was not ready for use. We also found that shower flushes had not been documented therefore we were unsure whether they had been carried out.

We found that equipment in the department had been safety checked. All of the electrical equipment we checked had up to date tests.

Equipment was serviced and maintained in line with manufacturer's guidelines, as there were maintenance contracts in place. To ensure accuracy, equipment was regularly calibrated.

We saw there were sufficient supplies of all equipment. This meant that if one suffered a mechanical breakdown, a spare machine was available.

We checked some of the stock held in the store rooms. We found a number of items had passed their expiry date. These included defibrillator pads. We brought the items to the attention of staff who disposed of and replaced them.

During our time in the department we found some cupboard doors open or unlocked. One store room in the paediatric department contained sharp implements that could harm patients and another in the adults department contained cleaning products that again could cause harm if mishandled or ingested.

We checked resuscitation trolleys and were unable to find a checklist, or signed list to show that regular checks had been made to ensure all equipment was present and in date. We looked at the contents of one trolley and found three pieces of out of date equipment and two further pieces due to expire within a month. We asked staff to carry out a resuscitation trolley check to make sure there were no further issues with other trolleys.

The waiting areas used by patients were spacious with sufficient seating for patients and relatives. They also had natural light making them a more pleasant environment for patients.

There was a separate secure waiting area suitable for children and young people. The department were planning to decorate it with murals and colourful fictional characters. Cubicles presented an interesting environment for children and young people and there were toys to distract and occupy children waiting to be seen or treated. The department had engaged with a local children's charity to decide how the rooms should be decorated.

The department had specific rooms suitable for adult and paediatric patients with mental health conditions. All designated rooms were ligature point free, had heavy furniture that could not be used as a weapon and private toilet facilities.

The adult department layout had been very well thought out with three identical layout areas; see and manage, high acuity and emergency ambulatory care. Each had a central hub for staff, surrounded by patient rooms on all four sides. This meant patients were easily visible to staff.

The paediatric department had a similar layout in one area (high acuity) and a slightly different layout in the treatment area. Patients were still easily visible to staff.

Treatment rooms and patient cubicles had a small hatch facing outward to the corridor that staff could use to restock the room with gowns and blankets without entering the room or disturbing the patient. This meant patient privacy was respected.

Assessing and responding to patient risk

Emergency Department Survey 2016 (results of the 2017 survey not available at the time of inspection)

The department used a system called streaming to make sure patients were seen in the correct department to meet their needs. Streaming was carried out by a registered nurse. Patients with minor illnesses or injuries were directed to the urgent care centre close by whilst ambulance patients and those with more serious conditions were triaged to establish the level of risk posed by their presenting concern.

There were also rapid assessment and ambulatory care pathways so patients who were told to attend by their GP could go straight to the appropriate department. These included Ear, Nose and Throat, Gynaecology and Urology.

We discussed streaming and triage with staff. They told us that more senior or experienced staff streamed and triaged; these were important roles in the department. The department had no specific criteria for when staff could triage however, this was agreed between the band 7 nurses and individuals. Individuals had to undergo assessment and have a desire to triage. If a band 5 nurse did not want to triage patients, they did not have to take on that role.

There was emergency medical equipment in the department and staff were experienced at dealing with sick patients. There were senior staff on hand to support less experienced staff until at least midnight and then by telephone after this time.

The department had an adult sepsis pathway and a paediatric sepsis pathway. Patients identified as being septic were started on the sepsis pathway. There was a department sepsis lead. The electronic record keeping system also had a trigger to remind staff to consider sepsis when entering information about patients.

We requested the latest sepsis re-audit information from the trust so we could see how well they were performing against national screening criteria. The department did not routinely audit sepsis screening however provided us with information about a blood screening audit carried out in January 2016. The results showed an improvement in screening for lactate and blood sugar levels from the rates in 2015. After our inspection, the trust provided us with information from January 2017 which showed audit results from 2016.

The department used the national early warning score (NEWS) for adults and the paediatric early warning score (PEWS) for children to assist in monitoring patients and identifying when a patient's condition was deteriorating. Staff were aware of the action they should take if patients deteriorated and there was a process in place for staff to follow.

We looked at the records of patients in the department and found that NEWS or PEWS had been completed regularly. This was made easier for staff because the electronic record keeping system showed when patient observations were due and reminded staff to carry them out.

We found that vulnerable patients could not always reach their call bells thus increasing their risk of not being able to attract attention should they become unwell.

Deteriorating patients were managed within the department and transferred to other departments once stable. Staff told us there were sometimes delays transferring patients to other departments due to bed capacity within the hospital. However, staff told us they had very good links with departments such as the intensive care unit who came to the department quickly if needed.

Staff told us about a new initiative to transfer some patients to wards unaccompanied by a nurse. However, there were very strict criteria and only some patients could be transferred this way, if they were medically stable and had a low early warning score.

Patients with allergies were given a red wristband to ensure that they were easily identifiable.

Staff were required to record known patient allergies in patient records. This was a mandatory field in the electronic record therefore this was recorded consistently.

Clinical staff were trained in a minimum of immediate life support or paediatric immediate life support. Ancillary staff told us they had undergone basic life support.

The trust provided us with information about specific life support training for adults and children. All staff at all grades and disciplines within the department had undergone some life support training. For example, domestic staff had undergone basic life support training. More senior staff had undergone life support training appropriate to their grades and responsibilities. We were assured that staff had undergone appropriate life support, paediatric life support and trauma life support as per Royal College of Emergency Medicine (RCEM) guidance.

The trust scored “better than” other trusts for two of the five Emergency Department Survey questions relevant to safety. The trust scored “about the same” as other trusts for the remaining three questions.

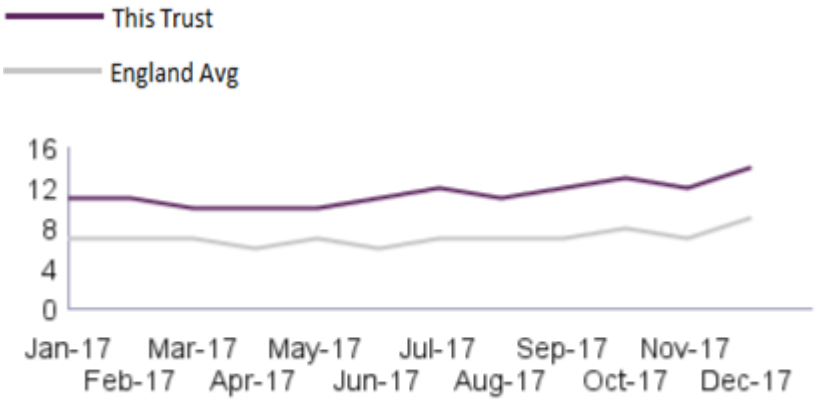
Question	**Score**	**RAG**
Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	8.5	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	7.2	Better than other trusts
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	7.1	Better than other trusts
Q33. In your opinion, how clean was the emergency department?	8.8	About the same as other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.3	About the same as other trusts

(Source: Emergency Department Survey – September 2016)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England median in all months over the 12 month period from January 2017 to December 2017**.** In the latest period, December 2017 the median time to initial assessment was 14 minutes compared to the England average of nine minutes.

Ambulance – Time to initial assessment from January 2017 and December 2017 at City Hospitals Sunderland NHS Foundation Trust



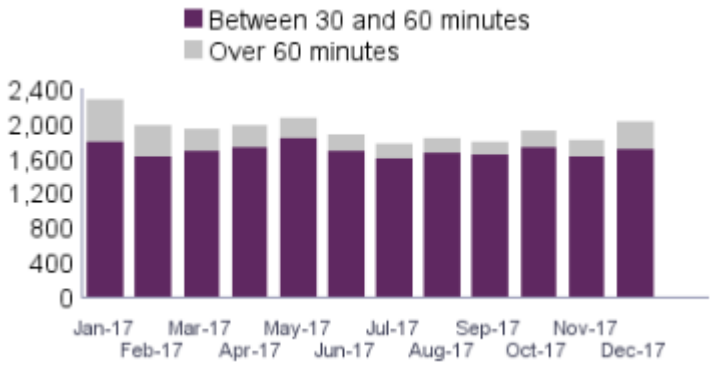
(Source: Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

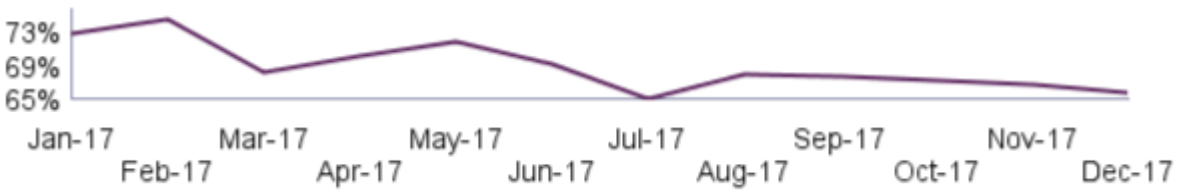
Sunderland Royal Hospital

From January 2017 to December 2017, there was a downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Sunderland Royal Hospital. In the latest period, December 2017, 66% of ambulance journeys had turnaround times over 30 minutes.

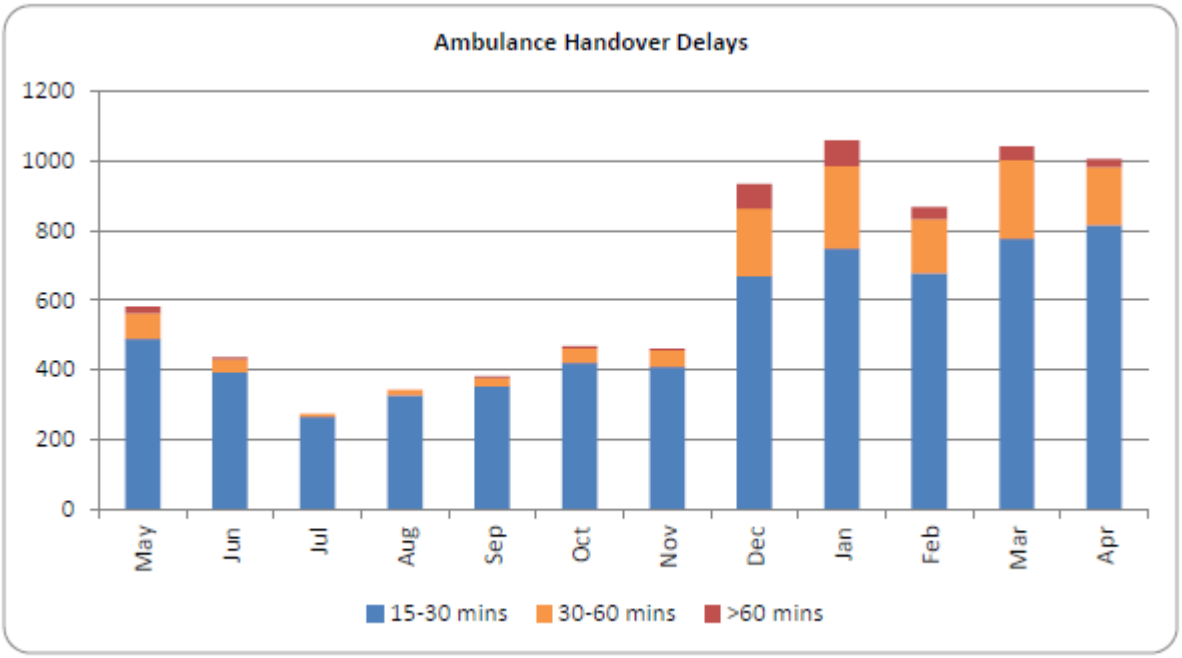
Ambulance: Number of journeys with turnaround times over 30 minutes - Sunderland Royal Hospital



Ambulance: Percentage of journeys with turnaround times over 30 minutes - Sunderland Royal Hospital



(Source: National Ambulance Information Group)



(Source- quality assurance and risk report May 2018)

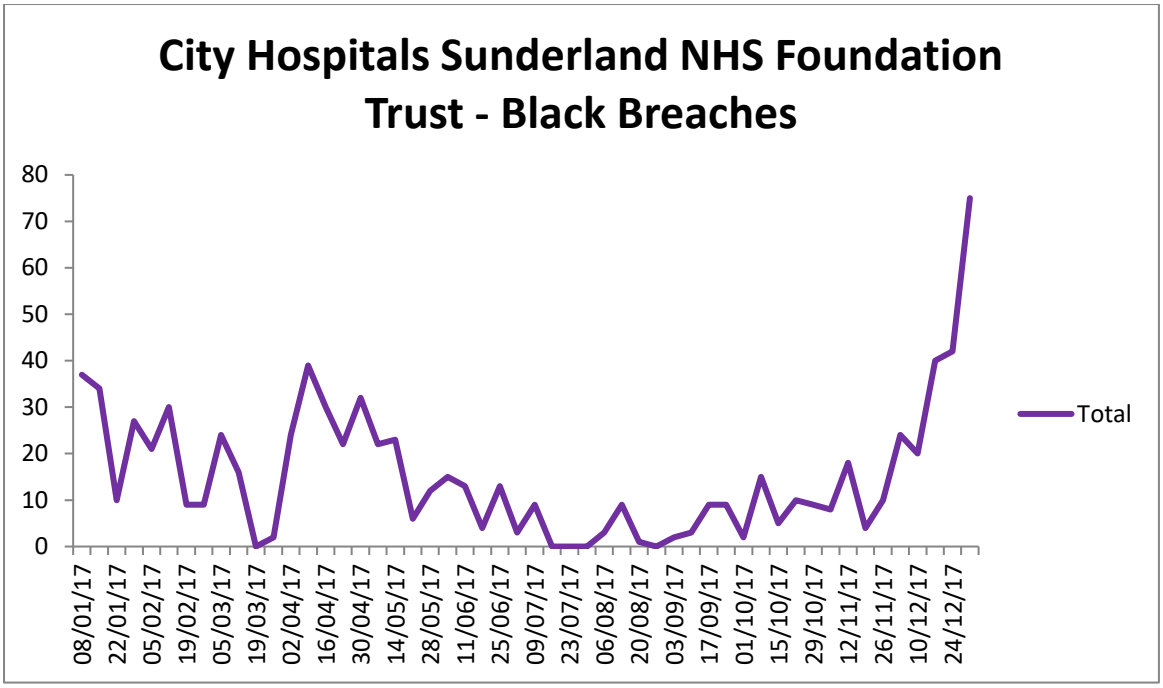
We spoke with senior managers in the department about time to initial assessment and ambulance turnaround times. The team told us they would provide us with the most up to date information about initial assessment and also ambulance handover times. Ambulance handover times are important because they show the time it takes for ED staff to register, accept and take responsibility for patients brought to the department. The national standard is that this should take place within 15 minutes of arrival by ambulance. Handover time is within the control of ED staff. Turnaround time is the time it takes to handover the patient and also the time it takes ambulance staff to make the ambulance ready to respond to another call. Some of this time can be influenced by ED staff however some of this time is also dependent on ambulance crews therefore it is not a reliable measure.

The department management team told us they were aware that handover times had been problematic however they told us that moving to a new building had seen a positive impact on handover times. The team also told us there had been working with local ambulance service providers to try to improve times further.

The average time to initial assessment for walk in patients was 18 minutes between April 2017 and March 2018. The length of wait peaked in December 2017 at 23.5 minutes and was at its lowest in June 2017. This performance was worse than the RCEM expected time to initial assessment of 15 minutes.

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From January 2017 to December 2017 the trust reported 804 “black breaches,” with an increasing trend over the period. This information was collected locally by each trust and therefore there was no nationally available to compare against.



(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)

The department management team were clearly sighted on the high number of black breaches that had occurred at the department, particularly over the winter months. Again, the team had been working with the local ambulance service provider to look at how to improve the situation.

Nurse staffing

The trust reported their registered nursing staff numbers as below as of December 2017 for urgent and emergency care, which showed an over-establishment of 2%.

Ward/Site	WTE Planned Staff	Number in post as at December 2017
Sunderland Royal Hospital	267.2	271.4
Total	**267.2**	**271.4**

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The paediatric department was solely staffed by registered sick children's nurses (RSCNs) and there was RSCN cover 24 hours a day, seven days a week.

Vacancy rates

As at December 2017, Sunderland Royal Hospital reported an annual vacancy rate of 0% in urgent and emergency care for nursing staff. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

As at December 2017, Sunderland Royal Hospital reported a turnover rate of 9% in urgent and emergency care. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
As at December 2017, Sunderland Royal Hospital reported a sickness rate of 4% in urgent and emergency care, which was the same as the trust target.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

Urgent and emergency care had 2,981shifts from April 2017 to December 2017 filled by bank and agency staff, which was the third highest core service uptake within the trust. Of this, two shifts were for nurse practitioners, 279 shifts were for the paediatric department, 2432 were for the adult department and 268 were for the emergency ambulatory care unit. There was a mixture of registered and non-registered staff shifts covered, with a split of 1789 registered and 1192 non-registered shifts. According to the information supplied, 12 hours of staffing was covered by agency staff.

When we spoke with staff from all disciplines none highlighted concerns to us about the level of nurse staffing in the department.

We looked at the reasons for requesting bank staff for the department. The most prevalent reason was vacancy cover at 944 shifts, followed by short term sickness at 905 shifts and escalation/increased workload at 427 shifts. This demonstrated that the department would alter staffing levels to manage increased workload and departmental pressures.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

We had concerns about nurse staffing related to the resuscitation area. This area was used solely for patients undergoing active resuscitation and therefore did not need to be staffed unless in use, which was not very often. Where we had concerns, was when the resuscitation area was in use, and in a worst-case scenario, for four patients, nursing and health care staff had to leave other areas in the department, such as see and manage or even the high acuity area to treat patients. This could mean a total of up to eight nursing staff being in the resuscitation area, leaving the other areas minus these eight staff. Whilst it was explained to us that this had been risk assessed we still had some concerns.

We also had some concerns about the high number of bank shifts used despite there being a zero vacancy rate and a low sickness absence rate. This could suggest that the department staffing establishment needed to be formally reviewed using an established tool to ensure the trust employed and deployed sufficient staff to meet the needs of patients.

Medical staffing

Sunderland Royal Hospital reported their staffing numbers below for the period from April 2017 to December 2017 for urgent and emergency care, which showed a 94% staffing rate.

Ward/Site	WTE Planned Staff	Number in post as at December 2017
Sunderland Royal Hospital	75.3	70.6
Total	**75.3**	**70.6**

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Doctors staffed the department 24 hours per day seven days a week. There was consultant cover from 8am to midnight. This met the Royal College of Emergency Medicine standard of consultant cover 16 hours each day. Doctors of all grades told us that consultants stayed as long as needed and would return to the hospital if their skills or experience was needed.

Consultants were flexible and when the department was busy or had very seriously ill patients, consultants often worked beyond their designated hours to support patients and staff.

The paediatric ED had sub-specialty consultants and trainee doctors trained in paediatric emergency medicine.

We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process. It was efficient and effective.

The trust reported to us that medical staff were fully up to date with revalidation requirements.

Vacancy rates

As at December 2017, Sunderland Royal Hospital reported a vacancy rate of 1% in urgent and emergency care. The trust did not provide a target rate however we had no concerns about the rate. The actual vacancy rate across the department and all grades of medical staff was 4.7 WTE.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

As at December 2017, Sunderland Royal Hospital reported a turnover rate of 39% in urgent and emergency care. The trust did not provide a target rate. This rate included junior doctors who rotated every six months.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

As at December 2017, Sunderland Royal Hospital reported a sickness rate of 1.8% in urgent and emergency care, compared to the trust target of 4%. We had no concerns about the sickness rate in this department.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

Urgent and emergency care had 762 shifts filled by bank and locum staff, which was the third highest core service uptake within the trust.

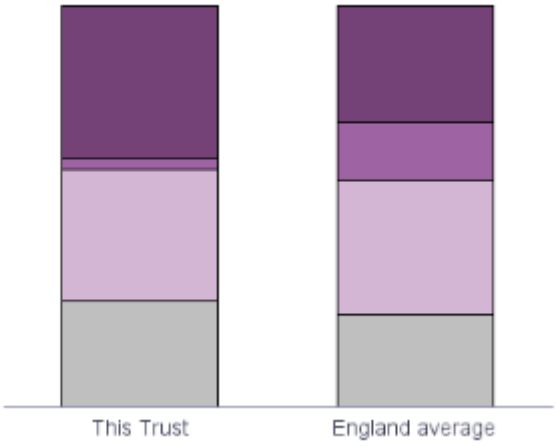
The trust did not provide accurate data for the total number of shifts overall and therefore we are unable to calculate the total percentage of shifts covered by bank and locum or the number of shifts left unfilled. However, we spoke with both nursing and medical staff about medical staffing levels. Staff told us that there were occasionally shifts left uncovered however none expressed concerns about the levels of medical staffing in the department

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

In October 2017, the proportion of consultant staff reported to be working at the trust were higher than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 38 whole time equivalent staff working in Urgent and Emergency Care at City Hospitals Sunderland NHS Foundation Trust



	This Trust	England average
Consultant	38%	29%
Middle career^	3%	14%
Registrar group~	33%	34%
Junior*	26%	23%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

All members of staff were required to attend information governance training. We found that 82% of medical staff and 87% of nursing staff had completed this training against a trust target of 90%.

The electronic record system in the ED had the facility to alert staff about specific needs of patients such as those living with a learning disability or mental health needs. There were also alerts for violent patients and patients with previously diagnosed conditions.

The department used an electronic system to record patient attendances. This was on display in the nurse's stations away from the sight of the public. This ensured that patients' personal information was not seen by other patients in the department.

Staff used fully electronic records other than signed consent forms and ECG (electrocardiograms) which were attached to print outs and added to the paper medical records. We had some concerns that these could be easily lost. Some staff felt the same however, we found no evidence of scans being lost.

Once a patient was discharged from the department, medical staff completed a discharge letter sent automatically to the patient's GP. There were two templates, one for consultants and another for other medical staff. The latter was more prescriptive in its content. There were checks in place to make sure these had been sent.

We looked at the electronic records of ten patients, adults and children. We had no concerns about the standard of patient records. Records contained information such as risk assessments for moving and handling patients, falls assessments, skin integrity (pressure care) assessments, nutrition and hydration and MUST (malnutrition universal screening tool) assessments. There were a number of mandatory fields for staff to complete. This made sure that vital information was always captured.

Records contained information about comfort rounds (regular checks with patients to ask if they need assistance to the toilet, provide them with a drink or snack or make sure they are generally comfortable, not in pain or in need of assistance). We saw staff regularly carry out these checks during our inspection.

Of the records we looked at all had been fully dated and timed automatically throughout and NEWS scores were recorded. The electronic system also had other functions such as indicating when patient observations were overdue, when patients had been referred for diagnostic tests or when the results had been returned. The named nurse and treating doctor were also easily identifiable from the patient record.

We looked at the standard of other records kept in the department such as cleaning logs, medication fridge checks and resuscitation trolley checks. We found that these were not always consistently completed and there were some gaps evident.

Medicines

The department used large electronic temperature controlled medicine storage units that were directly connected to the pharmacy department. Any temperature variations were notified to the pharmacy team and if the fridge temperature was outside of accepted limits, the department was notified and given advice about what action to take.

Medicines requiring refrigeration were stored appropriately and we saw evidence of fridge temperatures being checked regularly. The medicines fridge was electronically connected to the pharmacy.

Stock control was monitored by pharmacy to ensure that stock was rotated and supplies replenished regularly.

Controlled drugs were stored within the unit however there was extra security installed to ensure that regulations relating to the storage and dispensing of controlled drugs were met. We observed staff accessing controlled drugs and noted that they followed the correct protocols.

Controlled drug stocks were checked regularly to ensure any discrepancies were highlighted and investigated. There were examples where a discrepancy had been identified and evidence to show action had been taken to investigate the discrepancy. The department still used a controlled drugs book to record stock levels.

Medical gases were stored safely.

Patient group directions (PGD) (a patient group direction allows some registered health professionals, such as nurses, to give specified medicines (such as painkillers) to a predefined group of patients without the patient having to see a doctor) were used in the department. Not all eligible staff had signed to say that they understood them and were working within their guidance. For example, Lidocaine had not been signed by 12 eligible staff and Penicillin had not been signed by four eligible staff. In the paediatric department, seven staff had not signed the Ibuprofen PGD and three had not signed the paracetamol PGD.

Some nursing staff were independent nurse prescribers. This meant they had been assessed as competent to prescribe medication to individual patients outside of the PGDs.

The department employed a clinical pharmacist. They were responsible for overseeing medicines in the department and worked closely with the trust pharmacy team. They also took on a clinical role, preparing complex infusions, medicines used in resuscitation and other treatments and

seeing patients with medicines related conditions such as overdoses or addictions. They were supervised in this role by a senior consultant within the department.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2017 to December 2017, the trust reported no incidents classified as never events for urgent and emergency care.

(Source: NHS Improvement - STEIS)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from January 2017 to December 2017.

(Source: NHS Improvement - STEIS (January 2017 – December 2017)

The department reported 1163 incidents over the period February 2017 to January 2018. Less than 1% of these caused moderate or severe harm and there were no deaths attributed to incidents.

The most commonly reported incident category was access, admission, transfer, discharge (including missing patient) (192 or 16.9%). These included no deaths and no severe harms.

The second most commonly reported category was clinical assessment (including diagnosis, scans, tests, assessments) (168 or 14.8%). These included no deaths and no severe harms.

The severe harm incident related to infection control.

The majority (75%) of incidents were reported within 14 days although in April, May June, July and August 2017 some incidents took up to 90 days to report however by January 2018 100% of incidents were reported within 14 days.

The number of incidents reported each month was reducing and in January 2018 only 49 incidents (all of which were no or low harm) were reported compared to 133 in October 2017 (all of which were no, or low harm).

Information the trust gave us showed that the department had taken action as a result of incidents, used Duty of Candour appropriately and fed back to staff when errors had been made so lessons could be learned. The department held teaching sessions as a result of lessons learned and staff were able to give us an example of this.

We spoke with staff about their responsibilities around duty of candour. Providers of healthcare services must be open and honest with service users and other ‘relevant persons’ (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff were familiar with the phrase, ‘being open and honest’. Senior staff in the department took responsibility for the formal duty of candour process. They were able to describe it and give examples of when they had used the process.

Staff we spoke with told us they received regular feedback about incidents they had reported by email. Feedback and lessons learned were also disseminated via meetings, a newsletter and information posted on noticeboards in staff rooms.

We discussed incidents with staff. All the staff we spoke with were aware of the process for reporting incidents and had access to the electronic reporting system. All staff of all disciplines told us it was their responsibility to report any incidents they were involved in and did not rely on staff from other disciplines to take the lead.

Managers told us that all staff groups took responsibility for reporting incidents and were encouraged to do so. Managers also told us there was a strong self-reporting culture.

Senior staff in the department attended mortality and morbidity meetings held within the hospital and shared lessons learned at team meetings.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported three new pressure ulcers, two falls with harm and three new catheter urinary tract infections from December 2016 to December 2017 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at City Hospitals Sunderland NHS Foundation Trust

Total pressure ulcers

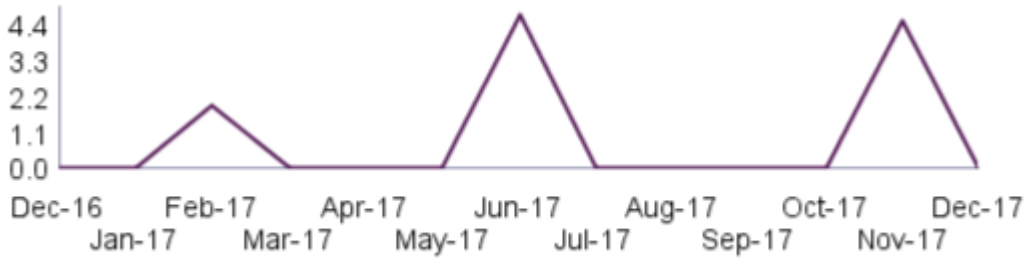
(3)

Total falls

(2)

Total CUTIs

(3)



(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

Staff in the department used a comprehensive variety of pathways and NICE guidelines together with Royal College of Emergency Medicine (RCEM) guidance to support them to achieve effective outcomes for patients in their care.

We saw comprehensive guidance on the trust's intranet which staff had access to, for instance, around the identification and management of sepsis, which was based on NICE guidance. There were links to trust wide policies, standard operating procedures, checklists and additional support information. This meant staff were able to ensure patients were receiving best practice care and treatment.

The governance lead in the department ensured new NICE guidelines were reviewed, reported on, and approved, and then training organised and performance audited. Patient safety and medication alerts were brought to staff attention and practice guidelines were changed in accordance.

For patients with mental illness, the department had appointed a lead, and staff used a detailed environmental and self-harm assessment form to assess the patient and ensure they stayed safe. Staff could also access pathways, for instance, in relation to deliberate self-harm.

Nutrition and hydration

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.6 out of 10 for question 35 "Were you able to get suitable food or drinks when you were in the emergency department?" This was worse than other trusts.

(Source: Emergency Department Survey - September 2016)

Arrangements were in place within the department to ensure that patients (and visitors) had easy access to food and drinks and where necessary patients were monitored to ensure that their nutrition and hydration needs were met.

In the waiting area for adults there were vending machines selling drinks and food. In the children's waiting area staff had access 24 hours a day to a beverage bay for sandwiches and drinks.

We saw evidence, while in the department, that patients had been offered food and drink. The results of the Emergency Department Survey 2016 shown above did not support this however, these results related to the old department and not the newly built facility.

If a patient had special dietary needs, for instance a child patient, we were told help could be obtained from the children's ward, or alternatively the patient was admitted and then seen by a specialist dietitian on the appropriate ward.

If a patient was assessed as requiring fluid management, for example following use of the vomiting pathway, we saw fluid balance charts were used to monitor and assess the need for additional fluids.

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 5.7 for question 31 "How many minutes after you requested pain relief medication did it take before you got it?" This was about the same as other trusts.

The trust scored 7.1 for question 32 "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

Question – Effective	Score	RAG
Q31. How many minutes after you requested pain relief medication did it take before you got it?	5.7	About the same as other trusts
Q32. Do you think the hospital staff did everything they could to help control your pain?	7.1	About the same as other trusts

(Source: Emergency Department Survey September 2016)

The department had systems and processes in place to support staff to effectively assess and record the pain patients had and we saw staff had access to appropriate pain relief medication. These included smiling and sad face charts for children and patients with communication challenges.

We saw pain scores were recorded on the electronic patient record at initial assessment and reassessed subsequently dependent upon the patient's NEWS score and how often their repeat observations were required. We saw pain relief being administered to patients.

A yearly pain management audit was conducted which we were told had improved year on year although staff were unable to show us the latest results. One action flowing out of the pain audit was a new initiative called 'we watch your pain'. This involved use of a pain clock with scores which determined the frequency and timing of further pain measurements.

We looked at the records of ten patients. We found evidence of pain scores recorded in all as this was a mandatory field in the electronic record. There was evidence that when the patient had a pain score, pain relief was given. From discussions with patients, when they told staff they had pain, they were administered medicines quickly.

Patient outcomes

The department took part in a number of national clinical audits such as asthma, consultant sign off and procedural sedation. Staff met regularly to present audit results and agree an action plan to improve performance going forward. Minutes from these meetings were shared with the clinical effectiveness team who also oversaw compliance with the action plan.

RCEM Audit: Moderate and Acute Severe Asthma 2016/17

In the 2016/17 Moderate and Acute Severe Asthma report, the trust failed to meet any of the standards.

The trust was in the lower UK quartile for four standards:

- Standard 1a (fundamental standard): Oxygen (O2) should be given on arrival to maintain saturations 94-98%. Trust achieved 7%; UK achieved 19%.
- Standard 3 (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the ED. Trust achieved 8%; UK achieved 25%. (Beta2-agonists (bronchodilators) are a group of drugs prescribed to treat asthma).
- Standard 5: If not already given before arrival to the ED, steroids should be given as soon as possible as follows:
    - Adults 16 years and over: 40-50mg prednisolone PO (orally) or 100mg hydrocortisone IV(intravenously)
    - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
    - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
        - Standard 5a (fundamental): within 60 minutes of arrival (acute severe). Trust achieved 0%; UK achieved 19%.
        - Standard 5b (fundamental): within 4 hours (moderate). Trust achieved 0%; UK achieved 28%.

The trust's results for the remaining three metrics were all between the upper and lower UK quartiles.

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the ED. Trust achieved 34%; UK achieved 26%.
- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. Trust achieved 71.2%; UK achieved 77%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
    - Adults 16 years and over: 40-50mg prednisolone for 5 days
    - Children 6-15 years: 30-40mg prednisolone for 3 days
    - Children 2-5 years: 20mg prednisolone for 3 days

Trust achieved 58.8%; UK achieved 52%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

In the 2016/17 Consultant sign-off audit, the trust failed to meet any of the standards.

The trust was in the upper UK quartile for two standards:

- Standard 1 (developmental standard): Consultant reviewed - atraumatic chest pain in patients aged 30 years and over 100%. Trust achieved 33.3%; UK achieved 11%.
- Standard 4 (developmental standard): Consultant reviewed – abdominal pain in patients aged 70 years and over. Trust achieved 20%; UK achieved 10%.

The trust scored between the upper and lower UK quartiles for one standard:

- Standard 2 (developmental standard): Consultant reviewed – fever in children under 1 year of age. Trust: 17.1%; UK: 8%.

The trust's result for the remaining standard was not reported:

- Standard 3 (fundamental standard): Consultant reviewed – patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. UK: 12%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Severe sepsis and septic shock 2016/17

In the 2016/17 severe sepsis and septic shock audit, the trust was not in the upper UK quartile for any standards.

The trust was in the lower UK quartile for six standards:

- Standard 3: O2 was initiated to maintain SaO2>94% (saturations of oxygen in excess of 94%) (unless there is a documented reason not to) within one hour of arrival. Trust achieved 0%; UK achieved 30.4%.
- Standard 4: Serum lactate measured within one hour of arrival. Trust achieved 0%; UK achieved 60%.
- Standard 5: Blood cultures obtained within one hour of arrival. Trust achieved 0%; UK achieved 44.9%.
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. Trust achieved 0%; UK achieved 43.2%.
- Standard 7: Antibiotics administered: Within one hour of arrival. Trust achieved 0%; UK achieved 44.4%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. Trust achieved 0%; UK achieved 18.4%.

The trust's results for the remaining two metrics were all between the upper and lower UK quartiles.

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU) alert, voice, pain, unresponsive or GCS (Glasgow coma scale)) and capillary blood glucose recorded on arrival. Trust: 80%; UK: 69.1%.

- Standard 2: Review by a senior trainee (Specialist Trainee level 4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED. Trust achieved 76%; UK achieved 64.6%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Vital signs in children 2015/16

In the 2015/16 Vital signs in children audit, the trust failed to meet any of the standards.

The trust was in the lower England quartile for one developmental standard:

- Standard 1. All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:
    - Standard 1b (developmental standard). Capillary refill time. Trust achieved 5%; England achieved 22.5%.

The trust's results for the remaining five metrics were all between the upper and lower England quartiles.

- Standard 1. All children attending the ED with a medical illness should have a set of vital signs recorded in the notes within 15 minutes of arrival or triage, whichever is the earliest. This should consist of:
    - Standard 1a (fundamental standard). Temperature, respiratory rate, heart rate, oxygen saturation, GCS or AVPU score. Trust achieved 39%; England achieved 37.6%.
- Standard 2 (developmental standard). Children with any recorded abnormal vital signs should have a further complete set of vital signs recorded in the notes within 60 minutes of the first set. Trust achieved 2.8%; England achieved 4.4%.
- Standard 3 (developmental standard). There should be explicit evidence in the ED record that the clinician recognised the abnormal vital signs (if present). Trust achieved 61.1%; England achieved 69.7%.
- Standard 4 (fundamental standard). There should be documented evidence that the abnormal vital signs (if present) were acted upon in all cases. Trust achieved 69.4%; England achieved 73.2%.
- Standard 5 (developmental standard). Children with any recorded persistently abnormal vital signs who are subsequently discharged home should have documented evidence of review by a senior doctor (ST4 or above in emergency medicine or paediatrics, or equivalent non-training grade doctor). Trust achieved 75%; England achieved 60%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Procedural sedation in adults 2015/16

In the 2015/16 Procedural sedation in adults audit, the trust failed to meet seven of the eight audit standards (which were all 100%).

The trust was in the upper England quartile for five fundamental standards and one developmental standard:

- Standard 1 (fundamental standard): Patients undergoing procedural sedation in the ED should have documented evidence of pre-procedural assessment, including:

- Standard 1a. ASA (American Society of Anaesthesiologists) grading
- Standard 1b. Prediction of difficulty in airway management
- Standard 1c. Pre-procedural fasting status

Trust achieved 48%; England achieved 7.6%.

- Standard 2 (developmental standard): There should be documented evidence of the patient's informed consent unless lack of mental capacity has been recorded. Trust achieved 81.6%; England achieved 51.8%.
- Standard 3 (fundamental standard): Procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities. Trust achieved 100%; England achieved 90%.
- Standard 4 (fundamental standard): Procedural sedation requires the presence of all of the below:
    - Standard 4a. A doctor as sedationist
    - Standard 4b. A second doctor, ENP or ANP as procedurist
    - Standard 4c. A nurse

Trust achieved 98%; England achieved 40.8%.

- Standard 5 (fundamental standard): Monitoring during procedural sedation must be documented to have included all of the below:
    - Standard 5a. Non-invasive blood pressure
    - Standard 5b. Pulse oximetry
    - Standard 5c. Capnography (Capnography is the monitoring of the concentration of carbon dioxide in the respiratory gases)
    - Standard 5d. ECG

Trust achieved 88%; England achieved 23.9%.

- Standard 7 (fundamental standard): Following procedural sedation, patients should only be discharged after documented formal assessment of suitability, including all of the below:
    - Standard 7a. (fundamental standard): Return to baseline level of consciousness.
    - Standard 7b. (fundamental standard): Vital signs within normal limits for the patient.
    - Standard 7c. (fundamental standard): Absence of respiratory compromise.
    - Standard 7d. (fundamental): Absence of significant pain and discomfort.
    - Standard 7e. (developmental): Written advice on discharge for all patients.

Trust achieved 33.3%; England achieved 2.6%.

The trust's results for the remaining metric was between the upper and lower England quartiles.

- Standard 6 (developmental standard): Oxygen should be given from the start of sedative administration until the patient is ready for discharge from the recovery area. Trust achieved 36%; England achieved 41%. *(Source: Royal College of Emergency Medicine)*

We spoke with a number of staff about the RCEM clinical audit results, including the clinical audit lead. They all told us that work has been undertaken within the department to address the shortfalls such as introducing mandatory recording fields on the electronic record to capture information in a timely way.

We formally requested details about re-audit results and changes made to practice as assurance that action has been taken. The trust provided us with assurance that action had been taken in relation to RCEM audit results however, had not yet undertaken any internal re-audits to assure themselves that practice had improved. This was mainly due to changes to the IT system and recording of information being made, that took time to happen. The governance lead gave us examples of changes to

We saw that the department had systems and processes in place to regularly review the effectiveness of the care it gave to patients.

We saw staff had access to a sepsis screening tool and a pathway to support them in identifying and managing a patient with sepsis. Information about sepsis was readily available to staff via the electronic patient record.

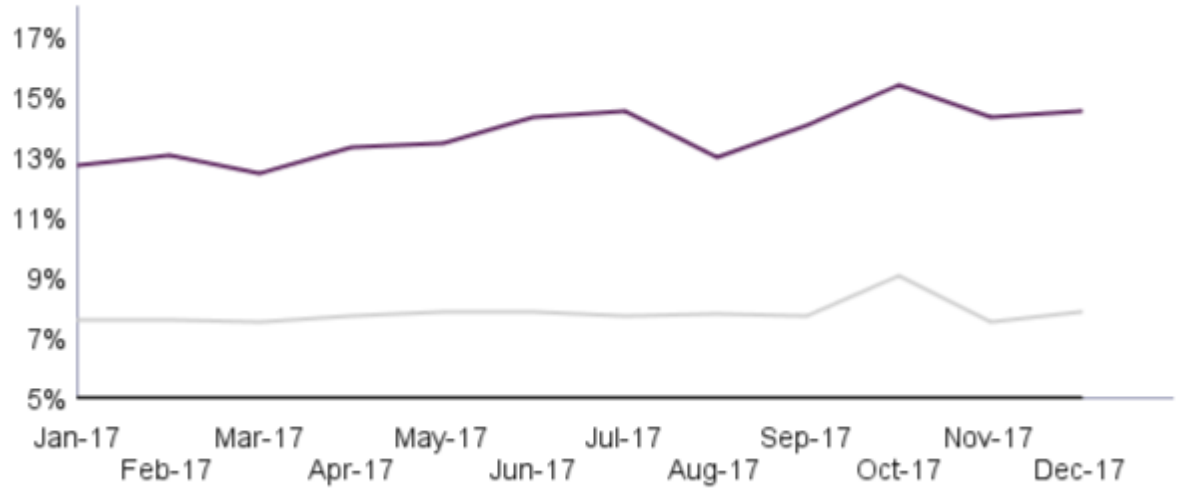
Staff described how they had personal treatment plans for regular attenders to the department to support them in achieving the best outcome for such patients. This was part of a national initiative called CQUIN (commissioning for quality and innovation).

Unplanned re-attendance rate within 7 days

From January 2017 to December 2017, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average with a decline in performance over the 12 months. In latest period, December 2017, the trust's performance was 14.6% compared to an England average of 7.9%.

The trust provided us with information about how it was addressing the re-attendance rate. In line with a national CQUIN (commissioning for quality and innovation), the department was working with the local mental health trust to devise strategies for supporting patients with mental health conditions who attended the department often.

Unplanned re-attendance rate within 7 days - City Hospitals Sunderland NHS Foundation Trust



(Source: NHS Digital - A&E quality)

Emergency readmission rates

Emergency readmission rates across the trust had reduced from 9% in January 2016 to 7% in December 2017, meaning fewer patients were being readmitted within 30 days of discharge via ED in December 2017 than in January 2016.

Competent staff

A mentor was allocated to newly registered staff who joined the department as part of their preceptorship and all staff joining the department for the first time also received an induction. The induction programme included checking of competencies, such as, for airways, breathing, ventilation and oxygenation. Staff reported that the induction to the department was useful because there were items of equipment that they would otherwise have been unfamiliar with.

The department had separate nurse and doctor teaching sessions where specific topics such as equipment, medical conditions or treatments were discussed. This ensured staff from both disciplines were up to date with new developments or techniques.

The department carried out simulation training for staff to ensure they were able to work confidently in unknown scenarios. This was a learning exercise but also gave staff confidence in real life situations.

Staff in the department spoke about additional competency training they had done over and above their mandatory training such as by attending clinical skills courses, or by undertaking paediatric immediate life support training. Other staff had taken on additional roles, such as patient safety, or had trained to become nurse practitioners.

Staff were competent in identifying vulnerable patients and referring them for specialist advice, such as from the psychiatric liaison team.

Senior staff told us that informal monitoring of the competency of staff was undertaken within the department and any concerns were addressed quickly with the staff involved.

Appraisal rates

Staff should have annual appraisals to help them identify their learning needs and career goals and based on discussions with staff it was clear the department provided opportunities to staff to help them remain competent in their roles.

As at January 2018, 58% of staff within urgent and emergency care at Sunderland Royal Hospital had received an appraisal. Registered nursing and midwifery staff had a 55% appraisal completion rate. We have asked the department for the most up to date information. This is shown in the table below.

All nursing staff we spoke with told us that they had received (or were booked to receive) an annual appraisal. Part of the appraisal identified learning needs for the staff member concerned. Staff reported good support with re-validation. Re-validation is the new process that all nurses and midwives in the UK go through to evidence their right to remain registered with the Nursing and Midwifery Council (NMC).

Managers were aware that the appraisal rates were below the 90% target and had scheduled outstanding appraisals

The trust had a target appraisal rate of 90%.

A split by staff group can be seen in the table below:

Staff Group	Individuals required (YTD)	Staff who have received an appraisal (YTD)	Completion Rate
Health Care assistants	102	71	70%
Sisters and Charge Nurses	34	26	76%
Specialist nurse practitioners	57	36	63%
Staff nurses	136	99	73%
Grand Total	**329**	**232**	**71%**

(Source: Additional data request DR51 Appraisals)

We spoke with staff about the support they received both at appraisal and generally within the department. Staff told us they were well supported and encouraged to keep their revalidation portfolios up to date. They were encouraged to attend training and develop their skills.

All medical staff had undergone an appraisal in the last 12 months and therefore medical staff as a group had surpassed the trust target of 90%.

Multidisciplinary working

The department operated 24/7 and staff we spoke with reported no issues with response times for diagnostic or pathology results that had been ordered.

Staff confirmed that they had 24/7 access to diagnostic services such as x-rays or computerised tomography (CT), which was available within an hour from the dedicated radiology suite. We were told that magnetic resonance imaging (MRI) was only available 24 hours a day for specific conditions.

Due to the IT infrastructure used by the department, staff could work flexibly between the main ED site and the Urgent Care Centre at Pallion to manage demand at each site and make sure patients were seen as quickly as possible in the correct location. Both nursing and medical staff could move as required.

Pathology support, such as blood testing was available 24/7 and staff reported no issues with the accessibility of the service or its response times which we were told was usually within an hour.

The department could also carry out its own point of care testing for some blood tests.

The department worked closely with the frailty team to support patients who had additional health and social care needs. They were able to arrange access to equipment such as walking aids and could organise short term social care for patients. This meant that patients who were medically well enough to go home were supported to do so. Admission avoidance was better for the patient and also assisted with bed availability and flow through the ED.

The trust worked closely with local care providers to provide a 24/7 team who could support patients in their own homes and prevent admission and reattendance at the department.

Health promotion

The drug and alcohol dependency team regularly visited the department to identify patients who had attended and who might benefit from their services so supporting better health by helping people to stop using drugs and alcohol.

The frailty team could identify patients who were frail or elderly and who may need extra support to ensure a safe and effective discharge. This team worked closely with outside agencies to ensure that patients leaving the department were looked after so promoting better health amongst those vulnerable patients who had visited the department.

We saw posters displayed in the department around health promotion so that patients were supported and encouraged to manage their own health. For example, there were posters around smoking cessation, weight loss and leading a healthier life which advertised guided parent/child sessions which patients could sign up to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood the importance of consent when delivering care to their patients and displayed a good understanding of the requirements of the Mental Capacity Act (2005) or knew where to obtain expert help, such as from the psychiatric liaison team.

Staff sought consent from patients prior to examination and treatment. In the majority of cases this was implied consent and not documented however when an intervention was required, formal written consent was sought.

Some common medical conditions seen in the ED that required written consent had pre-populated consent forms that listed the risks and side effects. Staff also explained this information to patients before asking them to sign. Consent forms were held within medical records.

Both medical and nursing staff were 100% up to date with their mandatory consent training.

Staff in the department were able to accurately describe the tests for assessing competence to consent to treatment for patients aged under 16 years.

We saw in records of patients that staff had completed capacity assessments and used the correct forms to consent patients who were unable to consent. Staff understood who could give consent on behalf of a patient and when an advocate or best interest decision should be used.

The Deprivation of Liberty Safeguards (DoLS) provide legal protection for those vulnerable people age 18 and over who are, or who may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in circumstances where deprivation of liberty appears to be unavoidable, in a person's own best interests.

Staff completed appropriate deprivation of liberty safeguard forms. The local authority approved such applications which were overseen and monitored for a final decision.

Staff were aware of the actions they should take if a patient was detained under the Mental Health Act and there was support available from the psychiatric liaison team if needed when this happened in the department.

The department had a policy in place for when restraint could be used and there were very strict criteria and protocols to follow in such events. Whenever a person was restrained an incident was recorded.

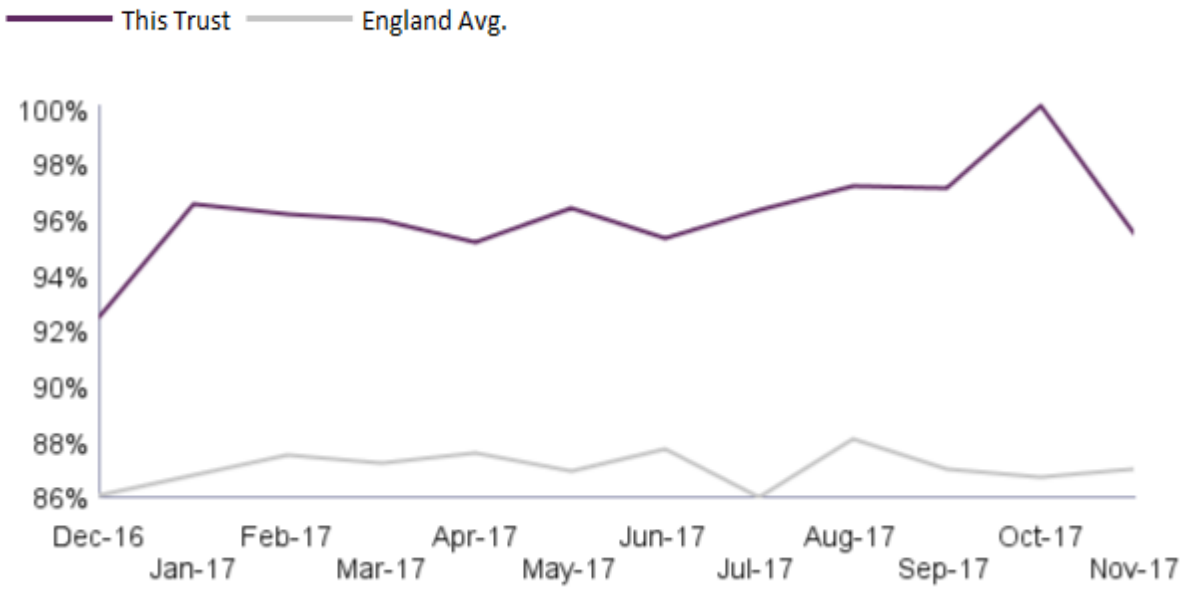
Is the service caring?

Compassionate care

Friends and Family test performance

The trust's urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from December 2016 to November 2017. In the latest period, November 2017, the trust's performance was 95.4% compared to the England average of 86.9%. In October 2017, performance reached 100% compared to 86.6% England average.

A&E Friends and Family Test Performance - City Hospitals Sunderland NHS Foundation Trust



(Source: NHS England Friends and Family Test)

During our inspection, we spoke with 14 patients and 13 relatives, all of whom were happy with the care they received. The majority provided us with positive feedback about the attitude of staff saying they were kind, pleasant and professional. However, we spoke with some patients living with mental health concerns. Three patients thought staff were not always compassionate. One patient who had been suicidal in the past, when explaining to a doctor how they felt, was told to 'try harder'. Another patient who had both physical and mental health problems told us they did not bother to mention their mental health any more as staff only seemed interested in the physical condition. A third patient told us that they sometimes felt that staff were nervous of them.

Staff respected people's dignity and cubicle doors were closed when care and treatment was being given. Patients described to us how staff treated them with respect and our observations corroborated this.

When we discussed care of patients with staff, there was a consistent message that staff wanted the patients to feel safe and cared for. Staff in both adult and especially paediatric ED were dedicated to looking after patients throughout their ED journey. Staff shared an example of an extremely anxious young person who had injured themselves and the nurse had not only stayed with them as they were treated but when they returned to the hospital for follow up care, attended the appointment with them. This demonstrated how staff would go above and beyond for their patients.

In the patient led assessment of the care environment survey undertaken in April 2017, the trust scored 86.6% for privacy, dignity and wellbeing. There were no figures specifically for the emergency department at Sunderland Royal Hospital.

During our time in the department, we saw patients being treated with dignity and respect. Staff were conscious of the cultural needs of patients and made sure this was respected whilst delivering their medical care. When patients expressed a preference for a particular gender of nurse of doctor, this was accommodated whenever possible.

Staff were busy however they took the time to deliver care that was compassionate and we saw patients being treated with patience and kindness at all times from all members of staff at all levels.

Emotional support

Staff told us about how they would support patients who were distressed, by chatting to them and trying to distract them. We saw examples of this during our inspection with patients who were confused or frightened. Staff reassured them, spent time with them and stayed with them until they felt reassured.

Staff told us they sometimes found it difficult to support people as much as they wanted to when the department was busy, however we saw staff going out of their way to make sure that no matter how busy the department was, patients received the emotional support they needed.

We observed all staff talking with patients and relatives in a calm way and offering reassurance to both concerned patients and their family members.

Staff offered support and gave information about support services available if this was required. Staff had undergone training about organ donation and having difficult conversations with patients and relatives at end of life so were able to offer support in difficult situations.

There was pastoral support available for patients of any or no religious belief.

Understanding and involvement of patients and those close to them

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in all questions relevant to caring.

Question	Trust	RAG
Q10. Were you told how long you would have to wait to be examined?	3.0	About the same as other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.6	About the same as other trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.0	About the same as other trusts
Q14. Did the doctors and nurses listen to what you had to say?	8.8	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.6	About the same as other trusts

Question	Trust	RAG
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	8.8	About the same as other trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	7.5	About the same as other trusts
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?	8.4	About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	7.9	About the same as other trusts
Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?	8.7	About the same as other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.7	About the same as other trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	8.6	About the same as other trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.1	About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	6.7	About the same as other trusts
Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?	7.9	About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests?	7.7	About the same as other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	8.6	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	8.7	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	4.0	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	4.6	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	5.7	About the same as other trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	6.0	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.2	About the same as other trusts

Question	Trust	RAG
Q45. Overall	7.9	About the same as other trusts

(Source: Emergency Department Survey – September 2016)

We saw patients being given information and supported to make decisions about the treatment they would like to receive. Parents told us that both they and their children were involved in discussions about treatment options.

During our inspection, we witnessed good interactions with patients. Staff took time to reassure patients and explain to them why they were waiting or what the next stage of their treatment or care was. This supported patients to make decisions about their treatment. People's emotional and social needs were considered by staff.

Staff made sure information they gave was in language that the patient and their family could understand without complicated medical terminology. Staff gave patients and relatives the chance to ask questions and time to think before making any decisions. Patients and relatives had no complaints about how information was presented to them.

Overall, patients told us staff responded compassionately when people needed help and supported them to meet their personal needs as and when required. However, one patient told us that when they had been incontinent due to a long term chronic health condition, a member of staff had made them feel uncomfortable and 'told them off'. The patient told us they felt humiliated at the time.

Staff helped people and those close to them to cope emotionally with their care and treatment.

Some relatives we spoke with told us they felt excluded from the care of their loved one as they were not allowed to accompany them through assessment and triage and had to wait in the waiting room until staff told them they could enter the treatment area. Two patients also told us they would have preferred to have had their relative with them.

Is the service responsive?

Service delivery to meet the needs of local people

The trust had recently reconfigured the services delivered by the department and moved in to a new purpose-built department with separate adult and paediatric EDs. There were also very close links to the urgent care centre located close by, that dealt with the more minor illnesses and injuries. Patients who attended SRH were briefly assessed and directed to the most appropriate area to deal with their condition. There were pathways in place so patients with certain conditions or letters from GPs could access services quickly. This reconfiguration took place with the support of the local Clinical Commissioning Groups and local stakeholders.

City Hospitals Sunderland ED was a trauma centre. The department was staffed by consultants between 8am and midnight every day. The department was meeting the RCEM 'rule of thumb' recommendations for consultant cover of 16 hours each day. All staff told us that consultants often worked beyond their contracted hours when the department was busy. Additionally, the medical staff overnight always had an experienced staff or middle grade doctor of specialist trainee level four or above as recommended by RCEM.

At the time of the inspection, SRH accepted a wide range of patients including those suffering stroke, trauma, cardiac arrest, surgical emergencies and obstetrics and gynaecology emergencies. There were some patients such as those having a heart attack, or victims of major burns or major trauma who were taken to their nearest major trauma centre or specialist unit.

The department had developed some new services for patients with heart conditions and any patient who suffered a heart attack once in the department was able to have a surgical treatment procedure on site. Patients with new onset atrial fibrillation (where the heart beats out of rhythm) could also undergo treatment on site to bring the heart back to its correct rhythm. These were newly introduced services.

The department had acknowledged the mental health needs of the local population. Patients had access to mental health support services on site via the psychiatric liaison team and the children and adolescent mental health services (CAMHS) team.

The hospital had a team of staff dedicated to supporting patients who had additional care needs, to ensure patients were only admitted to hospital if their health required so and to assist patients in accessing equipment and social care.

There was a large co-located paediatric ED therefore the hospital accepted babies, children and young people. There were two distinct waiting areas, one for children and one for young people. The department worked very closely with the children's wards and the paediatrics team to look after children who were unwell. In the case of a child needing to be in the resuscitation department, the department had a dedicated paediatric resuscitation room and two high dependency observation rooms.

The paediatric unit had an eight-bedded clinical decision unit where children and young people could stay if they needed observations or were waiting for test results. This was a pleasant and comfortable environment.

All staff were aware of the type of patients who attended the department and the potential incidents that could occur locally. Managers ensured that the department had the necessary equipment and trained staff to manage such situations. There were robust plans in place to manage major incidents or events such as football matches.

Meeting people's individual needs

The trust scored "about the same as" other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

Question – Responsive	**Score**	**RAG**
Q7. Were you given enough privacy when discussing your condition with the receptionist?	6.8	About the same as other trusts
Q11. Overall, how long did your visit to the emergency department last?	7.3	About the same as other trusts
Q20. Were you given enough privacy when being examined or treated?	8.6	About the same as other trusts

(Source: Emergency Department Survey – September 2016)

The waiting rooms for adults and children were able to accommodate wheelchairs and mobility aids and there were dedicated disabled toilets available.

There were facilities, such as chairs and wheelchairs, for bariatric patients and some trolleys were designed for larger patients. Specialist bariatric equipment such as hospital beds were stored as part of the trust's equipment library and could be requested when needed.

There were vending machines present in the department that relatives and carers could access and the hospital had a number of shops and places to purchase food.

There were private breast feeding facilities available to allow privacy if required.

The trust had access to interpreting services for people whose first language was not English. Staff we spoke with told us that family members were sometimes used however; interpreting services were available if required via telephone. It is not best practice to use family members for a number of reasons including reliability of translation and patient confidentiality. Most staff were aware of how to access telephone interpreters.

The department had produced a number of leaflets associated with patient pathways such as head injuries. These were automatically linked to the electronic patient record and printed off when the medical staff recorded the patient as treatment completed. We noted leaflets were in English however when we asked staff if they were available in other languages or formats such as large print or Braille, we got a mixed response. Some staff were aware of the process to access alternative formats and others were not.

The department had access to sign language interpreters for people living with hearing impairment.

There were private and quiet areas for relatives to wait whilst patients were being treated and there were relatives' rooms close to the department.

When a patient passed away, whenever possible, they were moved to a side room so that family could have privacy to visit. One of the relative rooms in the paediatric ED and one in the adult ED had viewing rooms so relatives could spend as much uninterrupted time with their loved one as they wished.

Staff were aware of the cultural and religious differences within the community and when patients passed away. They were sensitive to the needs of the family and the community in those circumstances and understood what was required.

The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals and would try to involve family and carers in discussions about care needs. The department had wrist bands for patients so staff could easily identify patients and there was a dementia trolley with distraction items such as twiddle muffs and books.

Staff we spoke with told us that whenever possible, people living with dementia or a learning disability were seen as quickly as possible in order to minimise distress for the patient.

Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.

There was access to chaplaincy services for patients and relatives of different faiths or none.

Patients with purely mental health needs waited in the mental health rooms or a quiet area. These rooms had been risk assessed and met specific required criteria such as no ligature points, two exits and furniture heavy enough not to be used as a weapon. Each patient was risk assessed to

make sure they were placed in a room that met their needs and reduced the risk of them harming themselves. There were specific mental health rooms in both the adults and the paediatric areas of the department. At night, patients living with a mental health condition were located in the ambulatory care area of the department, supported by at least two staff, away from the busy department.

Staff in the department had access to 24/7 psychiatric liaison support or child and adolescent mental health services (CAHMS) with a quick response time. Any patients who presented with a mental health condition were referred to one of these teams.

Staff told us that they had been trained to deal with violence and aggression and we were shown the portable personal alarms staff could use if they had any concerns.

The department had a specific team who carried out a comprehensive assessment of frail or elderly patients present in the department with a view to carrying out a holistic assessment of their physical, mental and social needs and arranged safe discharge for them.

Access and flow

The department had large wall murals in the adult and children waiting areas to assist patients to understand their patient journey. It showed the different stages of a visit to ED as well as approximate time scales for each stage. This supported patients to understand the different processes in ED and where they were in their journey.

At the time of our inspection, we spoke with senior staff about waiting times. They had introduced a number of measures in an attempt to improve patient waits. This included using streaming to direct patients to the most appropriate care setting, direct access to the emergency ambulatory care unit, direct admission for patients referred by GPs, pathways for Urology, Gynaecology and ENT and chest pain rapid assessment unit. Each of these received different types of patients with the aim of reducing the burden on the department, enabling them to see patients quickly and efficiently in the right place at the right time.

Patients were also directed to the Urgent Care Centre (UCC) located a five minute walk away for less serious illnesses and injuries. This was an extended part of the department where minor injuries and illnesses could be treated. The main ED at SRH had oversight of the patient attendance numbers at the UCC and could send additional staff if it was busy or request staff to come to SRH if it was not. Staff reported this had a positive impact on waiting times and were hopeful that the number of patients waiting more than four hours would reduce.

The department had a dedicated radiology suite with x-ray and CT facilities solely for the use of ED patients. This meant patients could be x-rayed or scanned quickly. This was particularly important for patients with time critical diagnoses such as stroke as it meant they could be started on treatment quickly thus helping to minimising the impact of their condition.

From our observations and discussions with patients and staff, patients were triaged and assessed quickly. Staff told us that patient waits to be seen by specialist staff such as surgeons or from other disciplines and departments were usually not too long. Staff also told us the department had good links with the intensive care unit and anaesthetists and intensivists came to the department if needed.

The location and design of the department worked well for patient flow and was created in consultation with staff working in the department. Specialist staff such as from the critical care unit were located close by and staff were transferred quickly.

During our inspection we did not witness any patients waiting long periods of time in the department to be moved to a hospital bed on a ward however, staff told us that during our inspection, the department had been unusually quiet.

The department was working hard to reduce the risks for patients who had long waits such as by moving patients from trolleys to hospital beds and using pressure relieving equipment for patients who were a high risk of developing pressure ulcers.

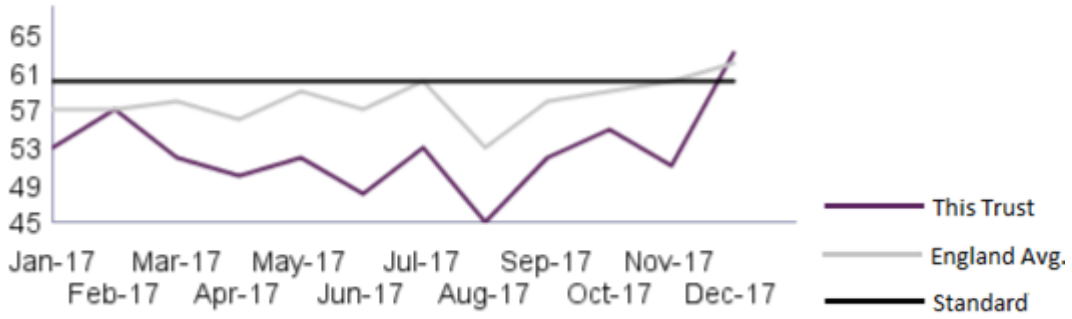
Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for 11 months over the 12 month period from January 2017 to December 2017.

The latest period, December 2017 the median time to treatment did not meet the standard and was 63 minutes compared to the England average of 62 minutes.

The trust's performance against this standard was generally better than the England average and followed a similar pattern from March 2017 to October 2017.

Ambulance – Time to treatment from January 2017 to December 2017 at City Hospitals Sunderland NHS Foundation Trust



(Source: Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

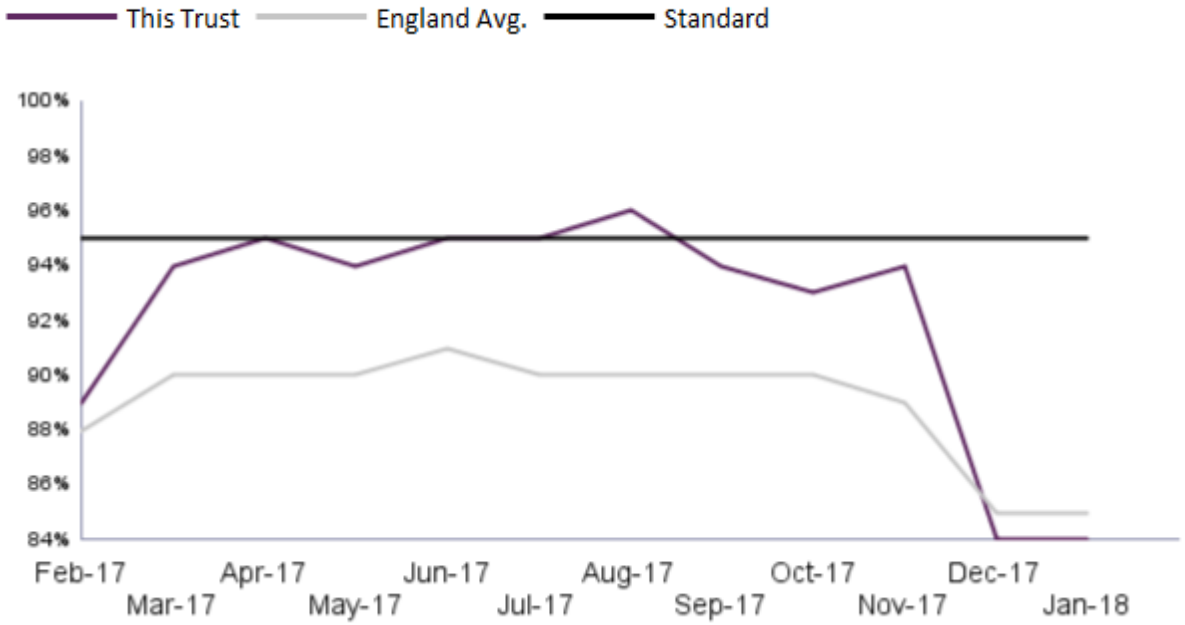
The trust met the standard four times from February 2017 to January 2018.

The trust breached the standard eight times from February 2017 to January 2018.

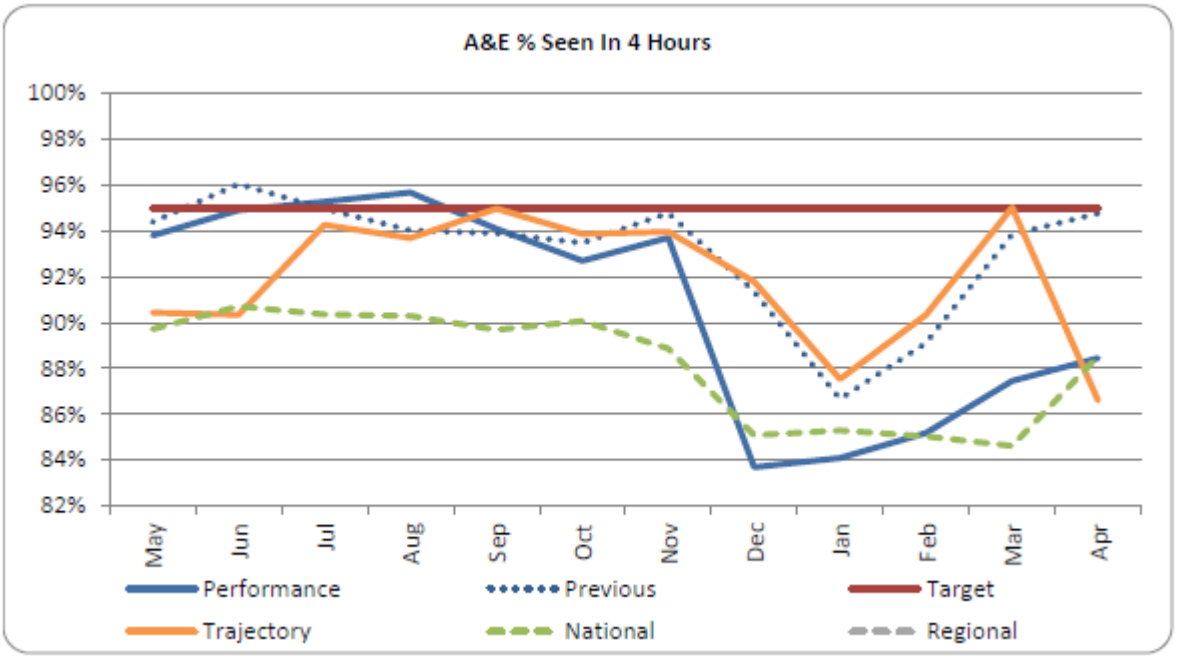
Latest information provided to us by the trust showed that from January 2018 to April 2018 the average was 81% of patients admitted, transferred or discharged within four hours.

Between March 2017 and September 2017 performance against this metric was about the same as the national standard and then saw a steep decline in December 2017. We discussed this with the department management team. They explained to us that Sunderland had a very high incidence of influenza over the winter period which had put the department under additional pressure other than expected winter pressures.

Four hour target performance - City Hospitals Sunderland NHS Foundation Trust



(Source: NHS England - A&E Waiting times)



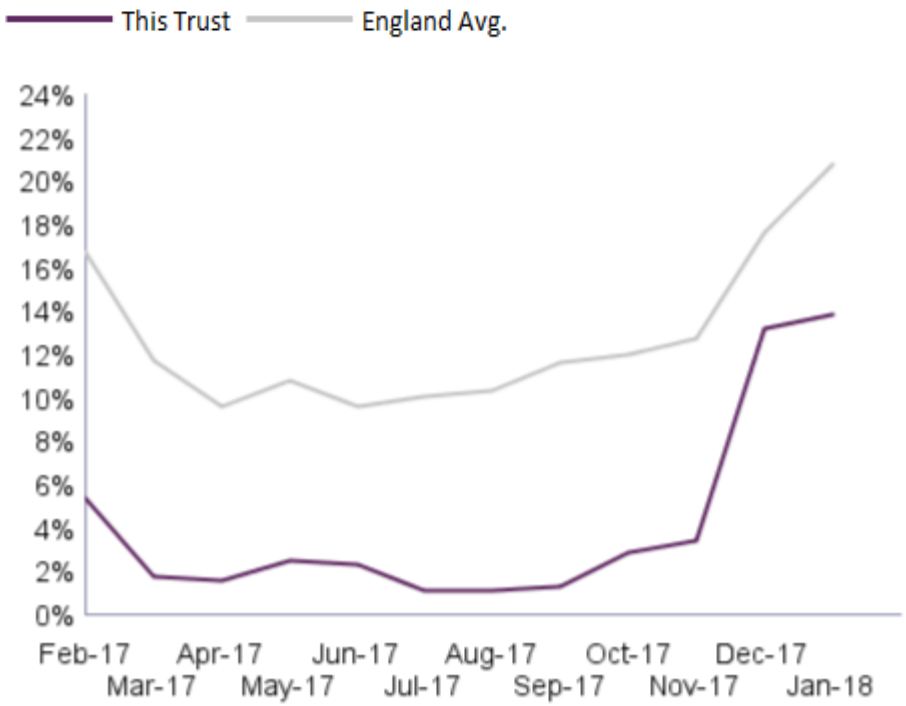
(Source- Quality, risk and assurance report May 2018)

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

From February 2017 to January 2018, City Hospitals Sunderland NHS Foundation Trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average.

Performance against this metric followed a similar pattern to the England average from February 2017 to November 2017 and then declined in December 2017. We spoke with the department management team about the sudden decline in performance in December. The team confirmed that this was as a result of a high incidence of influenza in Sunderland in addition to the expected winter pressures.

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - City Hospitals Sunderland NHS Foundation Trust



(Source: NHS England - A&E Waiting times).

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from February 2017 and January 2018, no patients waited more than 12 hours from the decision to admit until being admitted. The department had strong links with ward, the ambulatory care unit and the integrated assessment unit who all admitted patients from the ED.

	Number of patients between 4 and 12 hours	Number of patients over 12 hours
Feb-17	138	0
Mar-17	47	0
Apr-17	40	0
May-17	67	0
Jun-17	61	0
Jul-17	30	0
Aug-17	29	0
Sep-17	35	0
Oct-17	82	0
Nov-17	100	0
Dec-17	419	0
Jan-18	415	0

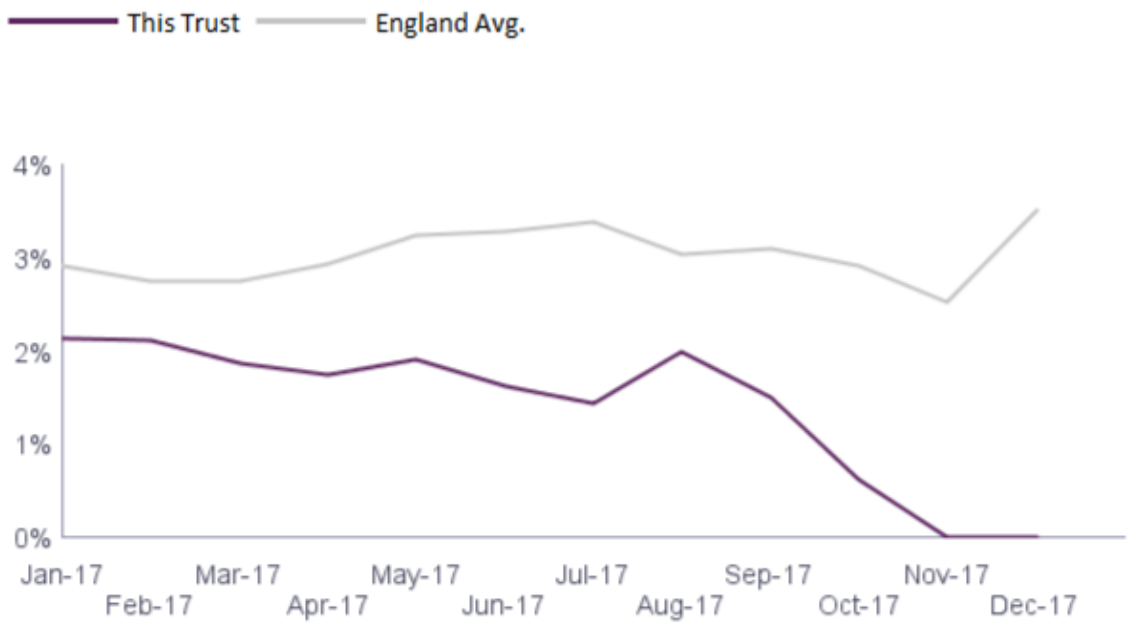
(Source: NHS England - A&E Waiting times)

Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment

From January 2017 to December 2017, the monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than the England average.

Performance against this metric showed gradual improvement over time and in the latest period, December 2017 there were no patients leaving the trust's urgent and emergency care services before being seen for treatment, compared to the England average which was 3.5%.

Percentage of patient that left the trust without being seen - City Hospitals Sunderland NHS Foundation Trust



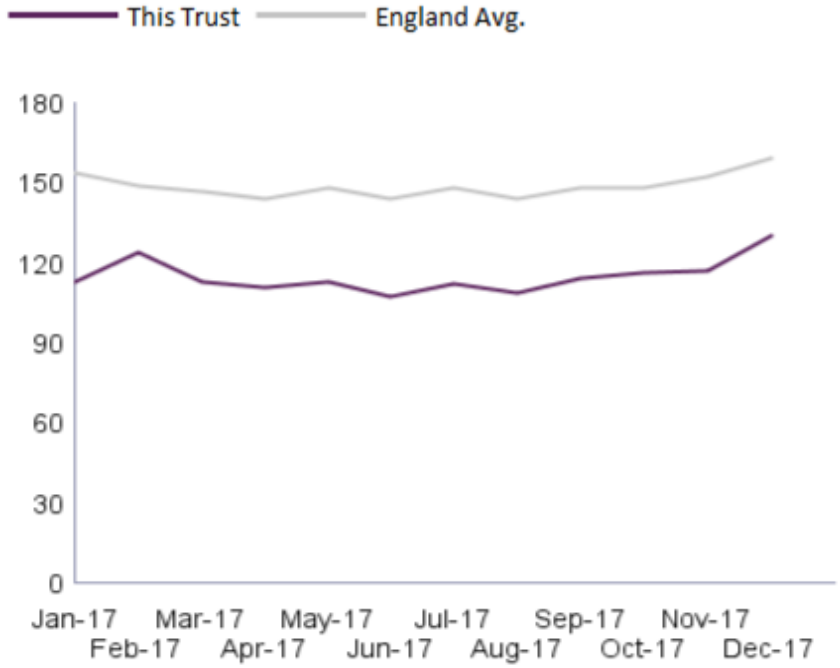
(Source: Source: NHS Digital - A&E quality indicators)

Median total time in A&E per patient (all patients)

From January 2017 to December 2017 the trust's monthly median total time in A&E for all patients was consistently lower than the England average. Performance against this metric followed a similar pattern to the England average.

In the latest period, December 2017, the trust's monthly median total time in A&E for all patients was 130 minutes, which is better than that of the England average which was 159 minutes.

Median total time in A&E per patient - City Hospitals Sunderland NHS Foundation Trust



(Source: NHS Digital - A&E quality indicators)

Learning from complaints and concerns

Summary of complaints

From January 2017 to December 2017 there were 37 complaints about urgent and emergency care services provided by either adults or paediatric ED. Of the 41 complaints, four were fully upheld, 12 were partially upheld, 19 were not upheld and two had no conclusion recorded. None of the complaints had been referred to the ombudsman.

The trust took an average of 28 working days to investigate and close complaints. This was slightly worse than their complaints policy, which stated complaints should be completed in 25 days.

The most prevalent themes were about patient care with 22 complaints (59%) and, values and behaviours of staff with 10 complaints (27%).

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Patients and relatives we spoke with were aware of how to make a complaint to the trust although none of the people we spoke with had made a complaint about the department.

There was information about how to raise concerns about the department or the trust on display in the department and there were leaflets available for patients to take away with them.

Staff were able to describe to us the action they would take if a patient or relative complained to them.

Staff and managers told us that feedback was given to staff when they were part of a complaint. Additional training was offered as a way of supporting staff when the issue related to clinical care. This was evidenced in the information sent to us by the trust.

Information about complaints and incidents was regularly sent to staff as part of a newsletter produced about lessons learned. The department was proactive in its approach to addressing complaints.

Is the service well-led?

Leadership

The department was overseen by a clinical director, matron and two operational managers. The adults ED and paediatric ED both had a senior nurse lead in post to oversee the daily management and requirements of the department. We met with these staff and found them to fully understand the challenges of the department in relation to performance, demand, staffing and risks. They presented a cohesive team committed to the ED and its staff.

Nursing staff we spoke with during the inspection told us that they felt well-led at a local level and had no concerns with their line managers. They told us the management team was approachable and supportive.

Similarly, medical staff told us their leadership was inclusive and provided good direction within the department and strong representation for the department within the wider trust. Leaders were supportive and committed to teaching.

Staff told us they felt able to suggest new ways of working and try new things to improve patient experience or the efficiency of the department. We saw this in examples of innovative working such as care of patients and relatives after death.

Staff we spoke with told us that senior executives from across the trust rarely visited the department. Most staff knew who the chief executive was but were unable to name the director of nursing or medical director and said they weren't sure if they would recognise them if they came to the department.

Vision and strategy

The management team had a strong and clear vision for the service and was working with other departments within the hospital as well as local providers and commissioners to ensure that services met the needs of the local populations.

Managers in the department were aware of the changing and increasing demands on the department and the types of patients accessing the department. Work was continually underway to manage demand. The management team worked flexibly to look at new and innovative ways of delivering patient care.

The trust had undergone an extensive programme of work prior to building a new A&E department. They had consulted with local commissioners, stakeholders, staff and patients as well as looking at department designs from around the world before deciding on the design of the department. The team involved in designing the department came up with plans designed to future proof the department and help to manage increasing demand on urgent and emergency care services in a safe, effective and efficient way. The new department incorporated facilities dedicated solely to the urgent and emergency care needs of the local population of Sunderland and the surrounding areas.

Urgent and emergency care services had been reconfigured to include new models of working with other specialties and an urgent care centre close by. The aim was to manage the staffing and bed base in a more effective and efficient way. Staff were flexible and could be moved to and from the urgent care centre according to demand

The management team were working closely to ensure that the service was sustainable for the future. This included developing new roles such as nurse practitioners who, in the future would be able to work within the junior doctor rota.

Culture

We spoke with a number of staff from different disciplines about the culture of the department. Most staff described the department as friendly and 'like a family'. The wider team worked and socialised together and there were very good working relationships.

Health care assistants, junior doctors, and nurses told us senior clinicians were keen to educate colleagues. They thought there was a very good learning culture and were very comfortable to ask questions to broaden their knowledge.

The atmosphere in the department showed that staff focus was on treating patients in an efficient way however staff also took time to support each other through difficult and stressful times.

The way we saw staff interact with each other demonstrated that there was professional communication between staff from different disciplines. Staff worked together to ensure patients received good coordinated care. Staff were very committed to the care of patients and we were told of examples when staff had worked extra hours or stayed late to be with a patient. During some extreme weather over the winter, some staff also stayed overnight at the hospital to make sure they were available for their next shift. This demonstrated an exceptional patient focussed culture amongst staff to treat and care for their patients.

Staff we spoke with told us they were able to report concerns and incidents without fear of reprisals and were confident that when issues were raised, they were dealt with appropriately.

If staff made errors they were able to report them and were confident they would be supported and managed fairly. Managers told us there was a strong culture of self-reporting within the department.

Staff felt that their hard work was recognised and they felt appreciated by their colleagues and line managers. One staff member also gave an example of receiving a letter of thanks from the chief executive after dealing with a particularly challenging case.

Governance

Nursing and medical staff both had patient safety roles in the department. They were given time away from clinical duties to carry out this work.

The department had governance leads who attended clinical governance, patient safety and mortality and morbidity meetings where information about complaints and incidents was shared. We saw minutes of these meetings and spoke with staff about them.

Information from committees such as complaints, learning from deaths and learning from incidents was regularly discussed with staff. The clinical governance lead produced a regular newsletter for staff to brief them about the latest complaints and incidents. The lead also arranged additional training for staff when this was identified as an outcome from complaints or incidents. We were given examples of when this had happened and 115 staff were provided with additional training about neurological observations after head injury.

There was a process in place to ensure all relevant NICE guidance, patient safety and drug alerts were assessed and implemented and that staff were aware of any changes. A member of clinical

staff took the lead however we saw other staff of different disciplines contributing to the knowledge resources such as patient pathways and care bundles.

The introduction of an online library of policies, procedures and guidelines meant that staff could access up to date information about care and treatment. There was detailed information about treatment pathways and medicines as well as links to the original guidance source.

There was a process in place for ensuring the results of radiology investigations were followed up to ensure any “missed abnormality” was followed up in a timely manner. Where abnormalities had been missed, staff involved were informed and offered additional support.

Management of risk, issues and performance

A departmental risk register was available and was under regular review to ensure that the content of the register was reflective of the real time risks within the department. These risks mostly correlated with the risks we observed during our time in the department.

The risk register was updated regularly and there were details about mitigating actions in place.

The staff we spoke with were clear about the risks the department faced.

When we spoke with the management team, they were able to clearly tell us about the risks posed to the department and how these were being addressed.

Managers discussed waiting time breaches regularly to identify any themes and were able to take actions to address issues, such as bed shortages across the hospital.

The department had a process in place to escalate the status of the department if it was under pressure. This was in the process of being aligned to a nationally recognised process called operational pressure escalation levels framework (OPEL). When the department was under pressure the OPEL level was increased, triggering extra support for the department from senior managers and departments from around the hospital.

Information management

The department collected information used to monitor and manage performance. There were robust measures in place to monitor and manage the performance of the department against local and national indicators. These were closely observed by the management team.

The department used a number of IT systems to collect and share information such as test and x-ray results, admission and discharge times and ambulance handover times as well as patient records. The department was almost 100% paper free. All clinical information other than ECGs and signed consent forms were saved on the electronic patient record system used in the department. This included medical and nursing records and patient observations.

Staff were able to access patient information using an electronic system. This included information such as previous clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. This meant that staff had information about the most up to date medications, health conditions and symptoms to enable them to make a better diagnosis and treatment plan. Ambulance staff could also share patient test results with the staff whilst en route to the department.

Some information such as test results and discharge letters were shared with GPs with the consent and agreement from patients.

Patients transferred to other services or sites took photocopies of their medical records with them.

There were a number of large monitors in clinical areas that showed the status of patients in beds and cubicles in the department. Although it displayed patient information this was an area the public could not access. Thus the privacy of patients in the department was protected.

The trust had information governance policies and procedures in place to ensure that information was stored securely and protected patients' privacy and security.

Staff were aware of their responsibilities in relation to data protection and making sure that information was accurate and managed securely. The department had introduced single sign on which meant that no matter which computer a person used, they would be taken to the record they last accessed. This saved time and encouraged staff to logoff when not at a computer terminal. Overall, data protection principles were followed however, we did witness one terminal with patient information left unattended on three occasions.

Information governance including data protection and confidentiality was monitored and any incidents reported appropriately.

During the inspection, we saw that TV screens were present to display waiting times in the waiting area. Patients could see the likely total waiting time in the department to see a nurse and also to see a doctor. The TV screens also displayed public health messages.

Engagement

Staff told us they had been involved in the design of the new department as well as when and how the department moved to its new premises. This showed that staff were valued and their opinions were important.

Staff told us that they were kept informed about opportunities to progress such as training and promotion opportunities at daily handovers, via emails and through huddles.

The department participated in the friends and family test and CQC surveys but had not carried out any local surveys in relation to the quality of urgent and emergency care services.

Staff from the department had taken part in trust wide engagement exercises such as online surveys. However, there had been no specific engagement work carried out with the department. It was unclear other than through observation within the department how managers gauged staff morale, job satisfaction or physical and mental health needs of staff.

Learning, continuous improvement and innovation

We asked the trust to tell us about any innovative work they were doing in the department, any learning and any continuous improvement. Staff told us about some specific learning that was carried out as a result of an incident in the department that led to 115 staff receiving training about neuro observations after a serious incident.

Staff had worked closely with the palliative care team to ensure that whenever possible patients were able to pass away in their preferred place of death. This included having easy access to equipment to ensure there were no delays in transferring patients home directly from the ED if that was what they wanted.

The trust had incorporated teaching about organ donation and how to approach the subject with patients and their family members in the immediate life support (ILS) training staff completed.

The department had carried out work to support relatives after patients had passed away. There were two adult and one child bereavement rooms. All of the rooms were tastefully decorated with sofas and comfortable chairs, a telephone and drinking facilities. One adult room had a viewing room so relatives could spend time with their loved one if they wished to. The children's room also had a separate adjoining viewing room. It had a glass window which changed from opaque to clear between the rooms so family members could view their loved one even if they couldn't enter the room. The trust also provided care bags to family members. These contained soft toys, forget-me-not flower seeds, and a clay hand and foot print kit staff could use to make imprints for families of children and babies.

Every Friday and Saturday night, the department had an IDVA (independent domestic violence advocate) present. They were contracted by the trust and able to support victims of abuse and signpost patients to further support available.

The department had three dedicated mental health rooms. These were low stimulation rooms that met the safety requirements for mental health rooms such as two exits, no ligature points and heavy furniture that could not be used as a weapon. The department had good access to the psychiatric liaison team which could be accessed 24 hours a day, seven days a week.

Patients living with dementia were well supported in the department and there was a dementia trolley that contained distraction tools such as games, books, playing cards and twiddle muffs. Patients were also given a special wrist band so they were easily identifiable. There was a dementia champion who oversaw a dementia friendly department.

There was a clinical pharmacist in the department who worked closely with clinical staff and had a limited clinical caseload overseen by a consultant, mainly of patients with health problems related to medicines such as drug overdose. They also worked on medicines patient pathways, prepared and mixed medicines and was responsible for medicines management in the department.

There were a number of pathways in place for patients to access wards quickly via ED. These included rapid access to ENT, gynaecology, urology and the local, linked urgent care centre. Additionally, there was an emergency ambulatory care assessment area staffed by the ED team where patients with an extensive specified list of conditions were treated.

The department had been nominated or won a number of local and national awards including team of the year for their work on the new department, best for training by ED registrars, student placement of the year 2017 and hospital team of the year within Sunderland and South Tyneside.

A registrar and consultant had developed a new technique for relocating dislocated shoulders without the need for sedation and lengthy recovery. This had improved recovery and healing time and reduced the number of patients needing to be admitted to hospital. The work was being recognised nationally.

Medical care (including older people's care)

Facts and data about this service

Sunderland Royal Hospital has 336 medical inpatient beds across 13 wards providing care and treatment for 16 specialties. There are four specialty units on site.

(Source: Routine Provider Information Request – Sites)

The division of medicine includes divisions of emergency care (including emergency department, cardiology and acute medicine).

- General internal medicine includes gastroenterology, metabolic medicine and thoracic medicine.
- Medical specialties include renal medicine, oncology, haematology and rheumatology.
- Rehabilitation and elderly medicine include care of the elderly, neurology, neurophysiology, neurorehabilitation and stroke services.

(Source: Routine Provider Information Request – Context Acute)

The trust had 28,382 medical admissions from October 2016 to September 2017. Emergency admissions accounted for 3,994 (14%), 2,089 (7%) were elective, and the remaining 22,299 (79%) were day case.

Admissions for the top three medical specialties were:

- Gastroenterology – 5,747
- Clinical oncology (previously radiotherapy) – 5,621
- Clinical haematology – 5,030

(Source: Hospital Episode Statistics)

Following a comprehensive inspection in 2014, the trust was required to complete the following actions:

- Ensure that there are sufficient qualified, skilled and experienced nursing and medical staff, particularly on medical wards. This is to include provision of staff out of hours, bank holidays and at weekends.
- Ensure that patient observation and monitoring charts for nutrition and hydration are fully and appropriately completed particularly on medical wards.
- Ensure that patient group directions (PGDs), which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation before treatment, are updated and monitored in line with the trust's policy.
- Review the available support by pharmacists and ensure that this meets the needs of wards and departments, including reconciliation of medication advice.
- Ensure that 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders are signed by the appropriate medical professionals, and that discussions with patients or family members are recorded.

- Ensure that patient's records are maintained and up to date including fluid balance and turning charts.
- Provide training on the grading of incidents and ensure that there are effective incident feedback mechanisms in place so that lessons can be learnt.

The trust was also requested to:

- Review the storage and provision of linen in ward areas so that staff are assured that it is clean before use.

During this inspection we visited wards B22 (cardiology), D46 (haematology), E52 (elderly care), E53 (endocrinology), E56 (elderly care), E58 (acute stroke unit), the coronary care unit, integrated admissions unit, medical assessment unit and the discharge lounge.

We spoke with 52 patients and relatives and 34 members of staff. We observed care and treatment and looked at 21 care records.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2017 to December 2017 for medical/dental and nursing staff in medicine is shown below:

Mandatory Training Completion by module – Medical and Dental Staff

Name of course	Number of eligible staff this year	Number of staff trained (YTD)	Completion Rate	Met (Yes/No)
Conflict Resolution - Dealing with Violence and Aggression	6	6	100%	Yes
Slips, Trips and Falls - Patient Falls	101	96	95%	Yes
Consent	20	18	90%	Yes
Resuscitation	79	71	90%	Yes
Blood Prescribing: Safe Transfusion Practice	61	54	89%	No
Blood Prescribing: Blood Components and Indications for Use	61	53	87%	No
Infection Control - Level 2	59	51	86%	No
Fire Safety	101	87	86%	No
Venous Thromboembolism|	20	17	85%	No
Equality, Diversity and Human Rights	101	85	84%	No

Information Governance	101	85	84%	No
Moving & Handling for People Handlers	61	49	80%	No
Infection Control - Level 1	101	75	74%	No
Fire Safety Classroom	101	66	65%	No
Grand Total	**973**	**813**	**84%**	

The 90% target was met for four of the 14 mandatory training modules shown above for medical staff. Fire safety classroom training module had the lowest completion rate with 65%.

At the time of inspection (end of March 2018) the trust provided information that showed training compliance had increased, e.g. Fire Safety Classroom (92%), Infection Control - Level 1 (84%).

Mandatory Training Completion by module – Nursing Staff

Name of course	**Number of eligible staff (YTD)**	**Number of staff trained (YTD)**	**Completion Rate**	**Met (Yes/No)**
Consent	1	1	100%	Yes
Slips, Trips and Falls - Patient Falls	264	260	98%	Yes
Conflict Resolution - Dealing with Violence and Aggression	170	161	95%	Yes
Baxter Colleague Infusion Pump	183	167	91%	Yes
Insights into Confusion / Health and Wellbeing	164	147	90%	Yes
Equality, Diversity and Human Rights	265	234	88%	No
Fire Safety Classroom	265	233	88%	No
Alaris GH Syringe Driver	178	155	87%	No
McKinley T34	130	113	87%	No
Fire Safety	265	228	86%	No
Information Governance	265	227	86%	No
Infection Control - Level 2	265	227	86%	No
Infection Control - Level 1	265	224	85%	No
Blood Administration Annual Refresher	210	168	80%	No
Resuscitation	265	203	77%	No
Moving & Handling for People Handlers	263	198	75%	No
Grand Total	**3418**	**2946**	**86%**	

The 90% target was met for five of the 16 mandatory training modules shown above for registered nursing staff. Moving and handling for people handlers training module had the lowest completion rate, showing as 75%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

At the time of inspection (end of March 2018) the trust provided information that showed training compliance had increased, e.g. Moving & Handling for People Handlers (79%), Resuscitation (83%).

A mental health inspector member of the team reviewed processes on the wards (E56 and B20) and the integrated assessment unit. The psychiatric liaison team (PLT) offered staff training to wards as requested, and had delivered attachment, self-harm, autism spectrum disorder, emerging personality disorder and mental health services in the local area.

The PLT also delivered training on the rolling preceptorship programme, nursing assistant course, and medical staff course including foundation year (F1, F2) and higher trainees. The consultant from PLT also taught on a perinatal course which had become part of mandatory training.

The PLT had rewritten the trust's mental health training to ensure if was reflective and up to date with current practice and legislation and had delivered challenging behaviour training to ward, stroke, diabetes and gastroenterology staff. The PLT also supported wards to debrief after incidents and undertake informal supervision with staff to explain decision making.

A consultant delivered mental health training sessions as part of staff induction, including Mental Health Act, Mental Capacity Act, Section 2 and Section 3, how to complete mental health documents, risk management, self- harm, suicide. The trust had designated December, 2017 and January, 2018 as mental health awareness months and staff used flyers to inform patients and staff of mental health services.

The delirium and dementia outreach team (DDOT) ran a course for staff called 'insights into confusion' which was mandatory for all elderly care staff and dementia awareness was also part of conflict resolution training.

Safeguarding

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to December 2017 for medical/dental and nursing staff in medicine is shown below:

Safeguarding Training Completion by module – Medical and Dental Staff

Name of course	Number of eligible staff (YTD)	Number of staff trained (YTD)	Completion Rate	Met (Yes / No)
Safeguarding Children (Version 2) - Level 3	1	1	100%	Yes
Safeguarding Children (Version 2) - Level 2	79	71	90%	Yes
Safeguarding Adults - Level 2	80	63	79%	No
Grand Total	**160**	**135**	**84%**	

The 90% target was met for two of the three safeguarding training modules for which medical staff in medicine were eligible. Safeguarding adults level two training had not met the completion rate (79%).

At the time of inspection (end of March 2018) the trust provided information that showed training compliance had increased, e.g. Safeguarding Adults - Level 2 (93%).

Safeguarding Training Completion by module – Nursing Staff

Name of course	Number of eligible staff (YTD)	Number of staff trained (YTD)	Completion Rate	Met (Yes / No)
Safeguarding Children (Version 2) - Level 3	7	7	100%	Yes
Safeguarding Children (Version 2) - Level 2	258	244	95%	Yes
Safeguarding Adults - Level 2	265	224	85%	No
Safeguarding Children Level 1	1	0	0%	No
Safeguarding Children Level 2	1	0	0%	No
Grand Total	**532**	**475**	**89%**	

The 90% target was met for two of the five safeguarding training modules for which registered nursing staff in medicine were eligible.

Both safeguarding children level one and level two had not met the completion target with 0%, although this is based on one eligible staff member for each training module.

Safeguarding adults level two also did not meet the target rate with 85% completion.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

At the time of inspection (end of March 2018) the trust provided information that showed training compliance had increased, e.g. Safeguarding Adults - Level 2 (95%), Safeguarding Children Level 1 (95%), and Safeguarding Children Level 2 (95%).

We reviewed training records and discussed the completion of mandatory and safeguarding training with managers and senior sisters on the wards. The completion of mandatory training was seen as a priority and local information showed that completion had increased by the end of March 2018.

The senior management team confirmed that the completion rate had improved for those modules not meeting the trust target by the end of December 2017.

Staff told us mandatory training was provided in different formats, including face-to-face classroom training and e-learning and was easy to access.

Cleanliness, infection control and hygiene

Wards and departments were visibly clean and ward cleanliness scores were displayed in all wards. All clinical equipment was clean and labelled which provided assurance of cleanliness.

Personal protective equipment (PPE) and hand sanitising gel was available throughout wards and departments. We saw that infection prevention and control information was visible on all wards and that staff wore PPE and complied appropriately with the principles of infection control.

Audits showed high rates of compliance (e.g. 100% hand hygiene compliance, 100% clostridium difficile toxin high impact intervention) and action plans were discussed and monitored through ward meetings. We saw staff washed their hands, used hand gel between patients and complied with ‘bare below the elbows’ policies.

At the previous inspection the trust was asked to review the storage and provision of linen in ward areas so that staff were assured that it was clean before use. We saw that linen was stored appropriately and the separation of clinical and non-clinical waste complied with trust policy.

Rooms were available on all wards for the isolation of patients with signage in place to advise anyone before entering an isolation room.

Environment and equipment

All equipment inspected had been electrical safety tested. The trust had systems in place for recording the service and maintenance of equipment identified through compliance stickers.

We saw that resuscitation trolleys were checked daily and they were accessibly located in ward areas. We inspected resuscitation equipment in wards and medical areas and confirmed daily checks had been undertaken.

Staff confirmed there was adequate equipment to meet the needs of patients, e.g. moving and handling equipment and equipment for bariatric patients.

Assessing and responding to patient risk

From January 2017 to December 2017, 80% of individuals did not move wards during their admission, and 20% moved once or more.

The trust stated that these moves were predominantly due to the requirement to manage medical patients outside of the division of medicine in other speciality areas due to lack of bed availability. This had been a major challenge over the winter period.

Patients had been managed on an acuity basis outside of the division and had not necessarily had several moves to their destination of discharge.

(Source: Trust Routine Provider Information Request – Ward moves)

The trust had procedures in place for the transfer of patients between wards and departments. This clarified the clinical accountability of the nursing, medical and support staff responsible for the patients' care to ensure the safe transfer of patients between wards and departments. Patients who had been moved at night said the reason had been discussed with them and the transfer was handled well.

We saw patient observations were recorded appropriately on the electronic system and concerns about deteriorating patients had been escalated in accordance with guidance and the national early warning score (NEWS) system. During our inspection we saw that deteriorating patients had evidence of appropriate escalation and intervention recorded.

Risks associated with falls, pressure ulcers, VTE, catheter and urinary infections were assessed on a monthly basis using the NHS safety thermometer.

We reviewed the initiation, treatment and ongoing management of patients requiring non-invasive ventilation. There was a standardised and documented 'Guidance for Non Invasive Ventilation' (October 2016) within the trust. We saw that the guidelines were followed.

The PLT provided a seven days a week service with two consultants to all ages of patients and all diagnoses. The PLT accessed trust and local mental health trust systems which were updated regularly and detailed a patient's history and risks at the point of admission. These were used to assess patient needs and develop care plans. Trust staff completed a risk assessment for self-

harm (RASH) on mental health patients which had been is started by a nurse during triage then completed in more detail by medical staff.

Nurse staffing

The service did not use an acuity tool to work out nurse staffing based on patient acuity or dependency.

Sunderland Royal Hospital reported their registered nursing staff numbers as below as of December 2017 for medicine, which showed a 90% staffing rate.

Ward/Site	WTE Planned Staff	Number in post as at December 2017
Sunderland Royal Hospital	424.5	381.3
Total	**424.5**	**381.3**

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Fill rates for registered nurses and non-registered care staff varied in the six months before inspection. However, they did not rise above 77% for registered nurses during the day and 81% at night. These shortfalls in registered nurse staffing had been met by an increase in non-registered care staff (113% during the day and 103% at night).

The acute stroke unit had significant challenges meeting safe staffing levels from January 2017 to the date of inspection, with fill rates of 63% to 77% over that period. This meant when nurse to patient ratios were compromised, there were associated risks to patient safety, recovery from stroke, and the hospital length of stay.

We raised with senior managers the impact of this on patients who needed hyper acute stroke care and thrombolysis and we did not receive assurance that the required nurse to patient ratio of 1:2 was met for these patients. This meant the service was not meeting national clinical guidelines (2016) for hyper acute and acute stroke units.

Vacancy rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a vacancy rate of 8% in medicine. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a turnover rate of 12% in medicine. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

At the time of inspection (end of March 2018) the trust provided information that showed an improved turnover rate of 3.4%.

Sickness rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a sickness rate of 4% in medicine, which was the same as the trust target.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

Medicine had 9,696 shifts filled by bank and agency staff, which was the highest core service uptake within the trust. No agency staff were used apart from registered mental health nurse (RMN) care for some individual patients with mental health needs.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Sunderland Royal Hospital reported their medical staffing numbers below for the period from April 2017 to December 2017 for medicine, which showed an 87% staffing rate.

Ward/Site	WTE Planned Staff	Number in post as at December 2017
Sunderland Royal Hospital	142.0	124.1
Total	**142.0**	**124.1**

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a vacancy rate of 13% in medicine. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a turnover rate of 32% in medicine. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

At the time of inspection (end of March 2018) the trust provided information that showed an improved turnover rate of 4.5%.

Sickness rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a sickness rate of 0.5% in medicine, compared to the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

Medicine had 3,924 shifts filled by bank and locum staff, which was the highest core service uptake within the trust.

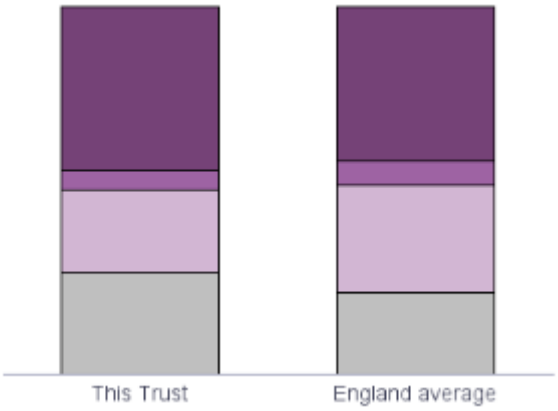
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

At the time of inspection the trust provided information that showed a decrease to 1131 shifts filled by bank and locum staff in the last six months (end of March 2018).

Staffing skill mix

In October 2017, the proportion of consultant staff working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 152 whole time equivalent staff working in medicine at City Hospitals Sunderland NHS Foundation Trust



	This Trust	England average
Consultant	44%	42%
Middle career^	5%	6%
Registrar group~	23%	29%
Junior*	27%	22%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce statistics - October 2017)

Ward managers and senior staff told us there were vacancies for registered nursing staff across medical wards. The trust had actively recruited nursing and healthcare staff and a number of new starters were ready to commence employment in the weeks following inspection.

Information on planned versus actual staffing numbers was displayed at the entrance to all ward areas and reported to the senior management team and trust board. Additional staffing was identified when one-to-one care was needed. Shortfalls in staffing were covered by substantive staff working additional hours and through bank staff.

However, we were told that staffing levels were reviewed three times each day and staff were moved from wards with higher levels of staffing to cover those working at less than safe levels. This was designed to ensure patient safety but had caused concern over the lack of continuity of care from staff moved at short notice to unfamiliar wards. Ward managers told us that staff moves were not based on a specific patient acuity tool and this led to inconsistency for staff and lack of continuity of care for patients.

Patients raised concerns over staffing numbers with us, but did not raise safety or care issues.

Staffing levels for patients requiring non-invasive ventilation (NIV) complied with trust guidance (October 2016). We reviewed staffing rotas for the care and treatment of patients requiring NIV. The trust met the British Thoracic Society guidelines that patients being initiated on NIV treatment should be identified as requiring Level 2 care and had increased nurse staffing levels that equated to 1:2 nurse to patient ratio for the first 24 hours.

The senior management team had developed strategies to recruit and improve the retention of staff. Managers and staff outlined the division's approach to supporting staff development and succession planning. Matrons and ward managers were dedicated to protecting time for staff development and training as far as possible and felt this was supported by the trust.

Records

The trust had introduced an electronic patient record supported by paper records for each patient as well as integrated patient assessment and bed management systems.

We reviewed 21 sets of nursing and medical records across the medical wards and checked care plans and risk assessments in detail. These were completed accurately and updated regularly and included nutrition, fluid balance, turning charts and hydration charts and DNACPR forms.

Ward managers and staff confirmed that the quality of record keeping was emphasised within the trust and matrons and ward managers carried out weekly documentation audits on records in all wards, these showed a variance in compliance and were used to identify learning and improvement. We saw that records were consistent, fully completed and learning needs were addressed with relevant staff. Common issues were shared with all staff at ward meetings.

The mental health needs of patients were clearly documented and showed involvement from the PLT and DDOT. Records included a mental state examination and attendance by the PLT consultant and one patient had an alcohol withdrawal tool completed every 6-8 hours.

The ‘standards of care’ document completed regularly by nursing staff included sections for mental health, personal safety, communication needs and privacy and dignity. Records showed consideration of capacity, whether the patient lacked insight into their health, an assessment of cognitive impairment and a Deprivation of Liberty Safeguards (DoLS) application where appropriate.

On one ward there was patient detained under the mental health act and staff had a copy of their leave papers from the mental health trust. Staff had also completed a tool they had designed that was called ‘identifying patients with a risk of absconding’ and detailed a description of the patient including clothing, height, hair colour and the reason for admission.

Medicines

We found inconsistent practice across wards regarding the management of medicines.

Arrangements for monitoring medicines which required refrigeration were in place. However, temperatures were not recorded on some wards and we found the maximum recorded temperature was outside the recommended range. We brought this to the attention of staff who acted upon our findings.

Procedures for the management of controlled drugs were in place; although checks had been completed, staff had not always recorded these in the same place making it difficult to ensure a weekly check had taken place.

We looked at the arrangements for the review, administration and supply of medicines. The trust used an integrated medicines management system. Medicines reconciliation was completed at the point of admission. The trust provided figures which showed that the trust completed 87% medicines reconciliation within 24 hours of admission. A pharmacy led discharge system was in place which ensured medicines were correctly prescribed, dispensed and counselling was completed.

A process was in place to ensure that patient group directions (PGDs) were effectively managed and staff were competency assessed and had access to copies if required. PGDs were updated and monitored in line with the trust’s policy. (Patient group directions allow some non-medical prescribers, to give specified medicines, such as painkillers, to a predefined group of patients).

Pharmacy cover was available on wards between Monday and Friday, with an on call system at weekends.

Incidents

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2017 to December 2017, the trust reported one incident classified as a never event for medicine which was a medication incident (January 2017).

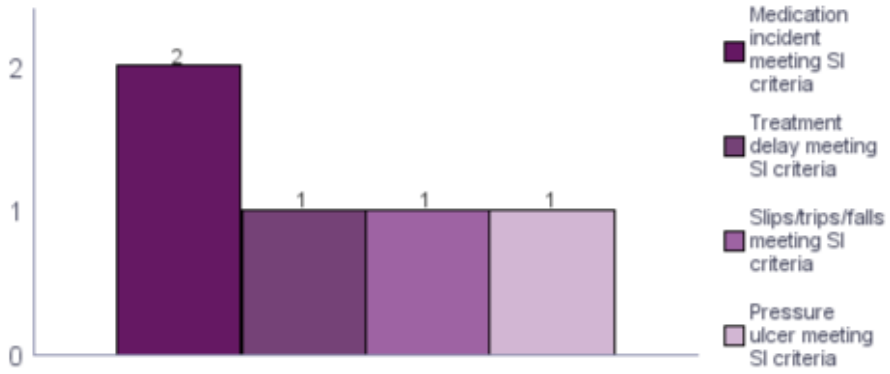
(Source: NHS Improvement - STEIS (January 2017 – December 2017))

We reviewed the root cause analysis for this incident and saw that a pre-investigation risk assessment had been carried out, background, context and relevant policies and guidance identified, chronology and detection of the incident outlined. The investigation examined care and service delivery, equipment and individual responsibilities and training.

This resulted in an identification of root causes, lessons learned and recommendations. Arrangements for shared learning (matron and ward manager forums, trust-wide lessons learned seminar) and the debrief of staff directly involved in the incident as well as feedback to the patient were identified.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from January 2017 to December 2017.



Of these, the most common types of incident reported were:

- Medication incident meeting SI criteria (40% of total incidents).
- Treatment delay meeting SI criteria (20% of total incidents).
- Slips/trips/falls meeting SI criteria (20% of total incidents).
- Pressure ulcer meeting SI criteria (20% of total incidents).

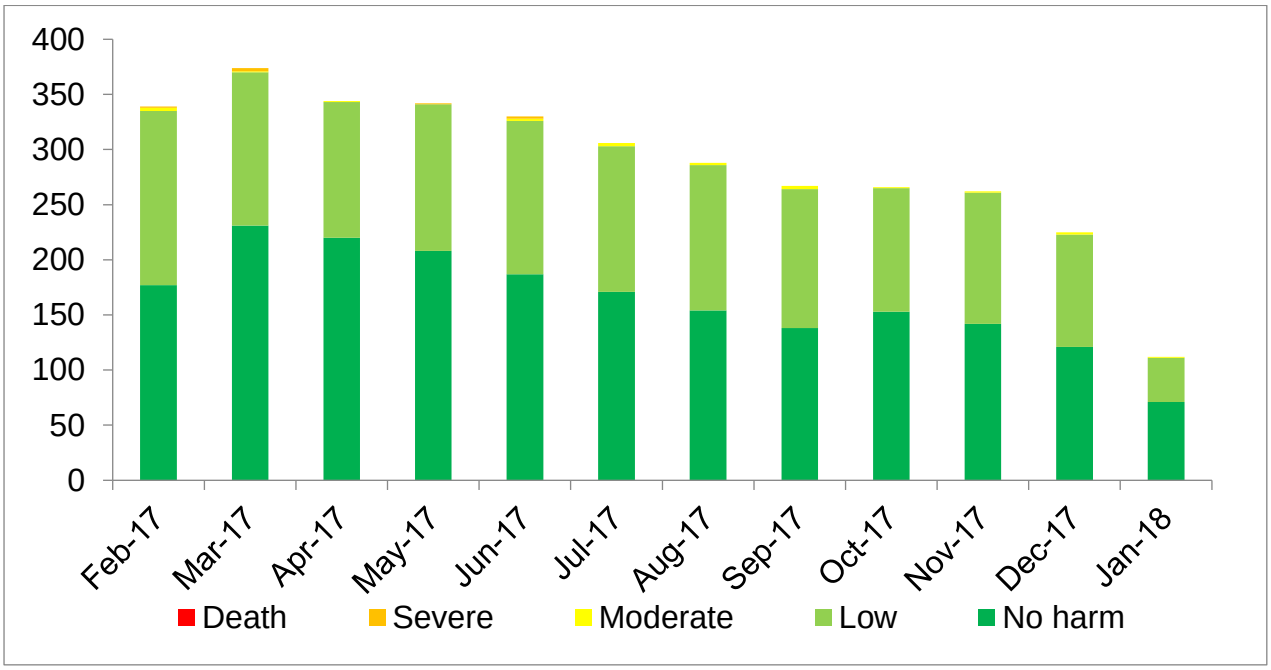
(Source: Strategic Executive Information System (STEIS))

All staff were aware of how to report incidents and gave examples of the types of things they would report including staffing shortages, senior staff on the wards felt there was a robust reporting culture.

Each ward manager we spoke with was aware of all incidents on their ward and told us information on incidents was shared in a variety of ways including team meetings, briefing sheets and handovers.

Staff were able to identify learning and changes in practice and we were given an example of lessons learnt from the use of an incorrect form leading to a prescribing error on the ward. The incident has been fully investigated and although there was no evidence of patient harm, an instruction had been sent to all staff not to use incorrect documentation or make up their own prescribing forms.

Although medical care had the highest number of incidents of any core service (3,455 or 34.8%), there had been a downward trend in the number of incidents reported each month.



No incidents resulted in death and seven incidents resulted in severe harm, none since June 2017. There was a downward trend in the proportion of incidents resulting in moderate harm and the majority of incidents (1,973 or 57.1%) resulted in no harm (potential harm that was prevented).

The most commonly reported incident category was patient accident (1,013 or 29.4%), these included no deaths and one severe harm. The next most commonly reported category was ‘implementation of care and ongoing monitoring/review’ (846 or 24.6%), these included no deaths and two severe harms.

The division reported 94% of incidents to the National Recording and Learning System (NRLS) within 30 days of occurrence and 6% were reported over 31 days. This was better than the proportion (93%) reported at trust level within 30 days and those reported (7%) over 31 days.

From November 2017 no incidents took more than 60 days to report and from December 2017 all incidents were reported within 30 days.

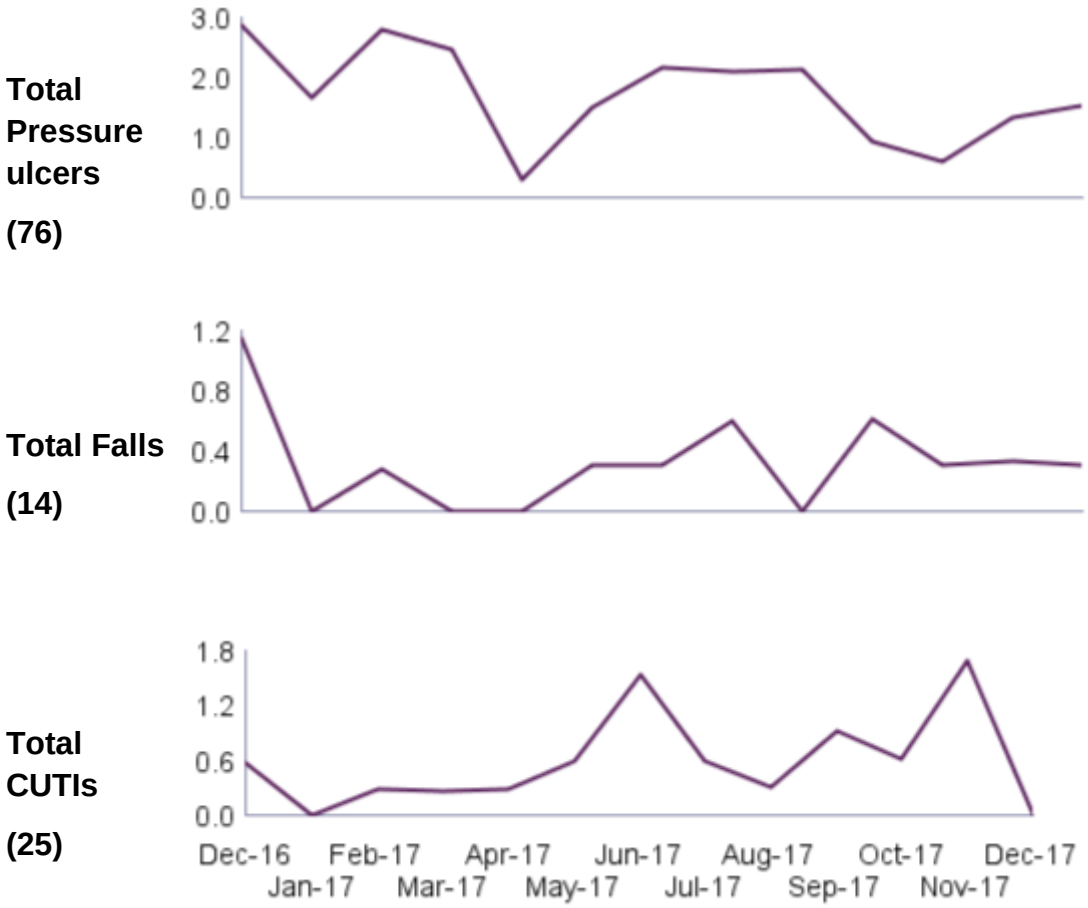
Safety thermometer

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed the trust reported 76 new pressure ulcers, 14 falls with harm, and 25 new catheter urinary tract infections from December 2016 to December 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at City Hospitals Sunderland NHS Foundation Trust



(Source: Safety thermometer - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

All policies and care pathways were based on NICE and Royal College of Physicians guidelines and were available to staff and accessible on the trust intranet site.

The medical division had care pathways for stroke, DVT, cellulitis, rapid access chest pain and sepsis in place. We reviewed policies and found them to be in date with version control and a named author.

The trust policy for non-invasive ventilation was compliant with British Thoracic Society guidance.

Audits were undertaken to monitor compliance with guidance, such as those which related to infection prevention and control. Ward managers completed trust-wide nursing audit programmes and we saw results and action plans in ward files. Medical staff undertook clinical audits and these were discussed at clinical governance meetings.

Ward managers completed a number of audits on patient experience and outcomes, these audits were completed internally and were completed by observation or review of documents. These audits included medicines administration, environment and hand hygiene.

Nutrition and hydration

We reviewed electronic and paper care plan documentation and risk assessments of 21 patients on wards at the hospital. These were fully completed and fluid, food and rounding charts were completed appropriately.

The electronic patient record enabled staff to identify patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Protected meal times were in place and we saw patients supported to eat and drink. Drinks were readily available and were in easy reach of patients.

We spoke with 52 patients and most said the food was good, menus were varied and they could ask for food at all times. The quality and quantity of food was monitored through patient led assessments of the care environment (PLACE) which show an overall satisfaction with food provided.

Pain relief

We reviewed care plans for pain management and saw pain assessments were carried out and recorded. Pain relief was provided as prescribed and there were systems in place to ensure additional pain relief could be accessed through medical staff.

Patients had no concerns about how their pain was controlled and staff checked that pain relief administered had been effective. We were assured about the assessment of pain for those patients who were unable to communicate they were in pain.

Staff used a pain-scoring tool to assess patient's pain levels and recorded the assessment within paper and electronic records.

Patient outcomes

Relative risk of readmission

From September 2016 to August 2017, patients at Sunderland Royal Hospital had a similar to expected risk of readmission for both elective admissions and non-elective admissions when compared to the England average.

Elective admissions

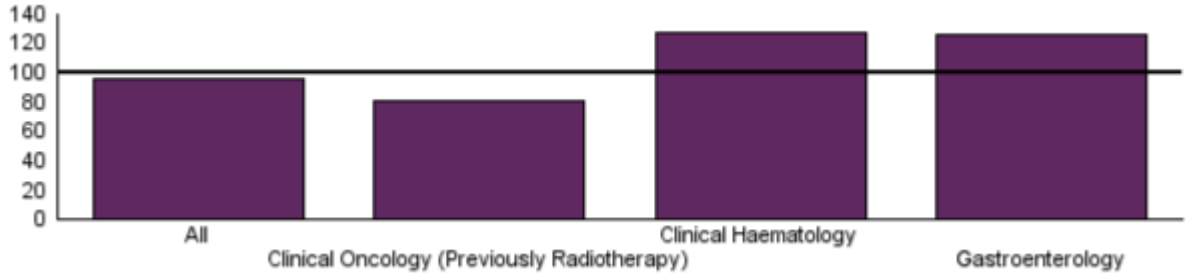
- Patients in clinical oncology (previously radiotherapy) had a lower than expected risk of readmission for elective admissions
- Patients in clinical haematology had a higher than expected risk of readmission for elective admissions

- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions

Non-Elective admissions

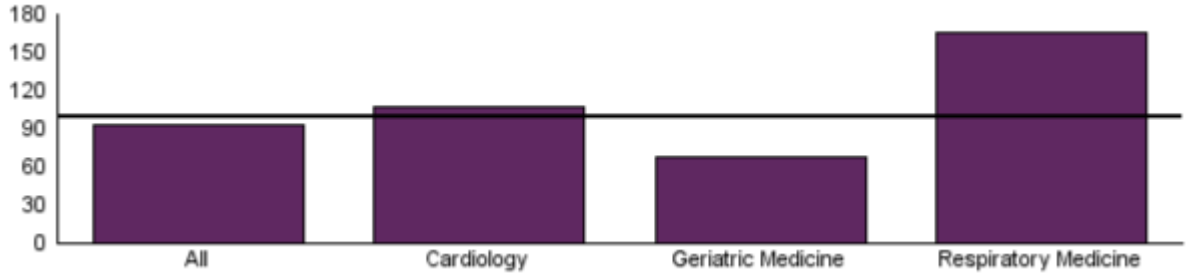
- Patients in cardiology had a similar to expected risk of readmission for non-elective admissions
- Patients in geriatric medicine had a lower than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

Elective Admissions - Sunderland Royal Hospital



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

Non-Elective Admissions - Sunderland Royal Hospital



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: HES - Readmissions (September 2016 – August 2017))

Sentinel Stroke National Audit Programme (SSNAP)

City Hospitals Sunderland NHS Foundation Trust took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, Sunderland Royal Hospital achieved grade C in the latest audit, August 2017 to November 2017, which was better than the previous audit, April 2017 to July 2017 up one score from the previous quarter.

Sunderland Royal Hospital

Overall Scores	Aug - Nov 16	Dec 16 - Mar 17	Apr - Jul 17	Aug - Nov 17
SSNAP level	D↑	D	D	D
Case ascertainment band	A↑↑↑	A	A	A
Audit compliance band	B	A↑	A	B↓
Combined Total Key Indicator level	D	D	D	C↑

Best A B C D E Worst N/A No assessment

- The audit compliance band was the only area that declined in performance, from grade A to grade B in the latest audit.
- There was an improvement in performance from grade D to grade C in the latest audit for combined total key indicator level.

Patient Centred Performance	Aug-Nov 16	Dec 16 - Mar 17	Apr - Jul 17	Aug - Nov 17
Domain 1: Scanning	B	B	B	B
Domain 2: Stroke unit	C	C	C	C
Domain 3: Thrombolysis	C↑	D↓	D	D
Domain 4: Specialist assessments	B	B	B	B
Domain 5: Occupational therapy	E	C↑↑	E↓↓	C↑↑
Domain 6: Physiotherapy	D	D	E↓	D↑
Domain 7: Speech and language therapy	E	E	E	E
Domain 8: Multi-disciplinary team working	D	C↑	B↑	B
Domain 9: Standards by discharge	D	C↑	C	C
Domain 10: Discharge processes	A↑↑↑	A	C↓↓	A↑↑
Patient-centred Total Key Indicator Level	D	C↑	D↓	C↑

Best A B C D E Worst N/A No assessment

Team Centred Performance	Aug-Nov 16	Dec 16 - Mar 17	Apr 17 -Jul 17	Aug 17 - Nov 17
Domain 1: Scanning	B	B	B	B
Domain 2: Stroke unit	C	C	C	C
Domain 3: Thrombolysis	C↑	D↓	D	D
Domain 4: Specialist assessments	B	C↓	B↑	B↑
Domain 5: Occupational therapy	E	C↑↑	E↓↓	C↑↑
Domain 6: Physiotherapy	D	D	E↓	D↑
Domain 7: Speech and language therapy	E	E	E	E
Domain 8: Multi-disciplinary team working	C↑	C	B↑	B

Domain 9: Standards by discharge	D	C↑	C	C
Domain 10: Discharge processes	A↑↑↑	A	C↓↓	A↑↑
Team-centred Total Key Indicator Level	D	D	D	C↑

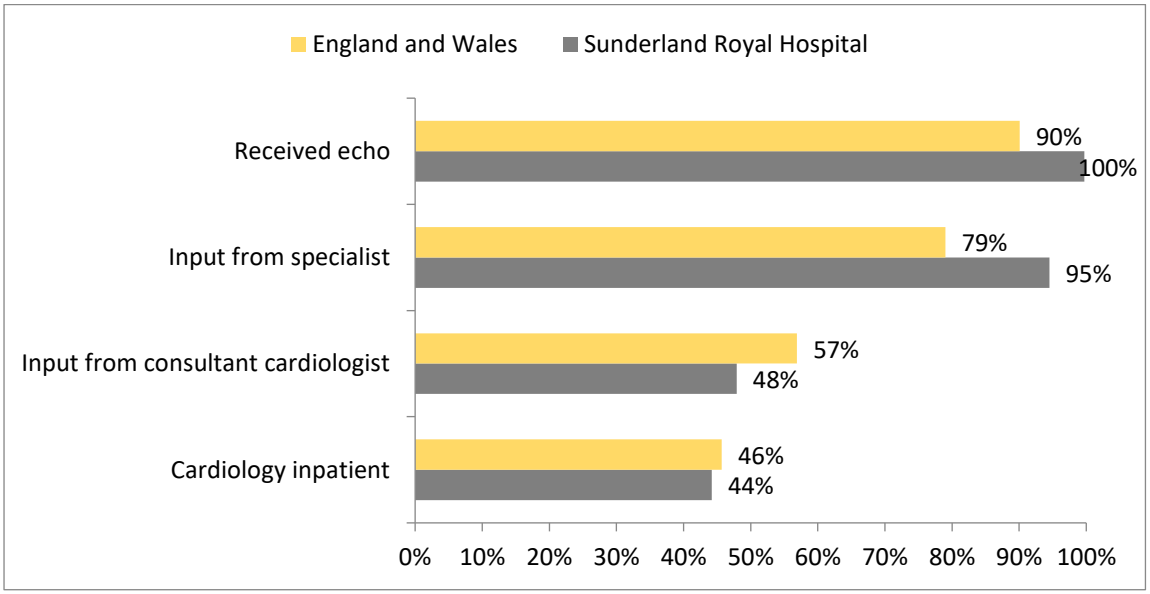
- Domain 5: Occupational therapy saw an improvement in performance from grade E to grade C in the latest audit for both patient and team centred performance.
- Domain 6: Physiotherapy saw an improvement in performance from grade E to grade D in the latest audit for both patient and team centred performance.
- Domain 10: Discharge processes saw an improvement from grade C to grade A in the latest audit for both patient and team centred performance.
- Total key indicator level saw an improvement from grade D to grade C in the latest audit for both patient and team centred performance.

(Source: Royal College of Physicians London, SSNAP audit)

Heart Failure Audit

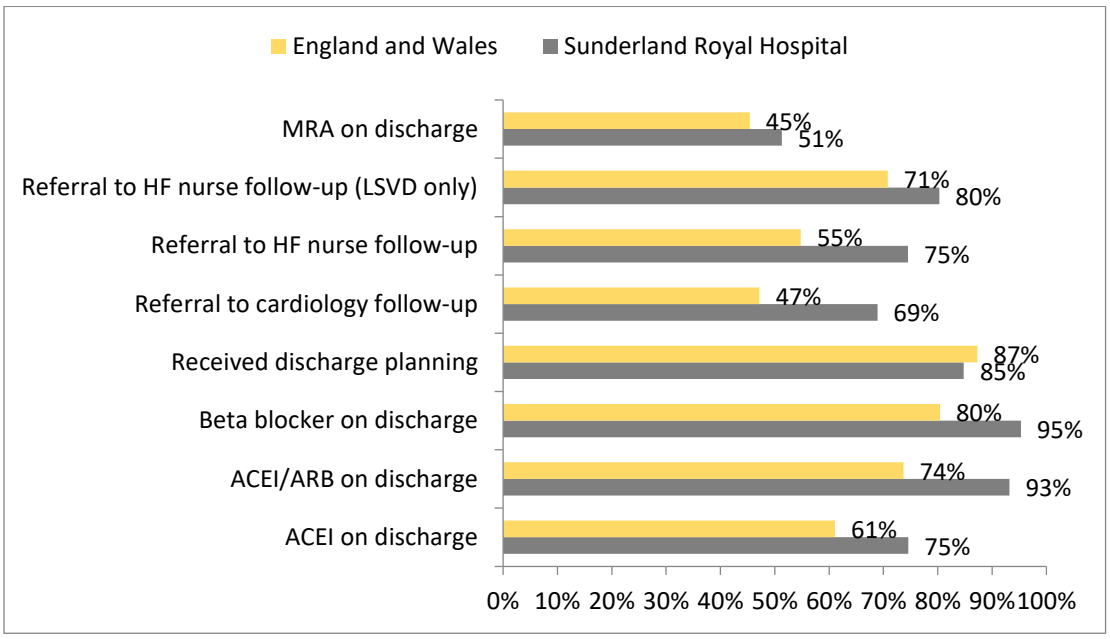
In-hospital Care Scores

Results for Sunderland Royal Hospital in the 2016 Heart Failure Audit were better than the England and Wales average for two of the four of the standards relating to in-hospital care. The cardiology inpatient rate was similar to the England and Wales average and input from a consultant cardiologist was lower than the England and Wales average.



Discharge Scores

Sunderland Royal Hospital results were better than the England and Wales average for eight of the nine standards relating to discharge. 'Received discharge planning' was slightly lower than the England and Wales average.



(Source: Heart Failure Audit 2016)

National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric (measure) which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2017 National Diabetes Inpatient Audit identified 113 in-patients with diabetes at Sunderland Royal Hospital. Of these 91% reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which placed this site in quartile 4, an improvement on the 2016 audit.

In Sunderland Royal Hospital in 2017, 31% of patients with diabetes experienced one or more medication error(s), which placed this site in quartile 3, compared to quartile 1 in the 2016 audit.

Of those patients with diabetes 20% experienced at least one prescription error, which placed this site in quartile 3, compared to quartile 1 in the 2016 audit.

(Source: National Diabetes Inpatient Audit 2017)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to by trust).

From April 2015 to March 2016, 92% of nSTEMI patients were admitted to a cardiac unit or ward at Sunderland Royal Hospital and 99% were seen by a cardiologist or member of the team compared to an England average of 56% and 96% respectively. (nSTEMI stands for Non-ST-elevation myocardial infarction. Sometimes an NSTEMI is known as a non-STEMI. A myocardial

infarction is the medical term for a heart attack. ST refers to the ST segment, which is part of the ECG heart tracing used to diagnose a heart attack)

The proportion of nSTEMI patients who were referred for or had angiography at Sunderland Royal Hospital was 94% compared to an England average of 84%.

2015/16	**nSTEMI patients seen by a cardiologist or a member of team**	**nSTEMI patients admitted to cardiac unit or ward**	**nSTEMI patients that were referred for or had angiography (incl. after discharge)**
Sunderland Royal Hospital	245	245	234 (234)
	99.2%	92.2%	94.0% (No data)
England: overall	47,039	47,039	39,082 (38099)
	96.2%	55.8%	83.6% (No data)

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a cancer nurse specialist was 83%, which was worse than the audit minimum standard of 90%. The 2016 figure was 77%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) who had received surgery was 15%. This was about the same as the national level.

The proportion of fit patients with advanced NSCLC who had received chemotherapy was 59%. This was about the same as the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) who had received chemotherapy was 90%. This was better than the national level and shows good practice.

The one year relative survival rate for the trust in 2017 was 39%. This was about the same as the national level.

(Source: National Lung Cancer Audit 2017)

National Audit of Inpatient Falls

The trust had a multi-disciplinary working group for falls prevention where data on falls was discussed at most or all meetings.

The trust participated in the 2017 National Audit of Inpatient Falls. The crude proportion of patients who had a vision assessment (if applicable) was 43%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 56%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 79%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 84%. This did not meet the national aspirational standard of 100%.

(Source: National Audit of Inpatient Falls 2017)

Information provided showed the trust had been consistently below (0.06-0.12 falls per 1000 bed days) the national average (0.19) for patients suffering harm from a fall in hospital.

The falls reduction group evaluated falls prevention strategies to maintain and further improve performance. The group monitored ward dashboard data and safety thermometer results and audited practice to assess compliance with the 'falls bundle'.

Competent staff

Appraisal rates

As at January 2018, 50% of staff within medicine at Sunderland Royal Hospital had received an appraisal. Registered nursing and midwifery staff had a 48% appraisal completion rate.

The trust did not provide a target completion rate.

A split by staff group can be seen in the graph below:

Staff Group	Individuals required (YTD)	Staff who have received an appraisal (YTD)	Completion Rate
Qualified Allied Health Professionals	1	1	100%
NHS Infrastructure Support Staff	104	66	63%
Qualified Healthcare Scientists	2	1	50%
Qualified Nursing Midwifery Staff	303	145	48%
Support to Doctors and Nursing Staff	256	118	46%
Grand Total	**666**	**331**	**50%**

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

At the time of inspection (end of March 2018) the trust provided updated information that showed an increase in the overall percentage of registered nursing staff who had received an appraisal of 79% and healthcare assistants of 83%.

At the time of inspection the trust provided information ((Medical appraisal annual report 2016/2017 (May 2017)) presented to the medical revalidation sub group that showed 100% of trust doctors required to complete an appraisal in the 2016/17 appraisal year did so.

Multidisciplinary working

Nursing and medical staff reported good multidisciplinary working and all medical wards participated in multidisciplinary board rounds. This led to a co-ordinated approach to treatment plans and decisions.

Specialist nurses were available to review patients in respiratory, diabetes, physiotherapy, speech and language, pharmacy, child and adolescent and adult mental health liaison. Specialist teams such as speech and language therapy (SALT) and stroke were also available to support staff with training and to participate in multidisciplinary meetings to discuss patient care and treatment.

Staff on the elderly care wards confirmed that there were good links with the mental health team who attended handovers and visited wards on a daily basis. The team provided the ward with advice and support as well as giving direct intervention to patients.

Other health professionals such as physiotherapists and dieticians confirmed there was good multidisciplinary working and they also offered training, such as the management of dysphagia to nursing staff where appropriate.

There was a strong multidisciplinary approach to assessment and facilitated fast-track discharge through working closely with discharge co-ordinators, the discharge lounge and the local authority discharge hub.

Seven-day services

The trust monitored its working scheme against NHS Services, Seven Days a Week Clinical Standards. There was 24 hour access to consultant led interventions such as cardiac pacing, critical care and thrombolysis for stroke. Consultants provided seven-day cover for medical wards and assessment units. All patients were seen on a daily basis by either an acute care physician or the physician of the day.

On-call consultants covered weekends and nights. Other medical out-of-hours cover was provided by one registrar, two foundation year two doctors and two foundation year one doctors.

There was availability of physiotherapy and occupational therapy staff Monday to Friday and physiotherapists covered weekends on a rota system to deliver interventions to identified patients on a basis of need.

Health promotion

Patients said staff gave them advice on smoking cessation, healthy eating, weight loss, wound care and infection prevention on all wards.

Patient leaflets were available throughout the hospital, prominently displayed on communication boards within wards and corridors and available for patients to take with them.

We did not see patient information leaflets in languages other than English but were assured they were available on request.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training were delivered as modules within safeguarding training (please see the safeguarding section for further detail).

At the time of inspection (end of March 2018) the trust provided information that showed training compliance for medical staff had increased, e.g. Safeguarding Adults - Level 2 (93%)

Also, at the time of inspection the trust provided information that showed training compliance for nursing staff had increased, e.g. Safeguarding Adults - Level 2 (95%), Safeguarding Children Level 1 (95%) and Safeguarding Children Level 2 (95%) as at the end of March 2018.

Staff liaised with the PLT to access mental health records and shared mental and physical health records to avoid unnecessary admissions. The PLT met with the DDOT (DDOT) daily and

reviewed new admissions and identified if the patient was already under the care of a mental health trust.

The PLT copied their entries and added them to the trust system, however, this wasn't the case in five records we reviewed where the discharge letter indicated the PLT had assessed a patient but the assessment wasn't on the trust system. Although staff spoke clearly about encouraging patients to remain, they were very clear on their responsibilities if the patient was not under detention.

Staff had access to an alcohol liaison nurse for patients who had a diagnosis of alcoholic liver disease and also made referrals to community substance misuse services for patients with substance misuse needs.

Staff showed a good understanding of mental capacity and referred to it as being decision and time specific. Staff had a good understanding of DoLS and used both the emergency and standard authorisation appropriately.

The DDOT had developed an 'all about me' document for dementia patients and staff had access to care plan documents on the electronic system.

The PLT contacted the wards daily to determine if any patient required a mental health assessment once they had reached a period of stability. Mental health patients were monitored in bed bays as side rooms gave limited observation.

Cohort nursing was used to manage patients who required additional levels of observation due to their mental health or risk of falls. These patients were placed in one bay where possible to ensure staffing was sufficient for enhanced observations. Ward B20 piloted an observation policy in 2017 that used a tool to determine patient risk and identified those who required increased levels of observation due to risk.

Wards identified for the care of mental health patients had been risk assessed and used convex mirrors in the ward, anti-ligature curtain rails and CCTV in the corridor. There was a designated interview room for mental health patients on B20 near the nurse's station and the door opened both ways to enable staff access. Although staff managed patients who were aggressive using distraction therapy and rarely used security staff, the ward was supported by security if the need arose. All staff had received breakaway training and were undergoing conflict resolution training.

We saw key pad locks had been installed on staff only areas when necessary and ligature points in bays, such as coat hooks and medical equipment that could be a potential ligature risk had been removed.

The trust undertook environmental audits using the Kings Fund Dementia Audit Tool and further funding had been identified to ensure ward E56 met all criteria. The ward also had a rotation system for HCAs with the DDOT to ensure they maintained their skills on the ward and shared learning.

Is the service caring?

Compassionate care

Friends and Family test performance

From December 2016 to November 2017, the friends and family test response rate for medicine at Sunderland Royal Hospital was 20% which was worse than the England average of 25%. Ward

DGF61 (neurology) had the highest response rate with 54% and ward DGB22/CPAU (cardiology) had the lowest response rate with 9%.

Friends and family Test – Response rate from December 2016 to November 2017 by ward

Ward name	Total Resp	Resp. Rate	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Ann. Perf.
DGF61	106	54%	92%	100%	100%	100%	93%	86%	83%	91%			100%	89%	93%
DGE52	296	45%	83%	91%	100%	96%	100%	100%	96%	100%	100%	93%	94%	95%	96%
DGE58	299	32%	97%	94%	100%	97%	100%	100%	100%	96%	100%	97%	93%	96%	98%
DGE53	355	32%	97%	100%	100%	97%	95%	95%	91%	97%	100%	96%	100%	95%	97%
DGE50	176	28%	86%	100%	83%	100%	100%	89%	95%	96%	85%	100%	100%	100%	95%
DGB26	340	25%	95%	95%	97%	100%	88%	96%	100%	100%	94%	93%	94%	94%	96%
DGB20	757	24%	100%	94%	100%	97%	93%	98%	100%	95%	96%	96%	98%	94%	97%
DGE51	150	22%	100%	100%		91%	100%	100%	100%		100%	87%	100%	100%	96%
DGE56	129	20%	88%	80%	100%	100%	88%	100%	100%	100%		97%	100%	100%	96%
DGE54	280	20%	93%	100%	96%	95%	91%	94%	94%	95%	87%		96%	100%	95%
DGB21	114	16%	100%		100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	99%
DGB28	198	16%	100%	100%	95%	100%	100%	100%	100%	100%	97%	100%	100%	100%	99%
DGB22/CPAU	318	9%	96%	100%		100%	99%	100%	100%	100%	95%	100%	100%	100%	99%

Highest score to Lowest score

Key	100%	50%	0%

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by response rate

(Source: NHS England Friends and Family Test)

We discussed the lower than England average response rate with staff and ward managers. There was no single explanation for the low rate and staff were unable to identify strategies for increasing the rate.

Staff were caring and compassionate and interacted with patients in a friendly way. This was confirmed through feedback from patients and relatives who valued that they and their relatives had been treated with dignity and respect.

We spoke with 52 patients and relatives throughout the inspection. All patients and relatives were positive about the care and treatment received and that staff were polite and respectful.

We saw staff responded promptly to call bells, requests for assistance and had enough time for patients and they introduced themselves. All patients seen looked clean and well cared for and able to move around, with staff assistance where necessary. Staff made sure they closed curtains and doors to maintain patient privacy and dignity. Discussions between staff and patients were carried out in a compassionate and supportive way, staff provided reassurance and provided information appropriate for the patient.

Patients with mental health needs told us staff had been kind, caring and respectful. They raised no concerns about the staff or processes on the wards. One staff member from the mental health trust who was with a detained patient said the staff had treated the patient well and she had no concerns.

We observed positive interaction with patients through staff giving patients a ‘pamper session’ and doing nails and hair.

Emotional support

We saw staff provide emotional support to patients through explaining their care and treatment in a calm and considerate manner. They clearly explained the individual care plan, answered any questions and reassured the patient. Staff were supported by a range of clinical nurse specialists at the trust and patients and staff spoke positively about their input. For example, diabetes and respiratory nurse specialists provided a high level of emotional support and practical advice.

Staff on medical wards and units spoke positively about links with the DDOT, mental health services and liaison staff who visited regularly to see patients with mental health needs and gave advice to staff on issues such as managing challenging behaviour.

Staff knew of active support groups for patients that could provide emotional support as well as practical advice.

The hospital had a multi-faith chaplaincy service and a bereavement service which staff could access to support patients or carers who needed.

Understanding and involvement of patients and those close to them

From reviewing patient notes and observation of interactions staff had with patients, we were assured staff had tried to understand patient needs and those close to them. We saw how staff attended to a patient who was shouting out, gave reassurance and spent time with the patient to calm them down.

Patients told us that they knew what was happening with their care and what their treatment plans were. Almost all patients said they had been kept informed and what was being done in a way they could understand so that they felt involved in their care.

All wards involved relatives in the care of patients where possible and with the permission of the patient. Although there were set visiting times, all wards were flexible and provided information regarding current care and treatment. Wards told us they were planning to pilot ‘open visiting’ times.

Is the service responsive?

Service delivery to meet the needs of local people

Average length of stay

From October 2016 to September 2017 the average length of stay for medical elective patients at Sunderland Royal Hospital was 3.4 days, which was lower than the England average of 4.2 days. For medical non-elective patients, the average length of stay was 7.7 days, which was higher than the England average of 6.6 days.

Average length of stay for elective specialties:

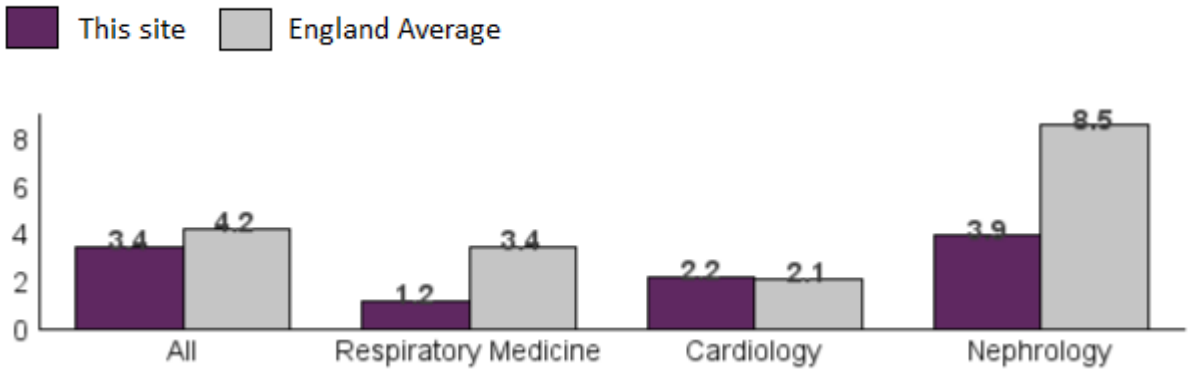
- Average length of stay for elective patients in respiratory medicine was lower than the England average.
- Average length of stay for elective patients in cardiology was similar to the England average.

- Average length of stay for elective patients in nephrology was lower than the England average.

Average length of stay for non-elective specialties:

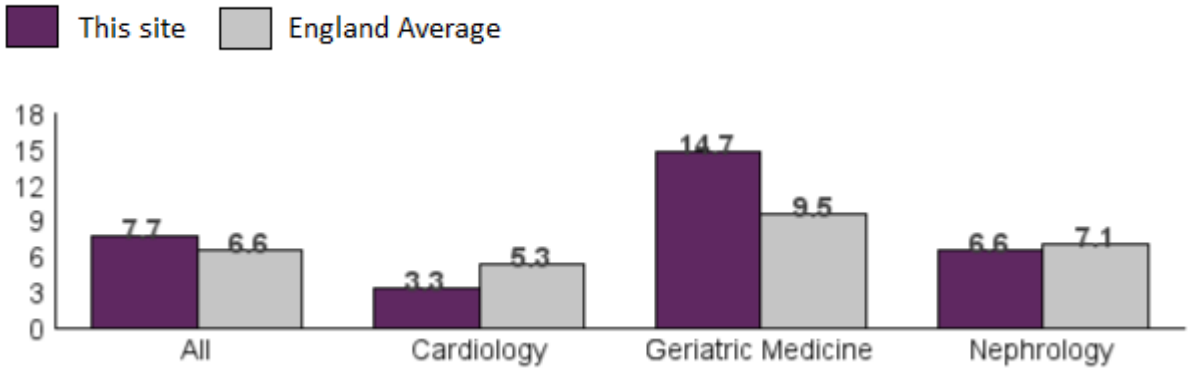
- Average length of stay for non-elective patients in cardiology was lower than the England average.
- Average length of stay for non-elective patients in geriatric medicine was higher than the England average.
- Average length of stay for non-elective patients in nephrology was similar to the England average.

Elective Average Length of Stay - Sunderland Royal Hospital



Note: Top three specialties for specific trust based on count of activity.

Non-Elective Average Length of Stay - Sunderland Royal Hospital



Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Meeting people's individual needs

The division used innovative approaches that provided pathways of care focussed on the individual and involved collaboration with other service providers, e.g. local authorities, local NHS trusts, specific service providers such as 'Wear Recovery'. These were designed to meet the needs of patients through co-ordination of services to ensure continuity of care.

The trust's 'delirium and dementia outreach team' (DDOT) saw around 500 new patients and, supported 250 patients each month through the Alexandra Centre. An additional 300 patients were given individual support on wards. The team was highly visible and easily accessible and supported ward staff to care for frail patients.

The aim of the team was to support better recognition of, and care for cognitively frail patients admitted and had a remit to improve the care and recognition of delirium. The team had a role in introducing and monitoring the use of a cognitive care pathway for patients with dementia and/or delirium. The team provided advice and support to clinical staff, patients and carers about delirium and dementia using a person-centred, evidence based approach.

The team also provided dementia friends training to staff, including training on induction for all new clinical staff and bespoke training to ensure a dementia friendly workforce. The team also facilitated delirium workshops in other trusts.

Facilities and premises had been designed to meet the complex needs of patients and provided treatment in a conducive environment. An example was the development of the Alexandra Centre as a dementia-friendly unit which was used as a day therapy suite for cognitively frail inpatients. The DDOT identified patients who were invited to attend the centre for a morning or afternoon to take part in therapeutic activities and have a meal in a café style environment.

Activities included reminiscence therapy, music, crafts, films, exercises, pamper sessions and pet therapy. The centre had been furnished and decorated using ‘dementia friendly’ principles.

A hospital elder life programme assistant (HELPA) provided stimulating activities on the wards for patients unable to go to the Alexandra Centre. They also encouraged dietary and fluid intake and ensured sensory deprivation was addressed (e.g. ensuring hearing-aids are working, etc.).

The division provided outreach clinics to enable patient access to services and appointments in a way and at a time that suited them. The electronic patient record and linked systems were used to ensure staff had the right information to enable treatment, support and care was provided in a timely way.

The division had developed a chest pain assessment unit for the rapid diagnosis of chest pain. This was consultant led, supported by a cardiac chest pain nurse, and provided a service, seven days a week.

The trust had developed a frailty team which consisted of a geriatrician, specialist pharmacist, nurse practitioner and a foundation year doctor. The team aimed to improve outcomes for frail people by providing a comprehensive geriatric assessment (CGA) to all frail patients admitted through the medical admissions unit. Patients included were over 65 years old and classified as frail according to the ‘Frailsafe’ tool (see below).

Results showed that intervention by the frailty team reduced the length of stay in those seen and effectively optimised patients’ medication. Of those admitted with a fall, 90% of patients seen by the frailty team had falls medication review documented compared to only 44% in those not seen. Patients seen by the team had a reduction in the number of medications from admission to discharge and the time to medication review for all groups was significantly better than the NICE quality standard.

The trust was part of the ‘Frailsafe’ pilot scheme that had trialled a ‘check and challenge’ safety checklist for frail patients. It resulted in prompts for decisions on resuscitation and the necessity of equipment such as catheters and the introduction of emergency healthcare plans (EHCP).

EHCPs aimed to anticipate and plan for emergencies, particularly in the frail population.

The ‘Frailsafe’ electronic document was completed for all patients seen by a member of the frailty team and geriatricians used the document for new patients who had not been seen by the frailty team prior to their admission to a base ward.

A frailty and community geriatrics service had been introduced which identified older patients with frailty attending the hospital and worked within existing admission practices with input from a frailty nurse practitioner.

We saw wards had pictures on the walls to stimulate patient memories and patients wore dementia identifying bracelets. Wards accessed picture booklets and sign language booklets and also a talking point booklet for patients whose first language was not English.

Staff contacted the complex discharge nursing team to support patients with complex needs. They also used the reablement at home service and step down beds in the community.

The trust worked with the local authority to ensure a continuity of discharge from hospital and had developed a 'Discharge Hub'. This involved trust and local authority staff in the identification of patient needs on return to their home and ongoing care needs.

The trust had a criteria led discharge pathway that was followed if the patient did not need medical input on discharge. This allowed nursing staff to discharge patients if they meet certain criteria e.g. seen by the PLT and a pharmacy review completed.

The discharge lounge was clean and spacious with beds and seats available in the lounge area if needed. There were magazines and a television available for patients. Staff provided drinks and food on request.

The trust reported a lower than average delayed transfers of care (DTOC) rate. Information provided (February 2018) at the time of inspection showed a DTOC rate of 1.1% (193 delayed days, 17 patients). We saw that the trust worked with local partners to reduce DTOCs and improved patient flow through integrating work with health and social care teams, the provision of rapid access care in the community and admission avoidance schemes.

The trust had developed a steering group for children and adults safeguarding and a trust dementia strategy group that linked in to the regional strategic clinical network for dementia.

Initiatives had been developed to meet the needs of vulnerable patients, such as the 'screening tool of older persons prescriptions in frail adults with limited life expectancy' (STOPPFrail).

The trust had developed the tool to assist doctors with stopping medication in older patients who meet all of the following: end-stage irreversible pathology, poor one year survival prognosis, severe functional impairment or severe cognitive impairment or both and symptom control is the priority rather than prevention of disease progression. The decision to prescribe or not was also influenced by the benefits of the medication outweighed by its risks and whether the administration, monitoring and adherence to the medication is challenging.

Patients requiring supervision to prevent falls were supported and we observed staff using appropriate distraction techniques with patients. Staff gave examples of when adjustments had been made to improve the patient experience, such as flexible visiting hours and family members being involved in meeting patients' care and emotional needs.

The division had identified and employed additional resource for endoscopic retrograde cholangio-pancreatography (ERCP). This was in response to an audit of all ERCPs performed in 2016 at a pancreatitis rate of 6% (national target of 5%) and a mortality rate of 1.4% (national target 1%).

A lead alcohol nurse specialist was employed by the trust and worked with a senior nurse, a data analyst, and 'Wear Recovery' (17.5 hours) to provide a five day service. This service provided nurse led day case and outpatient clinics for early discharge patients, nurse led paracentesis, and paracentesis training for junior doctors (paracentesis is the removal of fluid from a body cavity via a needle, cannula or another hollow instrument and can be used for diagnosis or treatment).

Telephone support and advice was offered for every patient with alcohol liver disease and all new staff were given Clinical Institute for the Withdrawal of Alcohol (CIWA) training.

The division had identified and recruited a further thoracic consultant in response to the need for additional clinical sessions to meet the needs of patients and maintain the waiting standards for two week cancer referrals. This also maintained routine 18 week national standards and reduced the increase in outpatient waiting times,

In response to patient concerns regarding chemotherapy delays following the introduction of electronic prescribing, a clinical pharmacy service was put in place. This included clinical pharmacist review of all outpatient chemotherapy and resulted in solving of prescription issues, improved access to pharmacist patient reviews, improved medicines administration guidance for nursing staff and specialist-pharmacist advice for acute oncology services.

The division identified the need to replace the reverse osmosis (RO) unit to deliver haemodialysis to patients who had chronic renal failure. This delivered haemodialysis to patients in a hospital setting for four hours, three times a week, and also provided haemodialysis at two satellite units, and home haemodialysis. The project resulted in an increase in the number of haemodialysis stations, HEPA filtered side rooms and renal beds within the hospital to meet increased demand and needs of patients.

We saw the division had proactively identified the changing needs and preferences of patients and responded appropriately, e.g. home haemodialysis. One example was that the renal service had developed home haemodialysis provision in response to a 5% annual growth in the number of haemodialysis patients and a clinical session increase of 7%. This development was supported by the national strategy from NHS Kidney Care (2010) which identified that home haemodialysis has positive effects on both quality of life and life expectancy.

Wards had dedicated waiting rooms which were used by adults and children and we saw that these were accessible to users of wheelchairs and mobility aids. Private breast-feeding facilities were available on wards. All wards adhered to a single sex policy within bays, toilet facilities and access, we did not observe any breaches.

Throughout the wards equipment for bariatric and larger patients was available, e.g. wheelchairs. Specialist equipment for bariatric patients was requested from central supplies when needed.

The division did not always adhere to the ‘five step’ communication process within the accessible information standard (identify, record, flag, share, meet) during admission and ongoing treatment for patients and carers with a disability, impairment or sensory loss.

Wards accessed sign language interpreters for people living with hearing impairment.

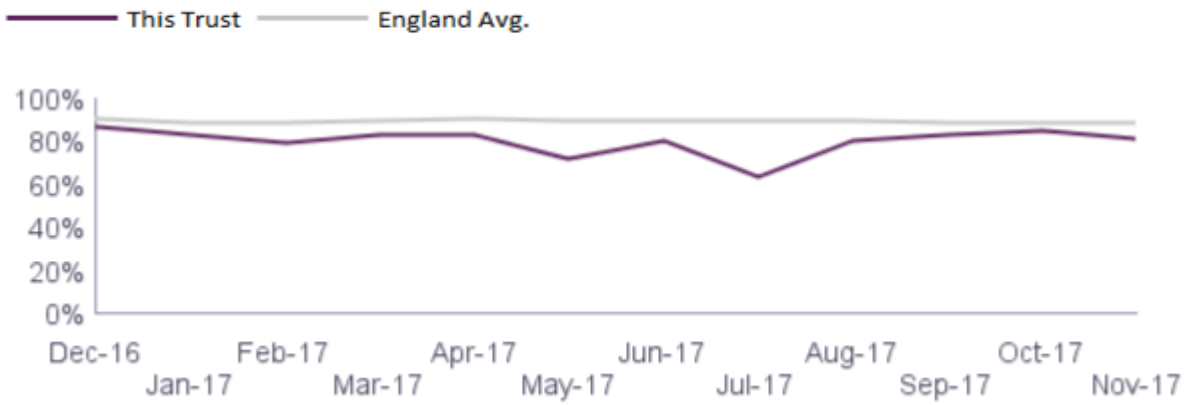
Although staff knew how to access translation services, they were unable to identify how they would access information leaflets in languages other than English.

Access and flow

Referral to treatment (percentage within 18 weeks) - admitted performance

From December 2016 to November 2017 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was below the England average. July 2017 had the lowest referral to treatment time with 64% of patients treated within 18 weeks for admitted pathways against the England average of 90%.

In the latest period November 2017, 81% of this group of patients were treated within 18 weeks versus the England average of 88%.



(Source: NHS England)

At the time of inspection (end of March 2018), the trust's referral to treatment time (RTT) for admitted pathways for medicine (91%) treated within 18 weeks was better than the England average (89%).

Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Geriatric Medicine	94.7%	97.9%

Three specialties were below the England average for admitted RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Neurology	83.3%	91.9%
Rheumatology	69.6%	93.5%
Thoracic Medicine	53.5%	93.3%

(Source: NHS England)

We discussed the RTTs with the senior management team. Improving RTTs had been set as a priority within the division and at the time of inspection, national data (NHS England, March 2018) showed referral to treatment times had improved for all specialities.

At the time of inspection (end of March 2018), these were all above the England average.

Specialty grouping	Result	England average
Neurology	99%	86%
Rheumatology	94%	91%
Thoracic Medicine	90%	88%
Cardiology	98%	89%
Geriatric medicine	97%	96%

Learning from complaints and concerns

Summary of complaints

From January 2017 to December 2017 there were 92 complaints about medical care. The trust took an average of 28 days to investigate and close complaints, this was slightly worse than their complaints policy, which states complaints should be closed within 25 days.

The most prevalent themes were about patient care with 48 complaints (52%) and communications with 18 complaints (20%). 14 complaints (16% of all closed complaints about medical care) took over 40 days to close.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Staff explained how they would deal with patient concerns immediately and they would escalate to their ward sister or manager, when necessary. Staff were able to signpost patients to the Patient Advice and Liaison Service.

Staff were able to give examples of complaints that had happened in their area and were aware of the findings from investigations and actions needed. Records of complaints and action plans were held in staff information files available on wards.

The divisional management team had responded to delays in investigating and responding to complaints through providing additional resource.

The trust had reviewed the complaints process and took steps to improve the turnaround times for formal complaint responses. This found that complaints that took longer to respond to were due to the complex nature of the complaint involving a number of directorates and external organisations. There were no complaints waiting for responses over 90 days and ongoing performance was monitored through weekly meetings.

Is the service well-led?

Leadership

The division of medicine (emergency medicine, general internal medicine, medical specialties, rehabilitation and elderly medicine) had a ‘triumvirate’ management structure in place with clear lines of responsibility and accountability. The clinical director, directorate manager and matron had responsibility for the delivery of services and were supported by deputy clinical leaders and managers. These were further supported by respective heads of service, service managers and matrons.

The senior management team had a comprehensive understanding of the current risks, challenges and pressures impacting on service delivery, particularly workload issues.

Staffing levels were planned so that ward managers were allocated supernumerary management time, although ward managers said this was difficult to take. Ward managers were well supported by matrons but said their contact with more senior management was infrequent.

Ward managers and sisters said they had constructive and positive relationships with matrons and that matrons visited wards on a daily basis. Staff felt that managers communicated well with them and kept them informed about the management of the wards and service changes.

Staff were encouraged to undertake professional development and received annual appraisals. At the time of inspection, we were given information that the appraisal rates for registered nursing

staff and non-registered care staff had increased. Staff told us they would be confident to raise a concern with their managers and were confident this would be investigated appropriately. All staff were confident in raising issues through the incident reporting system.

Junior doctors were well supported by senior colleagues and supervision from a mentor for each activity as well as an education supervisor. They had raised issues over the allocation to the rota precluding them from taking holidays and also with the availability of hot meals at weekends. The senior management team agreed to look at these and rectify if necessary.

Vision and strategy

Staff were clear about the vision and strategy for the service. There were displays of the trust vision ('…to deliver nationally recognised high quality, cost effective, sustainable healthcare for the people we serve with staff who are proud to recommend our services') and strategy within the division. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.

The trust website displayed the vision, mission and values and these were medical division operational strategy was developed to align with the trust strategy which identified quality priorities, why they had been chosen and plans for improvement.

Culture

Staff said the division had strong leadership and senior managers were visible and engaged with staff when appropriate. We interviewed a number of staff on an individual basis and held group discussions throughout the wards when possible. Staff spoke positively about the care they provided for patients. All staff were clear about their roles and responsibilities, patient-focused, and worked well together.

At ward level, we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.

Staff and junior doctors said they felt valued and supported and there was a positive, open and transparent culture on the wards and they felt able to raise concerns as necessary. All staff felt they received appropriate support from management to allow them to perform their roles effectively and there was a strong culture of learning, improvement and development was actively encouraged.

There was good teamwork within the division and we saw staff work well between specialities and across disciplines.

Governance

The senior management team told us divisional management meetings, operational team meetings and clinical governance meetings took place each month. The risk register, incidents, complaints and lessons learned were discussed. Matrons and ward managers disseminated information to ward staff through ward meetings, communication books and notices on staff boards.

Clinical governance meetings were well attended and ongoing audits, complaints, safeguarding, national guidance, risk management, incidents and never events, and learning were discussed.

Senior staff were motivated and enthusiastic about their roles and had clear direction with plans in relation to improving patient care.

Ward managers, senior managers and clinical leads showed knowledge, skills, and experience. A clear responsibility and accountability framework had been established. Staff at all levels were clear about their roles and understood their level of accountability and responsibility.

Management of risk, issues and performance

The division had a risk register which was detailed and thorough in identifying, recording and managing risks, issues and mitigating actions. Governance meeting minutes showed risk registers were reviewed regularly.

The highest risks identified were the inability to staff all care of the elderly and neurology wards appropriately for all shifts at all times, discrepancies relating to controlled drug checks (identified through incident reporting) and the potential failure of old equipment e.g. echo machines and ambulatory electrocardiogram recorders including automated external defibrillators. We discussed these with the senior management team who were well informed about the difficulties and had action plans in place to address the risks.

All senior staff were responsible for monitoring performance and quality information. Matrons conducted audits of the ward areas with ward managers to measure quality. A programme of clinical and internal audit was used to monitor quality and systems to identify where action should be taken.

Information management

Information provided (end of March 2018) by the trust showed 97% compliance with information governance training across the division.

Although staff said there was difficulty in accessing computers, policies and clinical guidelines were available on the trust intranet.

All patient observations and information was recorded on an electronic system accessible to authorised staff through the input of a password. This gave immediate access to risk assessments, test results, risk assessments and treatment of all patients.

Engagement

Patient feedback was obtained through the friends and family test. The response rate for medicine was 20% (worse than the England average of 25%); ward B22/CPAU (cardiology) had the lowest response rate with 9%.

We discussed the lower than England average response rate with staff and ward managers. Although staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families, there was no single explanation for the low rate and staff were unable to identify strategies for increasing the rate. The trust quality strategy (April 2018) identified ways to encourage public feedback in a more systematic way through internet and social media feedback.

The FFT showed between 89% and 100% of patients would recommend the hospital to family and friends. Patients were very complimentary about the care and treatment at the trust.

Patients were encouraged to give their opinion on the quality of care they received. Leaflets about the friends and family test, and the patient advice and liaison service were available on all ward and reception areas.

The national NHS Staff Survey (2017) showed the trust scored 3.8 (out of five) for an overall indicator of staff engagement. This was the same as the 2016 result (3.8) and was the same when compared to trusts of a similar type (3.8).

Senior managers engaged with staff well and we saw they communicated with staff through the trust intranet, e-bulletins, team briefs and communication notices. Ward managers held staff meetings and discussed issues for improving care and treatment.

Learning, continuous improvement and innovation

The division had developed a number of initiatives to improve and enhance care and treatment:

- The delirium and dementia outreach team supported better recognition of, and care for cognitively frail patients. The team helped to improve the care and recognition of delirium. The team had a role in introducing and monitoring the use of a cognitive care pathway for patients with dementia and/or delirium. The team provided advice and support to clinical staff, patients and carers about delirium and dementia using a person-centred, evidence based approach.
- The Alexandra Centre was a dementia-friendly unit which was used as a day therapy suite for cognitively frail inpatients. Patients were invited to attend the centre for a morning or afternoon to take part in therapeutic activities and have a meal, in a café style environment. Activities included reminiscence therapy, music, crafts, films, exercises, pamper sessions and pet therapy. The centre had been furnished and decorated using ‘dementia friendly’ principles.
- Hospital elder life programme assistants (HELPA) visited wards to provide cognitively stimulating activities at the bedside and encouraged dietary and fluid intake. They also did work to ensure sensory deprivation was addressed.
- There was a chest pain assessment unit for the rapid diagnosis of chest pain. This was consultant led, supported by a cardiac chest pain nurse, and provided a service seven days a week.
- The frailty team consisted of a geriatrician, specialist pharmacist, nurse practitioner, and a foundation year doctor. The team aimed to improve outcomes for frail people by providing a comprehensive geriatric assessment (CGA) to all frail patients admitted through the medical admissions unit.
- A frailty and community geriatrics service had been introduced which identified older patients with frailty attending the hospital and worked collaboratively with existing admission practices with input from a frailty nurse practitioner.
- A discharge hub had been developed with the local authority that identified patient needs on return to their home and ongoing care needs.

- A screening tool of older person's prescriptions in frail adults (STOPPFrail) with limited life expectancy was designed to assist doctors with stopping such medication in older patients who met defined criteria.
- Home haemodialysis had been developed in response to a 5% annual growth in the number of haemodialysis patients and a clinical session increase of 7%. This development was supported by the national strategy from NHS Kidney Care (2010) which identified that home haemodialysis had positive effects on both quality of life and life expectancy.
- There was a 'tookie vest' for renal patients. As a result of exploratory research through patient and public involvement focus groups, a class one medical device (an apparel), called 'the tookie vest for renal' had been specifically designed by haemodialysis (HD) patients for HD patients, clinicians and industry in a collaborative partnership to secure a central venous catheter, to prevent accidental fall out.

Surgery

Facts and data about this service

Sunderland Royal Hospital provided care and treatment for eight surgical specialties across eight inpatient wards with 213 beds. There was a pre-assessment unit, a fracture clinic and surgical day case unit on site.

(Source: Routine Provider Information Request (RPIR) – "Sites Acute" tab)

Within the division there were the clinical directorates of general surgery, urology, head & neck. This directorate included ENT, oral & maxillofacial surgery and orthodontics, ophthalmology and trauma & orthopaedics.

Patients were admitted to the surgical day case unit by staff and then seen by a doctor and anaesthetist prior to being prepared for theatre. Once prepared for theatre the patient was taken to the admissions lounge to wait for surgery. Patients from the ward either walked to theatre or were transferred on a bed or trolley accompanied by a member of the ward staff.

(Source: Routine Provider Information Request (RPIR) – "Context Acute" tab)

The trust had 55,519 surgical admissions from October 2016 to September 2017. Emergency admissions accounted for 10,106 (18%), 36,542 (66%) were day case, and the remaining 8,871 (16%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory courses from April 2017 to December 2017 for medical/dental and nursing staff in surgery is shown below:

Mandatory Training Completion by module – Medical and Dental Staff

Name of course	Number of eligible staff this year	Number of staff trained (YTD)	Completion Rate	Met (Yes/No)
Slips, Trips and Falls - Patient Falls	157	148	94%	Yes
Resuscitation	151	137	91%	Yes
Venous Thromboembolism	17	15	88%	No

Consent	17	15	88%	No
Fire Safety	157	135	86%	No
Blood Prescribing: Blood Components and Indications for Use	125	105	84%	No
Information Governance	157	131	83%	No
Blood Prescribing: Safe Transfusion Practice	126	105	83%	No
Equality, Diversity and Human Rights	157	125	80%	No
Infection Control - Level 2	135	106	79%	No
Fire Safety Classroom	157	121	77%	No
Moving & Handling for People Handlers	137	99	72%	No
Infection Control - Level 1	157	111	71%	No
Grand Total	**1650**	**1353**	**82%**	

The 90% target was met for two of the 13 mandatory training modules shown above for medical staff. Infection control – level one had the lowest completion rate with 71%.

At the time of inspection, the trust provided information that showed training compliance had increased.

Mandatory Training Completion by module – Nursing Staff

Name of course	Number of eligible staff this year	Number of staff trained (YTD)	Completion Rate	Met (Yes/No)
Moving and Handling - Level 1	2	2	100%	Yes
Slips, Trips and Falls - Patient Falls	376	362	96%	Yes
Fire Safety Classroom	378	352	93%	Yes
Consent	13	12	92%	Yes
Baxter Colleague Infusion Pump	266	244	92%	Yes
Equality, Diversity and Human Rights	378	345	91%	Yes
Fire Safety	378	345	91%	Yes
Conflict Resolution - Dealing with Violence and Aggression	40	36	90%	Yes
Infection Control - Level 2	376	334	89%	No
Alaris GH Syringe Drive	266	232	87%	No
McKinley T34	15	13	87%	No
Information Governance	378	327	87%	No
Infection Control - Level 1	378	320	85%	No

Resuscitation	376	318	85%	No
Blood Administration Annual Refresher	262	218	83%	No
Alaris PCAM Syringe Driver	100	83	83%	No
Moving & Handling for People Handlers	375	311	83%	No
Insights into Confusion /Health and Wellbeing	16	12	75%	No
McKinley Epidural Pump	16	12	75%	No
Grand Total	**4389**	**3878**	**88%**	

The 90% target was met for eight of the 19 mandatory training modules shown above for registered nursing staff. McKinley epidural pump and insights into confusion training modules both had the lowest completion rate with 75% each.

At the time of inspection, the trust provided information that showed training compliance had increased.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to December 2017 for medical/dental and nursing staff in surgery is shown below:

Safeguarding Training Completion by module – Medical and Dental Staff

Name of course	Number of eligible staff (YTD)	Number of staff trained (YTD)	Completion Rate	Met (Yes / No)
Safeguarding Children (Version 2) - Level 3	6	6	100%	Yes
Safeguarding Children (Version 2) - Level 2	145	127	88%	No
Safeguarding Adults - Level 2	151	118	78%	No
Grand Total	**302**	**251**	**83%**	

The 90% target was met for one of the three safeguarding training modules for which medical staff in surgery were eligible. Safeguarding children level two and safeguarding adults level two both had not met the completion rate with 88% and 78% respectively.

Safeguarding Training Completion by module – Nursing Staff

Name of course	Number of eligible staff (YTD)	Number of staff trained (YTD)	Completion Rate	Met (Yes / No)
Safeguarding Adults - Level 1	2	2	100%	Yes
Safeguarding Children (Version 2) - Level 1	2	2	100%	Yes
Safeguarding Children (Version 2) - Level 2	368	351	95%	Yes
Safeguarding Adults - Level 2	376	345	92%	Yes
Safeguarding Children (Version 2) - Level 3	8	6	75%	No
Grand Total	**756**	**706**	**93%**	

The 90% target was met for four of the five safeguarding training modules for which registered nursing staff in surgery were eligible. Safeguarding children level three had not met the completion target with 75%. We were given assurance that the target would be met.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The service had systems in place for the identification and management of adults and children at risk of abuse. We found that the surgical division had made 12 safeguarding referrals to the local authority from January 2017 to December 2017.

The service had a safeguarding policy, which was accessible on the intranet, and detailed the different types of abuse staff should report. Staff we spoke with were aware of what concerns could potentially be a safeguarding concern, and how to raise them. The safeguarding policy included information on Female Genital Mutilation (FGM).

During the inspection, staff we spoke with said that they had completed adult and children's safeguarding training as part of their mandatory training. They also said the trust safeguarding team were accessible and supportive when staff needed advice about safeguarding concerns.

Cleanliness, infection control and hygiene

We found wards and departments we visited were visibly clean and tidy, and we saw ward cleanliness scores displayed in public corridors.

The trust had an infection prevention and control (IPC) policy, this directed staff to other policies and protocols for guidance about cleaning, decontamination, and IPC practices.

The trust had a policy to screen surgical patients for Methicillin-resistant Staphylococcus aureus (MRSA) and some patients for Methicillin-sensitive Staphylococcus aureus (MRSA) as per best practice guidance.

We saw information displayed on the wards and departments visited on the number of days since the last hospital acquired clostridium difficile (c. diff) infection and Methicillin-resistant Staphylococcus aureus (MRSA). The service had significantly reduced the number of patients who acquired Clostridium difficile infection whilst in their care, and figures were in line with their target. On two of the wards we visited, we saw that the data displayed was one month out of date.

Infection, prevention and control training compliance rates from April 2017 to December 2017 showed 89% for nursing and medical staff had received training, slightly below the compliance target of 90%. Records we reviewed and conversations with staff confirmed that staff received and completed training in infection control.

Staff we spoke with were aware of their responsibilities in relation to infection prevention and control, for example, bare below the elbows and decontamination of their hands before and after patient contact, or contact with the patient environment.

Hand hygiene audits showed outcomes of 100% across the surgical wards and theatres.

Handwashing advice was clearly displayed and facilities for hand hygiene were available in the entrance to all wards. Hand hygiene compliance data was displayed on the wards and departments we visited. Staff used both handwashing facilities and alcohol gel.

We inspected reusable equipment stored on the ward, and all items were visibly clean and ready for use. Some equipment displayed 'I am clean' stickers to signify equipment was ready for use. Other equipment was visibly clean but stickers had not been used to clarify this.

We reviewed several pieces of reusable clinical equipment and found these to be clean and labelled. However, we saw bagged dirty linen stored in sluice rooms next to clean reusable equipment. We were advised that dirty laundry was collected three times per day.

We saw processes for clinical waste, including colour coded waste bags for clinical and non-clinical waste.

Staff we spoke with said they had access to appropriate personal protective equipment (PPE). We observed staff, using sterile gloves and appropriate aseptic techniques when instilling local anaesthetic for patients.

Sharps bins were used by staff to dispose of used disposable instruments, such as sharps, needles, and glass ampules.

Environment and equipment

During this inspection, we saw that processes were implemented for the checking of resuscitation equipment. All equipment we reviewed was clean, tidy, and ready for use and staff had checked the equipment as per the trust's policy. Trolleys we inspected were all locked, were all appropriately stocked, and all equipment was in date. Staff we spoke with said they had adequate stocks of equipment and we saw evidence of good stock rotation.

We looked at several pieces of equipment and found all to have been electrically safety tested within the review date and serviced in line with manufacturers' guidelines.

There was adequate equipment on each ward to ensure safe care.

We were advised that some theatre monitoring equipment was outdated and starting to fail which was causing problems. We were also advised that the division were part-way through the tendering process to replace the older equipment, and had tested equipment on a trial basis. Risk was managed by using parts from the machines no longer in use. There had been no incidents or patients harm caused, as a result of the outdated equipment.

Assessing and responding to patient risk

We reviewed 17 sets of patient notes and saw appropriate escalation of deteriorating patients. The matrons reviewed compliance with clinical observations in relation to national early warning scores (NEWS) as part of the matron audits.

Staff we spoke with confirmed they had completed NEWS and sepsis training. We were advised that a NEWS score of 5 or above for a patient triggered a prompt on the electronic recording system for the sepsis screening tool to be completed. The screening tool used the National Institute for Health and Care Excellence (NICE) guidance high risk criteria to identify patients with sepsis. Once the screening tool had been completed the outcome was escalated to a doctor. Staff caring for patients suspected of having sepsis followed the sepsis six bundle and administered antibiotics within 60 minutes of the NEWS identifying a concern.

Further ongoing support and advice was provided by the integrated critical care outreach team based within the integrated critical care unit (ICCU) and monitored by the ICCU consultant who was the designated sepsis lead.

We saw that outcomes from audit data was fedback monthly via the sepsis group, which staff felt was a robust system which was well embedded.

We observed consistency with five steps to safer surgery including the World Health Organisation (WHO) surgical safety checklist. From our observations it was apparent the five steps to safer surgery checklist was embedded as a routine part of the surgical pathway. We saw that consumables such as needles, scalpel blades and swabs were recorded. Instrument counts were undertaken.

Patient safety briefings were carried out pre-operatively. This included discussion around the order of patients on the list, the addition of any emergency cases and the instrument and equipment requirements.

Four of the surgical notes we reviewed contained surgical safety checklists. On all occasions the checklists were completed appropriately.

We saw there was access to national safety standards for invasive procedures (NatSSIPs) and local safety standards for invasive procedures (LocSSIPs).

We reviewed risk assessments including those for pressure damage, malnutrition, falls, bed rails, moving and handling and venous thromboembolism (VTE) compliance. In all sets of patient records, we found these were completed. We saw that patients identified as high risk had been referred to further services such as tissue viability teams, dieticians or provided with additional equipment such as pressure relieving devices.

We observed formal medical handovers take place during shift changes.

Nurse staffing

The service did not use an acuity tool based on patient depends to work out staffing based on patient's needs. Sunderland Royal Hospital reported their registered nursing staff numbers as of December 2017 for surgery, which showed a 95% staffing rate.

Ward/Site	WTE Planned Staff	Number in post as at December 2017
Sunderland Royal Hospital	482.8	461.0
Total	**482.8**	**461.0**

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

During the inspection, we saw that wards were meeting the planned staffing levels. Matrons monitored daily staffing numbers and moved staff around to ensure all areas were safe on a shift by shift basis. Bed meetings were held by matrons to identify and manage patient flow issues, staffing issues and the capacity and demand on each site. Staff we spoke with said there was effective discussion at the meetings which helped them to ensure ward staffing levels remained safe.

However, data showed that between 1 October 2017 and 31 March 2018 the wards D41, D42 and D48 had 56.6%, 44.5% and 63% (consecutively) unfilled shifts.

Staff we spoke with highlighted that they were regularly asked to move wards and work in other areas. They also said that staff being moved had resulted in more pressure in their area of work but they recognised that sometimes staff had to be moved to another ward to maintain patient safety. Senior nurses we spoke with could explain the processes used to determine which staff moved to which wards, and the consideration given to infection risk.

During the inspection staffing levels in theatres were in line with the national recommendations for safe peri-operative care (The Association for Perioperative Practice) 2016.

From January 2017 to December 2017, Sunderland Royal Hospital reported a vacancy rate of 7% in surgery. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From January 2017 to December 2017, Sunderland Royal Hospital reported a turnover rate of 12% in surgery. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From January 2017 to December 2017, Sunderland Royal Hospital reported a sickness rate of 3% in surgery, compared to the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Surgery had 6,688 shifts filled by bank staff, which was the second highest core service uptake within the trust.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Sunderland Royal Hospital reported their registered medical staff numbers as below as of December 2017 for surgery, which showed a 96% staffing rate.

Ward/Site	WTE Planned Staff	Number in post as at December 2017
Sunderland Royal Hospital	255.6	244.7
Total	**255.6**	**244.7**

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From January 2017 to December 2017, Sunderland Royal Hospital reported a vacancy rate of 4% in surgery. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From January 2017 to December 2017, Sunderland Royal Hospital reported a turnover rate of 15% in surgery. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From October 2017 to March 2018, Sunderland Royal Hospital reported a turnover rate of 3.14% in surgery. The trust did not provide a target rate.

From January 2017 to December 2017, Sunderland Royal Hospital reported a sickness rate of 0.4% in surgery, compared to the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

From October 2017 to March 2018, Sunderland Royal Hospital reported a sickness rate of 0.35% in surgery, compared to the trust target of 4%.

Surgery had 1,412 shifts filled by bank and locum staff, which was the second highest core service uptake within the trust.

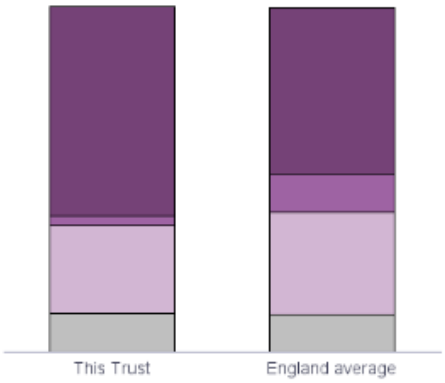
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

During the inspection we saw that for all surgical specialities a consultant was present on site 8am till 6pm, Monday to Friday. Acute general surgery and trauma and orthopaedics had consultant presence at the weekends.

On orthopaedic wards junior doctors were available throughout the day and consultants carried out daily ward rounds.

In October 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the whole time equivalent staff working at City Hospitals Sunderland NHS Foundation Trust



	This Trust	England average
Consultant	60%	48%
Middle career^	3%	11%
Registrar Group~	26%	30%
Junior*	11%	11%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Paper records were available for each patient that attended the wards and departments; the trust used an electronic patient management system to record key information about the patients' hospital stay and anticipated risks.

We reviewed 17 sets of patient records during the inspection and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of review or administration of treatment. We did observe that during the inspection, notes were not always stored in a locked area, this could potentially lead to patient's records going missing or a breach of confidentiality.

We saw that patient records held individualised plans of care and risk assessments, for example, sepsis, pressure area prevention and falls care plans. All records we looked at were completed accurately.

Whiteboards were available on all wards we visited; these provided staff with easy access to key information, such a discharge dates and review by other members of the multidisciplinary team, such as physiotherapists, and dietitians.

Medicines

We saw that staff recorded medicines refrigerator temperatures. However, we saw discrepancies in recording and found that on one ward there were 27 missed recordings over a 90 consecutive day period.

There were dedicated pharmacists on each ward on a daily basis. Pharmacy services were available seven days a week, 12 hours per day with on call support out of hours. Pain relief requirements out of hours were dealt with by an anaesthetist.

We checked that controlled drugs were stored safely and securely and found these had mostly been checked in line with policy. We found 13 discrepancies over 42 days on one ward.

Medicines reconciliation was completed by ward based pharmacists. Medicines reconciliation monitoring rates were lower in elective surgery patients but this was being addressed through a project focussed on pharmacist attendance at surgical pre-assessment clinics.

We reviewed three medicine administration charts and noted medicines were prescribed and administered in accordance with national guidance. We observed that the preparation and administration of controlled drugs was subject to a second independent check.

Antibiotic prescribing audits were completed monthly and considered the initial use, appropriateness and review / stop dates.

Medical gases we reviewed were all stored appropriately in designated holders.

Incidents

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

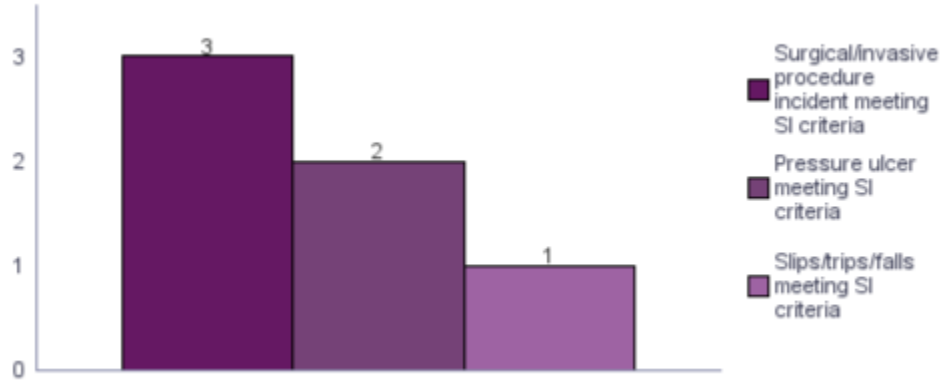
From January 2017 to December 2017, the trust reported two incidents classified as never events for surgery. These were both surgical/invasive procedure incidents meeting serious incident (SI) criteria.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from January 2017 to December 2017.

Of these, the most common types of incident reported were:

- Surgical/invasive procedure incident meeting SI criteria with three (50% of total incidents).
- Pressure ulcer meeting SI criteria with two (33% of total incidents).
- Slips/trips/falls meeting SI criteria with one (17% of total incidents).



(Source: Strategic Executive Information System (STEIS))

Surgery had the second highest number of incidents of any core service (2,532 or 25.5%). There has been a downward trend in the number of incidents reported per month. However, this was probably mainly due to delays in reporting incidents to the NRLS.

There were no incidents resulting in death, and one resulting in severe harm. There was a steady trend in the proportion of incidents resulting in moderate harm.

The majority of incidents reported in surgery (1,651 or 65.2%) resulted in no harm. The most commonly reported incident category was implementation of care and ongoing monitoring / review (497 or 19.7%). These included no deaths and one severe harm.

The second most commonly reported category was patient accident (379 or 15.0%). These included no deaths and no severe harms.

The severe harm incident related to Implementation of care and ongoing monitoring / review.

There was an overall downward trend in the numbers of most types of incident reported. This was in line with the downward trend in the number of incidents reported overall in surgery.

94% of incidents were reported to the NRLS within 30 days of occurrence. This was similar to the proportion at trust-level.

5% of surgery incidents were reported to the NRLS within 60 days of occurrence. This was also similar to the proportion at trust-level.

The timeliness of incident reporting had improved over the period. From October 2017 onwards, no incidents took more than 60 days to report. From December 2017 all incidents were reported within 30 days. During the inspection we found that the service had systems in place for reporting, monitoring, and learning from incidents. The service had an incidents and near miss policy in place. This provided staff with information about reporting, escalation, and investigation processes.

Staff we spoke with were aware of the reporting system and could tell us when they would report an incident. Staff we spoke with described a positive reporting culture within the division and said they were both encouraged and supported to report incidents.

During the inspection we found that learning from incidents was shared on during risk meetings, on a one to one basis, by email, during handover and at ward rounds within each surgical specialism. However, we found that lessons learned were not always shared across all surgical specialisms Risks were managed following national guidelines and best practice.

We looked at a root cause analysis for an incident following when the end piece of a catheter was left in situ and found that the incident, subsequent findings and lessons learned were discussed at the daily board meetings for two weeks and staff were informed of appropriate recording for medical devices. This information was also discussed at the following audit day meeting and the minutes sent out to all staff in theatre.

Ward managers said that if a serious incident occurred they would be involved in the root cause analysis process. We reviewed three root cause analysis investigations; we found these to include contributing factors, identification of lessons learned and recommendations to prevent recurrence of this incident. Duty of candour was detailed in the three investigation reports we reviewed.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

All grades of staff we spoke with were aware of the duty of candour and were able to provide examples of when they would use this. We were informed that the duty of candour had been applied across the surgical division on 16 occasions from January 2017 to December 2017.

Safety thermometer

The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.

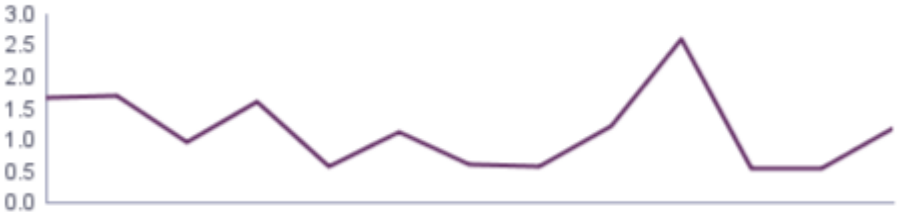
Data collection took place one day each month – a suggested date for data collection was given but wards could change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed the trust reported 26 new pressure ulcers, seven falls with harm and nine new catheter urinary tract infections from December 2016 to December 2017 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at City Hospitals Sunderland NHS Foundation Trust

Total Pressure ulcers

(26)

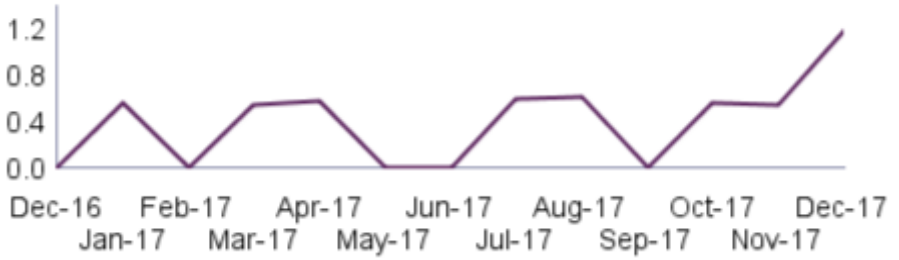


Total Falls

(7)

Total CUTIs

(9)



(Source: NHS Digital)

During the inspection, we saw patient safety display boards on the wards we visited, which showed when the most recent patient harm had occurred. For example, if patients on the ward had suffered any hospital acquired unavoidable pressure damage, falls or urinary tract infections.

Is the service effective?

Evidence-based care and treatment

Care and treatment for patients was based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists of Great Britain and Ireland, and the Royal College of Surgeons.

Clinical governance leads received NICE guidance on a monthly basis, along with any actions required, which were linked to specific guidance. The clinical governance leads provided an opinion on the relevance of each published NICE guideline specific to their area, and either led or participated in the completion of a baseline assessment (gap analysis) to ensure guidance was implemented and followed.

Local policies were written in line with national guidelines and updated every two years or when national guidance changed. For example, there were local guidelines for pre-operative assessments, and these were in line with best practice.

The surgical division took part in all the national clinical audits that they were eligible for. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.

Nutrition and hydration

During the inspection we saw that on the majority of occasions food and fluid charts were completed.

Protected mealtimes were promoted on the wards we visited. Symbols were used to identify patients who needed assistance with food and fluids. We saw that staff supported patients who needed assistance during our visit.

Pre-admission information for patients gave them clear instructions on fasting times for food and drink prior to surgery. Current guidance recommends fasting from food for six hours and fluid for two hours.

Staff identified patient risk of malnutrition by using the malnutrition universal screening tool (MUST) documentation. Patient notes we reviewed showed appropriate levels of completion.

The majority of the patients we spoke with said the food was good. Some wards had received lower than average patient-led assessments of the care environment (PLACE) scores for food, but there was no means to establish the cause or the problem.

Pain relief

During this inspection, we saw patients being offered pain relief. Patients we spoke with said staff offered them pain relief on a regular basis and said staff also checked that any pain relief administered had been effective. Patients stated that staff responded quickly; and when pain relief was not effective, they quickly asked a doctor to review their medicines.

We observed staff using pain scoring tools to assess patients' pain levels; staff recorded this information on the patients record.

Some surgical patients received intravenous pain relief post-operatively. This was in line with national best practice guidance from the British Pain Society. Pain relief requirements out of hours were dealt with by an anaesthetist.

Patient outcomes

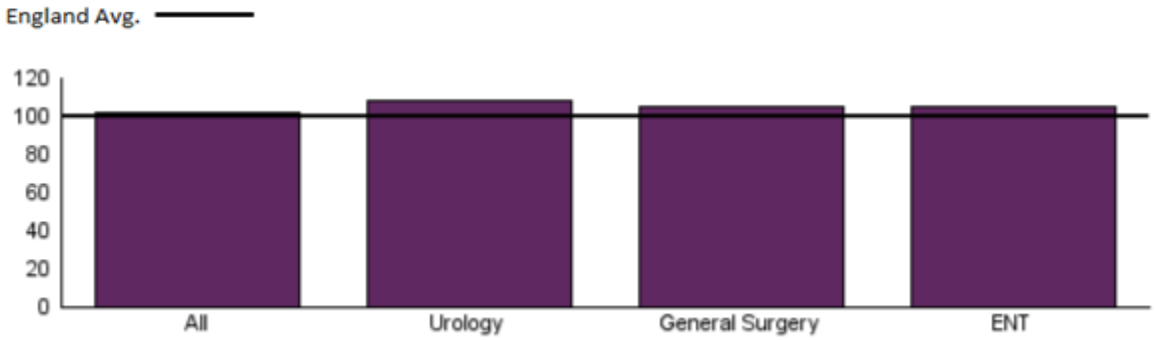
From September 2016 to August 2017, all patients at Sunderland Royal Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at Sunderland Royal Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.
- General surgery patients at Sunderland Royal Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.
- ENT patients at Sunderland Royal Hospital had a similar expected risk of readmission for elective admissions when compared to the England average.

All patients at Sunderland Royal Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.

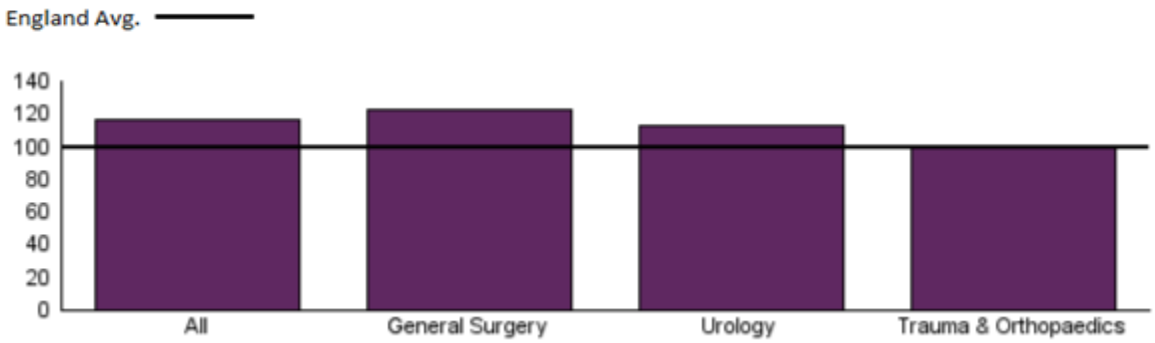
- General surgery patients at Sunderland Royal Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Urology patients at Sunderland Royal Hospital had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- Trauma & orthopaedics patients at Sunderland Royal Hospital had a similar expected risk of readmission for non-elective admissions when compared to the England average.

Elective Admissions - Sunderland Royal Hospital



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

Non-Elective Admissions - *Sunderland Royal Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (September 2016 – August 2017))

In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 6% which was within the expected range. The 2016 figure was 7.9%.

The proportion of patients having surgery on the day of or day after admission was 81%, which was worse than the national standard of 85%. The 2016 figure was 80%.

The perioperative medical assessment rate was 99.3%, which was just below to meet the national standard of 100%. The 2016 figure was 97.8%.

The proportion of patients not developing pressure ulcers was 90.9%, which falls in the bottom 25% of trusts. The 2016 figure was 94.7%.

The length of stay was 16.6 days, which sat in the top 25% of trusts. The 2016 figure was 19 days.

(Source: National Hip Fracture Database 2017)

In the 2017 Bowel Cancer Audit, 71.5% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 67.5%.

The risk-adjusted 90-day post-operative mortality rate was 3.2% which was within expected range. The 2016 figure was 3.6%.

The risk-adjusted 2-year post-operative mortality rate was 25.6% which was within expected range. The 2016 figure was 24.2%.

The risk-adjusted 30-day unplanned readmission rate was 15.7% which was within expected range. The 2016 figure was 11.3%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 59.2% which was within expected range. The 2015 figure was 54.8%.

(Source: National Bowel Cancer Audit 2017)

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0% for abdominal aortic aneurysms, indicating that the trust was within expected range, based on 36 cases. The 2016 figure was 0%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 12 days, which was better than the national standard of 14 days, based on 39 cases

The 30-day risk-adjusted mortality and stroke rate was 1.8% which was within expected range, based on 39 cases. The 2016 figure was 0%.

(Source: National Vascular Registry 2017)

In the 2016 National Oesophago-Gastric Cancer Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 8.9%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 16.7%.

The 90-day post-operative mortality rate was not eligible.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.2%, which was worse than the national aggregate of 37.6%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

In the 2017 National Emergency Laparotomy Audit (NELA), the Sunderland Royal Hospital achieved a green rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 157 cases. Green ratings show a positive outlier (below 99.8% control limit), whereas red ratings show a negative outlier (above 99.8% control limit). Green ratings show a positive outlier (below 99.8% control limit), whereas red ratings show a negative outlier (above 99.8% control limit).

Sunderland Royal Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 133 cases.

Sunderland Royal Hospital achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 97 cases.

Sunderland Royal Hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 61 cases.

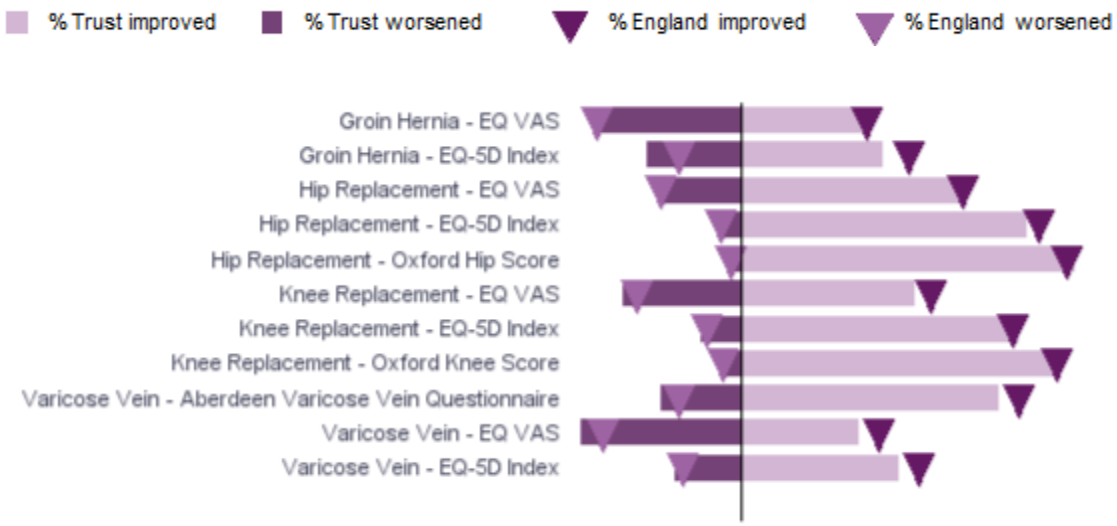
The risk-adjusted 30-day mortality for the Sunderland Royal Hospital was within expectations, based on 157 cases.

(Source: National Emergency Laparotomy Audit 2017)

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.



In 2015/16 performance on groin hernias was about the same as the England average.

For varicose veins, performance was about the same as the England average.

For hip replacements, performance was about the same as the England average.

For knee replacements, performance was about the same as the England average.

(Source: NHS Digital)

Competent staff

As of January 2018, 43% of staff within surgery at Sunderland Royal Hospital had received an appraisal. Registered nursing and midwifery staff had a 39% appraisal completion rate. The trust did not provide a target completion rate.

A split by staff group can be seen in the graph below:

Staffing Groups	**Individuals required (YTD)**	**Staff who have received an appraisal (YTD)**	**Completion Rate**
NHS Infrastructure Support Staff	247	128	52%
Other Qualified Scientific, Therapeutic, Technician Staff	37	19	51%
Qualified Healthcare Scientists	7	3	43%
Qualified Allied Health Professionals	20	8	40%
Qualified Nursing Midwifery Staff	283	111	39%
Support to Doctors and Nursing Staff	217	80	37%
Grand Total	**811**	**349**	**43%**

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

As of March 2018, appraisal completion rates for consultants were 100%, nurse managers 100%, staff nurses 77.3%, and technicians 90.3%.

Registered nursing staff we spoke with said that systems were in place to support them through their revalidation.

There was a competency framework for nursing staff which evidenced their progression from preceptorship. Development of nurses continued from student placements to a senior level. Staff received clinical supervision and annual appraisals to ensure competencies were maintained.

The trust appraisal policy required staff to be compliant with mandatory training and be appraised within the year in order to receive their annual increment. Regular reports were submitted to the executive committee to show overall performance, by area, and against each mandated field of training. Action was taken where these fell below set levels.

Multidisciplinary working

There were established multidisciplinary team (MDT) meetings for the discussion of patients on specific pathways or with complex needs, this included attendance from consultants, specialist nurses, allied health professionals and radiologists.

Nursing staff held daily multidisciplinary meetings on the wards we visited. Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships.

Staff highlighted that communication was good from senior level to operational levels and team working was well embedded.

Physiotherapy staff were integrated in to some of the areas we visited, for example, bariatric and orthopaedics.

We heard that surgical staff worked flexibly and as part of a whole divisional team. During the inspection we were made aware of team working across the division which has addressed theatre gaps and enabled smaller operations to improve theatre utilisation. It was explained that there was minimal theatre down time due to embedded multidisciplinary working.

Staff explained that the wards worked with local authority services as part of discharge planning.

Seven-day services

At the time of the inspection, junior medical staff were available seven days a week with support from middle grade doctors and consultants.

Surgical consultants provided a seven-day service. Consultants were available on call out of hours and would attend when required to see patients at weekends. The trust's pharmacy provided a seven-day service from 8am to 8pm.

We found that patients had access, seven days per week to diagnostic services – for example, x-rays.

Nursing staff said that medical staff were accessible and supportive when they needed advice.

Daily ward rounds were arranged for all patients and new patients were seen at weekends when necessary.

Health promotion

Health promotion information was available on wards we visited. This included display boards and information leaflets for patients on smoking cessation, healthy eating, wound care and infection prevention and control.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act (MCA) was designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

Following a capacity assessment, where someone is judged not to have the capacity to make a specific decision, that decision can be made for them, but it must be in their best interests. Staff

we spoke with were able to give a clear explanation about capacity assessment and the importance of recognising how ill health can impact on a patient's capacity.

The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLs). DoLs can only be used if the person will be deprived of their liberty in a care home or hospital. Staff we spoke with were aware of the legislation around deprivation of liberty safeguards.

Records we reviewed showed that patients had consented to surgery in line with trust policies and procedures, best practice and professional standards. We observed consent being obtained prior to carrying out treatment on patients. We looked at clinical records and observed that consent had been obtained and documented appropriately for all patients.

Staff told us mental capacity assessments were undertaken by the consultant responsible for the patient's care, and Deprivation of Liberty Safeguards were referred to the trust's safeguarding team.

Staff we spoke with said that they had access to mental health referral pathways and the psychiatric liaison team, and would use these resources if they had concerns about a patient.

We saw that where patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place these were stored at the front of care records in line with national best practice.

Is the service caring?

Compassionate care

From December 2016 to November 2017, the friends and family test response rate for surgery at Sunderland Royal Hospital was 29%, which was the same as the England average. Ward DGC31 (general surgery) had the highest response rate (47%) and the lowest annual performance (95%). The friends and family test average showed that 97.3% were likely or extremely likely to recommend the service.

Friends and family Test – Response rate from December 2016 to November 2017 by ward

Ward name	Total Resp	Resp. Rate	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Ann. Perf.
DGC31	826	47%	93%	94%	91%	94%	98%	96%	98%	97%	95%	97%	94%	94%	95%
DGC33	735	34%	100%	98%	100%	100%	100%	97%	97%	98%	100%	100%	96%	100%	99%
DGD48	759	33%	98%	100%	96%	95%	95%	99%	99%	98%	99%	96%	97%	100%	97%
DGD43	267	31%	91%	96%	100%	87%	100%	95%	93%	97%	96%	100%	100%	100%	96%
DGC36	362	29%	100%	100%	100%	97%	97%	94%	100%	96%	100%	95%	96%	97%	98%
DGD44	308	18%	95%	100%	100%	100%	100%	96%	100%	100%	98%	98%			98%
DGD42	323	18%	100%	100%	93%	100%	96%	97%	100%	96%	100%	93%	100%	100%	98%
DGC30	180	14%	93%	100%	95%	100%	100%	93%	100%	100%	100%	100%	100%	90%	98%

Highest score to Lowest score

Key	100%	50%	0%

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by response rate

(Source: NHS England Friends and Family Test)

Wards and departments we visited displayed their friends and family results.

We spoke with 11 patients on the surgical wards at this hospital. One patient said, ‘all staff worked very hard and gave help when it was needed’. This patient also said that pain was managed well and that they had received a rapid response when they deteriorated.

We observed staff caring for patients and found that they were compassionate and reassuring. A patient told us they had received immediate attention to address their pain. The patient said care was ‘very good’ and there was ‘nothing to improve’.

Another patient said they felt safe and were very happy with the care they received. They also said they ‘would recommend to family and friends’.

During the inspection, we saw patients had access to call bells and drinks at hand. We observed staff closing curtains/doors whilst observing personal care.

Emotional support

We saw that ward managers were visible on wards and relatives and patients were able to speak with them.

Clinical nurse specialists including vascular nurse specialists were available within surgery and attended wards to provide additional support and advice to patients.

Information was included within care plans to highlight whether a patient had additional emotional or mental health needs.

Patients were able to access counselling services, psychologists and the mental health team through the psychiatric liaison team, and delirium and dementia outreach team.

We were informed that learning disability specialist nurses advised on reasonable adjustments such as managing the stress of the environment and by offering clear, simple explanations of procedures and treatments.

There were weekly bariatric seminars led by bariatric specialist nurses who met patients and shared dietary advice, considered psychological impacts and provided support.

A multi-faith chaplaincy service was available for patients.

Understanding and involvement of patients and those close to them

We saw that information leaflets and advice posters were available on wards we visited, these included discharge information, specialist services and general advice about nutrition and hydration.

Ward managers were available on wards we visited and patients were able to speak to them if needed.

All the patients we spoke with had been made fully aware of the surgery that they were going to have; this had been explained to them.

The service had introduced bedside medication verification and electronic prescribing which enabled staff to involve patients more in understanding their medicines and in self-administration.

We saw the ‘this is me’ document in use within surgical services. The document provided professionals with information about the person diagnosed with dementia. The document helped to enhance the care and support given while the patient was in an unfamiliar environment.

We saw that the delirium and dementia outreach team (DDOT) provided additional support on wards and met with families and carers to provide support and information. Carers were actively encouraged to join patients in the DDOT centre and to join in with activities.

The learning disability nurse ensured that each patient had a hospital passport. The passport was designed to help people with learning disabilities to communicate their needs to doctors, nurses and other healthcare professionals.

Is the service responsive?

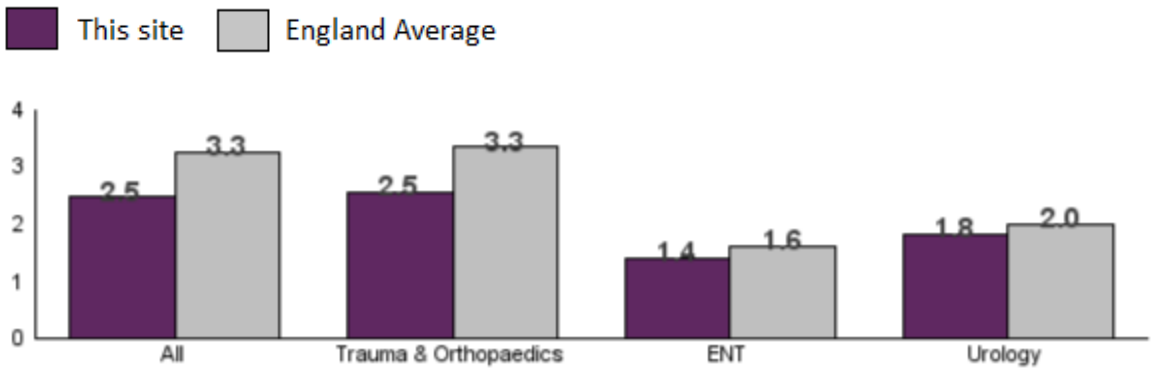
Service delivery to meet the needs of local people

Sunderland Royal Hospital - elective patients

From October 2016 to September 2017 the average length of stay for all elective patients at Sunderland Royal Hospital was 2.5 days, which is lower compared to the England average of 3.3 days.

- The average length of stay for trauma & orthopaedics elective patients at Sunderland Royal Hospital was 2.5 days, which is lower compared to the England average of 3.3 days.
- The average length of stay for ENT elective patients at Sunderland Royal Hospital was 1.4 days, which is about the same compared to the England average of 1.6 days.
- The average length of stay for urology elective patients at Sunderland Royal Hospital was 1.8 days, which is about the same compared to the England average of 2.0 days.

Elective Average Length of Stay - Sunderland Royal Hospital



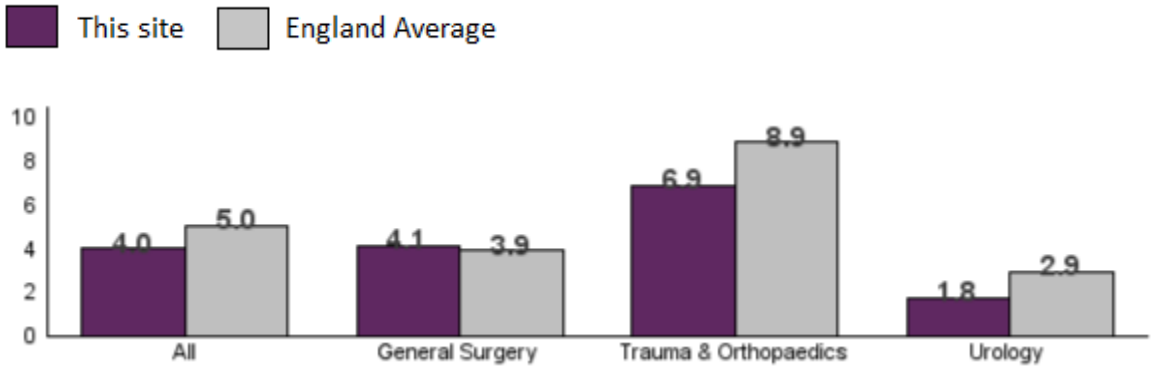
Note: Top three specialties for specific trust based on count of activity.

Sunderland Royal Hospital - non-elective patients

The average length of stay for all non-elective patients at Sunderland Royal Hospital was 4.0 days, which is lower compared to the England average of 5.0 days.

- The average length of stay for general surgery non-elective patients at Sunderland Royal Hospital was 4.1 days, which is about the same compared to the England average of 3.9 days.
- The average length of stay for trauma & orthopaedics non-elective patients at Sunderland Royal Hospital was 6.9 days, which is lower compared to the England average of 8.9 days.
- The average length of stay for urology non-elective patients at Sunderland Royal Hospital was 1.8 days, which is lower compared to the England average of 2.9 days.

Non-Elective Average Length of Stay - Sunderland Royal Hospital



Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Meeting people's individual needs

The hospital had an escalation policy and procedure to deal with busy times. Meetings were held to monitor the availability of beds in the hospital; staff reviewed data on planned patient discharge to assess the future availability of beds.

When patient numbers and demand were high, elective patients were reviewed and placed in an order of priority for cancellation to prevent urgent patients, including cancer patients, being cancelled.

The trust had a delirium and dementia outreach team (DDOT) who were available to support staff when caring for patients who needed additional support and advice to maintain their wellbeing and safety.

The DDOT team consisted of a multidisciplinary team of six elder life specialist practitioners (five registered nurses and one physiotherapist), one specialist pharmacist, seven hospital elder life programme assistants, two consultant geriatricians and a modern matron. The service provided therapeutic activities, one to one support, and education for staff and carers. Private consultation rooms were available for staff to meet with carers. Staff we spoke with were aware of the process to access DDOT support service.

We reviewed the notes for a patient diagnosed with dementia and saw there was a comprehensive 'this is me' document in place.

We were advised that visiting times were flexible for families and carers of patients who had dementia or who were receiving care at the end of their life. The wards used a butterfly symbol to identify and support patients living with dementia or delirium.

Patients with a learning disability were identified with a special indicator. An electronic notification was also sent to the learning disability specialist nurse to let them know when a patient with a learning disability was admitted. The learning disability nurse ensured that each patient had a hospital passport. The passport was designed to help people with learning disabilities to communicate their needs to doctors, nurses and other healthcare professionals.

The introduction of a day of surgery admissions unit had improved patient flow for urology and ear, nose and throat (ENT) patients and was positively commented upon by both patients and staff.

The pre-assessment team or the admitting ward reviewed patients' needs on admission, to identify any additional communication, physical or mental health needs.

The trust was using an external service for all interpretation requests. They were able to translate letters and documents for patient information into a variety of languages. The trust had access to a braille translation service, induction loop, and British sign language signing service. We saw that information leaflets were also available in a pictorial and easy-read format and described what to expect when undergoing surgery and post-operative care.

Patients with particular health needs were identified at staff briefings for example; those with learning disabilities, mental health conditions and living with dementia.

All providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard in full, from 1 August 2016 onwards – this means they must identify, record, flag, share and meet the information and communication needs relating to people with a disability, impairment or sensory loss. This includes carers and parents where appropriate. During the inspection we found that the 'five step' process (identify, record, flag, share, meet) were followed systematically and embedded into 'business as usual' working practices within the surgical division.

Specialised equipment for bariatric patients was available on the bariatric ward, such as beds, wheelchairs, commodes and chairs.

During the inspection we were advised that the bariatric unit had pioneered the introduction of loop gastric bypass in the United Kingdom (UK) with research and publications to support. In addition, the service had hosted educational events to over 50 surgeons across the UK to learn loop bypass, and recently hosted oversees surgeons. The bariatric unit was participating in the largest ever UK funded surgical randomised control study of the By-Band-Sleeve.

We were made aware that the surgical division invited a regional learning disability team to bring a group of teenage service users to hospital and asked them what they wanted when they attended surgery. As a result of this consultation, the department now received a care plan two week prior to any planned surgery, which outlined each young person's wants, needs, likes and dislikes. In addition to this, the anaesthetist met patients at the pre-assessment stage and clarified any additional needs. Plans were in place to ensure the process was streamlined. Following this process, the theatre division procured an operating chair, which enabled patients with learning disabilities to be sedated in the chair, and then reclined flat in theatre.

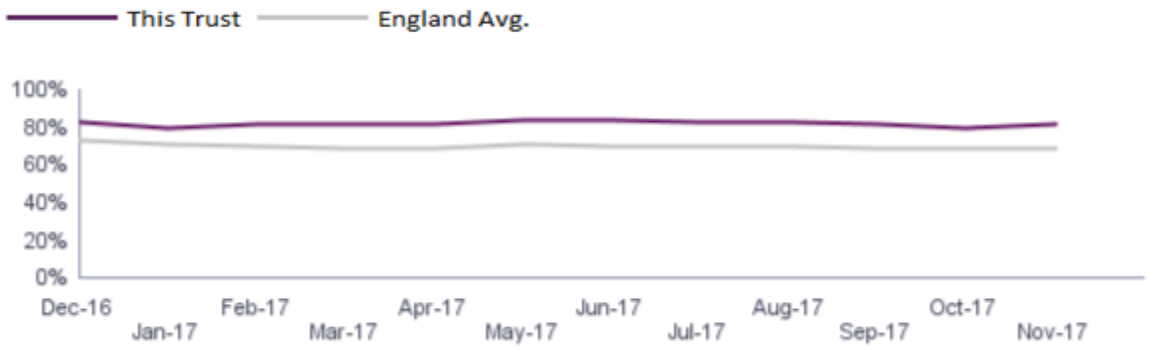
Relevant information for patients was displayed on the walls and corridors of wards we visited; this included audit performance, health promotion, and condition specific information.

The wards and departments were accessible for patients with limited mobility and people who use a wheelchair.

During the inspection we did not see any mixed sex breaches. We saw that male and female bays were clearly separated and male patients did not have to pass female bays to access bathroom facilities.

Access and flow

From December 2016 to November 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgery was better than the England average. In the latest period, November 2017 82% of this group of patients were treated within 18 weeks versus the England average of 69%.



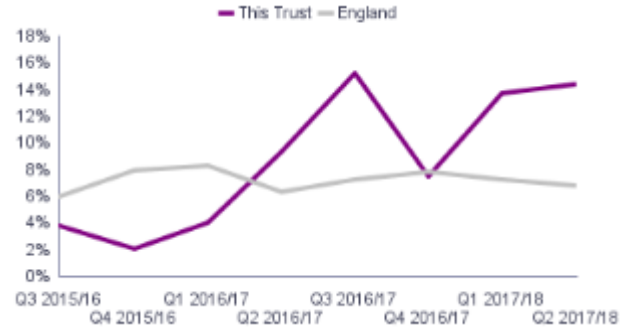
(Source: NHS England)

A breakdown of referral to treatment rates for surgery broken down by specialty is below. Of these, two specialties were above the England average and once speciality was below the England average.

Specialty grouping	Result	England average
Ophthalmology	94.8%	72.8%
Urology	85.4%	77.0%
Trauma & orthopaedics	54.7%	61.5%

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice

Percentage of patients whose operation was cancelled and were not treated within 28 days - City Hospitals Sunderland NHS Foundation Trust



Over the two years, the percentage of cancelled operations at the trust was generally higher than the England average. In the latest period, Q2 2017/18, this trust cancelled 83 surgeries. Of the 83 cancellations 14% weren't treated within 28 days. This was due to severe winter pressures.

Cancelled Operations as a percentage of elective admissions - City Hospitals Sunderland NHS Foundation Trust

Over the two years, the percentage of cancelled operations at the trust was generally lower than the England average with a slight decline in performance over the winter period. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

During the inspection we saw a ‘block room’ within theatres, for the purpose of nerve blocks prior to a surgical procedure, which increased the flow of patients.

The theatres division quality dashboard showed that theatre utilisation was 94.7% in February 2018, above or equal to the previous year’s figure for the ninth month out of 12. The allocation was adjusted to reflect the recent drop in ear nose and throat and general surgery, and the increase in Urology.

During the inspection, we saw that a number of surgical wards boarded medical patients (outliers). Boarded medical patients are when surgical beds are used for medical patients. The trust had recently been through a period of increased demand (winter pressures) and had postponed some elective surgery to accommodate additional emergency patients.

Learning from complaints and concerns

From January 2017 to December 2017 there were 185 complaints about surgical care. The trust took an average of 26 days to investigate and close complaints. This is was just outside of the complaints policy, which states complaints should be completed in 25 days.

The most prevalent themes were about patient care with 101 complaints (55%) and communications with 40 complaints (22%). 45% of complaints were not upheld, 33% were partially upheld and 18% of complaints were upheld.

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

Themes and trends of complaints were monitored by the matron and shared with staff through one to one discussions, emails, ward rounds and team meetings.

We saw information displayed in ward areas about how to raise a concern. Leaflets for the Help and Advice service, previously known as the Patient Advice and Liaison Service (PALS), was readily available.

Staff we spoke with could describe how they would respond if a complaint or concern was raised. This included offering an initial apology. Concerns would be dealt with at ward level initial and if the complaint could not be resolved, it would be escalated to the Help and Advice service.

Patients felt they could raise concerns and complaints and they would be listened to. Complaints and concerns were taken seriously by the surgical division and were acted on in a timely manner.

Is the service well-led?

Leadership

The surgical leadership team planned services by working with commissioners to ensure they could respond to the needs of the local community.

The surgical division strove to meet people's individual needs by providing access to care. The service recognised the importance of the views of patients and the public, and mechanisms were in place to hear and act on their feedback.

Ward managers we spoke with described positive, supportive relationships with the senior leadership team and matrons. We found the ward managers on the wards we visited knowledgeable and professional. They were visible and approachable for the staff they supported. However, staff felt that senior staff above matron level were not as visible.

Junior doctors we spoke with said they felt supported by senior colleagues. We were informed that all junior medical staff received support and supervision from a mentor for each named activity as well as an educational supervisor who recorded formal meetings.

Vision and strategy

The trusts vision 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's public website incorporated the trust's vision, mission and values and these were being visually embedded across the trust's hospital sites and through social media channels.

The surgical division operational strategy was in line with the overall trust strategy. One objective was to recruit, retain and motivate skilled staff. This was apparent when talking to staff as many told us they had been encouraged to learn and develop their skills.

Staff told us that the trust's values and objectives had been cascaded across the wards and departments and we saw these evident on ward areas.

We found that staff were aware of the trust vision and values and that further information was available when they logged into the electronic system. They said that values were embedded throughout the trust.

Culture

Staff we spoke with said they felt valued and supportive and there was a positive culture on the ward. Staff all worked together especially when the ward was very busy.

We established that staff were well engaged with the rest of the hospital and reported an open and transparent culture on the wards.

Foundation level doctors were supported by middle grade doctors. Junior doctors we spoke with said they felt supported working in the trust and felt able to raise concerns as necessary.

During the inspection we were told that staff followed a practice of excellence reporting and reported episodes of good care centrally. Staff members received feedback and recognition from the chief executive officer (CEO). Staff across the division had won awards locally and nationally as a result of good practice.

Governance

Clinical governance meetings were held each month. Representatives from each area attended the governance meetings so that information could be shared and disseminated across the wards and theatre. There were reporting mechanisms from the ward to the trust board and clear governance systems within the trust, which included effective communication mechanisms from the trust board to the various wards.

We were told that action plans for incidents were monitored across the division, and sub-groups were tasked with implementing elements of the action plan where appropriate. We saw evidence of action plans being monitored through clinical governance minutes.

We reviewed six sets of minutes from clinical governance meetings and found meetings to be well attended. We saw evidence of discussion around audits, complaints, safeguarding, national guidance, risk management including never events, and the sharing of lessons learned from incidents. All minutes were detailed and comprehensive.

Management of risk, issues and performance

The trust had a business continuity plan. This document detailed how the trust would respond to an incident or event, which disrupted services. Each surgical speciality had individual business plans which included intelligence, command, threats and actions.

The surgical division had risk registers in place. We reviewed the risk registers for surgery and theatres and found they highlighted current risks, documented mitigating actions to reduce the risk, review dates and action completion dates. Risks were reviewed and discussed at governance meetings and we saw escalation of the risks appropriately undertaken.

Consultants we spoke with said that they had a half day each month with no clinical work scheduled which allowed them to attend departmental, mortality and morbidity and audit meetings, undertake training and appraisals.

We saw that ward quality dashboards monitored all areas of risk, such as, hand hygiene audits, sepsis, pressure ulcer frequency, clostridium difficile (c. diff), methicillin-resistant staphylococcus aureus (MRSA), pain management and the number of falls on each ward. Staffing numbers, sickness levels, mandatory training and appraisal rates were also monitored on the quality dashboard.

Risk meetings were held at an operational level on a daily basis. All incidents were discussed, themes and trends identified. Improvements were highlighted and actioned as soon as was practicable.

Staff we spoke with on some surgical wards explained how the beds on the wards had been reconfigured in preparation for winter readiness to ensure the risk of bed shortages was addressed. Staff told us that although escalation beds had been provided, medical outliers still occurred. We were advised that the relevant medical consultants had continued to attend to medical patients on surgical wards on a daily basis.

Information management

Information provided by the trust, showed that 87% (December 2017) of nursing staff within the surgical division had completed training. This was worse than the trust's target level for training of 95%. After our inspection, the trust told us compliance with this training was 95% (but they did not provide evidence to corroborate this). We saw patient records on trauma and orthopaedic wards were not held in a locked room when not in use.

Computers were available on surgical wards; staff were able to access policies and clinical guidelines via the trust intranet. During the inspection, all computers were locked securely when not in use.

During the inspection we saw all patient observations and information was recorded electronically on a system which was accessible to all staff. The electronic system meant that nursing staff and doctors had real time access to each patient care needs, level of risk and medications.

Engagement

We were informed that as part of the trust's quality strategy launched in April 2018, a number of mechanisms were put in place to help capture public feedback in a more systematic way across the organisation and used to measure success and continuously improve services. For example, all online comments, ratings and feedback gained via social media will be fed into the trust's quality, risk and assurance reporting and a new visible 'feedback channel' was planned so that members of the public had an easy route to feedback their experiences in future.

Patients were asked to complete the path to excellence detailed survey, so that the division could capture the views of patients in an effort to improve services and the patient experience. We saw that staff views were also established through the path to excellence survey. As of February 2018, the response rate was 16.3%.

Patient feedback was also obtained through the friends and family test and when specialist nurses contacted patients to follow-up on their aftercare, pain management and wellbeing.

At the time of inspection, the trust scored above the national average on many indicators including the number of staff recommending the trust as a place to work or to receive care or treatment. 77% of staff agreed that the 'care of patients was the trust's top priority' and 90% felt that their role made a difference to patients.

Surgery, theatres and critical care divisions held a staff engagement workshop which gave staff the opportunity to be involved and influence change.

Learning, continuous improvement and innovation

The introduction of a day surgery admissions unit had speeded up patient flow for urology and ear, nose and throat (ENT) patients and was positively commented upon by both patients and staff.

The introduction of SMART week had resulted in better performance and, most importantly, better patient experience through improved scheduling, clinical ownership of lists and collaborative working between the theatre teams and users of theatres. The SMART week was a 'perfect week' taking place in theatres. It resulted in providing additional resource. The trust shared examples of improved working relationships between urology and theatres and allowed further developments for conversion of inpatients to day cases.

Some examples of improvements include the highest number of patients scheduled during 2017/18; theatre utilisation on average each week was 90% for the first time during 2017/18 against a norm of 82%; and the cancellation rate was below 5% for the first time in 2017/18 against a norm of 9.7%. An average of 30 patients attended for same day pre-assessment each day (156 per week) straight from clinic after being added to the waiting list. Previous attempts had achieved no more than 5 patients in a day.

The bariatric unit had pioneered introduction of loop gastric bypass in the United Kingdom with research and publications to support. In addition, the service had hosted educational events to over 50 surgeons across the UK to learn loops bypass, and recently hosted oversees surgeons. The bariatric unit were participating in the largest ever UK funded surgical randomised control study of By-Band-Sleeve.

During the inspection we saw a ‘block room’ within theatres, for the purpose of nerve blocks prior to a surgical procedure. This increased the flow of patients.

We were made aware that the surgical division invited a regional learning disability team to bring a group of teenage service users to hospital and asked them what they wanted when they attended surgery. As a result of this consultation, the department now received a care plan two weeks prior to any planned surgery, which outlined each patient’s wants, needs, likes and dislikes. In addition to this, the anaesthetist met patients at the pre-assessment stage and clarified any additional needs. Plans were place to ensure the process was streamlined. Following this process the theatre division received an operating chair which enabled patients with learning disabilities to be sedated in the chair, and then reclined flat in theatre.

The trust had a delirium and dementia outreach team (DDOT) who were available to support staff when caring for patients who needed additional support and advice to maintain their wellbeing and safety. The serviced provided therapeutic activities, one to one support, and education for staff and carers. Private consultation rooms were available for staff to meet with carers.

We observed that a new central store had been created for the whole of the theatre division. We were advised that this had created more space for patients, more efficiency for the department and increased financial savings.

During the inspection we saw that patients undergoing the pre-assessment process, who were identified as having low iron levels, were given an IV iron infusion during the pre-assessment in an effort to ensure normal levels and prevent cancellation of their surgical procedure.

The surgical division utilised a phone app for exercise in patients with peripheral arterial disease, when they were unable to get funding for a physical exercise programme recommended by NICE. The phone app had been presented nationally with plans to present follow-up information at the vascular society

Maternity

Facts and data about this service

Sunderland Royal Hospital has 35 maternity beds across two wards: antenatal/postnatal ward (13 beds) and the delivery suite (22 beds). There also is an antenatal day unit and one theatre on site.

(Source: Trust Provider Information Request – Acute sites)

Sunderland maternity unit is purpose built and opened in 2000. It is situated on Level D in the Chester Wing. There is a community midwifery-led approach and additional support available from a team of consultants for patients with medium or high-risk pregnancies.

Antenatal care is provided by community midwives based in children's centres, GP practices and during home visits. The antenatal day unit is available for consultants, midwives and patients to refer into should they have any concerns about the wellbeing of the patient or baby. Staff on the antenatal day unit could undertake various investigations and arrange medical input should this be required.

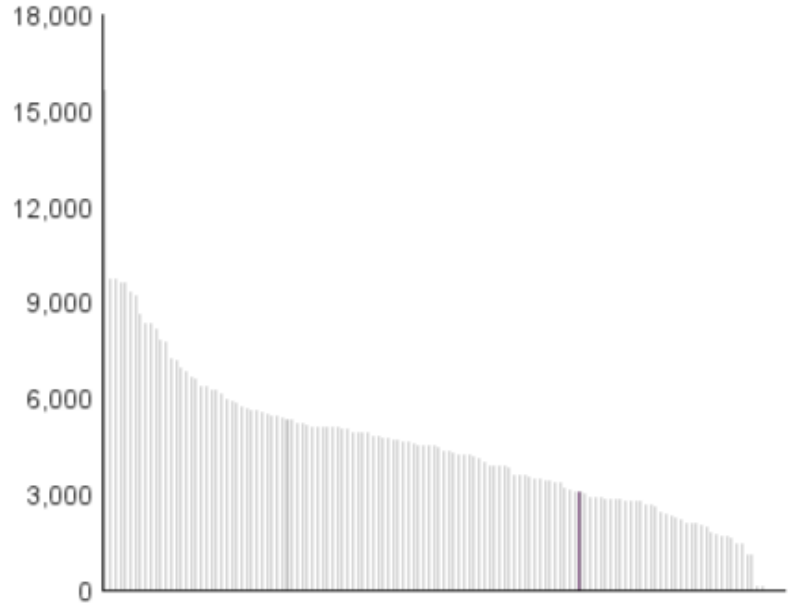
The delivery suite has 22 LDRP (labour, delivery, recovery and postnatal) rooms, which were single en-suite rooms.

(Source: Trust Provider Information Request – Context Acute)

From October 2016 to September 2017 there were 3,042 deliveries at the trust.

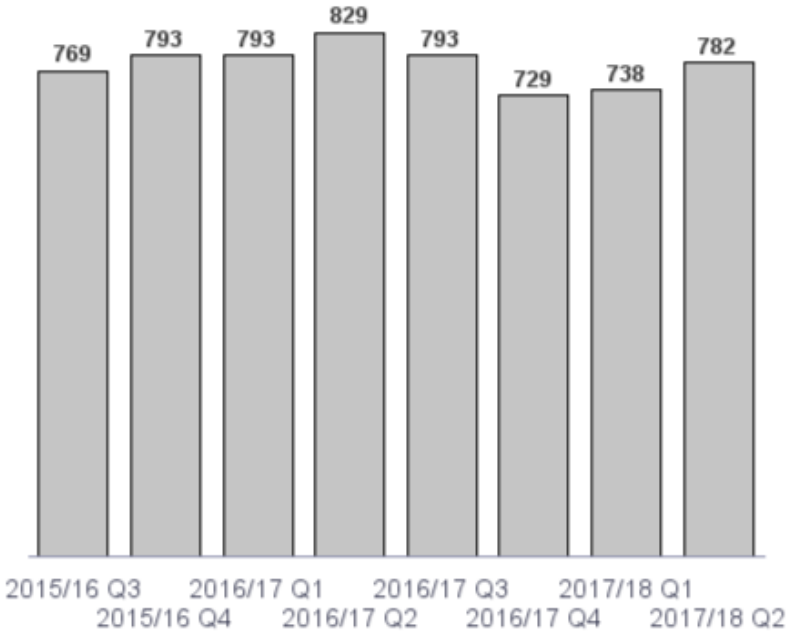
A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below.

Number of babies delivered at City Hospitals Sunderland NHS Foundation Trust – Comparison with other trusts in England.



Trends by quarter for the last two years can be seen in the graph below.

Number of deliveries at City Hospitals Sunderland NHS Foundation Trust by quarter



SOURCE: HES - Deliveries (October 2016 - September 2017)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Staff told us the mandatory training compliance target was 100% and staff would not be allowed to complete their annual appraisal without full compliance. With reference to the tables shown below, we spoke with staff about the compliance rates with mandatory training and were assured that the compliance figures would improve as the year progressed and so patient safety was not at risk.

A breakdown of compliance for mandatory courses from April 2017 to December 2017 for medical and nursing/midwifery staff in maternity is shown below:

Mandatory Training Completion by module – Medical Staff

Name of course	Number of eligible staff this year	Number of staff trained (YTD)	Completion Rate	Met (Yes/No)
Slips, Trips and Falls - Patient Falls	18	18	100%	Yes
Venous Thromboembolism	2	2	100%	Yes
Consent	2	2	100%	Yes

Conflict Resolution - Dealing with Violence and Aggression	12	12	100%	Yes
Resuscitation	15	12	80%	No
Fire Safety	18	14	78%	No
Maternity: NeoNatal Resuscitation	12	9	75%	No
Maternity: Obstetric Emergencies	12	9	75%	No
Fire Safety Classroom	18	13	72%	No
Equality, Diversity and Human Rights	18	13	72%	No
Information Governance	18	13	72%	No
Maternity: CTG	12	8	67%	No
Maternity: Theatre Recovery/EWS	12	8	67%	No
Blood Prescribing: Blood Components and Indications for Use	13	8	62%	No
Blood Prescribing: Safe Transfusion Practice	13	8	62%	No
Infection Control - Level 2	13	8	62%	No
Infection Control - Level 1	18	11	61%	No
Moving & Handling for People Handlers	14	8	57%	No
Grand Total	**240**	**176**	**73%**	

The 90% target was met for four of the 18 mandatory training modules shown above for medical staff. Moving and handling people handling training modules had the lowest completion rates with 57%.

Mandatory Training Completion by module – Nursing and Midwifery Staff

Name of course	**Number of eligible staff this year**	**Number of staff trained (YTD)**	**Completion Rate**	**Met (Yes/No)**
Moving and Handling - Level 1	1	1	100%	Yes
Conflict Resolution - Dealing with Violence and Aggression	4	4	100%	Yes
Fire Safety Classroom	141	135	96%	Yes
Slips, Trips and Falls - Patient Falls	140	134	96%	Yes
Resuscitation	140	132	94%	Yes
Fire Safety	141	132	94%	Yes
Maternity: Neonatal Resuscitation	140	129	92%	Yes
Maternity: CTG	136	123	90%	Yes
Maternity: Maternal and Newborn Screening	136	123	90%	Yes

Maternity: Obstetric Emergencies	140	124	89%	No
Maternity Infant Feeding	138	121	88%	No
Baxter Colleague Infusion Pump	136	118	87%	No
Alaris GH Syringe Drive	136	116	85%	No
Maternity: Mental Health Awareness	140	116	83%	No
Maternity: Theatre Recovery/EWS	140	114	81%	No
Information Governance	142	114	80%	No
Equality, Diversity and Human Rights	141	108	77%	No
Infection Control - Level 2	140	107	76%	No
Blood Administration Annual Refresher	136	103	76%	No
Moving & Handling for People Handlers	140	103	74%	No
Infection Control - Level 1	141	102	72%	No
Grand Total	**2649**	**2259**	**85%**	

The 90% target was met for nine of the 21 mandatory training modules shown above for registered nursing/midwifery staff. Infection control level one training module failed to meet the target with 72%.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The service had systems and processes in place to ensure that staff could access mandatory training and staff we spoke with confirmed they had enough time to complete mandatory training.

Staff we spoke with could show us and explain their department mandatory training matrix and assured us all staff including midwives, health care assistants, managers and medical staff, were rostered to attend all elements over a two-day course. Courses were held monthly and were organised for the whole team by a designated education midwife. Any staff who had not yet attended the two-day course had a date to attend to ensure 100% compliance within a 12-month period. Those who did not attend received a reminder, copied to their team leader.

Staff completed e-learning modules and classroom based sessions. The second day of each course was carried out using SimMom (an innovative, multi-disciplinary team training programme) at a local university. This was a scenario-based immersive suite and staff learned as a multidisciplinary team to incorporate the human factors element of learning. Sessions included management of shoulder dystocia, postpartum haemorrhage, and failed intubation for anaesthetists.

All maternity staff, including community midwives, completed skills training and emergency drills including birthing pool evacuation and obstetric emergencies.

Safeguarding

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding courses from April 2017 to December 2017 for medical and nursing/midwifery staff in maternity is shown below:

Safeguarding Training Completion by module – Medical Staff

Name of course	Number of eligible staff (YTD)	Number of staff trained (YTD)	Completion Rate	Met (Yes/No)
Safeguarding Children - Level 2	15	14	93%	Yes
Safeguarding Adults - Level 2	15	9	60%	No
Grand Total	30	23	77%	

The 90% target was met for one of the two safeguarding training modules shown above for medical staff.

Safeguarding Training Completion by module – Nursing and Midwifery Staff

Name of course	**Number of eligible staff this year**	**Number of staff trained (YTD)**	**Completion Rate**	**Met (Yes / No)**
Safeguarding Adults - Level 1	1	1	100%	Yes
Safeguarding Children (Version 2) - Level 1	1	1	100%	Yes
Safeguarding Children Level 4 - 3 Years	1	1	100%	Yes
Safeguarding Children (Version 2) - Level 3	132	123	93%	Yes
Safeguarding Children (Version 2) - Level 2	7	6	86%	No
Safeguarding Adults - Level 2	140	104	74%	No
Grand Total	**282**	**236**	**84%**	

The 90% target was met for four of the seven safeguarding training modules shown above for registered nursing/midwifery staff. Safeguarding children level two and safeguarding adults level two training modules both failed to meet the target with 86% and 74% respectively.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust had systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was everyone's business. Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns.

At the last inspection staff told us that additional midwifery hours had been created to support safeguarding processes. At this inspection the position had improved because the service had a dedicated safeguarding lead midwife, who worked alongside staff, and was responsible for safeguarding patients and children. Activities included further training. For instance, staff told us representatives from the local refuge provided teaching sessions for staff in a group supervision forum. The last session had been about domestic violence.

We saw that the trust had up to date safeguarding policies for adults and children.

In the period November 2016 to October 2017 the service made seven safeguarding referrals. All midwives could make safeguarding referrals via an electronic referral system. We saw red cards

used in patient records to identify any patient with a reported safeguarding concern. Staff told us an alert would also show on any electronic record. Staff could give us examples of safeguarding referrals made including domestic abuse, child protection, and female genital mutilation (FGM).

The service had a specialist midwife for children who worked closely with the trust paediatric team and two paediatric designated doctors. We saw evidence to show the team identified babies at risk at birth due to social issues. The service offered postnatal contraception prior to discharge specifically for vulnerable patients at risk of abuse. The service planned to widen this offer to all patients.

The lead midwife for safeguarding was also the FGM lead. In terms of FGM, patients were asked at antenatal booking about it and any answer was shared with the GP and health visitors. The trust had a policy to guide staff on issues relating to FGM. Staff could report using an online notification tool. Where a woman had had FGM the midwife would complete a notification in relation to the birth of the baby.

Any children at risk of child sexual exploitation were dealt with through the trust's safeguarding children processes.

The trust had a substance misuse midwife who was key in supporting patients who met the criteria for this service and had complex physical or psychological health needs. Examples of vulnerable patients included, patients involved in abuse of drugs or alcohol. Staff told us the specialist substance misuse midwife was involved in development of birth plans and worked closely with the mental health perinatal team.

Staff we spoke with were aware of the trust's abduction policy, which detailed actions to be taken in the event of a baby being taken. At this inspection staff told us the service had looked at introducing security tagging but had not found a suitable system. Instead, the service used swipe access doors in and out of the delivery suite together with a signing in book at the dedicated delivery suite reception. While the service did not use pressure alarmed mattresses, patients were reminded to stay with their baby, and the delivery suite reception was always staffed. We observed staff and visitors were compliant with ward security, using passes and challenging visitors. We observed notices on the doors reminding staff to ensure the door was closed. CCTV monitored the main corridor leading to the unit.

Cleanliness, infection control and hygiene

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene.

We found no cleaning rotas or checklists for delivery rooms or the birthing pool although there were checklists in electronic format so staff were aware of what was expected of them. Staff explained that every midwife was allocated a room at the beginning of a shift and it was their responsibility to ensure cleanliness and hygiene throughout their shift. Domestics held cleaning rotas for public areas and the domestic supervisor carried out spot checks of these areas. Staff told us cleaning audits were carried out quarterly.

Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and on corridors. There was clear signage encouraging visitors and staff to wash their hands. We observed staff using personal protective equipment when required, and they adhered to 'bare below the elbow' guidance. Staff encouraged visitors to use hand gel when they entered clinical areas.

Patients we spoke to said they had observed all disciplines of staff washing their hands and using hand gel. All wards displayed the results of hand hygiene audits. All the wards we visited achieved 100% in March 2018.

Single rooms were available in all areas if a patient needed to be isolated.

We observed staff cleaned equipment after use and used assurance stickers to indicate it was clean and ready for use.

We saw clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate utility areas were designated for clean and dirty use. Separate bins for clinical and domestic waste were evident throughout all wards visited. Waste was removed from the department twice a day.

Staff told us midwives had undertaken vaccination training and patients were offered flu vaccinations.

As part of the pre-operative assessment, patients were screened for Meticillin resistant staphylococcus aureus (MRSA) before undergoing elective caesarean sections.

Environment and equipment

We found that the wards were accessible using a buzzer system, with good signage. All entrances to the delivery suite and antenatal/postnatal ward were locked and admission was only possible via a telecom system. Staff and visitors gained entry and could only exit via a swipe card system. Closed-circuit television (CCTV) cameras were installed at the entrances to the wards. Visitors to the delivery suite were required to sign in and out and wore a visitor's badge. Badges were printed in different colours to show the time and day a visitor had entered the ward.

We visited the antenatal day unit and, while it was small, privacy was enhanced with the use of curtains in a four-bedded bay. For intimate examinations there was a separate treatment room across the corridor.

There were two dedicated obstetric theatres located just off the delivery suite, this enabled easy access. One theatre was in regular use for elective and emergency use and the second theatre was used approximately four times in the previous 12 months. Staff were allocated to keep this theatre clean and fully stocked every day.

Staff we spoke with reported having enough equipment that was ready and safe to be used. While staff reported there was a shortage of storage facilities which meant some equipment had to be stored on corridors, it did not pose a risk to patient safety.

Cardiotocography (CTG) equipment was available to enable staff to monitor the fetal heart rate in labour. The trust had a medical devices and equipment policy which set out how checks on equipment were done, how faults or damage were reported and what monitoring was in place. At the last inspection, we reported that a business case was being prepared to purchase a central station for fetal monitoring. At this inspection the system was in place, working, and staff reported it supported them in monitoring.

Planned preventative maintenance was managed between estates and team leaders. Repairs needed earlier could be requested through the estates department. All the equipment we saw had visible evidence of electrical testing indicating safety checks.

The delivery suite was situated on the first floor and could be accessed via a lift or stairs. Midwifery had a designated entrance but could also be accessed internally via the main hospital corridors.

Staff used the midwives' station for coordinator handovers and an empty delivery room for medical staff handovers. This allowed space for the whole team including anaesthetists to attend and discuss patient care in a confidential environment.

The delivery suite had a separate four-bedded recovery bay for patients who had undergone an elective caesarean section and fitted the criteria for enhanced recovery. Most of the delivery rooms had en-suite facilities and a wet room. Delivery rooms close to the midwives' station were used for patients with higher risk scores and other rooms were used for patients at lower risk. There was no separate midwifery led unit.

A birthing pool was available on the delivery suite and a safety net was stored in the room. Staff ran emergency pool evacuation simulation as part of their mandatory training.

At the last inspection we noted an issue with the airway rescue trolley. At this inspection we found no issues. Resuscitation trolleys were located on the main corridors in each of the areas we visited. We checked the resuscitation trolleys in all the clinical areas and found all stocks and supplies were checked in line with best practice in all clinical areas.

At our last inspection we reported wall-mounted resuscitaires did not have facilities for

blended oxygen. Staff told us at this inspection that all resuscitaires in LDRP (labour, delivery, recovery and postnatal) rooms were equipped with facilities for blended oxygen, in line with guidance from the Newborn Life Support Resuscitation Council (UK) (2010).

We found resuscitaires on corridors made up with bedding but staff could not tell us how long they had been prepared for and therefore if cleanliness could be assured. Staff immediately removed the bedding and stored it ready for use in a bag to keep it free from dust and infection.

Assessing and responding to patient risk

Within the maternity service staff used the modified early obstetric warning score (MEOWS) and the national early warning score (NEWS) respectively to assess the health and wellbeing of patients. These assessment tools enabled staff to identify if a patient's clinical condition was changing. Patients on the delivery suite and antenatal/postnatal ward were assessed using the MEOWS score.

We reviewed seven sets of records and found there was sufficient and regular information recorded for staff to assess patients' conditions and staff understood escalation protocols and interventions.

The trust sepsis pathway complied with NG51 NICE guidelines. There was a specialist midwife for sepsis and a lead obstetrician. The sepsis pathway was embedded in maternity care and staff used flags to identify sepsis risks.

Staff used the World Health Organisation (WHO) safety checklist, modified for maternity, for all interventional procedures and staff told us the checklist would be started in the delivery room from the time of decision to proceed. We observed completion of the checklist in theatre and reviewed records of two patients who had been to theatre. All WHO checklists had been completed correctly.

We observed two surgical procedures, one of which we left after the preparation stage, and found arrangements were in place to ensure checks were made prior to, during and after in accordance with best practice principles.

We observed midwives and medical staff handovers and saw staff at all levels and grades took part fully in handovers of care from one shift to the next. Staff gave updates on labouring patients, transfers to and from other wards or theatre and details of patients requiring additional care. We saw staff used a situation, background, action and result (SBAR) framework to transfer between teams. This appeared to work well.

We saw evidence the unit used the 'fresh eyes' approach, a system that required two members of staff to review fetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation of the heart tracings. Further, staff could see 'live' fetal heart tracings on screens located at the nursing station.

Midwives completed risk assessments at booking to identify patients with any medical, obstetric, psychological or lifestyle risk factors. This determined if an individual was high or low risk. High risk patients were referred to consultant led antenatal clinics.

Consultant obstetricians were available out of hours for emergency caesarean section and if a condition gave rise for concern.

The service had an agreement in place with the local ambulance service to attend babies born before arrival at home. Community midwives told us they informed the ambulance service before attending any home birth in case an emergency arose.

Midwifery and nurse staffing

The service employed a total of 84 midwives of all grades and 16 health care assistants. Two new housekeeper posts had been recently created to organise and replenish stores and supplies. Staff had been recruited but had not yet started in post.

Midwife staffing levels were risk assessed daily and the service used Birthrate Plus to manage and balance risk. Staff told us they currently ran the service with a deficit of 11 midwives due mainly to several staff being on maternity leave at the same time. The latest Birthrate plus model in 2018 had shown the department was two or three midwives short. Following presentation of a business case to the trust board they had been allowed to over recruit by four midwives to ensure a safe service.

We found staffing levels were displayed on the entrance to all wards and during the inspection we saw that planned and actual staffing levels matched. Staff on delivery suite told us this was managed well.

At our last inspection we reported there was a lack of formal handover of care for interdepartmental and intradepartmental transfers using formal handover tools such as Situation, Background, Assessment, Recommendation (SBAR). At this inspection we noted midwives used this tool when a patient was transferred from one midwife to another.

We observed a medical handover from the night team to the day team. The handover was attended by the consultant and junior medical staff and included the midwifery coordinator, anaesthetists, and gynaecology medical staff. The handover was comprehensive and included

feedback regarding postnatal patients, patients receiving midwifery-led care and patients being treated by gynaecology. The handover was detailed and concise. Clinical information was discussed formally and recorded in handover notes.

Staff told us they discussed staffing and patient allocation at the coordinator handover and we observed this was recorded on the coordinator's handwritten sheet. We were told, and we saw from notes made on coordinator sheets, this was used to communicate wider issues which needed dissemination, for example, learning from incidents.

Vacancy rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a vacancy rate of 1% in maternity. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a turnover rate of 12% in maternity. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

The service told us the turnover rate was historical and not a concern and was caused by staff retiring and staff graduating moving elsewhere.

Sickness rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a sickness rate of 6% in maternity, compared to the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness).

Staff told us there had been some long-term sickness and that staff were beginning to recover and return to work. Staff taking regular sick days were met with to manage and support their needs.

Bank and agency staff usage

Maternity had 330 shifts filled by bank staff, which was the sixth highest core service uptake within the trust.

The trust did not provide accurate data for the total number of shifts overall and therefore we are unable to calculate the total number of shifts covered by bank and the number of shifts left unfilled.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Data supplied by the trust showed that in the last 12 months a total of 36 nursing assistant shifts and 66 other staff shifts were filled by bank staff on the delivery suite. The service did not use agency staff.

Midwife to birth ratio

As of September 2017, the trust had a ratio of one midwife to every 26 patients, which was about the same as the England average and similar to the previous period.

(Source: Electronic Staff Records – ESR Data Warehouse)

The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (2007) recommend a ratio of one midwife to 28 births (1:28). Staff we spoke with told us, as of April 2018, the midwife to birth ratio was 1:29, and they were assured that patients received safe care through audit results and friends and family survey results.

At the last inspection, staff told us they did not always achieve one to one care in labour. At this inspection, we noted the position had improved. For the period April 2017 to March 2018, the

average percentage for one to one care in established labour was 94%. During a busy period, when the service had accommodated extra patients when a neighbouring unit had closed for six weeks in December 2017 and January 2018, the percentages were 92% and 91% respectively.

We spoke with five patients who said they had received one to one care in labour.

Medical staffing

There were 11 full time equivalent (FTE) consultants in post. They provided 66 hours medical cover per week. This was higher (better) than the Safer Childbirth standard of 60 hours per week for a unit with 2500 to 6000 births. Medical staff provided a rota with a "consultant of the week" for the delivery suite and antenatal/postnatal ward between 8.30am and 6pm from Monday to Friday.

Consultant on-call cover was provided for nights and weekends. Out of hours, the on-call consultant was required to attend within 30 minutes when needed. Staff reported consultants were contactable when required and said they received consultant and medical care which met their needs.

Specialty trainees provided cover for every shift.

Daily antenatal and postnatal ward rounds took place in line with current guidance.

A consultant anaesthetist was allocated to the delivery suite and was available 24 hours a day, seven days a week.

Vacancy rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a vacancy rate of 3% in maternity. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From January 2017 to December 2017, Sunderland Royal Hospital reported a turnover rate of 7% in maternity. The trust did not provide a target rate.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From January 2017 to December 2017, Sunderland Royal Hospital the trust reported a sickness rate of 7% in maternity, compared to the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

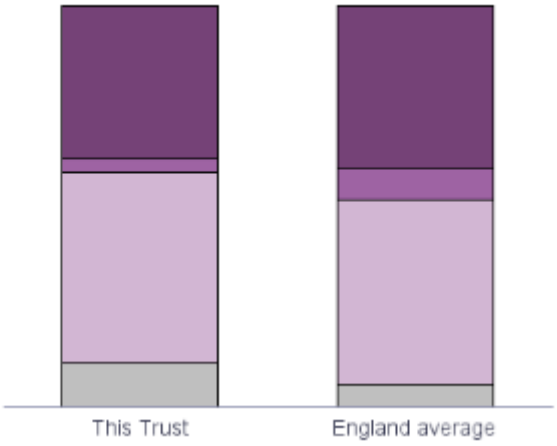
From January 2017 to December 2017, Sunderland Royal Hospital did not report any bank and locum usage in maternity.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

In October 2017, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 27.9 whole time equivalent staff working in maternity at City Hospitals Sunderland NHS Foundation Trust



	This Trust	England average
Consultant	38%	40%
Middle career^	4%	8%
Registrar group~	48%	46%
Junior*	11%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

We reviewed seven sets of records and found them to be legible, detailed, signed, and safely stored. Records showed each patient had a named midwife responsible for their care. Individualised care plans for pregnancy and labour were documented and venous thromboembolism (VTE) risk assessments were completed.

Patient records were a mix of electronic and paper patient notes (for instance, inpatient notes and nursing care plans were paper based). Paper records were stored on site and maternity used an electronic record so data could be shared with community services. The trust told us they were in the process of transitioning to full electronic patient records in the community.

Patients carried their own hand-held records throughout their pregnancy. These were shared with community midwives and GPs. Results from antenatal tests were documented in these records.

Antenatal risk assessments were completed at booking to identify any medical, obstetric, or psychological risk factors. Midwives we spoke with told us risk assessments were repeated at each antenatal visit. We saw evidence of this in records we reviewed.

Information relating to discharge was communicated using the SBAR tool to ensure timely communication on discharge from the maternity unit. Information was sent by post to patients' GPs and health visitors, while community midwives could access the information electronically. Staff said if a woman had complex needs they would contact the relevant professional in addition.

All staff could access test results using the trust's electronic system.

Staff we spoke with told us senior midwives undertook a monthly spot check record audit of records and results were reported at staff meetings. Any trends or good practice were disseminated to clinical areas.

Medical records were stored securely in line with the trusts data protection policy.

The ‘fresh eyes’ approach was used to review CTG’s and we saw evidence of this in the patient records we reviewed.

At the last inspection we reported that there was a risk posed to patient confidentiality by some computer screens facing outwards. We did not find this to be an issue at this inspection. When a screen was not in use it was locked. When in use it was not possible to see any patient information when walking past.

Medicines

We checked the storage of medicines on the wards we visited. We found that medicines were stored securely in appropriately locked rooms and fridges and stocks were in date.

We checked the storage and administration of controlled drugs, which require specific controls, in all clinical areas. We found controlled drugs were appropriately stored with access restricted to authorised staff. Records showed the administration of controlled drugs were subject to a second check. After administration, the stock balance was confirmed to be correct and the balance recorded. Intravenous fluids were securely stored in all the clinical areas we visited.

Medicines that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. All fridge temperatures were checked and recorded daily. There were no gaps in recording. Staff we spoke with understood their responsibilities for raising concerns if the fridge temperature went out of range.

We checked six prescription charts. Records showed patients were receiving medicines promptly and any allergies were clearly recorded.

All midwives were practising under patient group directions (PGDs). (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicine(s) to a predefined group of patients without them having to see a doctor.) Records showed PDGs were in date and included exemptions.

Community midwives told us all home birth equipment, including medicines and medical gases, was stored on the delivery suite and they would collect the pack immediately before attending a patient at home. Community midwives did not carry or transport medical gases at any other times.

Incidents

The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trust’s electronic reporting system. The staff we spoke with could describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses.

Between February 2017 to January 2018 there were 802 incidents specifically categorised as obstetrics and reported to the National Reporting and Learning System (NRLS), which was the fourth highest number of incidents of any core service. No reported incidents resulted in severe harm and there were no incidents recorded as resulting in death. 585 of these (73%) resulted in no harm, 215 (27%), resulted in low harm, and two (0.2%) resulted in moderate harm. The most commonly reported incident category was ‘treatment, procedure’ with 181 followed by ‘clinical assessment (including diagnosis, scan, tests, assessments’ with 127. Overall, there was a downward trend in the numbers of most types of incidents reported.

Staff told us they completed details of actions taken to prevent a recurrence of an incident and for serious incidents they also identified and documented areas of good practice followed by staff. Most incidents (94%) were reported to NRLS within 30 days which was similar to the proportion at trust level.

Staff we spoke with said feedback from incidents was shared in many ways including; staff meetings, case reviews, and face to face feedback.

Staff told us medical staff held maternity case review meetings three mornings a week to discuss individual cases. These meetings were open to the whole team. We saw records of these meetings where staff provided a description for each case, evidence from medical records and a timeline of events. There was evidence of a team discussion and lessons learned. Staff also highlighted any areas of good practice.

The service held monthly perinatal mortality meetings (attended by gynaecology, obstetric and neonatal staff). The trust provided one set of minutes from January 2018 where serious case reviews were discussed.

We reviewed two root cause analysis reports (RCA) from serious incidents and found actions plans and lessons learnt were identified. (One of the RCAs we reviewed was for the never event which had occurred). Actions taken after the RCA findings included providing feedback to staff.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Staff we spoke with understood and could describe duty of candour requirements and understood the importance of being open and honest with patients. It was evident in the serious incident investigations we reviewed that the duty of candour had been applied.

There were clear escalation processes to activate plans during internal critical incidents such as shortfalls in staffing levels or bed shortages.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2017 to December 2017, the trust reported one maternity/obstetric incident: mother only, which was classified as a never event for maternity. This was for a retained swab following instrumental delivery.

The trust provided their root cause analysis (RCA) report with lessons learned and actions to be taken immediately and in future by medical and midwifery staff to prevent any repetition of this type of incident. During our inspection, we saw evidence of the changes that had been put in place.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two maternity/obstetric incidents meeting serious incidents (SIs) criteria: mother only, in maternity which met the reporting criteria set by NHS England from January 2017 to December 2017.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.

At our last inspection we reported we found no evidence of the NHS safety thermometer in use by the service. However, at this inspection, we found the NHS safety thermometer displayed on the wards we visited. At the time of our inspection staff had reported 100% harm free care with no falls or pressure ulcers on any of the wards we visited. Hand hygiene and bare below the elbow checks were 100% compliant every month.

The trust told us they found overall performance with the safety thermometer was very positive, and reviewed it monthly. Each ward received individual feedback and results and the matron developed actions to address these where necessary.

Is the service effective?

Evidence-based care and treatment

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) and Royal College of Obstetricians and Gynaecologists (RCOG). All staff we spoke with could access on the trust's intranet, guidelines, policies and procedures relevant to their role.

We spoke with the clinical lead responsible, along with a midwife, for ensuring that clinical guidelines were updated in accordance with NICE or RCOG guidelines, and had an author and a review date. This team met weekly. Once reviewed, a policy would be circulated, and after comments had been received, the clinical and governance committee would sign it off for wider distribution to staff as approved.

On a review of clinical pathways and guidelines we found that many guidelines had an author and were within their review date. However, as in the last inspection in 2014, there were many guidelines that were beyond their published review date.

The service was assured that patient safety was not at risk because staff told us those guidelines awaiting review were those that were little used in practice. The team leading the review of guidelines told us that guidelines that were impacted by changes in NICE or RCOG guidance had been prioritised for review. Further, before we left site, staff informed us that to ensure the actions to address the reviews were monitored and visible, this issue would be placed on the service's risk register. The team were making progress with their review work, with nine guidelines having been signed off in the previous week to the inspection.

The service had an annual national and local audit programme. Doctors and midwives were involved in the audit programme. For instance, we saw audits on maternal and fetal monitoring in labour or indication for induction of labour. Actions from audits were discussed and monitored at clinical governance meetings and following monthly presentation of audits.

Staff used the growth assessment protocol (GAP) which drew on standard fundal height measurements and plotted this on a customised growth chart.

The service had an active research programme with five research midwives who had all been 'good clinical practice' trained who met monthly to discuss the progression of the research programme. The research was used to inform evidenced based care.

Nutrition and hydration

For nutrition and hydration, the service met the needs of patients having babies, babies and visitors, carers or relatives of both.

For patients undergoing labour on the delivery suite there was toast, or if appropriate, a light diet, whereas on the antenatal and postnatal ward patients had a varied choice from a menu of hot food. Drinks were available to patients. Meal times took place at set times to help patients to obtain their nutrition and hydration in a supportive way.

For those patients who had specific dietary needs staff explained to us how different food could be ordered from the kitchen.

The United Nations Children's Fund (UNICEF) baby friendly initiative is a global accreditation programme developed to support breast feeding and promote parent/infant relationships. The service was fully accredited and staff told us a re-assessment was due in 2018. The service had a breastfeeding coordinator who was responsible for the coordination of quality infant feeding practices.

The service had a range of initiatives to support patients to breastfeed, and make informed choices and receive support, including trained breastfeeding support staff, volunteers, and a social media platform called 'bosom buddies'. The team of trained breastfeeding staff worked at the hospital and in the community. Patients who wished to feed using formula milk were advised to bring their milk in with them in ready made up bottles.

Visitors, relatives and carers had access to drinks and snacks from a vending machine at the delivery suite reception.

Before the baby left, all new born baby checks were done at the hospital by staff in the adjacent neonatal unit with support from paediatricians. The service was in the process of training some of its midwives to enable them to carry out new born baby checks.

Community staff we spoke with explained that they carried weighing scales to monitor the weight of mums and babies to ensure nutrition was taking place.

Pain relief

To help patients manage their pain we saw that the service could offer a range of options, both medical and non-medical. Patients we spoke with did not report any issues with the management of their pain.

Staff told us that patients could use the birthing pool to help them manage their pain. Telemetry for use in the pool, to permit continued monitoring of the baby while the patient was in the pool, could be loaned if necessary. In addition, there were birth balls available or a TENS machine supplied by physiotherapy colleagues.

For those patients who wanted medical pain relief there was 24/7 anaesthetic cover available to the service for epidurals. We saw a local audit of patient satisfaction with epidurals. For the period 1/4/2017 to 31/3/2018 out of 492 epidurals, 234 patients said they were very satisfied with the epidural with most of all other respondents saying they were satisfied and only 12 saying they

were unsatisfied. In the same period, 82% of patients had received their epidural within 5 minutes of requesting it.

Other medical pain relief consisted of injectable diamorphine or use of air and gas which was piped into each labour, delivery and recovery room.

In the community, staff told us any required pain relief for a home birth would be prescribed by the GP but staff attending from the delivery suite would bring with them air and gas.

Patient outcomes

The service had systems and processes in place to monitor patient outcomes. This included: three weekly case reviews, use of a maternity dashboard, safety thermometers, and taking part in a programme of national and local audits, the results from all of which were used to improve the experience of its patients.

In relation to the dashboard, at the last inspection, we were told that there were problems with extracting and accessing data from systems to populate a dashboard. At this inspection there had been some improvement as the service had an electronic dashboard which presented raw data on certain key indicators. Staff told us it had been challenging to get to this position. The dashboard was not fully developed. There was no parameters or any way to show which indicator was at green, amber or red status. Staff told us that this could be added and that they were assured they knew where they were at on each indicator. The RCOG good practice guide suggests use of red, amber, green to show when results were at a high or low threshold. The guide also suggests using parameters such as the ones below in order to monitor deviation from expected performance;

- clinical activity
- workforce
- clinical outcomes
- risk incidents/complaints or patient satisfaction surveys.

Staff described how they used the data in the dashboard. For instance, they were aware that the number of spontaneous births (147) was low. In relation to forceps delivery, the national position was 7%-15% and the service at Sunderland was 9.3%.

Trust wide data provided by the service showed between April 2017 and March 2018, the unit reported 1.3% of vaginal births at the unit experienced 3rd and 4th degree tears. This was better than the England average of 2.3%.

Between April 2017 and March 2018, the number of women who had a post-partum haemorrhage of more than 1000mls was 2.2% this was better than the England average of 8.5%.

Between April 2017 and March 2018, the number of babies born with an Apgar (appearance, pulse, grimace, activity, respiration) score of less than seven at five minutes, was 4.3% this was marginally worse than the England average of 4%.

Staff explained that they used the dashboard, not in isolation, but as a tool to improve patient outcomes. If an indicator was worse than expected they would discuss it at one of the forums used to monitor quality or risk, such as the weekly case review meetings.

This outlier was not necessarily an indicator of poor performance but did require investigation. The service used the dashboard to monitor how many cases met the criteria and then carried out a

detailed review of each case to see whether the outcome could have been improved. Training for staff was organised and staff told us the scores were improving.

A sample of audits undertaken are shown below together with a brief comment about the audit where necessary.

National Neonatal Audit Programme (NNAP)

In the 2016 National Neonatal Audit, Sunderland Royal Hospital's performance was as follows:

Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?

- There were 60 babies born at <32 weeks included in this audit measure for the unit. 98% of these babies had their temperature measured within an hour of birth. This was above the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

- There were 95 eligible mothers identified for inclusion in this audit measure for the unit. Of these mothers, 87% were given a complete or incomplete course of antenatal steroids. This was above the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

What proportion of babies < 33 weeks gestation at birth were receiving any of their own mother's milk at discharge to home from a neonatal unit?

- To more confidently attribute feeding outcomes to the unit, only babies who had a final neonatal discharge to 'home' at the end of their first episode of neonatal care are included in this analysis. Babies who were transferred between neonatal units at any point are excluded.
- There were 42 babies born at < 33 weeks who met the criteria for inclusion in the unit. Of these babies, 53% were receiving mother's milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit. This was below the national average, where 59% of eligible babies were receiving any mother's milk at the time of their discharge from neonatal care.

(Source: National Neonatal Audit Programme*, Royal College of Physicians and Child Health)*

The NNAP assesses whether babies admitted to neonatal units in England receive consistent high-quality care. It identifies areas for quality improvement in relation to the delivery and outcomes of care.

The service had a breastfeeding co-ordinator part of whose role it was to try and improve the breastfeeding rates of patients attending the service.

Standardised Caesarean section rates and modes of delivery

From July 2016 to June 2017 the total number of caesarean sections was lower than expected. The standardised caesarean section rates for elective sections as expected and rates for emergency sections lower than expected.

Standardised caesarean section rates					
Type of caesarean	**England**	**City Hospitals Sunderland NHS Foundation Trust**			
	Caesarean rate	**Caesareans (n)**	**Caesarean rate**	**Standardised Ratio**	**RAG**
Elective caesareans	12.1%	331	10.7%	101.2 (z=0.1)	Similar to expected
Emergency caesareans	15.4%	335	10.8%	72.4 (z=-2.3)	Lower than expected
Total caesareans	27.5%	666	21.6%	84.3 (z=-2.2)	Lower than expected

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

In relation to other modes of delivery from July 2016 to June 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

Proportions of deliveries by recorded delivery method			
Delivery method	**City Hospitals Sunderland NHS Foundation Trust**		**England**
	Deliveries (n)	**Deliveries (%)**	**Deliveries (%)**
Total caesarean sections[1]	666	21.6%	27.5%
Instrumental deliveries[2]	459	14.9%	12.5%
Non-interventional deliveries[3]	1,964	63.6%	59.7%
Other/unrecorded method of delivery	0	0.0%	0.3%
Total deliveries	3,089	100%	100% (n=608,950)

[1]Includes elective and emergency caesareans
[2]Includes forceps and ventouse (vacuum) deliveries
[3]Inlcudes breech and normal (non assisted) deliveries

Normal (non-assisted) delivery rates were higher than the England average and total caesarean sections were lower.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As of January 2018, the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

In November 2017 the service was identified by the National Maternity and Perinatal audit (NMPA) as an outlier for one of its audit indicators, namely, an Apgar score of less than seven at five minutes. The service carried out an audit and satisfied themselves that patient safety was not at

risk. However, the service put in place actions to ensure, going forward, that the outlier was not repeated, if possible.

As noted above, the issue was being actively monitored on the service's maternity dashboard, with each case being looked at in detail to see if anything could have been done differently.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.36. The comparator group was 6.44.

(Source: MBRRACE UK)

The service scored better than the comparator group in the above audit. To support staff in monitoring baby heart rates, and thus reduce the number of still births, the service had invested in cardiotocograph (CTG) screens in the delivery suite which showed a 'live' feed of any woman in the service who were attached to a CTG. In addition, we saw that CTG training was part of the mandatory training for all staff which took place over two days in each year.

Competent staff

To place the information below about appraisal rates in context, following the inspection the trust told us that the target rate for appraisal completion was 90%. Latest data supplied the trust showed that for maternity, the combined staff nurse and healthcare assistant completion rate for appraisal was 90%. Staff we spoke with confirmed that they had received an annual appraisal or were booked to receive one.

Appraisal rates

As at January 2018, 57% of staff within maternity at Sunderland Royal Hospital had received an appraisal. Registered nursing and midwifery staff had a 61% appraisal completion rate.

The trust did not provide a target completion rate.

A split by staff group can be seen in the graph below:

Staffing Groups	Individuals required (YTD)	Staff who have received an appraisal (YTD)	Completion Rate
NHS Infrastructure Support Staff	3	3	100%
Qualified Nursing Midwifery Staff	71	43	61%
Qualified Allied Health Professionals	2	1	50%
Support to Doctors and Nursing Staff	7	2	29%
Other Qualified Scientific, Therapeutic, Technician Staff	3	0	0%
Grand Total	**86**	**49**	**57%**

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The service ensured that staff were competent in their roles by ensuring staff received an annual appraisal, or through sharing information by email or at team meetings or in a newsletter, and by offering staff additional training, including support for the new professional midwife advocate role.

Staff told us that there were eight professional midwife advocate roles. This role had replaced the supervisor of midwives' role. Midwives felt supported particularly around revalidation. Student midwives we spoke with reported that they felt well supported and newly registered midwives worked through a preceptorship package. Staff told us all newly registered staff spent their first month as supernumerary and were allocated a preceptor. They would spend their first 12 months working on delivery suite with no night shifts for the first six months. All staff, except specialist midwives and community midwives, rotated six-monthly between delivery suite and the antenatal/postnatal ward to ensure up to date skills and competence in all areas.

The service had many midwives occupying specialist roles, such as research, substance misuse, bereavement, safeguarding and breastfeeding. The head of midwifery was the bereavement lead for the service.

We saw that staff were given the opportunity to become involved in audits and had received training and support in how to carry out an audit effectively. At a meeting of their peers, staff involved in audits would present their audit and action plan.

At the yearly two-day training staff received training in sepsis awareness, neonatal life support, basic life support, the deteriorating patient, and pool evacuation. This training was multi-disciplinary and attended by all staff.

Third parties, such as bereavement charities, were encouraged and supported to attend the service to supply further training to staff.

We were told that staff in the hospital had arranged to supply additional training to community staff around mental health, GAP charts, fetal monitoring, and diabetes.

Junior doctors reported to us that they felt well supported and felt able to approach senior colleagues if advice was needed.

Multidisciplinary working

To ensure effective services were delivered to patients, we saw different teams and health professionals working with staff at the service.

At a handover from night to morning staff that we observed we saw that there was open and honest, structured, and detailed communication between doctors, midwives, and anaesthetists. By attending the handover, anaesthetists were made aware of any high-risk patients.

The service paired consultants and midwives together to oversee certain work streams such as review of clinical guidelines or the annual audit programme. All meetings were open meetings so if any staff member wished to attend, for example, a consultant meeting on a Wednesday, they were welcome to do so.

Hearing screeners were part of the new born team and worked across the region but were based at the hospital.

We saw that healthcare assistants were a highly valued part of the team who assisted, amongst other duties, with the running of clinics and were trained to provide breastfeeding and antenatal smoking cessation support in the community and at the hospital.

Many clinics that the service ran drew on specialist consultants or other health professionals from outside the service such as the diabetic clinic which was run by an endocrinologist and dietitian. Also, the maternal medicine clinic was run by a consultant in epilepsy.

The substance misuse midwife worked closely with GPs, social workers, health visitors, and support workers, in addition to local support groups, to ensure that vulnerable patients received effective care. This midwife had good links with the perinatal mental health team who could provide assessment and treatment as necessary. For example, we were told of a case where the mental health team stayed with a woman who had a diagnosis of psychosis.

The trust had a multi-faith chaplaincy team that worked closely with clinicians in the service to support families with bereavement.

Staff in the community setting worked with the safeguarding midwife and interested agencies, such as advocate agencies, to ensure patients had effective care. The substance misuse midwife was also a source of expertise for these staff to draw on.

While community staff no longer rotated into the hospital, (although they were used in escalation in low risk areas), staff at the hospital reported that links with community staff were effective. This was because of the multi-disciplinary two-day training which took place each year, and because of contact through additional training given by hospital staff to community staff, and by use of daily communication books and emails.

We saw an example of a discharge summary which was legible, detailed, signed and dated. However, because the GPs were not on the same system, although the summary was electronic, it had to be posted out. Community midwives could access the electronic discharge summary and they worked out of local GP surgeries.

Seven-day services

Apart from the antenatal day unit and clinics, the service was open 24/7 with access to at least one dedicated theatre on the unit and full anaesthetic cover.

Consultants conducted two ward rounds a day and were on call out of hours. We spoke with some consultants who confirmed all consultants were available to attend the service within 30 minutes of being called to attend. Some consultants made use of the on-call room on site which was available. This meant they could respond more quickly if they were needed. Out of hours an anaesthetist was on call 24/7. No concerns were expressed about the availability of consultants or anaesthetists.

The antenatal day unit was open Monday to Sunday 08:30 to 20:00. Out of hours patients were referred to the delivery suite or, if this was busy, the antenatal ward. Staff told us that the service was looking to extend the opening hours to 23:00 throughout the week.

Antenatal clinics were open Monday to Friday from 08:30 to 18:00 with no cover at weekends.

Staff reported that they had enough sonographers for scans, (four midwife trained sonographers and eight supplied by the radiology department) and were meeting all the key performance indicators for the growth assessment protocol (GAP).

Health promotion

The service had various initiatives running to promote healthy lifestyles, including around smoking cessation and obesity, and had some specialist midwives in post to support this vital work.

The service had a public health midwife who oversaw the smoking cessation programme. Patients were seen at the dating scan and supplied with smoking cessation advice. The healthcare assistants had been trained to recruit patients who were smoking into the local 'myquit' trial.

Another specialist midwife ran an obesity clinic at which patients with high body mass index scores received advice about diet and exercise and healthcare assistants carried out glucose tests.

Midwifery staff in the community ran parenting classes and this included advice about healthy lifestyles and referred patients to third parties who could provide support with exercise, such as aerobic swimming classes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff knew the importance of gaining consent to treatment and had received training in consent, mental capacity and deprivation of liberty safeguards. While there was a consent for examination or treatment policy the trust told us it was under review.

Data supplied by the trust showed that 75% of staff working in the service had completed the training on mental health awareness. Staff told us this was a three-yearly requirement with standalone sessions which staff could access.

Our discussions with staff and review of patient records showed that consent was written where there was some sort of medical procedure involved, such as a caesarean section, but verbal for everyday tasks, such as taking blood pressure. For instance, we reviewed three records of patients undergoing a medical procedure and noted that consent was properly evidenced in writing in all three records. Patients would have been given relevant background information for procedures involving written consent, say in a caesarean section preparation clinic. This promoted better understanding and ensured consent was informed consent.

Staff could describe what was meant by Gillick competence, (a test used to assess a young person's ability to give consent), with staff informing us this was part of their mental health awareness training. Staff gave examples when they would use this.

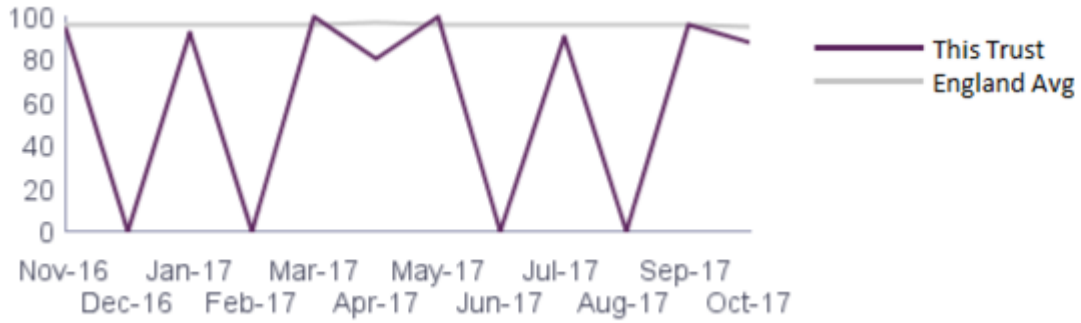
We were told by staff that they had good support from the mental health team which was supplied by a local trust but could also draw on support and advice from their own mental health liaison team. A pathway existed for vulnerable patients and staff told us that if a patient was diagnosed, say with psychosis, the mental health team from the local trust would stay with them. A vulnerability assessment was completed and this ensured that the patient was reviewed postnatally as well as ante-natally and referrals made to appropriate third-party support agencies.

Is the service caring?

Compassionate care

Friends and Family test performance

Friends and family test performance (antenatal), City Hospitals Sunderland NHS Foundation Trust



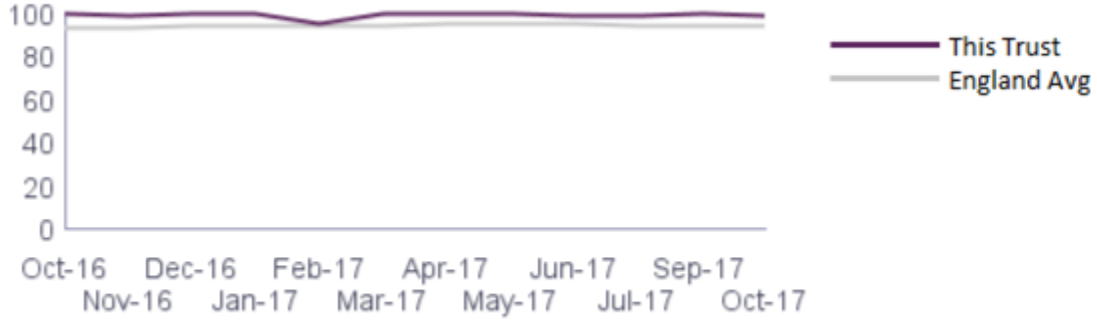
From November 2016 to October 2017 the trust's maternity friends and family test (antenatal) performance (% recommended) had four months in the period with less than six responses which shows on the graph as a 0% recommend.

For the months where there were more than six responses the trust was worse than the England average for four months, similar for two months and better for two months. In the latest period, October 2017, performance for antenatal was 88% compared to the England average of 96%.

Friends and family test performance (birth), City Hospitals Sunderland NHS Foundation Trust

From November 2016 to October 2017 the trust's maternity friends and family test (birth) performance (% recommended) was better than England average. In the latest period, October 2017 performance for birth was 100% compared to the England average of 96%.

Friends and family test performance (postnatal ward), City Hospitals Sunderland NHS Foundation Trust



From October 2016 to October 2017 the trust's maternity friends and family test (postnatal ward) performance (% recommended) was better than the England average. In the latest period, October 2017 performance for postnatal wards was 99% compared to the England average of 94%.

(Source: NHS England Friends and Family Test)

CQC Survey of women's experiences of maternity services 2017

The trust performed about the same as other trusts for 17 out of 19 questions in the CQC maternity survey 2017 and among the best performing trusts for the remaining two questions.

Area	Question	RAG	Score
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	About the same	8.6
	During your labour, were you able to move around and choose the position that made you most comfortable?	About the same	8.4
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	About the same	9.8
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	About the same	9.2
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	About the same	9.4
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	About the same	8.2
	Thinking about response time, if attention was needed during labour and the birth, did a member of staff help within a reasonable amount of time?	About the same	9.1
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	About the same	7.7
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	About the same	9.6
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	About the same	8.9
	Thinking about your care during labour and birth, were you treated with respect and dignity?	About the same	9.5
	Did you have confidence and trust in the staff caring for you during your labour and birth?	About the same	9.2
Care in hospital after the birth	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	About the same	7.4
	Looking back, was there a delay in being discharged from hospital?	About the same	6.2

	Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?	Best performing trusts	8.6
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	Best performing trusts	8.7
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	About the same	9.3
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	About the same	8.7
	Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?	About the same	8.2

The two questions that scored among the best performing trusts were 'Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?' and 'Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?'

(Source: CQC Survey of Women's Experiences of Maternity Services 2017)

Staff told us that patients completed Friends and Family Realtime feedback and reported a 40% response rate for March 2018. Managers congratulated staff on such a good response for a patient survey.

Displayed at the midwives' station, we saw letters and cards of appreciation and positive comments about patients' experience.

We spoke with five patients and four partners, all of whom spoke positively about their experience. Patients told us they felt well cared for and that the midwives made them feel safe. Patients told us staff were always available if they needed them and staff introduced themselves. One patient told us I "can't speak highly enough about staff and care". Patients and partners described staff as "caring, supportive, professional, reassuring and compassionate".

In all areas we inspected, we observed staff reacted promptly to telephones and call bells.

Patients could contact the antenatal day unit or their community midwife if they had any concerns. We observed good interaction between midwives in the antenatal day unit and patients attending there. We heard staff providing encouragement and reassurance to patients who were anxious or worried.

Emotional support

In all areas we inspected, staff valued and cared for families' emotional needs.

At our last inspection we reported the service did not have a dedicated bereavement facility. However, at this inspection, we noted the delivery suite had a separate bereavement suite, away from the main delivery suite, so patients and their families experiencing pregnancy loss had privacy. Staff said families used the suite usually for around 24 hours. The bereavement suite had

been developed using a donation of funds from a family who had suffered a loss and they continued to support the unit. The chaplaincy service could also provide support if requested.

Staff had received bereavement training and support from the Stillbirth and Neonatal Death Society (SANDS), a charity that provides support for bereaved parents and their families.

The delivery suite offered a memento package to families who had experienced a stillbirth or neonatal death. Memory boxes were offered to patients who had suffered an early pregnancy loss.

The trust chaplaincy team responded through the provision of religious, pastoral and spiritual care appropriate to the needs of individual patients. The trust chaplaincy held a memorial service on an annual basis for families who had experienced the loss of a baby or child. This service was known as the “Enfolded in Love” service and had taken place the week before our inspection. Staff told us over 30 families had attended, some of whom had suffered their loss many years ago.

Perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the postnatal period. Patients with a suspected mental health illness were cared for in partnership with the perinatal mental health team for further assessment and treatment.

The substance misuse midwife also saw vulnerable patients, such as teenagers and those with late development who wished to continue with their pregnancy.

Staff told us families who were fostering or adopting a neonate could stay with the baby on the postnatal ward, thus preventing admission of the baby to the neonatal unit.

Staff told us the team had developed a surrogacy guideline following a baby being born to a surrogate mother. The couple involved and the surrogate mother had all reported a positive caring experience, which was well planned with good leadership.

Understanding and involvement of patients and those close to them

Staff administered antibiotics and phototherapy to babies on the postnatal ward therefore eliminating the need to separate any patient from their baby.

Partners could visit delivery suite and the postnatal/antenatal ward. However, the ward also facilitated, where possible, time for partners to spend with their partner and baby following transfer from the delivery suite and allowed them to stay overnight where possible. They facilitated this by providing reclining chairs for partners.

Patients we spoke with said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby.

From patient records we reviewed we saw evidence of discussions of the risks and benefits of different birthing locations and discussions about birthing preferences.

The service told us midwives completed birth plans to support patients with complex and difficult birth choices.

Is the service responsive?

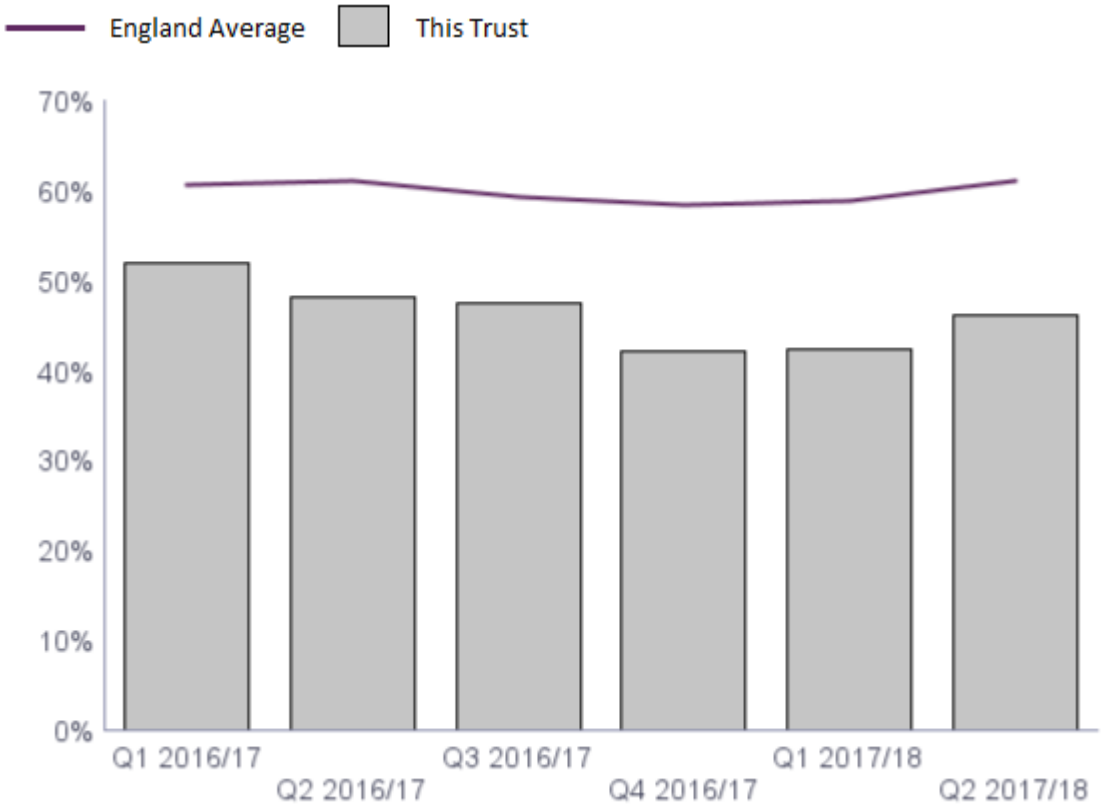
Service delivery to meet the needs of local people

Service delivery to meet the needs of local people

Bed Occupancy

From April 2016 to September 2017 the bed occupancy levels for maternity were lower than the England average, with the trust having 46% occupancy in Q2 2017/18 compared to the England average of 60%.

The chart below shows the occupancy levels compared to the England average over the period.



(Source: NHS England)

When we spoke to the senior leadership team we were told that they had engaged in the pathway to excellence clinical review which was designed to help shape the maternity services in the local region to make sure it met the needs of local people.

While, following the recent service review, the outcome of the planning of services to meet the needs of local people was not yet fully clear, what was clear is that the service did regularly review its local provision while preparing for any future changes.

For instance, since 2014, the day unit had experienced high demand from patients. To tackle this, the service planned and acted on several initiatives. It looked at the referral criteria and sent a reminder to GPs about who should be referred to the unit. It also analysed who it was seeing. This led to the development of a telehealth service so that patients could monitor their own blood pressure so avoiding a trip to the unit. The unit was hoping to extend this service for patients with diabetes. Another way the unit responded to demand was to refer patients requiring a caesarean section to one of the clinics which had better capacity to handle these referrals.

The service conducted gap analysis to see how it could improve the service to respond to local people's needs. Staff told us of one such analysis of better births. This had led to a pilot looking at

how feasible it was for a midwife to stay with a woman from start to finish of their pregnancy journey.

To respond to the demand for caesarean sections the service persuaded the trust to introduce a dedicated caesarean section list in main theatres which ran every Wednesday.

The service took part in a regional arrangement for babies born before arrival. This meant that if a patient rang in the service assessed them and rang the ambulance which meant community staff were no longer sent out. The service was currently examining the rate of born before arrival with a view to developing a standard to enable audit of how responsive the service was.

The community staff worked out of local GP surgeries which helped patients to receive antenatal and postnatal care closer to home. Community midwife teams were organised around five distinct areas to ensure patients had a responsive local service.

Patients had the option to deliver at home as well as on the delivery suite within the service. The service had responded to feedback about partners staying overnight by allowing partners to stay overnight in the delivery suite.

The trust website had a dedicated area about maternity services with a video about the service. Outside the clinic areas there was literature and leaflets supplied to patients giving them information they might want to know about concerning their pregnancy.

Meeting people's individual needs

The service treated patients as individuals and strived to develop care plans that responded to their individual needs having considered any risk factors.

Patients we spoke with told us that they felt the service had listened to them and involved them in their care.

The substance misuse midwife was responsible for planning the care of and supporting patients who had addictions that could harm the baby but also provided a source of expertise for all staff to draw on. Staff showed us the questions patients were asked on booking about vulnerabilities which led to a referral to the substance misuse clinic where a more in-depth vulnerability assessment could take place. This supported staff in shaping the care plan to respond to the needs of the patient and their baby. This included referral to the perinatal mental health team where necessary.

Community staff described how they used advocates to help them respond to the needs of patients with learning disabilities. Community staff explained how, for patients with learning disabilities, they would often offer longer appointment times and provide face to face parenting classes which directly responded to their needs. The records of such patients could also be noted so that they were never seen on their own where it was not appropriate. Community staff also supported patients with healthy living and could signpost patients to aqua aerobics.

A specific pathway existed for patients with multiple births. This ensured such patients were seen by a consultant and a multi-disciplinary team was set up to manage the birth with links to a local trust for more complex cases. The service took part in the twins and multiple births association (TAMBA) audit to support it in responding to the needs of this group of patients.

The labour, delivery and recovery rooms were spacious and supported wheelchair access and had en-suite facilities.

While we did not see any leaflets that were not in English staff told us that leaflets could be produced and supplied in a different language. Staff also described how they could access translation services. The trust's website was designed so that a language other than English could be selected.

Access and flow

The service had systems and processes in place to monitor access and flow through the service to ensure that it remained responsive to the needs of patients in its care.

Patients could self-refer into the service and community midwives conducted the booking appointments at GP surgeries or appropriate venues throughout the local area that was served. All booking appointments were offered according to national guidelines.

The service had a dedicated midwife whose role it was, amongst other things, to monitor performance around waiting times within the unit and if necessary more slots were offered to match demand. Any issues around access and flow would be discussed at the regular clinical and governance meetings.

To respond to the needs of patients who required reassurance, and to help manage the flow of the antenatal ward, the service operated an antenatal day unit. This unit could offer patients intimate examinations in a private room where required or within curtained bays, it could monitor the patient. The scanning clinics were adjacent to the unit and on the same floor so that, if a patient required a scan at short notice, this could be arranged. Patients were triaged during a phone call to the unit and when they arrived their paper records were available and a brief re-assessment conducted to decide how soon they needed to be seen. Out of hours the same assistance could be accessed on the delivery suite or antenatal ward.

To help with flow in the delivery suite theatre there was a four-bedded recovery unit on the delivery suite adjacent to the theatre. This was always staffed by two staff. Patients were stabilised and awake before they left theatre to enter the recovery area. This facility improved flow through the delivery theatre. Issues with flow in theatres on the unit reported at the last inspection no longer existed because the trust had since implemented a dedicated caesarean list in its main theatres.

The service had full time delivery suite co-ordinators who operated a paper based system to keep an eye on bed availability with the aim of discharging patients and babies, if it was safe to do so, within 24 hours.

While community staff could access the electronic discharge summaries they were informed about patients leaving the service through use of daily discharge or communication books. This supported community staff in ensuring they visited the mother and baby within 24 hours of discharge.

The service had not closed to patients in labour in the last year. On the contrary, when a local trust's service had to close, the service, along with local partners, managed the increased demand on its services by staff working extended hours.

Learning from complaints and concerns

Summary of complaints

From January 2017 to December 2017 there were 11 complaints about maternity. The trust took an average of 23 days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be closed in 25 days.

The most prevalent theme was about patient care with nine complaints (82%).

(Source: Provider Information Request P55)

The service had a system in place to encourage complaints and compliments with a view to improving its service to patients. Staff would seek to resolve a concern informally but complaints were dealt with formally by offering a recorded meeting or a written response from the chief executive officer. The governance arrangements in place ensured that lessons from complaints were shared amongst staff.

The service advertised by notices displayed within the unit how to complain and signposted patients or their carers or relatives to the trust's help and advice service for support in making a complaint.

Staff described how they received regular updates and reports from the trust's help and advice team about complaints which supported them in ensuring that complaints were responded to in time. Staff explained to us that they responded to complaints within the prescribed time limits but if, for any reason, they were unable to do so, they would keep the complainant informed about the revised timescales.

The trust supplied us with data about the complaints received about the service but we could not identify any themes or trends.

Any themes or trends about complaints were discussed at regular clinical and governance meetings as well as in other forums such as risk meetings.

Staff confirmed and we saw that lessons learnt from complaints were shared in the service's bi-monthly newsletter or by email or during handover, or at specific one to ones with staff members impacted by the complaint.

The service told us that it had two open complaints. We saw a response to one of the complaints. It was detailed, written in plain English, and set out what steps the service intended to take to improve the service going forward.

Is the service well-led?

Leadership

The service sat within the trust's obstetrics department and was led by a clinical director, head of midwifery, matron, and business managers who together formed the leadership team at a local level.

We met the local leadership team who had worked together for many years and noted that collectively they were able to draw on decades of experience of running a maternity service.

Members of the local leadership team met regularly with the director of nursing or the medical director and through them they had ready and open access to the board. An individual board member was designated as a lead for maternity and staff told us there was a governor who

championed the service. The head of midwifery and the clinical governance lead for the service were members of the trust's clinical governance steering group. The team also met with leaders in local trusts to benchmark its service against their services and share good practice and learning.

The team were approachable and available and this was confirmed by staff we spoke with who also said they felt supported and listened to. The team met regularly in different forums to discuss issues of quality, finance and governance.

The leadership team were supported by a team of band seven midwives, shift co-ordinators and professional midwife advocates.

Community staff, who no longer rotated into the hospital (apart from during escalation) felt able to directly access the leadership but staff we spoke with were also comfortable raising concerns through their band seven team leader.

The trust told us that its leadership and talent development strategy was approved in 2017. This had led to a range of leadership programmes that were delivered internally with national leadership academy programmes being accessed where appropriate.

Vision and strategy

Broadly, the trust's vision and strategy for the service, flowing out of the pathway to excellence clinical review, was to have obstetric led care at Sunderland and midwife led care at South Tyneside. Whilst any decisions made were not yet final decisions, the senior leadership team confirmed high quality, sustainable, and cost-effective patient care was at the core of its vision, with a workforce who were proud to recommend the service.

When we spoke to staff they were positive about the engagement that had taken place around the clinical review and were able to describe the next steps around putting the vision and strategy into action, which was a meeting arranged for later in the year.

The trust encouraged and supported business planning away days where staff discussed pressures on the service and plans. Forward planning was based on the Better Births vision and a gap analysis had been completed. Implementation sub-groups included departments, teams and individuals from community staff as well as the core service.

Culture

The service had a positive culture with staff that were passionate about providing focussed care to patients throughout their pregnancy journey.

Staff we spoke with told us that they enjoyed working at the service and many staff had been with the service for several decades while others had trained with the service and stayed with it after training. Staff felt supported and were confident about raising concerns.

Senior staff told us the whole team worked together closely, shared values and cared passionately for their patients, the department and their colleagues. The service wanted to develop its staff but funding was an ever-present issue.

One striking feature of the culture was the availability and accessibility of the leadership team to all staff. During our inspection the head of midwifery was available each day to our inspection team while at the same time making time for their own team. Staff assured us this was normal. It did feel like it was part of the culture.

Staff said to us that they had many ways in which they could express their views and be heard. Midwives reported that consultants were available and approachable. Many staff told us that what they liked about the culture was the way in which staff spoke to each other as equal partners in care.

Staff that were in training spoke positively about the support, buddying, and mentorship they received from colleagues.

We saw that staff were open and honest and we saw examples where a duty of candour had been used.

We did not come across any complaints or concerns about bullying or harassment. Staff told us they took part in fundraising initiatives such as a local 10k run, Macmillan coffee mornings and Comic Relief.

Governance, risk management, and quality measurement

The service had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed.

Governance was the responsibility of the local leadership team which met regularly at clinical governance meetings to review a range of issues such as budgets, performance, risk and quality measurement. The team also met with external bodies to the service to learn lessons and benchmark the service's performance against local services. We saw minutes of business and clinical governance meetings. Standing agenda items included: matters arising; ratification of guidelines; patient leaflets; incident reports; root cause analyses; risk register; complaints and claims; mandatory training; infection prevention and control; engagement; external reports; midwifery advocates; dashboard; safeguarding; and any other business.

The service had a risk midwife whose role was to work full time on: reviewing risks posed to the service, oversee root cause analyses into serious incidents, distribute learning, say, through the service's regular newsletter and chair regular risk meetings. This was one meeting where the service's risk register was considered but the register was also considered at the clinical governance meeting. We saw minutes for a recent risk harm meeting which showed standing agenda items were: cases; escalation; complaints; root cause analyses; the risk register; the newsletter; and recent RCOG standards; and a gap analysis. Staff confirmed that embedding of learning was still ongoing regarding the never event in 2017 with spot checks on compliance with new procedures and consultation with staff on new swabs.

The service's risk register supported the local leadership team in tracking risks and ensuring that staff were taking actions to reduce or extinguish the risk. We reviewed the service's risk register and saw that each risk was given a unique identifier, a risk rate, a status, brief details, the review date, and the person who owned the risk. The service had 18 risks in total, 12 of which were rated as moderate. An example of a moderate risk was the room used in emergencies for medical procedures which required an upgrade of its airflow systems. The actions showed that a business case had been put in to upgrade the airflow system. But a control of the risk was that the room was used rarely, particularly since there was an established list for such operations in main theatres. Another moderate risk was availability of fetal monitors. This had been addressed by obtaining new monitors. A further risk concerned the migration from paper to electronic records in the community setting. This showed that the project had been put on hold while the interface was re-designed and a further pilot took place.

The local leadership team ensured that consultants, working with midwives, supported them in reviewing clinical guidelines and keeping them up to date, and organised and ran a rolling audit programme, in addition to conducting regular case reviews and contributing to the maternity dashboard. Staff were empowered to become involved in audit presentations and action plans flowing from audits were monitored at the clinical governance meeting.

The directorate managers looked after budget issues but also worked with the local leadership team by conducting gap analyses, say, on better births, and reviewed risks and complaints.

The maternity dashboard was not fully developed and was not in line with RCOG guidance which would ensure continuous improvement in clinical care.

Information management

We saw from speaking with staff and reviewing information supplied in electronic format, that staff at all levels could access information in a digital format which could be interpreted rapidly and used to help improve the service.

For instance, we had questions about the service's response times to requests for epidurals. We saw that staff could quickly interrogate the service's electronic records and extract from the electronic discharge summary, details of time to response from request for an epidural. The resulting statistics supported staff in answering our questions about response times. But it also revealed a need for staff to incident report cases that took longer than an hour and the need for staff to complete the relevant field in the discharge summary in every case. The information generated also allowed staff to investigate the limited number of cases that took over an hour to find out why this occurred.

The example above demonstrated how information could be accessed easily and managed in a well-led way to help improve the service.

Engagement

Staff described feeling engaged by the service and explained how the service engaged with the public with a view to ensuring their views were used to help to shape the service.

All meetings within the service were 'open' meetings and staff confirmed that any of them could attend whichever meetings were of interest to them. Staff were given specific roles such as leading on planning and execution of clinical reviews or audits. Staff took part in audit production and presentation. In addition to a newsletter staff described how the service used email to share lessons or pass on important messages. Team leaders had regular meetings and passed on information to staff at handovers or through communication boards. All staff had regular appraisals. The trust operated an excellence scheme where individual staff members could be nominated for displaying excellence and staff we spoke with found this was a positive initiative.

The senior team held a staff forum quarterly. Following a reduction in attendance, the times of these had been changed to include staff on night duty and encouraged email contact for those unable to attend. The team included staff from a local trust for some meetings.

In terms of public engagement, the service used friends and family boxes (which were distributed liberally around the unit). This showed the percentage of patients recommending the service at 99% for February 2018.

In addition to friends and family, the service actively sought out patient feedback, by conducting random in-depth interviews with patients. Feedback from these interviews was shared monthly and actions taken. As at February 2018 satisfaction rates were at 75%. It was following feedback from this initiative that partners could stay overnight on the delivery suite.

As part of the pathway to excellence clinical review the service ran a series of co-production events with the public in local venues to obtain their views about the future shape of the service. In addition, staff regularly attended the local maternity voices partnership to gather views of patients using the service.

The bereavement suite had been developed using a donation of funds from a family who had suffered a loss and they continued to support the unit by attending patient engagement events and contributing to staff training.

Within the unit the service proudly displayed the many research programmes patients using the service had thoughtfully taken part in which confirmed to the public that it was 'ok to ask' about research. Staff told us the national research body recognised the service's effective engagement of the public in research by arranging to visit the service to congratulate them.

Learning, continuous improvement and innovation

Prior to the inspection, and while on inspection, the service shared with us the following examples of learning, continuous improvement and innovation:

The service was active in maternity related research programmes, such as 'pre-eclampsia in hospital early induction' or 'expectant management' or 'use of pessary to reduce spontaneous pre-term labour in twin pregnancy'. As noted earlier, the service employed a team of full time research midwives whose role it was to recruit and monitor the progress of patients taking part in research trials. The service was recognised as one of the highest recruiters, for example for the folic acid trial. In the last five years 2600 patients had taken part in 40 research trials with numbers increasing year on year. Nine hundred patients joined trials in 2017. The service was visited by staff from NIHR (National Institute of Health Research) to congratulate them on recruitment to research trials.

'SimMOM' was a collaborative project between the trust and local stakeholders and a university to provide an innovative, multi-disciplinary team training programme in the management of obstetric emergencies. Staff reported to us how much they enjoyed using SimMOM and how it really helped the team to work as a team when facing an emergency. This project led to a finalist position in a national most innovative education provider 2017 awards.

Staff were undertaking 'Force' training as a multidisciplinary team to reduce the risk of brachial plexus injury. (Brachial plexus injury in babies can be related to excessive force being used during delivery).

Staff were developing an antenatal teaching package to include community midwives. This included training on MCA and DoLS, gestational diabetes, GAP surveillance, patients at risk of mental health problems, substance misuse and the interpretation of non-standard test results.