South Tyneside NHS Foundation Trust

Evidence appendix
South Tyneside District Hospital
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South Shields
Tyne and Wear
NE34 0PL

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Date of inspection visit: 31 October to 7 December 2017
Date of publication: xxxx> 2017

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

South Tyneside NHS Foundation Trust provides acute hospital services at South Tyneside District Hospital, a full range of community services and some mental health services across South Tyneside, Gateshead, and Sunderland.

In February 2016 the trust formed a strategic alliance with a neighbouring NHS foundation trust and established the South Tyneside and Sunderland Healthcare Group serving a population of 430,000 and employing in excess of 3,500 staff.

Services are commissioned by South Tyneside Clinical Commissioning Group.

It provides the following acute core services:
- Urgent and emergency care
- Medical care (including older people’s care)
- Surgery
- Critical care
- Maternity and gynaecology
- Children and young people
- End of life care
- Outpatients and diagnostics

The trust provides the following community health services:
• Community health services for children and young people
• Community services for adults and long-term conditions
• Community end of life care
• Community dental services

The trust provides the following community mental health services:
• Wards for people with a learning disability or autism
• Community mental health services for people with a learning disability or autism

Is this organisation well-led?

Leadership

South Tyneside NHS Foundation Trust gained foundation trust status in January 2005. Since the last CQC comprehensive inspection of South Tyneside NHS Foundation Trust in May 2015, there had been changes within the executive leadership team.

Board members

From June 2017 the South Tyneside NHS Foundation Trust board was made up of the following;

- Of the South Tyneside board members at the trust, 16% were BME and 79% were female.
- Of the South Tyneside executive board members at the trust, 16% were BME and 50% were female.
- Of the South Tyneside non-executive board members, none were BME and 29% were female.

<table>
<thead>
<tr>
<th></th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive</td>
<td>16%</td>
<td>50%</td>
</tr>
<tr>
<td>Non-executive</td>
<td>0.0%</td>
<td>29%</td>
</tr>
<tr>
<td>Total</td>
<td>16%</td>
<td>79%</td>
</tr>
</tbody>
</table>

In the 18 months prior to our inspection the trust had undergone significant change. In March 2016 South Tyneside NHS Foundation Trust formed a strategic alliance with a neighbouring NHS trust, creating a partnership of the South Tyneside and Sunderland healthcare group. In November 2016 the trust formed a new single executive and management team across both partnership trusts. With the exception of the medical directors, all executive directors held the same position at both foundation trusts. South Tyneside NHS Foundation Trust had retained its own board of six non-executive directors.

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.

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1 RPIR – Universal: Board tab
Leaders at executive level understood the challenges to quality and sustainability. The size and breadth of the portfolios of some executives were a challenge. This was listed as a risk on the board assurance framework and the chief executive was mindful of this capacity risk.

There was a quality strategy focussed on process and members of the executive team told us they were working on a new, improved quality strategy. Each executive had a clear plan of actions to address the challenges they had identified. However there was not an overall published plan which identified and determined prioritisation of these actions. There were no formal mechanisms to evaluate or measure the impact of these actions.

Leaders were visible and approachable. There was a strong sense that they worked collectively and collaboratively. Non-executive directors and governors felt well informed and trusted. Governors were engaged, enthusiastic, committed to the pathway to excellence work and proud of the hospital, the staff and their relationship with executives.

The chief executive and his team of directors met informally once a week to discuss priorities. Formal board meetings were held monthly.

There was a leadership strategy which was described to us consistently by individual directors. The Leadership and Talent Development Strategy had been developed for the Healthcare Group to cover 2017-2020. A range of leadership programmes were being developed internally for employees at every level. Other national Leadership Academy programmes were available and accessed as appropriate. The strategy included work over the next 12 months to support the development of leadership capacity and to ensure the supply of future leaders.

The trust has not had an external well led review since they achieved foundation trust status in 2005. However, an independent assessment under the NHSI new framework ‘Developmental review of leadership and governance’ is planned for quarter four of 2017/18.

The chief executive carried out formal appraisals of each executive director annually. The chair carried out appraisals of each of the non-executive directors and the chief executive. The senior independent director carried out the annual appraisal of the chair supported by the lead governor. The annual appraisals of each non-executive director were reviewed by the nomination, appointments and review committee, a sub-committee of the council of governors.

The trust had two divisions; acute and community. The divisions were led by a divisional director with a head of nursing and a Clinical Director. The acute division had four directorates: acute and emergency care, medicine and care of the elderly, surgical specialities and maternity and clinical support services. The community division had three directorates: Sunderland, Gateshead and South Tyneside. Each directorate was led by a business manager, an operations manager and a nursing matron.

Vision and strategy

In the 18 months prior to our inspection the trust had undergone significant change. In March 2016 South Tyneside NHS Foundation Trust formed a strategic alliance with a neighbouring NHS trust. Working in partnership as the South Tyneside and Sunderland healthcare group, the trust formally committed to collaborating to transform local healthcare services. The aim of the collaboration was to ensure local communities received high quality, safe and sustainable hospital and community health services in the future.

There was a clear statement of vision linked to the path to excellence transformation programme, strategic alliance and clinical system reviews. There was a clear set of values which were
embedded at all levels of the organisation. Frontline staff were aware of the vision even though at times they expressed concern about the uncertainty surrounding the clinical service reviews. All staff spoke confidently about the values.

Non-executive directors were clear about their involvement in the development of the strategy and were fully committed to it. They talked about the benefits to patients and the overall health economy.

A director of communications had recently been appointed with a key part of their role to support communication around strategic changes.

The vision, values and strategy had been developed using a structure planning and review process in collaboration with people who use services, commissioners, governors and local partners.

The path to excellence is a five year transformation programme which began in autumn 2016 with the aim of improving the quality of healthcare services across South Tyneside and Sunderland. The programme is aligned to the national vision for the NHS, as set out in the Five Year Forward View focusing on care and quality, system efficiency and health and wellbeing. It was set up to ensure that future services are developed in a way that provides the highest quality of safe patient care and the best possible clinical outcomes for patients in line with all available clinical evidence and guidance. By changing how some hospital services are delivered in the future, the programme hopes to also address recruitment challenges by creating innovative services in South Tyneside and Sunderland which would be attractive to medical and nursing professionals.

The path to excellence programme began the first phase of public consultation in July 2017 for a range of options for the trust’s three core areas of acute hospital care which were most vulnerable:

- Stroke care services
- Maternity and women’s healthcare services
- Urgent and emergency paediatric services

Phase one of the consultation closed in October 2017 and a decision is expected to made on the future of these services by the commissioners during February 2018.

The first phase of the clinical service reviews had not engaged staff in an appropriate way and Director of Human Resources had recognised this. The revised plan for the second phase of the clinical service reviews would consult earlier with staff.

Phase two of the consultation is planned to begin in 2018 with a formal public consultation from May 2019. This phase will consider a range of options for the following services:

- Acute medicine and emergency care
- Acute surgery, theatres and critical care
- Planned care and specialist services
- Clinical support services

There was a lack of clarity around a benefits realisation plan and it was unclear how the trust would know they had achieved their vision. We asked the trust to provide evidence of documentation used by the board to monitor the delivery of the strategy. They provided information about workshops and training for non-executive directors and governors rather than monitoring information. Following inspection the trust told us the Board had continued to be
advised about service and care delivery through normal business processes and performance data.

There were some gaps in strategies and strategic implementation. The executive team were aware of most of these gaps and plans were in place to address these within the challenges they faced around the path to excellence and the strategic alliance.

Executive leads told us the current quality strategy was process rather than outcome driven and did not include any quality improvement strategy. However, they were aware of the need to update this.

There was no workforce strategy or organisational development strategy although the director of human resources and organisational development was aware of this and working on the organisational development strategy. A decision had been taken to await the outcome of the clinical service reviews before developing a workforce strategy. This would enable the trust to have a clearer understanding of future workforce requirements.

There was no mental health strategy, however the medical director had taken over the trust lead for mental health three weeks prior to our inspection and was in the process of developing one.

There was no patient and public engagement strategy or patient experience strategy. The director of nursing and patient experience was aware of this.

There were no strategies for equality and diversity or dementia, although the former was due to be presented in draft to the equality and diversity steering group in February 2018.

Culture

Most staff, both in the community and acute services told us they felt supported, respected and valued. Overwhelmingly staff were positive about and proud to work in the organisation, even though some expressed anxiety about the future. They were passionate about their services and morale was generally high. The culture at the trust was centred on the needs and experiences of people who use services; staff were caring and compassionate.

Staff did not always raise concerns. We were concerned about a lack of understanding of and inconsistent use of formal structures for raising concerns. A minority of staff told us they felt unable to report some poor behaviours. The director of human resources and organisational development was the trust Freedom to Speak Up Guardian. The initiative was still in its infancy at the time of inspection. Only two members of staff had contacted the Guardian or ambassadors in the previous 12 months. Information was available to staff on the trust intranet.

The Guardian had recruited two ambassadors and the Guardian planned to recruit a full establishment of nine across the trust. The ambassadors were recruited based on their roles within the trust, the most junior holding a Band 7 position. The Guardian acknowledged this could present a barrier to some staff who may prefer to speak with a less senior member of staff. The Guardian also acknowledged their own senior position might discourage staff to speak up and spoke of plans to review the process in the next year.

Historically performance issues had not been appropriately addressed but the trust leaders had started to lead the management of performance issues including sickness absence and conduct which was inconsistent with the vision and values. We reviewed information relating to five cases of disciplinary processes and two cases of grievance processes. The disciplinary policy was in date and in all the cases we reviewed had been followed appropriately. The grievance policy was
overdue for review from August 2017. The grievances we reviewed were dealt with according to the policy although one took longer than the recommended timeframe.

During our inspection of May 2015 we identified concerns about the culture in surgical services and the difficult working environment within theatres. During this inspection we found the culture had improved and changes in leadership had had a positive impact. Processes and trust guidance was being followed more consistently to manage issues. However, we were still provided with examples of inappropriate behaviour and not all staff felt able to report this.

Sickness rates

The trust’s sickness levels from May 2016 to March 2017 were higher than the England average for the entire reporting period, although the trend generally mirrors that of the England average.

Sickness absence rates

Since the single executive leadership team appointment non-executive directors told us of a more transparent culture both internally and externally. Governors were well informed and supportive of the trust and leadership team. Whilst leaders understood the importance of staff being able to raise concerns there was an over reliance on informal processes. We were concerned at the low level of concerns raised through formal processes such as whistle blowing, the freedom to speak up guardian or incident reporting.

The trust reported low levels of incidents. Executive leaders told us this was because the system for reporting was time consuming. However, staff in services gave us other reasons for low reporting such as lack of feedback or perceived action, and union representatives and some staff told us they did not raise incidents for fear of the consequences.

**NHS Staff Survey 2016**

- The trust has eight key findings below the average for similar trusts in the 2016 NHS Staff Survey. No findings were better than the England average.

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2 Source: NHS Digital  
3 NHS Staff Survey 2016
The trust had mechanisms for providing all staff at every level with the development they need. The trust’s target rate for completion of appraisals was 90%. Staff we spoke with in the core services we inspected told us they valued the appraisal process. However completion rates in some areas were below the trust target.

There were pockets of poor compliance with mandatory training.

There were processes to support clinical supervision for staff. Revalidation for doctors was up to date and the trust were developing processes to monitor nursing revalidation compliance rates.

There was a strong emphasis at the trust on the safety and wellbeing of staff. There was a health and wellbeing group and occupational health support. Union representatives worked with the trust to support staff who were on sick leave and the director of human resources and organisational development was planning an employee benefits day for 2018 where staff could access various support services and also meet some of the executive team. There were a number of general initiatives in place to support the wellbeing of staff including but not limited to health promotion campaigns, intranet resources and exercise opportunities.

Data published in the 2016 NHS staff survey showed the trust performed worse than other trusts in relation to BME staff who had experienced bullying and harassment. Although the current percentage was still high (37%), it showed a decrease of 14% since the previous year. The trust’s equality and diversity lead advised there were no common themes for bullying. There was a specific case in 2015 following which the trust arranged for an external investigation. The subsequent report and key actions included a well-being programme that focused on resilience and organisational development. The trust had also introduced ‘listening advisors’ who provided peer support. Staff spoke positively about the changes within the service.

The trust had developed a Workforce Race Equality Standard (WRES) action plan in response to the staff survey results. Key priorities included the development of a new equality and diversity (E&D) strategy that incorporated WRES. However, WRES data from the current staff survey highlighted that BME staff were 1.3 times more likely to enter a formal disciplinary process. There was no evidence to demonstrate the trust planned to investigate and explore the reasons why.

The trust acknowledged there was still work to do to improve equality and diversity across the organisation. This included reviewing the quality and accuracy of the protected characteristics data held on the Electronic Record System (ESR). At the time of the inspection there were no groups for employees with protected characteristics, the trust did not include sexual orientation in their workforce report and the trust had not engaged with stakeholders around their EDS2 self-assessment. The main purpose of the EDS2 is to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.

The Board had oversight of equality and diversity through the trust’s workforce committee, which received information from the equality, diversity, and human rights steering group. The steering group included a representative from the patient carer public experience committee (PCPEC), the director of estates and facilities, and a non-executive director. The trust’s equality and diversity strategy was due to be presented to the steering group in February 2018.
The trust had taken no action to implement the accessible information standard. From 1 August 2016 onwards, all organisations that provide NHS care are legally required to follow the accessible information standard. 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.

**Staff diversity**

- As shown in the annual report 2016/17, the trust employed a total of 3995 staff of which 84% are women.

Breakdown of staff gender by staff group:

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors</td>
<td>8</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Other Senior Managers</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Employee</td>
<td>599</td>
<td>3372</td>
<td>3971</td>
</tr>
</tbody>
</table>

Breakdown of staff by age:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Headcount</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-16</td>
<td>2</td>
<td>0.05</td>
</tr>
<tr>
<td>17-21</td>
<td>72</td>
<td>1.80</td>
</tr>
<tr>
<td>22 Plus</td>
<td>3921</td>
<td>98.15</td>
</tr>
</tbody>
</table>

Breakdown of staff by ethnicity:

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Headcount</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>3617</td>
<td>90.54</td>
</tr>
<tr>
<td>Mixed</td>
<td>26</td>
<td>0.65</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>78</td>
<td>1.95</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>34</td>
<td>0.85</td>
</tr>
<tr>
<td>Other</td>
<td>240</td>
<td>6.0</td>
</tr>
<tr>
<td>Grand Total</td>
<td>3995</td>
<td>100.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Headcount</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>612</td>
<td>15.32</td>
</tr>
<tr>
<td>Female</td>
<td>3383</td>
<td>84.68</td>
</tr>
<tr>
<td>Transgender</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>3995</td>
<td>100</td>
</tr>
</tbody>
</table>

- The ethnic origin of the workforce is predominantly White British, accounting for 90.5% and employees with ‘other’ background make up 6% of the workforce.
- The largest proportion of staff at the trust fall into the 22 years and over group with 98%.
The trust has 24 key findings below the average for similar trusts in the 2016 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response rate</td>
<td>41.1%</td>
<td>42.7%</td>
</tr>
<tr>
<td>Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.76</td>
<td>3.55</td>
</tr>
<tr>
<td>Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.95</td>
<td>3.90</td>
</tr>
<tr>
<td>Key Finding 3. Percentage of staff agreeing that their role makes a difference to patients / service users</td>
<td>90.1%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Key Finding 4. Staff motivation at work</td>
<td>3.94</td>
<td>3.81</td>
</tr>
<tr>
<td>Key Finding 5. Recognition and value of staff by managers and the organisation</td>
<td>3.45</td>
<td>3.32</td>
</tr>
<tr>
<td>Key Finding 6. Percentage of staff reporting good communication between senior management and staff</td>
<td>32.6%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Key Finding 7. Percentage of staff able to contribute towards improvements at work</td>
<td>70.1%</td>
<td>63.3%</td>
</tr>
<tr>
<td>Key Finding 8. Staff satisfaction with level of responsibility and involvement</td>
<td>3.92</td>
<td>3.79</td>
</tr>
<tr>
<td>Key Finding 9. Effective team working</td>
<td>3.75</td>
<td>3.72</td>
</tr>
<tr>
<td>Key Finding 10. Support from immediate managers</td>
<td>3.73</td>
<td>3.66</td>
</tr>
<tr>
<td>Key Finding 11. Percentage of staff appraised in last 12 months</td>
<td>86.2%</td>
<td>78.3%</td>
</tr>
<tr>
<td>Key Finding 12. Quality of appraisals</td>
<td>3.11</td>
<td>2.97</td>
</tr>
<tr>
<td>Key Finding 13. Quality of non-mandatory training, learning or development</td>
<td>4.05</td>
<td>3.97</td>
</tr>
<tr>
<td>Key Finding 14. Staff satisfaction with resourcing and support</td>
<td>3.33</td>
<td>3.31</td>
</tr>
<tr>
<td>Key Finding 15. Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>50.6%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Key Finding 17. Percentage of staff feeling unwell due to work related stress in the last 12 months</td>
<td>35.2%</td>
<td>39.9%</td>
</tr>
<tr>
<td>Key Finding 19. Organisation and management interest in and action on health and wellbeing</td>
<td>3.61</td>
<td>3.60</td>
</tr>
<tr>
<td>Key Finding 24. Percentage of staff/colleagues reporting most recent experience of violence</td>
<td>67.3%</td>
<td>60.3%</td>
</tr>
<tr>
<td>Key Finding 27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>45.5%</td>
<td>42.2%</td>
</tr>
<tr>
<td>Key Finding 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>90.3%</td>
<td>88.0%</td>
</tr>
<tr>
<td>Key Finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.72</td>
<td>3.67</td>
</tr>
<tr>
<td>Key Finding 31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.65</td>
<td>3.69</td>
</tr>
</tbody>
</table>

- **Overall engagement score**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>National</td>
</tr>
<tr>
<td>3.81</td>
<td>3.64</td>
</tr>
</tbody>
</table>

The trust has five key findings better than the average for similar trusts in the 2016 NHS Staff Survey:

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5 NHS Staff Survey 2016
<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Finding 16. Percentage of staff working extra hours</td>
<td>71.2%</td>
<td>65.2%</td>
</tr>
<tr>
<td>Key Finding 22. Percentage of staff experiencing physical violence from</td>
<td>15.0%</td>
<td>10.2%</td>
</tr>
<tr>
<td>patients, relatives or the public in last 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Finding 25. Percentage of staff experiencing harassment, bullying or</td>
<td>27.6%</td>
<td>21.5%</td>
</tr>
<tr>
<td>abuse from patients, relatives or the public in last 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Finding 28. Percentage of staff witnessing potentially harmful errors,</td>
<td>30.6%</td>
<td>22.5%</td>
</tr>
<tr>
<td>near misses or incidents in last month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Key Finding 32. Effective use of patient / service user feedback</td>
<td>3.70</td>
<td>3.76</td>
</tr>
</tbody>
</table>

**NHS Staff Survey 2016 – Performance on questions relating to harassment, bullying and equal opportunities**

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.

| KF25 Percentage of staff experiencing harassment, bullying or abuse from | Your Trust in 2016 | Average (median) for combined acute and community trusts | Your Trust in 2015 |
| patients, relatives or the public in last 12 months                      | White 21% | 27% | 21% |
| BME 22%                                                                  |          | 27% | 22% |
| KF26 Percentage of staff experiencing harassment, bullying or abuse from | White 21% | 22% | 22% |
| staff in last 12 months                                                   | BME 37% | 26% | 51% |
| KF21 Percentage of staff believing that the organisation provides equal  | White 88% | 88% | 86% |
| opportunities for career progression or promotion                        | BME 68% | 75% | 72% |
| Q17b In the last 12 months have you personally experienced discrimination | White 6% | 6% | 6% |
| at work from manager/team leader or other colleagues?                    | BME 12% | 14% | 13% |

The responses from BME and White staff at the trust were significantly different for KF26, KF21 and Q17b.

**Governance**

**Board Assurance Framework**

- The trust have provided their Board Assurance Framework/Corporate Risk Register, which for 2017/18 contains 11 risks which impact upon strategic ambitions.
- The six strategic ambitions outlined by the trust are as follows:
  1. Deliver high quality and safe services to our patients (four risks)
  2. Continually improve our service (no risk)
  3. Ensure strong financial performance (three risks)

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6 NHS Staff Survey 2016
7 RPIR – Universal – submission P113 STFT BAF July
4 – Deliver excellent partnerships for the benefit of our patients (no risks)
5 – Be an excellent employer (two risks)
6 – Always listen, learn and act ‘you said, we did’ (two risks)
   • There are 18 key risks scoring 12 and above on the Board Assurance Framework/Corporate Risk Register.
   • A score of 12 and above is defined by the trust as “a significant serious risk to the trust which must be reported to and managed through the Board of Directors via EARC (Executive Assurance and Risk Committee)

<table>
<thead>
<tr>
<th>Risk Score</th>
<th>Risk Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Recruit optimum staffing levels</td>
</tr>
<tr>
<td>16</td>
<td>Replace medical devices/equipment in a timely manner</td>
</tr>
<tr>
<td>16</td>
<td>Create positive patient safety culture</td>
</tr>
<tr>
<td>16</td>
<td>Comply with timelines for incidents, complaints and RCA’s</td>
</tr>
<tr>
<td>16</td>
<td>Receive income to cover activity/maintain financial performance</td>
</tr>
<tr>
<td>16</td>
<td>Proposed service changes impact on use of resources</td>
</tr>
<tr>
<td>16</td>
<td>The trust doesn’t have sufficient workforce with the right values and skills to deliver objectives</td>
</tr>
<tr>
<td>16</td>
<td>Poor staff experience resulting in adverse patient care</td>
</tr>
<tr>
<td>16</td>
<td>Not engaging with stakeholders, patients and the public</td>
</tr>
<tr>
<td>16</td>
<td>Adverse media and reputational damage</td>
</tr>
<tr>
<td>15</td>
<td>Deliver 2017/18 CIP programme</td>
</tr>
<tr>
<td>12</td>
<td>Operational pressure due to increased activity</td>
</tr>
<tr>
<td>12</td>
<td>Continued increase in A&amp;E activity</td>
</tr>
<tr>
<td>12</td>
<td>Failure to recruit senior medical staff to key specialities</td>
</tr>
<tr>
<td>12</td>
<td>Deliver CQC and safeguarding improvement plans</td>
</tr>
<tr>
<td>12</td>
<td>Have in place emergency planning procedures, policies and protocols</td>
</tr>
<tr>
<td>12</td>
<td>Have a common vision as a Group and Trust</td>
</tr>
<tr>
<td>12</td>
<td>Identify and secure opportunities for market share and income growth</td>
</tr>
<tr>
<td>12</td>
<td>Ensure effective strategic planning, anticipating and mitigating key risks</td>
</tr>
<tr>
<td>12</td>
<td>Poor governance in place impacts on compliance with statutory responsibilities</td>
</tr>
</tbody>
</table>

The board assurance framework was overseen by the director of finance and reviewed twice yearly by the board following a review by the governance committee and approval by the audit committee. There was a process for quality impact assessments to support the delivery of cost improvement plans.

Following the development of the strategic alliance and the establishment of a single executive team, the trust reviewed its sub-committee structure. A decision was made to establish some joint committees across the alliance trusts to avoid duplication where possible. The revised board committee structure had been in place since April 2017 and is detailed below.

Reporting directly to the South Tyneside NHS Foundation Trust board of directors were the audit committee, finance and performance committee and the remuneration and appointments committee. Reporting to both acute trust boards were the joint policy committee, the joint strategy committee, the joint patient, carer and public engagement committee and the joint workforce committee. The join remuneration and appointments committee reported to the individual remuneration and appointments committee for South Tyneside NHS Foundation Trust and via that committee to the individual acute trust board.
This structure allowed the authority for decision making across the two organisations to remain with individual boards. Appropriate delegated authority was clarified in the terms of reference for each sub-committee.

The programme management group reported into the finance and performance committee. The equality and diversity sub-group reported into the joint workforce committee. The capital development steering group and the IM&T strategy board reported into the joint strategy committee. The joint patient care and public experience group reported into the joint patient, care and public experience committee. The clinical governance steering group and the corporate governance steering group both reported into the governance committee. The trust provided a clearly defined list of the responsibilities of each of these steering groups.

Executive and non-executive directors told us there was still work to do on the governance and assurance framework however they felt there had been significant improvement over the previous 12 months. We found the multiple committees and sub-committees were confusing and difficult to navigate at times. However the structure was appropriate for the current alliance arrangements.

Following board committee meetings the chair of each committee produced a key issues report for the board which identified matters discussed by the committee, matters for escalation and key decisions made or actions identified. Some of the key issues reports we reviewed also made reference to the impact on the board assurance framework.

Directorates and divisions had monthly clinical governance meetings. These meetings reported to two sub-committees, the Clinical Governance Steering Group and the Corporate Governance Steering Group. These two groups reported to a sub-board Governance Committee chaired by a non-executive director. The governance committee met monthly and one of the schedule of papers included a Quality, Risk and Assurance report. This report was presented to the monthly meeting of the Executive Committee and to Board of Directors to provide assurance on safety, quality, risk management and patient experience.

There was a board visiting programme to clinical and community areas and a chair’s visiting programme. Following these visits reports were submitted to the board.

At the time of our inspection the trust did not have a mental health strategy. The medical director had assumed the executive lead for mental health three weeks prior to our well led review visit and acknowledged the trust had a lot of work to do in this area. The trust did not have a non-executive director lead for the Mental Health Act 1983 (MHA).

The medical director told us they were using the national confidential enquiry into patient outcome and death (NCEPOD) January 2017 ‘Treat as One’ self-assessment report as the basis for the trust strategy. They were able to discuss with us the priorities and risks for the trust which included staff training, and the development of a signed service level agreement (SLA) with the a local NHS mental health trust.

During our unannounced inspection of the critical care unit we found a lack of formal governance arrangements. Evidence based clinical guidelines specific to critical care were not in use and the unit did not adhere to all national standards or consistently monitor the effectiveness of care and treatment through continuous local and national audits.

Previous CQC inspections in 2016 identified concerns in relation to safeguarding children, including a lack of management oversight and governance. A follow-up inspection in July 2017 found the trust had taken appropriate action in response and there was evidence of improvement. This included the appointment of an assistant director of safeguarding (adults and children) across the healthcare group, and the creation of a cohesive team of dedicated safeguarding...
professionals, advisors and administrative staff working across acute and community services. Governance arrangements at senior level and at the frontline were sufficiently robust. The director of nursing chaired the monthly safeguarding assurance group, which included relevant healthcare practitioners from all services. Safeguarding was also a standard agenda item at operational departmental meetings.

Management of risk, issues and performance

Financial summary from NHS Improvement

South Tyneside NHS Foundation Trust were set a financial plan deficit (‘control total’) for 2017/18 of £0.9m by NHSI. This includes receipt of Sustainability and Transformation Funding (STF) of £4.2m therefore the control total deficit that the trust needs to achieve (excluding STF) is £5.1m.

During Q1 2017/18 the trust fell behind it’s phased control total as a result of underperformance on planned reductions in block funding from South Tyneside CCG where the trust has been unable to reduce corresponding costs and overspend on pay on bank and agency staff (medical and nursing, partially offset by a 5% vacancy rate). These trends have continued into Q2 2017/18 and as a result the trust has lost STF of £2.1m.

At Month 6 given the degree of slippage in actual financial performance against plan the trust board made a decision to revise its financial forecast deficit downwards by £5m following escalation meetings with the NHSI regional team. The trust’s financial forecast deficit (excluding STF) is now £10.1m.

Whilst the trust board is fully committed to implementing a financial recovery plan for 2017/18, which gets the trust as close to the original control total as possible there is a greater focus on the medium to long term financial recovery plan for the South of Tyne Local Health Economy (STFT, CHSFT, STCCG and SCCG).

NHSI regional team is supporting the trust in the short term to identify further operational productivity and financial grip and control improvements that can be incorporated into 2017/18 financial recovery and facilitating discussions for a longer term solution for the Local Health Economy.

Finances overview*

<table>
<thead>
<tr>
<th>Financial Metrics</th>
<th>HISTORICAL DATA</th>
<th>PROJECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2 years ago) (£'000)</td>
<td>Last Financial Year (2016/17) (£'000)</td>
</tr>
<tr>
<td>Income</td>
<td>£210,749</td>
<td>£200,640</td>
</tr>
<tr>
<td>Surplus / (deficit)</td>
<td>(£3,153)</td>
<td>(£7,438)</td>
</tr>
<tr>
<td>Full costs</td>
<td>£213,902</td>
<td>£208,078</td>
</tr>
<tr>
<td>Budget</td>
<td>£193,576</td>
<td>£195,062</td>
</tr>
</tbody>
</table>

During our interview with the director of finance they indicated a move towards a system financial recovery plan.

---

* RPIR – Universal – Finances tab
Local risk registers were poorly developed and used inconsistently across the trust. Risks were not being escalated to a corporate risk register. The trust told us they captured their risks on their board assurance framework. The trust did not have a process which would trigger formal escalation of risks. Some risks we identified at inspection had not been identified by the trust’s internal governance processes.

There were plans to have a single risk management process across the health care group. Potential risks in relation to unexpected events were not always taken into account when planning services. A business continuity policy was approved by the executive board in December 2014 and due for review in January 2018. The policy stated all trust services should have a documented business impact analysis and business continuity plan based on a standard template. The emergency planning committee oversaw audits of compliance with the policy and testing of business continuity plans.

However, when we asked for this information the trust told us they were conducting a major review and implementation of the trust incident response plan. The emergency planning lead was working with information technology colleagues to understand the best way to cascade emergency planning information to the relevant staff. The trust confirmed that the new business continuity standard template had been agreed but not yet implemented and audits were planned but not yet conducted. During our unannounced inspection we found staff in the emergency department were working with an out of date major incident policy, major incident equipment checklists were not up to date and they had not practised for a major incident for over a year.

Risks to patients with mental health conditions attending the emergency department were not fully assessed and mitigated. The room staff used to assess patients for mental health was not appropriate principally because it contacted ligature risks and did not meet psychiatric liaison accreditation network’s quality standards (PLAN).

In theatres we found a lack of consistency with the World Health Organisation (WHO) surgical safety checklist. This had been identified by the trust’s own audit data. There was also a lack of adherence with the ‘stop before you block’ safety initiative and the ‘stop at red’ campaign.

Staffing risks – The trust had engaged the services of NHS Professionals from October 2017 in an effort to reduce their expenditure on bank and agency staff. The board had received a nurse staffing review report in November 2017 based on which they had approved funding for priority areas to reduce the risk of the impact of nurse staffing shortages on quality and safety.

There was a programme of clinical and internal audit. A rolling three year strategic internal audit plan and a detailed one-year operational plan were submitted annually to the Audit Committee for review and approval. However, at core service level we found some audits had not been conducted or not conducted consistently.

We found low compliance in the completion of the risk of malnutrition screening tools. Although our findings reflected the trust’s own audit findings senior leaders were not aware of this risk and actions had not been taken to mitigate the risk.
Mortality

The trust had been a persistent high outlier for the summary hospital level mortality indicator (SHMI) and for the hospital standardised mortality rate (HSMR) since 2015. In November 2017 the North East Quality Observatory completed an independent investigation into mortality at the trust. They found that some issues of coding and the inclusion of reported deaths at the trust’s St Benedict’s Hospice impacted on the indicators. After adjustment they found the trust’s crude mortality rate had been stable over the previous five years, the SHMI was within expected range and there was no excess mortality showing for the trust at weekends.

Infection prevention and control

The infection prevention and control (IPC) committee met every 2 months reporting to the Clinical Governance group which reported into the Governance sub committee of the board.

The trust’s infection prevention and control annual report 2016/17 was presented at part two of the trust board rather than the public meeting. Although the report was published on the trust’s website we were not clear why the report had not been presented at a public meeting. Following the inspection the trust advised us the report had been presented to the Annual General Meeting.

During our inspection the IPC team raised concerns regarding the pressure on the team caused by lack of staff due to vacancies and sickness. Capacity was mentioned in the 2016/17 board report (page 24 and page 28) where it stated that proactive clinical placements have not been undertaken in 2016/17 due to capacity within the IPCT and the capacity of the IPC team has been low due to vacancies. The team had therefore been working as outlined in the team business continuity plan to ensure all critical workload was undertaken. We were unclear what further trust action had been taken as there were no minutes from part two of the board meeting and staff we interviewed were unable to clarify.

Infection prevention and control guidance for NHS providers states that boards should receive a quarterly report from clinical directors and matrons. We found a discrepancy in the number of reported cases of clostridium difficile.

- The trust’s Open and Honest Care publication for August 2017 highlighted zero cases of C Diff the month – year to date two
- The trust’s Open and Honest Care publication for September 2017 highlighted zero cases of C Diff the month – year to date four (increase from August but 0 cases documented)
- The trust’s Team Brief Sept from the Chairman and Chief Exec mentioned 4 cases of C Diff - two to be appealed but two linked to cross infection with a reminder to staff about IPC measures and policies. This was not represented in the open and honest papers.

The difference in consecutive month board reporting was explained by the IPC team as being due to cases awaiting arbitration as to whether they were trust attributable.

The trust’s Open and Honest Care publication for October 2017 highlighted two cases of C Diff for the month – year to date six.

Information management

The trust had not been affected by the NHS wide cyber-attack in 2017 but they had been disrupted. As a result they were requesting an independent review of cyber essentials and there had been a board session on cyber security.
The trust were in the process of developing a single information management and technology strategy with an ambitious strategic vision. The other acute trust in the strategic alliance was one of 16 globally identified digital exemplars (GDE) and South Tyneside had applied to be a fast follower.

The trust target was to be paperless by March 2021, achieving HIMMS accreditation at level five. The Healthcare Information and Management Systems Society (HIMSS) is an international organisation dedicated to improving healthcare quality, safety, cost-effectiveness and access, through the best use of IT. HIMSS has developed a European Electronic Medical Record Adoption Model (EMRAM) which measures progress and the cumulative capabilities of Electronic Medical Record (EMR) systems within hospitals.

The medical director had taken on the role of Caldicott Guardian following changes in the Exec team from September 2017 and had completed the training in October 2017. The Director of Finance was the senior information and risk owner and one of the trust’s medical staff was the information governance officer. There had been two information governance breaches during 2017 both of which had been reported to external bodies as required and to patients under the requirement of duty of candour. We saw evidence that lessons had been learnt and shared.

During our unannounced inspection of medical and surgical services we raised concerns about the security of patient records. When we returned for our announced well led review the trust were reviewing arrangements to ensure patient records were securely stored.

The trust had effective arrangements to ensure the quality of data used to manage and report on performance. The trust’s data quality analyst conducted tests of data against various data quality rules prior to submission to national data sets. Data quality audits were part of the trust’s annual internal audit plan.

A data quality sub group, reporting into the Information Governance Group (IGG) had recently been set up to improve data quality completeness and/or integrity and where issues or areas of best practice were highlighted, this group was responsible for implementing corrective action plans to remedy.

Engagement

Staff Engagement

The first phase of the clinical service reviews had not engaged staff in an appropriate way and trust leaders had recognised this. The revised plan for the second phase of the clinical service reviews would consult earlier with staff.

During our unannounced inspection of core services at the trust we found there was a lack of patient information leaflets available within services.

Public and Patient Engagement

Patients and the public were actively engaged in shaping services through the path to excellence programme. The first phase of public consultation began in July 2017 for a range of options for the trust’s three core areas of acute hospital care which were most vulnerable:

- Stroke care services
- Maternity and women’s healthcare services
- Urgent and emergency paediatric services
Phase one of the consultation closed in October 2017 and a decision is expected to be made on the future of these services by the commissioners during February 2018.

Phase two of the consultation is planned to begin in 2018 with a formal public consultation from May 2019. This phase will consider a range of options for the following services:

- Acute medicine and emergency care
- Acute surgery, theatres and critical care
- Planned care and specialist services
- Clinical support services

Although we heard about good examples of collaborative partnership working between the trust, commissioners and the local authority, outside of the path to excellence programme there was limited evidence available of public and patient engagement at the trust. There was no patient or public engagement strategy. Governors we spoke with were not able to articulate a strategy for increasing public membership or for engaging with the public.

The trust did not utilise EDS2 effectively. EDS2 is a system designed to promote engagement with key stakeholders to help access organisations. The trust had not embedded EDS2 across the organisation and there was a lack of involvement from stakeholders.

There was no evidence of engagement with LGBT, disabled or BME staff groups and no related staff networks. There was also no evidence of engagement with external equality and diversity organisations.

The trust did not have systems in place to ensure the voice of all patients was heard. There was no dementia strategy to support staff with caring for frail elderly patients and no dementia specialist nurse, although we saw some good examples of dementia friendly environments at the trust.

We found there was a lack of patient information on general display on the wards and the onus was on patients to ask for this.

There was transparency and openness with stakeholders regarding performance.

The trust had a duty of candour policy. 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. We reviewed evidence demonstrating staff had applied the principles appropriately.

We reviewed four serious incident investigations and found evidence that families were informed and involved in each of them. We reviewed six patient complaints. In each case complainants were kept informed and communication with them was personalised and appropriate.

### Accessible Information Standard

All providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard in full from 1 August 2016 onwards - in line with section 250 of the Health and Social Care Act 2012

The Accessible Information Standard applies to people using the service (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss. It covers the needs of people who are blind, d/Deaf, deafblind and/or
who have a learning disability. Plus, people who have aphasia, autism or a mental health condition which affects their ability to communicate.

The trust had not taken any action to implement the requirements of the Accessible Information Standard. This was confirmed in interviews with the equality and diversity.

**Learning, continuous improvement and innovation**

**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.

<table>
<thead>
<tr>
<th>What is your internal target for responding to complaints?</th>
<th>In Days</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 working days</td>
<td>99% (June 17)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your target for completing a complaint</th>
<th>25 working days</th>
<th>93% (June 17)</th>
</tr>
</thead>
</table>

If you have a slightly longer target for complex complaints please indicate what that is here

<table>
<thead>
<tr>
<th>Number of complaints resolved without formal process in the last 12 months?</th>
<th>903</th>
</tr>
</thead>
</table>

**Complaints**

- The trust received 150 complaints from August 2016 to July 2017.
- Medicine received the most complaints with 38 (38% of all complaints).
- The average number of working days taken to close complaints was 46. The total days ranged from 204 – 6.
- The maternity core service was the only one able to meet the trust target of closing complaints within 25 days.
- The 25 working day complaints target was not met for eight out of the nine core services below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Proportion of total</th>
<th>Average of Number of days to close</th>
<th>Trust target for dealing with complaints (days)</th>
<th>Target met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>22</td>
<td>14.6%</td>
<td>45</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Medicine</td>
<td>38</td>
<td>25.3%</td>
<td>56</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>25</td>
<td>16.6%</td>
<td>56</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Maternity</td>
<td>2</td>
<td>1.3%</td>
<td>19</td>
<td>25</td>
<td>Yes</td>
</tr>
<tr>
<td>Community</td>
<td>50</td>
<td>33.3%</td>
<td>38</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>End of Life</td>
<td>2</td>
<td>1.3%</td>
<td>31</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Children</td>
<td>1</td>
<td>0.6%</td>
<td>31</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>OPD</td>
<td>5</td>
<td>3.3%</td>
<td>46</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td>Critical Care</td>
<td>5</td>
<td>3.3%</td>
<td>57</td>
<td>25</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td></td>
<td><strong>46</strong></td>
<td><strong>25</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>
The customer services department handled all informal and formal complaints. They worked to a standard operating procedure and within a policy on the handling of concerns and complaints. However the policy they were using was overdue for review from 3 September 2017. We discussed this with staff who told us the review had been delayed for consideration of changes to the case manager role. Case managers told us the trust was also working towards a consistent approach within the health care group. The director of nursing confirmed that the strategy for patient experience was under review as part of the development of the new quality strategy.

We found there was a lack of information displayed or available in the hospital telling patients how to raise concerns or complaints. Whilst the trust had produced a leaflet called ‘Listening, acting, improving’ it was not widely visible or available and not produced in accessible formats. The trust’s policy states leaflets explaining how people can comment on our services must be available on all of our wards, departments, health centres etc.

We reviewed six patient complaints. In each case people were supported to make a complaint and the process was easy. In most cases there was evidence that the complaint was investigated thoroughly and formally recorded. Complainants were kept informed and communication with them was personalised and appropriate.

The data supplied above showed that complaints were generally taking longer to deal with than the trust target. However, this had improved at the time of our inspection and staff explained there had been a backlog due to staff shortages which had been addressed.

There was evidence of organisational learning from complaints. For example, issues highlighted about a patient’s care led to the production of a short film involving staff, carers, and volunteers. This captured the patient’s experience and the trust used the film as part of staff training sessions about the role of carers. The learning also contributed to the development of a carers’ charter.

Complaints were discussed at the joint patient carer public experience committee (PCPEC). The monthly quality, risk, assurance report (QRA) to the board contained a high level summary of complaints. However, the trust did not yet receive information about themes or learning from complaints. The director of nursing told us there was more work to do in this area and this would be developed as part of the quality strategy.

The trust fulfilled its statutory responsibility to produce an annual complaints report for 2016/17 which had been published in May 2017.

**Learning from deaths**

The trust had made good progress ahead of the requirement to meet the national guidelines on reviewing and investigating deaths. Their mortality review policy had been in place from late 2016 and updated to incorporate the new guidance in 2017. The deaths of all patients who died under the care of the trust were investigated at departmental level and reviewed by the trust mortality review group which met six times per year. The mortality review group which commissioners also attended reported to the clinical governance group. All internal investigations were conducted by appropriately trained staff. Where the death met specific criteria such as the death of a person with learning disabilities or a serious mental disorder, there was a secondary independent review. Between January and September 2017 17.4% of deaths at the trust were subject to a secondary review. The trust had developed a learning from deaths dashboard which was presented to the board for the first time in November 2017 in line with national guidelines. Subsequently there was a plan to present this report to the board quarterly. The medical director and the non-executive chair of the governance committee were the trust board leads for mortality and learning from
deaths. The trust was working on a plan to increase the involvement of families and carers in the investigation of deaths to the extent to which they wished to be involved. The medical director was working with regional medical directors to agree a local approach to this sensitive issue. We reviewed nine learning from deaths reviews at South Tyneside hospital and found five out of nine had no learning points or actions, although reviews were mostly comprehensive and all reported deaths were classified as unpreventable. A death is **preventable** if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.

**Learning from serious incidents**

We reviewed four serious incident investigations. All four had evidence of appropriate investigations, focused on learning and led by an appropriate member of staff. There were action plans in place for each of them with accountable persons and achievable dates.

**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.

- The table below shows which services within the trust have been awarded an accreditation together with the relevant dates of accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme</th>
<th>Details of accreditation and date (if available)</th>
<th>Related core service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy (2014) with a next visit planned 2018</td>
<td>Medicine (including older people’s care)</td>
</tr>
<tr>
<td>Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care</td>
<td>St Benedict's is in the process of becoming an accredited trainer for GSF for care homes</td>
<td>End of Life Care</td>
</tr>
<tr>
<td>NHS Screening quality assurance visit</td>
<td>Cervical screening programme</td>
<td></td>
</tr>
<tr>
<td>Safe Practice Scheme Conscious Sedation for Dentistry (SAAD)</td>
<td>Community Dental Service (Palmer, Monkwearmouth HC, Washington PCC, QEH; Wrenkenton HC; Blaydon PCC) November 2016</td>
<td></td>
</tr>
</tbody>
</table>

South Tyneside District Hospital endoscopy unit was awarded JAG (Joint Advisory Group on Gastrointestinal endoscopy) accreditation, which it has achieved every year since it was introduced in 2006. The Gastroenterology team was recognised in the 2016 HSJ awards as the best in the country for global impact on clinical research.

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11 RPIR – Universal – Accreditation tab
Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services

- South Tyneside District Hospital

(Source: Trust Provider Information Request)

Activity and patient throughput

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

There were 68,765 attendances between April 2016 and March 2017 at South Tyneside NHS Foundation Trust as indicated in the chart above.

(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 has increased between year 1 and year 2. In year 2, rates were slightly higher than the England average. *(Source: NHS England)*

**Urgent and Emergency Care attendances by disposal method**

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>15,770</td>
</tr>
<tr>
<td>Discharged*</td>
<td>43,181</td>
</tr>
<tr>
<td>Referred*</td>
<td>5,556</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>744</td>
</tr>
<tr>
<td>Died in department</td>
<td>48</td>
</tr>
<tr>
<td>Left department#</td>
<td>2,031</td>
</tr>
<tr>
<td>Other</td>
<td>102</td>
</tr>
<tr>
<td>Not known</td>
<td></td>
</tr>
</tbody>
</table>

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

*(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 provided mandatory training to its staff and staff we spoke with confirmed they had enough time to do mandatory training and that they were up to date with it.

At the last inspection we reported there were variable completion rates for mandatory training amongst staff working in the department. The rates were still variable, particularly amongst medical and reception staff, but with nursing staff meeting the target in many modules.

The trust told us changes were recently made to levels of training required for specific staff groups which reduced the compliance rates for staff who were previously compliant. The trust told us it would take some time before these staff would become compliant. For instance, in Mental Capacity Act and adult safeguarding training.

We reviewed a department plan to tackle variable mandatory training completion rates. Actions included booking staff who were on maternity leave onto the training when they returned from leave and reminding staff who had not completed the training to do so by a specified date in the near future.

At this inspection staff told us the target for mandatory training was 85% and that mandatory training covered the following modules: moving and handling patients; infection control; medical device awareness; conflict resolution; fire safety; health and safety; infection control; information governance; resuscitation; mental capacity; safeguarding adults and children; and equality and diversity.

Staff across all groups met the target for moving and handling and information governance. In all modules apart from conflict resolution; infection control; Mental Capacity Act; and adult safeguarding, nursing staff in the children’s emergency department met the target.

In other modules the picture was variable. For instance, for Mental Capacity Act training medical and reception staff were at 25% and 23% completion. But nursing staff in the children’s emergency department were 83% and in adults 75%. For adult safeguarding, the percentage completion rates were 25%, 85%, 78% and 75% respectively. Children safeguarding was at 50%, 92%, 96% and 78% respectively. For resuscitation training nursing staff in the children’s emergency department met the target (87%) but medical and nursing staff in adults did not (42% and 69% respectively).

Staff told us new staff received an induction and we saw an example of the induction pack used to induct new staff, which included agency and locum staff.

We requested training targets and compliance rates for immediate life support training and advanced life support training, however the trust informed us this was not available. Based on the training data supplied in their provider information request we were not assured that all medical staff had received appropriate emergency lifesaving training.

The trust set a target of 90% for completion of mandatory training. Overall the trust had an 82% completion rate for all A&E staff.
A breakdown of compliance for mandatory courses between June 2016 and July 2017 for medical/dental and nursing staff in Urgent and Emergency care is shown below:

The trust exceeded the target completion rate of 90% for four training modules completed by medical & dental staff. All four of these modules had 100% completion. Resuscitation had the lowest.

The trust exceeded the target completion rate of 90% for three mandatory training modules undertaking by nursing & midwifery staff. Infection control had the lowest completion rate with 56%.

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

The physical environment for assessing a patient with mental health conditions required improvement (see Environment and equipment below) but otherwise the department had systems and processes in place to support staff in identifying and dealing with adults or children at risk. When speaking with staff and reviewing patient records, we found the systems and processes were being used, so that safeguarding was the responsibility of everyone.

The trust had appointed an Assistant Director for Safeguarding and three Named Nurses supported by Safeguarding Advisors. Trust policies were in place for adult and children safeguarding and to monitor safeguarding across the trust a dashboard was used which was reviewed on a quarterly basis at a trust level. In the period 31 July 2016 to 1 August 2017, across the trust, there had been 680 adult safeguarding referrals and 450 child safeguarding referrals.

One of the departmental nurses was the departmental link nurse for safeguarding.

The trust’s electronic patient system allowed staff to flag if a patient had any safeguarding issues. For instance, in the children’s treatment area, staff could flag whether the child patient was subject to a child protection plan and how many times they had attended the department. Any cases of female genital mutilation or child sexual exploitation were reported on the trust’s incident reporting system and followed up by the trust’s safeguarding team.

To enable staff to call security if staff or patients were at risk each computer terminal had an electronic emergency call bell on it.

Staff told us that the doors leading into the children waiting area were locked from 10pm until 8.30am but otherwise, outside of these hours, staff tried to ensure that there was always a member of staff at the nurses’ station in the waiting area. We found that on most occasions we visited the children waiting area this was so.

Staff were supported to effectively report safeguarding issues. For example, in each cubicle in the adult majors treatment area, there was a safeguarding file with flow chart. In addition, we saw staff could access a safeguarding know-how file which was held in the department.

Within the patient records we reviewed we saw there was a section called ‘think safeguarding’ which required staff to think about safeguarding issues and confirm whether there were any. We saw staff had completed this part of the patient record and where necessary made referrals to third parties, such as social workers.

Staff could tell us about times when they had made a safeguarding referral. Staff told us of an example where a safeguarding referral had been made using the trust’s incident reporting system when a staff member observed an adult strike another adult in front of a child.

Staff were trained in safeguarding to level three for adults and children and staff told us the training figures showed that staff in the department were 100% compliant in terms of the target for safeguarding training. This meant that the Royal College of Emergency Medicine (RCEM) Safeguarding Children Standards were met.
Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training, overall for A&E staff the trust had a safeguarding completion rate of 97%.

A breakdown of compliance for safeguarding courses between June 2016 and July 2017 for medical/dental and nursing staff in Urgent and Emergency Care is shown below:

The trust exceeded the safeguarding completion target of 90% for three modules (all of which scoring 100%) Safeguarding children level 3 failed to meet the target with a 50% completion rate.

The trust exceeded the target completion rate of 90% by scoring 100% for all four safeguarding training modules undertaking by nursing & midwifery staff.

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

Cleanliness, infection control and hygiene

Overall the department was visibly clean and tidy, we saw staff cleaning the department, and (unlike during the previous inspection) there was hand gel available at the main department reception and in the waiting areas. We pointed out to staff there were still no signs encouraging the public or patients to use the gel and staff told us this is something that would be considered.
We spoke with staff doing the cleaning and they showed us the schedule they worked to in order to clean, for instance, a cubicle in majors. Staff told us that they had enough equipment to do the cleaning, with colour coded mops and buckets, for use in different areas or tasks, which we saw. Signage was in place within the room used by domestics about control of substances hazardous to health. Staff doing the cleaning wore aprons and gloves and part of their role was to replenish gels. We found only one gel dispenser which was empty. Staff reported that the domestic staff provided good support in helping them to maintain a clean environment.

We looked at key areas such as the waiting areas, cubicles, treatment rooms, the sluice, the nurses’ stations, waste management area and staff room and (with the exception of the adult sluice, staff room and waste management area on day one of our inspection) found them all to be clean and tidy.

The adult waste management area, sluice and staff room all required a swipe card to access them and so were not open to the public. On day one of our inspection we found the waste management area (which was shared with the emergency assessment unit and paediatrics (not part of the department)), was untidy with glass in a cardboard box on the floor. The staff room was dirty and untidy, and the adult sluice had a blood product which had been left and not disposed of within 24 hours. We noted that on the subsequent days of our inspection all these areas were clean and tidy.

In the children treatment area toys provided for use by children were visibly clean and staff told us one of the nursery nurses kept a cleaning rota for the toys.

The flooring and equipment we saw appeared to be designed to promote ease of cleaning. For instance, computer keyboards had a flat keyboard which could be wiped clean easily.

The department had adequate hand washing facilities, gels, and paper towels together with supplies of personal protective equipment, such as aprons and gloves. Staff were seen to be ‘bare below the elbow’ and washing hands and using personal protective equipment when caring for patients.

Sharps bins that we saw were properly assembled, stored off of the floor, signed and dated, although we noted in some areas they appeared to be very full or not partially closed.

We were told that a member of staff was tasked to routinely check the mattresses to see if they needed replacing but this was not documented. We looked at a sample of mattresses and did not see any mattresses that required replacing.

Staff spoke with described what they would do if a patient was considered to be infectious. This included: removing equipment from the treatment room and placing it outside the room; ensuring adequate stock of appropriate personal protective equipment was to hand for use by staff; placing notices on the door alerting staff to the infection; and using different hand washing techniques, plus use of barrier nursing techniques, including masks. We saw a specific cleaning checklist for domestics to use after a room had been used by an infectious patient which ensured the room received a deep clean.

The department had a know-how folder about infection control available for staff to use and one of the senior nurses led on this. We saw the infection control audit schedule for 2017. Staff carried out a monthly infection control audit looking at: hand hygiene; aseptic technique; use of personal protective equipment; peripheral venous cannula insertion; and urethral catheter insertion. The schedule we saw showed 100% compliance from April to September 2017. The results were sent to the trust’s central infection control team, which undertook spot checks.

We saw evidence of daily commode checks and all commodes we saw were clean.
Environment and equipment

While we did not consider the facilities for conducting assessments of adults and children with mental health conditions were safe, (and the relatives’ room used to comfort bereaved relatives was not ideal), the environment generally was modern and welcoming and supported staff in providing patients with safe care using equipment that was available, safety checked and maintained.

The department was situated on the ground floor with level access for wheelchair users, and close to the x-ray department (also on the ground floor) and theatres (on the first floor). It consisted of a main reception area where walk-in patients were booked in and referred to a separate adult or children treatment area, each with its own dedicated waiting area and nurses’ station. Broadly, both the adult and children treatment areas were split into minors; majors; and resuscitation. The relatives’ room and mental health assessment room were located in the minor injuries section of the adult treatment area which also had a café/snack bar run by volunteers. For patients arriving by ambulance there were dedicated ambulance entrances to the adult or children treatment areas.

On our previous inspection we noted that chairs in the adult waiting area had splits in them and we found this to be so when we inspected this time. Staff told us the splits we saw occurred after new chairs were installed following the previous inspection. We were assured that this would be addressed. Also on our previous inspection we noted that there was noise from overhead fans and that handovers for patients were taking place at or near the nurses’ station in the children treatment area. We did not notice any noise from overhead fans or handovers taking place at the children nurses’ station at this inspection.

The signage to the department was effective and we saw all doors leading into the department, whether from the front or the rear, could be locked down. To access areas not open to the public, including access between the children and adult areas, a swipe card was required to unlock the doors. Although there was a constant staff presence, it was possible to access the department from the rear main hospital corridor, leading from the x-ray department. All areas had CCTV and a third party contractor provided security staff, who could be called using emergency buttons.

We saw fire exit signs and there were fire extinguishers. Toilets were available for public use (including a wheelchair accessible toilet) and they were clean.

Each waiting area had a nurses’ station which patients reported to. Staff were able to easily observe patients in the waiting areas from the nurses’ station in each area. The seating in each waiting area was adequate and in the children’s waiting area the seating fabric was made up of different colours. The adult waiting area had a coffee machine and water machine. In the children’s area drinks were offered.

At or near the nurses’ station in each treatment area there was an electronic whiteboard which contained patient identifiable information and information to support staff in caring for the patient. It was possible for patients and/or their relatives/carers, if they chose to, to see this information. Staff told us they tried to mitigate this by moving patients and/or their relatives/carers past the board as quickly as possible.

The adult treatment area had a clean and dirty utility, discharge lounge (with television and adequate seating and a constant staff presence), a staff room, an assessment room, eleven major treatment rooms (all with doors and privacy glass), a six bedded resuscitation bay (with one designated bay for trauma), and a minors area with three treatment rooms with doors. The children treatment area had a clean and dirty utility, a staff room, four assessment rooms (all with doors and privacy glass), a one bedded resuscitation bay, and a three bedded short stay unit.
(which had piped oxygen) where children could stay for up to 24 hours pending transfer to another hospital.

The room staff had to use to assess patients for mental health conditions was not appropriate for its use principally because it contained ligature risks and so did not meet Psychiatric Liaison Accreditation Network’s Quality Standards (PLAN). While staff put measures in place to try and mitigate these risks, such as staying with the patient, this did not remove the risk, to either the staff or patient. This is because, while the room had two entrances/exits (only one opened outwards), there was no CCTV or emergency call bell. Even though staff had personal alarms, the room was windowless and the doors also, so there was no way to see or hear effectively if staff or the patient required help. In addition there were no non-ligature risk toilets in the vicinity. The room itself opened out into either the staff room or the waiting room. Child patients who required a mental health assessment were seen in a treatment room within the children’s treatment area, which was not safe, as it too contained ligature risks, and was not the designated room for mental health assessments.

The room used by staff to comfort bereaved relatives was not ideal. It was a long walk from the adult resuscitation area past one side of the adult majors area. It was possible to hear the noise (and television) from the minors waiting area. The room was windowless and small, although it had a table, chairs and a box of tissues, and some pictures on the wall.

All equipment used was logged on the trust’s medical device management software and overseen by the trust’s medical devices group who delivered training, issued alerts and carried out maintenance. Apart from chairs in the adults’ waiting area, we found no issues with any of the equipment we saw.

Staff we spoke with confirmed that there was enough equipment for them to safely carry out their roles. There were sufficient computer terminals available for staff to use. All cubicles in the majors area, treatment rooms in the children treatment area, and the resuscitation bays, had call bells in them.

All equipment we saw had been safety checked and waste was managed appropriately.

**Assessing and responding to patient risk**

The department had systems and processes in place to assess risks to patients, and monitor and manage their safety.

Staff were able to observe from the nurses’ station patients waiting to be seen. This meant that, if a patient became unwell rapidly, staff could react promptly to give assistance.

The department used an effective triage system. Walk-in patients were booked in by staff on the main reception and called from the waiting area. If reception staff considered a patient required immediate assistance they would be directed to triage immediately. To do this staff on reception would use their common sense rather than any specific escalation guidance or flowchart. In triage initial observations would be taken and entered onto the patient information system and paper records. At this stage also any investigations would be done such as bloods or an ECG. Key information from this would automatically populate the electronic whiteboard.

The patient would then pass to the co-ordinator for assigning to a nurse and appropriate treatment area. The department used the national early warning scores (NEWS) and paediatric early warning scores (PEWS) to monitor the condition of patients and recognise if their health was
deteriorating. Completion of the NEWS and PEWS was audited monthly and if the audit results fell below 80% it was audited weekly until performance rose above 80%.

In terms of monitoring patients, in addition to taking regular observations using NEWS or PEWS, in the adult treatment area the department used a patient care record which was completed hourly. This was timed and dated and looked at issues including whether the patient was asleep, in pain, that the call buzzer was with the patient, skin condition, any pressure ulcers, any damage, and incontinence. In the children treatment area each child had a named nurse and they ensured that regular observations and comfort rounding took place and we saw this occurring during our inspection. The staff in the children treatment area had access to a paediatric consultant (who was on-call if not in the department) with a middle grade doctor overnight supported by an advanced nurse practitioner.

In relation to sepsis management, we noted that in the 2016/2017 Severe Sepsis and Septic Shock Audit the trust, compared to trusts nationally, had not performed better in any areas, and was worse in five areas and similar in three. We asked the department what they were doing about the audit results. Staff told us the trust had appointed a sepsis lead nurse who was responsible for training on sepsis and auditing compliance within the department. It was this nurse who had led on ensuring that each cubicle in majors had a sepsis screening tool, that posters about sepsis management were on display around the department, and that staff had access to sepsis know-how packs. Staff could flag on the patient record if the patient had sepsis. For the two targets relevant to the department - identifying patients with sepsis and prescribing antibiotics within an hour of identification - for October 2017 the department had scored 95% and 86% respectively, against a target of 90%. The action plan in place to increase the score for antibiotic prescribing within an hour included training more nurses to be competent in prescribing and this work was ongoing.

To manage emergencies safely the department made use of clinical stress pathways. For instance, we saw such a pathway for gastro-intestinal bleeds.

We saw that there were enough staff, so that, if required, patients could be escorted to receive a scan or x-ray.

Staff described effective joint working arrangements to meet the needs of patients at mental health risk. The psychiatric liaison team were available for department staff to call on if required seven days each week between the hours of 08:00 to 21:00. The consultant worked one day each week, which meant there was a risk that complex patients may not receive the support they needed in the department when the consultant was not working. The team aimed to respond to a request for assistance within 60 minutes. Out of hours department staff could contact the mental health crisis team or the on-call consultant psychiatrist. Children aged 16 and 17 were supported by the team but for younger children department staff sought support from a local hospital's children and young person’s mental health team between the hours of 08:00-20:00. Outside of these hours children would be placed in a treatment bay in direct line of sight of the nurses’ station and receive support while awaiting transfer to another hospital. As noted above this was not safe because the treatment room had ligature points.

The mental health act section 136 place of safety was located at a nearby hospital.

Staff told us discharge summaries were automatically shared with GPs and if the patient was a child, their school nurse and health visitor as applicable.

The trust provided information for the time of arrival to initial assessment or triage. This data showed that between April 2017 and September 2017 the data ranged from nine minutes to ten minutes.
Emergency Department Survey 2016

The trust’s scored “about the same as other trusts” for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>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?</td>
<td>6.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the Emergency Department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency Department, did you feel threatened by other patients or visitors?</td>
<td>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

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 did not meet the standard for eight months over the 12 month period between September 2016 and August 2017.

Performance against this standard showed a trend of improvement however July 2017 saw one of the trust’s highest rates at 66 minutes for time to treatment compared to the standard of 60 minutes. Aside from September 2016 the trust was consistently higher than the England average throughout the reporting period.

Ambulance – Time to treatment between September 2016 and August 2017 at South Tyneside NHS Foundation Trust

(Source: NHS DIGITAL: A&E quality indicators)
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 for the entire period between September 2016 and August 2017.

In the latest month, August 2017, the median time to initial assessment was 10 minutes compared to the England average of seven minutes.

Ambulance – Time to initial assessment between September 2016 and August 2017 at South Tyneside NHS Foundation Trust

(Source: NHS DIGITAL: A&E quality indicators)

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

South Tyneside District Hospital

Between October 2016 and September 2017 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at South Tyneside District Hospital.

Ambulance: Number of journeys with turnaround times over 30 minutes - South Tyneside District Hospital

(SOURCE: NHS Digital: A&E quality indicators)

Ambulance: Percentage of journeys with turnaround times over 30 minutes - South Tyneside District Hospital

(Number of black breaches for this trust)

(Source: Routine Provider Information Request (RPIR) AC11 – Black Breaches)
The trust did not provide this information but nationally published data for November 2017 showed that ambulances remaining at this hospital for more than 60 minutes had increased to 8.7% from a figure of 1.5% in November 2016.

Nurse staffing

Senior staff told us they had enough nursing staff available to provide safe care to patients and we saw that there was a good mix of different levels and skills of nursing staff.

The department operated two shifts 07:30-20:30 and 20:30-07:45. Handovers between nurses took place separately from doctors and were carried out in the morning and the evening when the shift was changing. We observed an evening handover between nurses that took place in one of the empty treatment rooms with the door closed. This was robust and detailed covering each patient and assigning tasks. Nursing staff reported that they found the process useful.

The department did not use any tool to support it in deciding on the right numbers or skill mix of staff. Senior staff reported that there were no national guidelines mandating nursing staffing levels in an emergency department although they were aware of relevant RCEM guidelines.

The nurses in the department reported to a matron who delegated staffing needs to a nurse co-ordinator who reviewed staffing needs on a daily basis and throughout the day. Staff told us that the trust had done an annual review of staffing in July 2017 and the only issue that arose in terms of the department’s nurse staffing was perhaps a need for an evening nurse co-ordinator.

The nurses did not rotate or swap between the adult/children treatment area principally because the nurses in the children treatment area had specialist training for treating children. The co-ordinator ensured that adult resuscitation always had one registered nurse and health care assistant on duty at all times. If more staff were required these were flexed from other areas of the adult treatment area.

In the adult treatment area, during the day the department aimed to have seven registered nurses on duty with three health care assistants. At night it aimed to have five registered nurses on duty with two health care assistants.

In the children’s treatment area, during the morning the department aimed to have three registered nurses on duty, in the afternoon three registered nurses with one health care assistant and at night it aimed to have two registered nurses on duty with one health care assistant. All of the nurses in the children treatment area were children nurse specialists and also amongst them there were three advanced paediatric nurse practitioners and four paediatric nurse practitioners.

Any gaps in staffing tended to be filled by existing staff taking on extra shifts and so there was little need to use an external bank. Staff told us any bank staff used also received an induction but the department would tend to use staff that had previously worked within the department.

Staff told us that, owing to historical issues around sickness, the department had, in the past, used agency staff, who received a full and comprehensive induction. We saw the induction pack that the department used. Presently the department rarely used agency staff because sickness levels had improved. Staff told us this was due to a more robust sickness policy that the trust had introduced in April 2017.

Whilst we did not see any daily staffing details on display for the public to see, the department was staffed as expected during our inspection and there were no vacancies reported to us.
South Tyneside District Hospital reported their staffing numbers below for the period April 2017 and July 2017. The trust had 5.69 WTE fewer staff in post as required to provide safe and planned care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post April 2017 – July 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Tyneside Hospital</td>
<td>127.89</td>
<td>122.20</td>
</tr>
<tr>
<td>Total</td>
<td>127.89</td>
<td>122.20</td>
</tr>
</tbody>
</table>

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

Vacancy rates
Between August 2016 and July 2017 South Tyneside District Hospital reported a vacancy rate of 8% in Urgent and Emergency Care.

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

Turnover rates
Between August 2016 and July 2017 South Tyneside District Hospital reported a turnover rate of 2% in Urgent and Emergency Care.

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

Sickness rates
Between August 2016 and July 2017 South Tyneside District Hospital reported a vacancy rate of 5% in Urgent and Emergency Care

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

Bank and agency staff usage
The trust did not provide this information.

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

Medical staffing
While medical staffing did not meet RCEM guidelines, (with 12 hours a day of consultant cover instead of 16), senior staff reported that medical staffing was safe, with certain mitigating measures in place, such as: an overlapping shift pattern: capability for home working by consultants (for instance, so they could view diagnostic images from their home); consultants living close by if needed through the on-call rota; and 24/7 cover from a registrar with a minimum of four years post qualification experience.

Medical staffing consisted of five consultants, ten full time junior doctors and seven registrars (some of whom were four years or more post qualification). The shift patterns were designed to overlap with three shifts: 08:00 to 18:00 then 13:00 to 22:00 and 22:00 to 08:00. A doctor with at least four years post qualification experience or above was always on duty 24 hours a day.

Whilst the number of hours of consultant cover was less than recommended by RCEM guidelines (12 hours a day instead of 16 hours) staff told us that the department had in place arrangements to mitigate this, such as consultants living close by and all consultants having the ability to view diagnostic results and patient records from home. Junior doctors we spoke with reported that...
consultants were approachable although if they needed to be contacted out of hours this was usually done by the registrar.

If extra medical cover was required staff told us that a medical locum would be used who would be inducted and supervised by one of the consultants. The department tried to use medical locums who had worked within the department previously.

Consultant staff looking after children were trained in paediatric advanced life support.

Senior staff told us that the consultant body felt under pressure and ideally, having done some benchmarking of consultant cover against similar sized departments, felt there should be eight consultants instead of five. Recruitment was an issue and while the existing registrar pool was a source of potential recruitment opportunities. Senior staff told us that the consultant body felt under pressure and ideally, having done some benchmarking of consultant cover against similar sized departments, felt there should be eight consultants instead of five. Recruitment was an issue although the existing registrar pool was a source of potential recruitment opportunities.

South Tyneside District Hospital reported their staffing numbers below for the period between April 2017 and July 2017. The trust is currently overstaffed by 1.39 WTE than required to provide safe and planned care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Planned Staff</th>
<th>Number in post April 17 – July 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Tyneside Hospital</td>
<td>44.75</td>
<td>46.14</td>
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<tr>
<td>Total</td>
<td>44.75</td>
<td>46.14</td>
</tr>
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</table>

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

Vacancy rates

Between August 2016 and July 2017 South Tyneside District Hospital reported a vacancy rate of 15% in Urgent and Emergency Care.

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

Turnover rates

Between August 2016 and July 2017 South Tyneside District Hospital reported a turnover rate of 6% in Urgent and Emergency Care.

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

Sickness rates

Between August 2016 and July 2017 South Tyneside District Hospital reported a sickness rate of 0% in Urgent and Emergency Care.

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

Staffing skill mix

As of June 2017, the proportion of consultant staff and junior (foundation year 1-2) reported to be working at the trust were higher than the England average.
Staffing skill mix for the 15 WTE staff working in Urgent and Emergency Care at South Tyneside NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>33%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career</td>
<td>27%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>7%</td>
<td>31%</td>
</tr>
<tr>
<td>Junior</td>
<td>33%</td>
<td>25%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Records

We reviewed 21 patient records, being a mix of adult and child records, and found them to be accessible, detailed and readable which supported staff in providing safe care to patients. Also we reviewed six patient records where a mental health assessment had taken place and in these notes the level of detail varied so that in some records it simply recorded the fact that an assessment had taken place.

The department used a mixture of paper and electronic records to record patient information. The electronic part of the record was used mainly to populate key information on the electronic whiteboards whereas the detailed notes were in the paper records and paper charts. Once discharged from the department patient records were scanned into an electronic archive system so that staff had ready access to those prior records if they needed them. If a patient was admitted to a ward then the paper records from the department would travel with them and form part of the ward’s patient record.

The paper record was designed in such a way that staff, if appropriate, could capture any specific needs of the patient in relation to mental health, learning disability, autism or dementia although none of the 21 records we saw involved these needs.

At the last inspection we noted that the department was not recording risk assessments, details of nursing care, nutrition and hydration, or the timing of a decision to admit or discharge. Our review of the 21 records found that staff were routinely capturing all of this information and so this had improved. For instance, we saw that time of arrival and time of initial assessment was captured. Further, details of the presenting complaint, previous medical history, any allergies, medication, and diagnoses were recorded. Where a decision to admit was made the time had been recorded. All notes seen were dated and signed.

For patients who left the department against medical advice there was a disclaimer form staff used. Whilst the records assumed mental capacity, where mental capacity was absent, and the psychiatric liaison team had been involved, that team would print off a hard copy of their records to
be placed with the department’s paper records so that all staff could have access to any mental health assessment, including around capacity.

**Medicines**

We found that across all areas of the department medicines, including controlled drugs and those used in an emergency, were stored securely and managed safely.

The medicine policy we saw was in date with a review date of January 2018. The department used an automated drug dispensing cabinet to store and manage medicines, which cabinets were situated in the clean utility within each treatment area.

Staff would need to use swipe access to gain entry to the clean utility and then either log on or use their fingerprint to access drugs from the automated drug dispensing cabinet, having selected a patient.

Controlled drugs were only stored in the automated drug dispensing cabinet situated in the adult resuscitation area. Two members of staff were required to access controlled drugs although this could be overridden if necessary and in accordance with the policy. Staff were tasked to carry out daily checks of controlled drug balances but on the first day of our inspection (but not subsequently) we found this had not been done (although there were no other gaps). Checks of controlled drug balances were conducted by the nurse in charge in resuscitation together with the nurse co-ordinator.

The automated drug dispensing cabinets were not refrigerated and so drugs that required refrigeration were stored separately in a fridge situated in the clean utility in each treatment area. With the exception of the fridge in the adult treatment area on the first day of our inspection (but not subsequently) we found all fridges had daily fridge temperature checks. Staff were aware of the procedure to follow if recommended temperatures were exceeded.

We checked the drugs on the resuscitation trolleys and did a random check for expired drugs in the fridges and in the automated drug dispensing cabinet in adult resuscitation and found them all to be in order.

When we observed a morning handover on day two of our inspection we saw staff were reminded of the importance and need to observe and perform the daily fridge temperature and controlled drug balance checks and we saw that this had been done.

Patient allergies were noted on patient records we reviewed and the department used a yellow wrist band system to indicate that a patient had an allergy.

Intravenous fluids containing potassium were stored in the automated drug dispensing cabinet. We looked at a sample of intravenous fluids and saw that they were in date and stored securely in a room requiring swipe access.

Drugs were reconciled daily during the day and out of hours the trust’s central pharmacy team would re-stock the automated drug cabinets and remove expired drugs.

Medical gases such as oxygen were stored appropriately in a room that required swipe access.

The department made use of patient group directions (PGDs) (written instructions that allow non-prescribing healthcare professionals to supply and administer specific medications to patients who meet set criteria) and these were reviewed monthly. We saw a sample of these and noted that they were in date and staff had signed them.
Whilst not specific to the department, the trust reported that it had introduced a real time monthly medicines safety walkabout which highlighted some medicines storage issues but also lots of good practice. Also a non-medical prescribing audit was undertaken in the acute trust which identified some areas of poor compliance with prescription writing, but some improvement was seen after a repeat audit. Lastly, there were monthly antibiotic audits undertaken as part of CQUIN and targets were being achieved.

**Incidents**

The department had systems and processes in place to record and capture details of incidents and learn from them.

We saw the trust’s incident policy which was not in date (last review date September 2017) and also the Being Open Policy, which was also not in date (last review date February 2017). After the inspection we reviewed examples of incident investigations the trust sent to us which appeared detailed and thorough, and noted each had an action plan and lessons learned.

In spite of the lack of an up to date policy, staff we spoke with told us that within the department there was a good reporting culture around incidents, but apart from safeguarding referrals or ambulance transfer delays, no staff member we spoke with could recall a recent incident that they had reported using the trust’s electronic reporting system.

We spoke with staff about the duty of candour. 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 staff we spoke with knew about the duty of candour but none of them could recall an occasion recently when they had used it.

Staff told us that when reporting an incident on the trust’s electronic reporting system they could tick a box to indicate whether they wanted to receive feedback.

In relation to the one serious incident reported between September 2016 and August 2017 that concerned an interpretation of an ECG causing a delay in transfer, staff told us that the investigation into this incident was still ongoing with a report due to go to the trust’s commissioners in November 2017. Staff told us that the clinical investigation review group look at serious incidents and learning is discussed at morning huddles, and shared by email, at a monthly department meeting and copied to the matron file which staff had access to.

Staff we spoke with confirmed that feedback and learning from incidents was discussed in daily morning huddles, one to ones, at appraisals and during monthly team meetings, in addition to receiving learning in emails or a newsletter.

Clinical staff met to discuss learning from mortality in the department and we saw minutes for the September 2017 meeting which covered learning points and actions.
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.

Between September 2016 and August 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 one serious incident (SIs) in Urgent and Emergency Care which met the reporting criteria set by NHS England between September 2016 and August 2017.

This incident reported was.

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (100% of total incidents).

(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)

Safety thermometer

Major incident awareness and training

We were assured that staff would know what to do if a major incident was declared but because the major incident policy had not been updated, (although work to update it was ongoing), some staff felt they were not supported in responding to a major incident, particularly because no practice had taken place for over a year.

In spite of the out of date major incident policy and the lack of recent training, staff, on the whole, were confident that they would know what to do if a major incident were declared. This involved responding to a cascade call, mustering in the canteen area, and being assigned roles by the clinician in charge. All staff knew where to access the major incident equipment store in the department, which contained a tent and specialist clothing to deal with contaminated patients. When we checked this store we noted that the checklist of the equipment had not been completed recently.

In terms of progress to update the policy one of the consultants told us that they had met with the person tasked with updating the plan throughout the year and was due to meet with that person again in the week of our inspection. Several issues needed to be addressed such as: updating of the cascade list in the adult treatment area, updating of role cards, and removal of capacity to offer two resuscitations in the children treatment area.

Until the policy had been updated it was not possible to organise training for staff. We were told that the lack of an updated major incident policy was on the department’s local risk register and the corporate risk register and that the executive team of the trust were fully aware.

All areas had CCTV and staff told us that security guards provided support on occasion for incidents of violence/aggression. Security staff (who were supplied by a third party contractor) told us they had received training in physical intervention and first aid. Security staff could also be used to assist with observation of patients either by sitting in the waiting room or outside a treatment room.
Is the service effective?

Evidence-based care and treatment

The service had a lead clinician for department audits and a senior manager we spoke with told us audits were discussed at governance meetings. The service participated in national royal college of emergency medicine (RCEM) audits.

We requested information on audit from the trust and were provided with a document showing emergency department audits between November 2016 and October 2017. This showed the audit title, current status and whether an action plan had been received. This showed audits such as sepsis screening which had a status of active and an asthma audit which had been completed and the document highlighted the action plan had been received.

Staff told us audits undertaken also included trauma and research network (TARN) audits and the trauma management audit. Staff also told us they completed three monthly sepsis audits. We requested sepsis audits from the trust, however these were not provided for admission areas.

There were a range of department protocols and pathways on display and available in the emergency department. For example on display in clinic rooms and notice boards around the department was the sepsis six pathways and a sepsis screening tool. There was a protocol for transfer to surgical wards which detailed the transfer protocol between 08:00 and 17:00 and 17:00 and 08:00. Staff we spoke with told us they had received training on people living with dementia in addition to trust mandatory training.

The trust governance facilitators would highlight when there was new guidance and would send updates to the matron, business manager and clinical lead. A member of the team would then be asked to review the guidance.

Different areas in the emergency department used systems relevant to their service, for example the adult emergency department used the national early warning score (NEWS) and the children’s emergency department used the paediatric early warning score (PEWS). Pain scores were measured on the assessment charts used.

The national early warning score report provided by the trust for September 2017 for the emergency department showed an overall compliance of 87%. This included the emergency assessment unit and the emergency department. The paediatric early warning score report for September 2017 showed compliance of 98% in the summaries of outcomes against standards.

The department used a triage process through the electronic system. Staff had access to a frailty team and could request this team as support for patients attending the department. The children's emergency department had recently received a talk on antibiotics from the trust microbiology team. The psychiatric liaison service was provided by a local mental health NHS trust and was available for support and advice when requested.
Nutrition and hydration

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 7.4 for the question “Were you able to get suitable food or drinks when you were in the A&E Department?” This was about the same as other trusts.

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

Snack packs were available for patients who had been in the department for a period of time. The department waiting area had drinks machines available for purchase for patients and visitors.

Pain relief

Emergency Department Survey 2016

In the CQC Emergency Department Survey, the trust scored 6.3 for the question “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 8.1 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (30/09/2016)

Pain assessment and scores were part of the initial assessment for patients attending the emergency department and were documented on the patient assessment with a pain score. Patient assessments seen during the inspection had these pain scores completed. Staff in children’s emergency department told us they would provide pain relief as soon as required in the department.

Pain assessment in children’s emergency department used the faces system to establish what the level of pain was.

Staff in the department had no specific tool to assess pain levels in patients who were non-verbal communicators. They described other methods to assess this, including body language, facial expression and written communication.

The trust provided a document showing the audits the emergency department completed. This showed an active audit for the management of moderate to severe pain in the emergency department.
Patient outcomes

We requested from the trust audit action plans and audits carried out the urgent and emergency care. The trust provided a clinical audit action plan for the RCEM consultant sign off in the ED audit. This highlighted the recommendation and the actions required along with a review date and person responsible. This was from September 2017.

The trust provided a clinical audit action plan from September 2017 for the RCEM moderate and severe asthma audit report 2016 included recommendations and actions required.

The trust provided a clinical audit action plan from August 2017 for severe sepsis and septic shock – 2016/2017. The group/meeting responsible for monitoring the action plan was highlighted as the department (A&E) audit steering group and the A&E governance team.

RCEM Audit: Consultant Sign-Off (2016/17)

The 2016/17 Consultant Sign-Off Audit monitors the proportion of patients of various groups who were reviewed by a consultant in emergency medicine prior to discharge from the ED. For each group, the RCEM standard is that 100% of all patients receive a review from senior medical staff on discharge.

Of all patients aged over 30 admitted for chronic chest pain in the 2016/17 audit, 18% were seen by a consultant and 54% were seen by an ST4 or above. This failed the RCEM standard of 100%.

Of all children under one year of age admitted with a fever in audited in 2016/17, 2% were seen by a consultant and 22% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.

Of all patients making an unscheduled return to the ED in 2016/17 with the same condition within 72 hours of discharge, 14% were seen by a consultant and 46% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.

Of all audited patients over 70 years of age who were admitted with abdominal pain, 30% were seen by a consultant and 66% were seen by an ST4 or above. This did not meet the RCEM standard of 100%.

Unplanned re-attendance rate within 7 days

Between September 2016 and August 2017, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and worse than the England average. In latest period, August 2017 trust performance was 9% compared to the England average of 7%.
Unplanned re-attendance rate within 7 days - South Tyneside NHS Foundation Trust

(Source: NHS Digital - A&E quality)

Competent staff

Appraisal rates

Between August 2016 and July 2017 74% of staff within Urgent and Emergency Care at the trust had received an appraisal compared to a trust target of 90%, this was worse than the previous year’s appraisal rate of 88%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff told us they had received additional training and training for different equipment such as pumps. Staff told us they had access to online sepsis training. Some staff we spoke with had completed additional training such as plaster training, ILS and a trauma course. Senior managers told us there was a nurse in the department who had taken the lead for sepsis.

Staff had annual appraisals and these were used to assess learning requirements for the team.

The trust provided an emergency department training action plan for October 2017 which included appraisals and had the reasons for variance in training compliance along with actions to be taken. These actions were not complete on the action plan.

The children’s emergency department had an educational lead nurse who assisted in managing and organising the training of registered nurses and the nurse practitioners. The department had recently started clinical supervision with staff. The children’s emergency department had advanced nurse practitioners as part of the team.

Staff in the children’s emergency department told us they had around four nurse practitioner led study days each year where they received talks about different topics and they could discuss guidance. For example the team had received a presentation for an update on antibiotics from microbiology.

Multidisciplinary working

Staff described effective joint working arrangements to meet the needs of patients. This included support from psychiatric liaison team (PLT), specialist learning disability nurses, frailty team, psychiatry, dieticians and discharge nurses. This was evidenced in the care records we reviewed.
The PLT would put a safety plan in place for patients well enough to go home (when physical health issues are addressed) until a crisis team or community mental health team could pick the patient up (or until the patient received psychiatric admission if applicable).

Staff told us there was effective working with other trust services such as surgery and the radiology department. There were standard response times for x-ray and CT scans. Staff had access to a trust frailty team who would attend the department and assist with any patients at risk of falls for example.

**Seven-day services**

Ambulatory care was open between 7:30 and 21:00 Monday to Friday and on a weekend between 09:25 and 16:30. The emergency department was open 24 hours a day, seven days a week.

There was consultant presence in the department between 09:00 and 21:00 each day and there was an on call consultant allocated to the rota each day.

The x-ray department was available 24 hours a day, seven days a week.

**Health promotion**

Staff were able to provide patients with details about smoking cessation and could provide information on the assistance available from some charity organisations.

There were a number of patient information leaflets available across the department.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that between August 2016 and July 2017 Mental Capacity Act (MCA) training has been completed by 25% of staff in within Urgent and Emergency Care this did not meet the trust target of 90%.

(Source: Trust Provider Information Return P14/P49)

The psychiatric liaison team (PLT) provided mental health (MH) assessment and onward referrals as appropriate (not treatment) for patients in A&E. Mental health (MH) assessments we viewed were comprehensive. Assessments had a strong focus on risk assessment. Psychiatric liaison team (PLT) staff provided immediate feedback to the patient’s named nurse where possible (or other ward staff). Staff updated detailed MH assessments on the electronic system (Local mental health trust electronic case management system) and would print a hard copy off which was given to ward staff for inclusion in patient record.

There was no capacity within the PLT to provide MH training to acute staff. PLT felt this training would have been beneficial for ward staff.

Staff told us they had completed training in MCA and deprivation of liberty standards. An urgent and emergency directorate governance report from August 2017 showed that 60% of A&E nursing staff had completed mental capacity training, emergency care had a compliance rate of 43% and A&E medical staff had a compliance rate of 25%.

There was access to e-learning MCA training and the self-discharge form had a mental capacity assessment attached. Staff told us they would request advice from a doctor if required.
Is the service caring?

Compassionate care

We saw staff dealt with patients and any relatives or carers in a compassionate way. For instance, we observed how a patient was seen and within a short period of time nursing staff had offered food and hydration and sought consent before carrying out an ECG. The doctor was also seen to speak with the patient about their diagnosis, and none of this was rushed.

Staff demonstrated their compassion in the way they interacted with patients. We saw a patient who received really clear communication, who had their observations done promptly and was given excellent pain control.

Staff respected patient dignity and privacy by closing curtains and by closing doors. Maintaining privacy of patients whose details appeared on the electronic whiteboards was a challenge to staff because of the physical environment. On a couple of occasions we saw computers used by staff in majors were left logged on and open so patient details could be seen but this was quickly dealt with when we pointed it out to staff. Privacy of patients was promoted by the booking in system because - although the main reception was a large space, which meant it was possible to overhear conversations held with reception staff - staff at reception only took basic details and referred patients to a dedicated waiting area.

All patients we spoke with were very happy with the admission process and the compassionate care they received from staff. Staff were described as ‘lovely’, ‘brilliant’, and ‘very approachable’.

Friends and Family test performance

The trust’s Urgent and Emergency Care Friends and Family Test performance (% recommended) was generally better than the England average throughout the reporting period aside from December 2016 to February 2017 where performance either met or was lower than the average. In the latest period, July 2017 performance was 89% compared to the England average of 85%.

A&E Friends and Family Test Performance - South Tyneside NHS Foundation Trust

(Source: NHS England Friends and Family Test)
Emotional support

In the children’s treatment area play staff had decorated the waiting area with a Halloween theme and staff in the department wore appropriate Halloween head dress and children were offered Halloween sweets. This all contributed to creating an environment that supported the emotional needs of the type of patients visiting the department. One patient told us the children department felt ‘very homely’.

We saw a member of staff provide constant kindness and re-assurance to a patient who was distressed and promptly sought advice about that patient’s observations.

Each treatment area, within the waiting area, had a TV playing, and in the children’s area the TV played children appropriate DVDs. The waiting area in the adult treatment space had a waiting time board which was updated during our inspection.

Staff told us how they had supported a patient who was at risk by providing meals and signposting the patient to agencies that could help.

Understanding and involvement of patients and those close to them

Several patients we spoke with were able to describe the stage they were at in their treatment. For instance, they told us they were waiting for their x-ray or their bloods. This demonstrated that staff had involved the patient in understanding their care.

Many patients we spoke with told us that they had their pain levels reviewed and were offered pain relief which showed that staff tried to understand what the patient was experiencing. One patient told us how they were seen quickly, asked about pain relief but declined it, but said staff handled them really well, explaining in a way they could understand, leaving them feeling it was a nice experience.

We saw a staff member sing a song to help them interact with a patient who needed some observations but was in a distressed state. The understanding shown by the staff member helped calm the patient down so that the observations were successfully taken.

Emergency Department Survey 2016

The results of the CQC Emergency Department Survey 2016 showed that the trust scored about the same as other trusts in 23 of the 24 questions relevant to caring. The trust scored better than others for Q24. If you were feeling distressed while you were in the Emergency Department, did a member of staff help to reassure you?

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>-----------------------</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren’t there?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the Emergency Department, how much information about your condition or treatment was given to you?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>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?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the Emergency Department, did a member of staff help to reassure you?</td>
<td>7.9</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the Emergency Department, did you get the results of your tests?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could</td>
<td>5.3</td>
<td>About the same as</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>resume your usual activities, such as when to go back to work or drive a car?</td>
<td></td>
<td>other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the Emergency Department?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the Emergency Department?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 30/09/2016)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Service planning was carried out through a variety of meetings. There was an A&E delivery board where the clinical commissioning groups, local authority and mental health representation attended to discuss service planning. A strategic group was also in place for service planning. Senior staff in the emergency department attended these groups meetings.

There was an emergency department business meeting where performance would be discussed, for example the service were not meeting the 25% target for patients going from the emergency department to ambulatory care and this is where these concerns would be addressed. Senior managers told us information for these meetings would feed into team meetings in the departments.

Senior managers we spoke with told us attendance at daily bed meetings assisted in capacity and demand planning for the department.

Services provided included an adult and children’s emergency department, ambulatory care, minor injuries and a general practitioner hub located in the department. The emergency department had two allocated assessment rooms for triage.

The senior nurse co-ordinator was supported by a co-ordinator healthcare assistant during shifts to assist in patient flow.

The services offered included the adult and children’s emergency department, an ambulatory care unit, minor injuries and a general practitioner hub. Patients were streamed to the appropriate area.

In the children’s treatment area, every other Tuesday, staff welcomed children from local schools into the department so they could understand what occurs. We saw this and staff told us they had received positive feedback about this initiative.
Meeting people’s individual needs

Emergency Department Survey 2016

The trust scored “about the same as others” for all the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the A&amp;E Department last?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 30/09/2016)

The service had a form which was used for self-discharge. This form included a section on the back for mental capacity assessment with a number of questions and would be completed for patients who wanted to self-discharge.

Pain scores were completed as part of the initial assessment and staff told us where required and appropriate they would be able to use images for pain assessment.

The department had access to a private room where patients could sit if required and staff told us patients could sit in the discharge lounge if appropriate or requested which was located in the area around the emergency department whilst waiting for appointments as this was often quieter than the main waiting room.

We found signage around the department highlighting the different areas.

The trust had a learning disability registered nurse who was able to attend the emergency department and support patients. Staff told us that if required for vulnerable people they could arrange for a bed to be ready upon arrival and could designate a quiet room for patients.

There was a trust frailty team available which were utilised in the department and the team included physiotherapists, occupational therapists and registered nurses. The frailty team assisted patients where extra support was required and staff in the department could contact the frailty team at the trust.

Translation services were available if required. The patient and information board in the department had the carers’ charter attached and the different areas and waiting areas had various patient information leaflets available.

There was a private and quiet room available for bereaved families.

Chaperones were available across the children’s emergency department.

The learning disability team were made aware when a learning disability patient was in the department through the information system. The learning disability team were able to attend the department as required.
Access and flow

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 A&E.

The trust met the standard 7 times between October 2016 and September 2017.

The trust breached the standard 5 times between October 2016 and September 2017.

Between October 2016 and September 2017 performance against this metric showed a trend of improvement which mirrored the trend of the England average.

**Four hour target performance - South Tyneside NHS Foundation Trust**

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

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

Between October 2016 and September 2017 South Tyneside NHS Foundation Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average. Performance against this metric showed a trend of improvement which mirrored the England average.
Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - South Tyneside NHS Foundation Trust


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

Over the 12 months from October 2016 and September 2017, no patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting between four and 12 hours were in January 2017 with 166 and December 2016 with 104.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients between four and 12 hours</th>
<th>Number of patients over 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-16</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Nov-16</td>
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<td>Dec-16</td>
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<td>0</td>
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<td>Feb-17</td>
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<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>16</td>
<td>0</td>
</tr>
</tbody>
</table>

(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

Between October 2016 and September 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. In August 2017 the median percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 2.0%, compared to the England average which was 3.0%.

Between October 2016 and September 2017 performance against this metric didn’t show any discernible trends.

Percentage of patient that left the trust without being seen - South Tyneside NHS Foundation Trust

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

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

Between October 2016 and September 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 didn’t show any discernible trends. In the latest period, August 2017 the trust’s monthly median total time in A&E for all patients was 129 minutes, which was better than the England average which was 144.
Median total time in A&E per patient - South Tyneside NHS Foundation Trust

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

At a previous inspection we found concerns around the way data was captured for emergency department targets and indicators. At this inspection we found this had been addressed. For example, the way the service recorded the time the patient left the department was being recorded only when the patient had left the department. Breaches were validated by senior managers on a daily basis to provide assurance of this.

We asked senior managers about escalation processes for capacity and flow in the emergency department. Senior managers told us the escalation process involved the department coordinators contacting the trust site manager when there were capacity and bed availability issues. This would then be escalated to the emergency department operational manager. The operational manager attended most bed management meetings during the day to understand the hospitals bed availability challenges. They also discussed what the expected number of beds required for the day will be.

We requested escalation procedures for the emergency department and the trust provided us with a document for the proactive management of patient time in the emergency department, preventing a breach of the 4 hour access target. This showed the timeline of up to eight hours of the patient being in the emergency department. The document also had information on preventing a 12 hour trolley wait in the emergency department.

Senior managers told us that if a patient did breach the four hour indicator in the emergency department, the operational manager would try and address the issues and if the patient was in the department for four to six hours, staff would check they were on an appropriate bed, check diet and nutritional needs and as part of the daily comfort round. Pressure areas would also be taken into account if they had been in the department for a period of time.

Staff completing the triage and streaming process considered ‘fit to sit’ during the assessment and where appropriate patients could wait into the waiting area after initial assessment.
Senior managers told us that urgent mental health patients were referred to the psychiatric liaison team (PLT) which had a response time of one hour. The PLT were based on site and if crisis team involvement was required, there was a four hour response from the referral time.

There was a 15 minute target for the ambulance handover in the emergency department. The wait time to see a nurse and wait time to see a doctor was highlighted on a sheet on the reception window in the main waiting area.

There was a surgical referral from the emergency department pathway showing the pathway between 08:00 and 17:00 and 17:00 and 08:00.

Senior managers told us they had achieved the four hour emergency department target in the previous seven months. The data above confirmed this target had been achieved since March 2017.

A poster in the emergency department during our inspection showed that the accident and emergency department four hour performance standard was achieved in quarter one 2017 at 96.9% and in quarter two 2017 was achieved at 97%.

During our inspection on the 31st October 2017 the waiting time poster in the department in the morning showed there was a 20 minute wait to be assessed by a nurse, 45 minute to be assessed by a doctor and the wait for admission to the ward was around four hours. The time and date was attached to this form.

Staff told us the decision to admit time had improved and when a member of staff caring for a patient was aware the patient would require admitting to the hospital, they would inform the coordinator in the department and a bed would be requested through the system.

**Learning from complaints and concerns**

**Summary of complaints**

Between August 2016 and July 2017 there were 25 complaints about Urgent and Emergency Care services. The trust took an average of 56 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should completed within 25 days.

- 83% of all complaints related to all aspects of clinical treatment
- 42% of complaints occurred in the accident and emergency – minors department.

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

Following our inspection the trust provided information which showed that they had improved the time taken to investigate, respond to and close complaints.

There was a poster on display in the main reception of the emergency department waiting rooms showing patients how to complain. Staff we spoke with told us that feedback from complaints would be provided by department managers.

Senior managers told us they would try and deal with complaints informally at first and would raise complaints at the daily huddle. Formal complaints were often received from the customer services team and would be received by the department matron.
Is the service well-led?

Leadership

There was a clear leadership structure in urgent and emergency services. Services were managed by a clinical director, business manager, and operational lead with responsibility for patient flow across the services and a matron. The matron role for the department had been implemented in 2016.

The emergency department and children’s emergency department were managed by a senior nurse in each department. In the emergency department, the senior nurse also co-ordinated patient flow. The department had a clinical lead and lead for audit across the directorate.

Services visited sat within the urgency and emergency care directorate at the trust.

Senior managers had responsibility for the emergency department, children’s emergency department and minor injuries.

Staff we spoke with told us managers had an open door policy and were supportive and available as required.

Vision and strategy

Senior managers told us their vision of maintaining performance around the accident and emergency standards, for example the four hours target and ensuring patients were seen the first time in the right place in the department. Senior managers told us they had worked with other specialities such as medicine regarding flow through the hospital and this had assisted in addressing the four hour standard.

Senior managers told us the service strategy included working closely with a local mental health trust and looking at pathways with general practitioners.

Since the previous inspection there had been other changes in the service also such as rotating staff through the different departments to increase teamwork and a focus on sepsis. Senior managers told us there was now an escalation tool in place and breaches in the department were validated each day and that learning from breaches would be shared with department co-ordinators.

Not all staff were able to describe the vision of the trust.

Culture

Morale amongst staff was generally good across the services; however this could vary during busy times. Staff told us of good teamwork between the teams and that senior nurses were approachable, visible and available for support. Senior managers told us they monitored morale through annual staff surveys and daily huddles and that there was a health and wellbeing team accessible by staff. The trust provided a 2016 staff survey, however, the national staff survey does not provide a breakdown for urgent and emergency services.

Overall staff we spoke with felt respected and valued.

Staff we spoke with in the children’s emergency department told us that team work was good.

Staff told us that senior nurses and managers had an open door policy.
The service had begun to rotate staff through the emergency department areas, ambulatory care and minor injuries to embed better team working and understanding of roles in the services.

We asked about lone working in the main reception of the emergency department. Senior managers told us there was usually two administrative staff on shift during the day until 20:00. Between 20:00 and 08:00am there was a reception staff member who was always at reception. If they had to leave the reception area for a period of time, they would contact the emergency department co-ordinator and they would organise for a healthcare assistant to stay in reception until the reception staff returned. The reception area was covered by safety glass and computers in the office had access to an emergency button if required.

On-site security was available 24 hours a day and was situated close to the emergency department. Staff could contact security for assistance as required.

Staff told us that security guards provided support on occasion for incidents of violence/aggression. Security staff (external contractors) could be used to restrain patients. Security staff told us they had received physical intervention training and first aid. We have requested a copy of the training syllabus for this course and restraint incident data as it was unclear whether the externally contracted security staff reported/recorded incidents of restraint via the trust reporting system. The trust provided a report showing the number of incidents of restraint by department and ward and further information provided by the trust highlighted that security staff had received control and restraint training, however, compliance figures were not provided by the trust. The trust provided information highlighting that incidents of restraint were logged on their incident reporting system and that these were investigated by the department’s operational manager and security manager.

Security staff could also be used to assist with observation of staff (sitting in waiting room or outside treatment rooms).

Psychiatric liaison teams (PLT) staff did carry alarms – these omitted an audible alarm when activated, but these were not linked to any external system. PLT staff were reliant on ward staff hearing the alarm and responding – if staff were not nearby this could mean PLT staff were at risk and unsupported.

Governance

There were governance arrangements in place. The department had two local governance meetings, one for the children’s department and one for the emergency department. There was then an overall directorate governance meeting attended by senior managers. Risks and governance concerns from this meeting would be escalated to trust governance meetings as required and then to board level from these meetings. The governance lead for the department was the matron.

Senior managers told us of the three main risks to the departments. These included medical staffing, finance and delivering the urgent care hubs. Mitigations included ensuring the trust continues to attempt to recruit medical staff when needed, regular finance meetings with finance managers to assess financial performance and the service were having meetings with clinical commissioning groups and considering options regarding urgent care hubs.

A daily huddle was in place and occurred every morning in the emergency department and enabled staff to share information such as the staffing levels for the day. This was attended by clinicians, nurses, healthcare staff and managers.
The trust had a sepsis lead nurse and the department had a lead clinician for sepsis. The trust provided an urgent and emergency directorate report from August 2017 from the urgent and emergency directorate governance meeting which highlighted items on the minutes such as safety including pressure ulcer incidents, alerts, quality and audit.

**Management of risk, issues and performance**

Performance reports were produced for the services to enable managers to assess performance across the different departments. These performance reports showed indicators such as the emergency department standards and how the trust was currently performing with these. Performance data was also provided to managers on a daily basis.

Governance meetings across the services enabled risk and issues to be raised at these meetings. A risk register was in place at the service and risks were documented electronically. The risk register was reviewed when the risk was due for review, the electronic system notified the relevant manager when a risk was due for review. The trust provided a risk register for the emergency department and showed a number of risks, for example, staff vacancies in nursing and healthcare support worker roles. The trust provided an emergency planning risk register report from November 2017 showing information on emergency planning.

Although the trust undertook audits to help assess performance and quality, for example sepsis audits, documentation audits and RCEM audits to assess how they are meeting national standards, we did not have sufficient evidence to demonstrate that they were used to improve care.

During a daily huddle in the emergency department, concerns and risks in the department were raised. For example, staffing for the day was discussed and ensuring daily medicine cabinet checks were completed. A huddle themes document attached to the staff notice board for 15 October 2017 showed that sepsis, CQC, mental capacity and safeguarding and documentation were highlighted.

Incidents and risks were captured on an electronic reporting system.

Managers we spoke with were aware of the risks to the service. For example, during our inspection we found concerns around the major incident plans being out of date and training had not been kept up to date in the last 12 months. Managers were aware of this and it was on the corporate risk register. Managers told us these documents were being updated during our inspection and the service had an emergency planning manager located at a local NHS trust.

Performance in areas such as the four hour target had improved since the previous inspection and staff told us this was better now. The service had also addressed concerns raised at the previous inspection regarding the time patients were booked in and the time patients were booked out. Staff and managers confirmed at this inspection, patients were booked in once they had arrived in the department and would not be booked out of the department until the patient had left the department to ensure accurate reporting of the four hour waiting standard.

Managers told us they assured themselves of the accurate reporting of times by completing a validation of breaches each day to ensure these were correct.

We asked senior managers about winter management plans and were told these were ongoing and had not yet been agreed during our inspection.
We requested daily huddle minutes from the service and minutes from the 25/10/2017 showed that performance, bed capacity, decision to admit/documentation, safeguarding, staffing and other topics were part of the daily huddle.

**Information management**

Staff had access to information systems such as patient records, ambulance status and arrival information and a system showing where patients were allocated in the department and whether a hospital bed was requested or ready for transfer.

Incident reporting systems were available. Policies were accessible and available on the trust intranet. Policies in the emergency department were being updated during our visit.

Data and quality information was provided to managers in monthly reports.

**Engagement**

The services carried out friends and family test to receive feedback from patients. Senior managers told us they had recently spent time in the emergency department waiting area and spoken with patients about the environment and what could improve it. The service was considering options for changes to the waiting room area to improve patient flow and the environment.

The children’s emergency department held regular days for children from local schools to attend and see an ambulance and the department. Senior managers told us feedback from this was positive.

Engagement with staff occurred through regular daily huddles and use of the trust staff survey. Staff told us they received communication by email from the trust.

Staff told us there was good communication across the children’s emergency department and there were regular team meetings.

**Learning, continuous improvement and innovation**

The department had received some funding to improve the environment in minor injuries.

The emergency department had a pilot for a streaming process of patients arriving from general practitioners to go to ambulatory care which had been carried out in September 2017. Senior managers told us they were hoping to continue this as it had been positive and had attended a recent review meeting for it.

Staff across the different areas of urgent and emergency services had started in the previous 12 months to work across the different areas to try and embed further team working between areas.
Medical care (including older people’s care)

Facts and data about this service

The medical care service at South Tyneside District Hospital provides care and treatment for general medicine, care of the older person, diabetes & endocrinology, infectious diseases, gastroenterology and specialist & rehabilitation services. There are 177 medical inpatient beds within this service.

(Source: Routine Provider Information Return - Acute-Sites)

The trust had 21,059 medical admissions between June 2016 and May 2017. Emergency admissions accounted for 8,081 (57%), 191 (4%) were elective, and the remaining 12,787 (39%) were day case.

Admissions for the top three medical specialties were:

- General medicine - 12,787
- Gastroenterology - 3,028
- Medical oncology - 2,480

(Source: CQC Insight)

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

All staff we spoke with told us that they completed mandatory training. Most staff said they felt they were up to date and were supported to complete training.

The trust provided further information after the inspection that showed that overall compliance for the medical division was 75%, which is lower than the trust target of 90%. Nursing staff were 80% compliant and medical staff were 70% compliant.

Safeguarding

The trust employed named nurses for safeguarding children and adults. There were 680 adult safeguarding referrals trust wide between July 2016 and August 2017.

Staff we spoke with were aware of the trust’s policies and could tell us when they would raise a safeguarding concern, this included nurses, doctors of all grades, allied health professionals and pharmacy staff. All staff were aware of their responsibilities in relation to safeguarding. More junior staff told us that they would report any concerns to the nurse in charge.

We saw information advising staff how to raise a safeguarding concern, and contact details for the trusts safeguarding team displayed on the wards.
The trust provided training compliance data for safeguarding training. This showed that 65% of medical staff and 59% of nursing staff had completed level two safeguarding adults training. Staff also completed safeguarding children training; compliance rates were 80% for medical staff and 93% for nursing staff.

**Cleanliness, infection control and hygiene**

The wards we visited were visibly clean and most items of equipment had labels attached to equipment to indicate when it was last cleaned. However, on three wards we saw some items of equipment were not identified as being clean. On two of these wards, we also saw equipment in storerooms that were visibly dusty.

There were no cases of avoidable blood stream methicillin-resistant staphylococcus aureus (MRSA) at the trust between April 2016 and March 2017 and there had been no cases in the first quarter of 2017/2018. There had been five cases of clostridium difficile between April 2016 and March 2017 and no cases during the first quarter of 2017/2018.

Information in the chairman and chief executive’s office team brief for September 2017 highlighted four clostridium difficile cases, two of which were to be appealed and two which had been linked as due to cross infection. We saw that within the breach, staff were reminded about the importance of good infection control practices.

Staff told us that infection prevention and control (IPC) was part of their mandatory training requirement. Most staff felt that they were up to date with training. Figures provided by the trust indicated that compliance with IPC training was 68%, which was below the trust target of 90%. Medical staff were 58% compliant and nursing staff 77% compliant.

Hand washing facilities were available on all wards we visited. Personal protective equipment (PPE) including aprons and gloves, and sanitising hand gel were also available.

We observed staff using appropriate personal protective equipment when completing clinical tasks. They complied with bare below the elbows policy, correct handwashing technique and use of sanitising hand gels.

Staff we spoke with were able to describe the process they would use when a patient with an infection needed to be isolated to prevent cross infection. This included barrier nursing in a side ward, and ensuring the patients’ previous bed space was deep cleaned. We saw notices displayed on doors where patients with infections were being cared for. The doors to these rooms were closed in line with best practice. The trust’s electronic patient status system had a flag to identify patients who had infection so that this information was readily available to all staff.

The trust provided observational IPC audits for two medical wards. These showed that compliance with hand hygiene and PPE was consistently between 90 and 100% from April 2016 to September 2017.

**Environment and equipment**

In 2015, we had concerns about the lack of equipment maintenance, insecure storage of chemical products and razors in the sluice areas. We observed equipment ready for use with out-of-date portable appliance test dates. At this inspection, we found equipment maintenance had improved, we found some concerns about the storage of chemical products on two wards however overall this had also improved.
Information provided by the trust indicated that all electrical devices were managed through a medical device management software system that contained an inventory for the trust. Some ward managers told us that they needed to prioritise medical device training for their staff but they were able to identify how they intended to ensure that staff were kept up to date. Information provided by the trust showed that 89% of nursing staff and 74% of medical staff were compliant with medical device training.

We looked at 72 items of equipment and medical devices and found that these had been serviced in line with manufacturer's guidelines and tested for electrical safety.

Staff told us that they had sufficient equipment to support them to care for patients. This included pressure-relieving equipment, moving and handling equipment and falls sensors for patients who had been assessed as being at high risk of falls.

Most of the wards we visited were clutter free, visibly clean and well maintained with the exception of two wards where we found that some toilets were visibly dirty. We had some concerns that the corridor on ward 2 appeared cluttered however, we saw that the lack of storage had been raised as a risk and was on the risk register.

We looked at equipment in storage cupboards, for example dressings, intravenous fluids and equipment used for taking blood. We found that all equipment we checked was in date.

Emergency resuscitation equipment on each ward had daily checks completed in line with policy. These trolleys contained drawers that were sealed for security. We checked consumable items, such as gloves, oxygen masks and suction equipment and did not find any items that were out of date of any of the trolleys.

We saw that hazardous substances, such as cleaning agents were stored securely in locked cupboards on most wards. On one ward, we found the dirty utility door propped open and on another we found the domestic cleaning cupboard unlocked. Both of these rooms contained items that should be stored under the control of substances harmful to health regulations (COSHH).

On ward 19, we noted that bed spacing did not appear to meet the recommendations of Health Building Note (HBN) 04-01 – ‘Adult in-patient accommodation’ in some rooms. The HBN states: ‘Ergonomic studies have established that most activities carried out at the bedside can be accommodated within the dimensions 3600 mm (width) × 3700 mm (depth). This represents the clear bed space and does not include space for fixed storage, preparation and worktops.’ We spoke with staff about this issue at the time of our inspection.

Assessing and responding to patient risk

National patient safety alerts (NPSA) are crucial to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. Staff we spoke with told us they were made aware about new alerts through morning huddles and team meetings.

During 2016 - 2017, the trust achieved a sepsis-screening rate of 81% on in-patient wards. This was an improvement compared to 2015/2016. In the first quarter of 2017/2018, the trust achieved a screening rate of 96% screening for in-patient wards.

During 2016 - 2017, 77% of patients with confirmed sepsis received their antibiotic within 60 minutes for in-patient wards. This was an improvement from 42% achieved in 2015/2016. During the first quarter of 2017/2018, 81% of patients with confirmed sepsis received antibiotics within 60 minutes.
The trust attributed the improvements in sepsis performance directly to the appointment of a sepsis nurse in October 2016. This staff member had direct input into the education of staff including the development of an e learning pack. Some staff we spoke with, including junior doctors told us they had completed this training.

All staff we spoke with about sepsis told us that they used the sepsis six bundle. We saw this information displayed in ward areas.

The National Early Warning Score (NEWS) is a tool that is used to alert health care practitioners to deteriorating patients and therefore trigger an escalation of care and review of the unwell patient.

The trust used NEWS; we saw these completed in all care records we reviewed. We also saw that staff escalated patients for review in line with triggers.

We saw that nursing records contained appropriate risk assessments, these included pressure damage, malnutrition, hydration, moving and handling and falls risk assessments. These were completed to a high standard with the exception of the malnutrition risk assessment where we found only 10 of 18 (55%) patients had been risk assessed.

On ward 3, the specialist gastrointestinal (GI) ward, patients who were at risk of GI bleeding automatically had two intravenous cannulas inserted to ensure that rapid venous access was available in the event of a major GI bleed. In addition to this, the trust had developed a GI bleed pathway and had a joint GI bleed medical rota in place in conjunction with a neighbouring trust.

We had a concern that some patients who were admitted via the emergency admission unit (EAU) and subsequently transferred to another ward might not be reviewed by a consultant within 14 hours due to their being no consultant presence in the hospital overnight. We raised this with the senior leadership team who explained that patients were not routinely transferred from the EAU at night. If this were necessary, due to periods of escalation, the patient would be flagged, using the electronic extra med system, as an outlier for urgent review the following morning.

Nurse staffing

The trust has reported their staffing numbers below for the period April 2017 to July 2017 for Medicine.

There is 16.88 fewer WTE staff in Medicine then the trust planned for to provide safe care.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>WTE</th>
<th>Number in post April 17 – July 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing &amp; midwifery staff and health visitors</td>
<td>154.45</td>
<td>137.57</td>
</tr>
<tr>
<td>Total</td>
<td>154.45</td>
<td>137.57</td>
</tr>
</tbody>
</table>

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

Vacancy rates

Between August 2016 and July 2017, the trust reported a vacancy rate of 5% for nursing and health visiting staff at South Tynesside Hospital.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
### Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 2% for nursing and health visiting staff at South Tyneside Hospital.

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

### Sickness rates

Between July 2016 and June 2017, the trust reported a sickness rate of 3% for nursing and health visiting staff at South Tyneside Hospital.

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

### Medical staffing

The trust has reported their staffing numbers below for the period April 17 to July 2017 for Medicine.

There is 2.59 more WTE staff in Medicine then the trust planned for to provide safe care.

<table>
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<tr>
<th>Staffing group</th>
<th>WTE</th>
<th>Number in post April 17 – July 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; dental staff</td>
<td>65.35</td>
<td>67.97</td>
</tr>
<tr>
<td>Total</td>
<td>65.35</td>
<td>67.94</td>
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(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

### Vacancy rates

Between August 2016 and July 2017, the trust reported a vacancy rate of 7% for medical & dental at South Tyneside Hospital.

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

### Turnover rates

Between July 2016 and June 2017, the trust reported a turnover rate of 4% for medical & dental staff at South Tyneside Hospital.

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

### Sickness rates

Between July 2016 and June 2017, the trust reported a sickness rate of 1% for medical & dental staff at South Tyneside Hospital.

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

### Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template however the data is not available at core service level.

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

### Staffing skill mix

As of June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.
Staffing skill mix for the 69 whole time equivalent staff working in Medicine at South Tyneside NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
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<tbody>
<tr>
<td>Consultant</td>
<td>35%</td>
<td>42%</td>
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<tr>
<td>Middle career</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>16%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>43%</td>
<td>22%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - Workforce statistics (01/06/2017 - 30/06/2017))

In 2015, we had concerns about staffing levels. Nurse staffing levels were affected by high sickness rates and vacancies and were regularly supported by use of bank and agency. At this inspection, we found that vacancy and use of bank and agency staff had reduced.

The trust used a safer nursing care tool on a shift-by-shift basis though the electronic roster system. The roster system showed the planned staffing levels and identified any gaps that were reviewed on a daily basis by the matron. A red flag system was used to identify critical gaps in registered nurse cover.

The trust had a staffing escalation procedure to ensure appropriate actions were taken to safely cover all in-patient areas. Staffing concerns were highlighted at the bed management meeting.

We saw planned and actual staffing levels on display on most wards we visited. We found that the planned staffing levels were met during our inspection however some gaps needed to be filled using bank and agency. Ward managers did not raise any concerns about gaps in staffing. Ward managers told us bank and agency staff usually worked on specific wards, which maintained continuity of care for patients and temporary staff were familiar with the ward environments and routines.

We looked at the trust board papers and saw that in February 2017, the fill rate for nursing staff was 97%.

We saw that some planned staffing ratios were below the trust target of one registered nurse to eight patients. For example on ward 19, there were 29 beds and three registered nurses on day and night duties. This ward also cared for high numbers of patients living with dementia. The ward had a volunteer who provided diversional activities for two hours, three days per week.

We found that on some wards night duty staffing ratios dropped to one registered nurse to 15 patients, for example on wards 10 and ward 6 which incorporated the coronary care unit. However, during the week of our inspection, several ward managers told us that they had received the outcome of a recent staffing review. This had resulted in an immediate uplift in the planned registered nurse levels. One manager told us that they felt listened to and were delighted about the outcome of the review. During the week of our inspection, several ward managers told us that they had received the outcome of a recent staffing review. This had resulted in an immediate uplift in the planned registered nurse levels. One manager told us that they felt listened to and were delighted about the outcome of the review.
Records

During this inspection, we looked at 44 sets of nursing, medical and therapy records.

We found most records were completed in full however, we found a small number were not always completed in line with staff registering bodies (the Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC), and the General Medical Council (GMC). For example:

- Not all entries had times, dates and signatures.
- We did not see patient identifiers on each page of the records.
- We also saw that abbreviations were used but there was no guide on the recognised acceptable abbreviations that could be used within the records.
- We found some gaps in the completion of risk assessments, in particular the malnutrition-screening tool.
- We saw pain scores documented in records however; we did not see any evaluation of pain relief taken by patients.

The trust provided details of monthly record keeping audits. We found some correlation between our findings and the trust report however not all of the concerns highlighted during our inspection had been identified in the trust’s findings.

We also had some concerns, on some wards about the security of care records. We reviewed this following our inspection and were assured that the trust had taken action to address our concerns and ensure records were stored securely. Information provided by the trust showed that 84% of medical staff and 87% of nursing staff were compliant with information governance training.

Medicines

In 2015, we had concerns about medicines management. We observed inaccurate prescribing and medication errors including missed doses and delays in administration.

We saw monthly medicines reports that were created for each ward. These covered controlled drugs reports, antimicrobial use, medicines incidents, medicines safety thermometer outcomes and any actions taken as a result of concerns highlighted.

The trust pharmacy department provided a five-day service Monday to Friday 9am until 5pm. An emergency service was available outside of normal working hours.

We spoke with a pharmacist who told us that they aimed for medicines reconciliation to be completed within 24 hours of admission in line with guidance from the National Institute for Health and Care Excellence (NICE). However, we did see some medication charts where this had not been achieved, for example, when patients were admitted on a Friday or Saturday, as there was no routine weekend cover.

We looked at the trusts audits of medicines reconciliation for seven wards between April and October 2017. Predominantly the 80% target was not achieved and performance was inconsistent. However the trust did exceed 80% compliance on ward 20 in June 2017 (100%), ward three (83%) and ward six (95%) in August 2017.

The pharmacy staff held daily safety huddles with the chief pharmacist. This meeting was used to communicate pharmacy and trust wide information.
We looked at medicine administration charts and found that medicines which could increase the risk of a patient falling were highlighted with a stamp.

We checked that medicines, including controlled drugs were stored safely and securely on all wards and found no concerns. We looked at the controlled drugs registers on seven of the wards and saw weekly checks were fully completed on all wards in line with policy and best practice. We looked at the trust’s audits of controlled drugs and found these were in line with our findings on inspection.

We also checked the medication fridges and saw daily minimum and maximum temperature checks were completed on all wards. We saw action was taken when temperatures were not within an acceptable range, for example, we saw staff had noted that a fridge temperature was prone to rising when the fridge was pushed back against the wall. A notice had been displayed to prevent this happening again.

On one ward we saw a notice on a medicines fridge advising that the fridge must be locked however we found the fridge unlocked.

We looked at medicine administration charts and found that on two occasions, patients were on oxygen that was not prescribed. We raised this with the senior leadership team at the time of the inspection who told us that this had also been identified through the trust’s medicines audits and was being addressed with staff.

**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.

Between September 2016 and August 2017, the trust reported one incident classified as a never event for Medicine.

14/11/2016: Ward 2 – Medication incident meeting SI criteria

Patient was given oxycodone orally when this was in fact meant to be administered via sub/cut line.
Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England between September 2016 and August 2017.

Of these, the most common type of incident reported was:

- Slips/trips/falls meeting SI criteria with eight (40% of total incidents).
- Pressure ulcer meeting SI criteria with five (25% of total incidents).
- Treatment delay meeting SI criteria with three (15% of total incidents).
- Medication incident meeting SI criteria with two (10% of total incidents).
- Apparent/actual/suspected self-inflicted harm meeting SI criteria with one (5% of total incidents).
- All other categories with one (5% of total incidents).

(Source: Strategic Executive Information System (STEIS))

At the last inspection in 2015, we had concerns about the learning from incidents. During this inspection, we were assured that processes had improved and learning from incidents was identified and shared with staff.

At this inspection, staff from all disciplines including medical and nursing staff, allied health professionals, pharmacy and administrative staff, told us they were aware of and could competently use the trust’s incident reporting system. We saw information about how to report an incident displayed on most wards.

Staff said feedback was given following incidents. One member of staff told us that following the last inspection, they saw a real emphasis to ensure that learning from incidents was improved. Nurses, therapists and doctors told us that feedback was given individually, at ward huddles and team meetings. Most team meeting minutes we reviewed showed that incidents were discussed and lessons learned were shared.

Several staff were able to tell us about changes to practice that had occurred following incidents. We looked at reports created following serious incidents and saw lessons learned were identified and action plans created.

The trust held a clinical incident review meeting which was attended by senior ward staff. We saw that incidents were discussed in the monthly chairman and chief executive’s office team brief.
Duty of candour

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 give examples of when they would use this.

We looked at a sample of root cause analysis and serious incident reports and found that duty of candour was completed in all cases.

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 26 new pressure ulcers, six falls with harm and 10 new catheter urinary tract infections between September 2016 and September 2017 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at South Tyneside NHS Foundation Trust

![Graph showing prevalence rate of pressure ulcers]

(Source: Safety thermometer - Safety Thermometer)
The NHS safety thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare. These are pressure ulcers, falls, urinary tract infection (UTI) in patients with a catheter and venous thromboembolism (VTEs).

Data is collected through a point of care survey on a single day each month on 100% of inpatients. This enables wards, teams and organisations to understand the burden of particular harms at their organisation, measure improvement over time and connect frontline teams to the issues of harm, enabling immediate improvements to patient care.

We did not always see specific safety thermometer data displayed however; we saw patient safety data, for example, the numbers of patient falls, displayed on most of the wards we visited.

Ward managers and their deputies told us that they collated data each month for the NHS safety thermometer and the outcomes were fed back to staff through team meetings.

Patient safety data and initiatives were detailed in the monthly chairman and chief executive’s office team brief. In the August 2017 edition, information about a pressure ulcer improvement plan was included.

Information provided by the trust showed that the trust wide percentage of harm free care, across all acute wards, between November 2016 and October 2017 was 92.1%. The highest level of harm free care was 94.8% in June 2017; the lowest rate was 83.8% in October 2017. The England average for harm free care in January 2017 was 94.1%.

**Is the service effective?**

**Evidence-based care and treatment**

We saw that some clinical protocols and patient pathways were in date and had been developed based on national best practice guidance. For example, the ambulatory management of asthma in adult’s protocol showed reference to the Department of Health 2011 outcome strategy for chronic obstructive pulmonary disease and asthma in England. However, we saw examples of other pathways for diabetes, alcohol detoxification for inpatients and shortness of breath that were out of date for review and did not contain any best practice guidance references.

We looked at trust policies, including the consent, deprivation of liberty and the mental capacity policy. These policies had been reviewed, were in date and were in line with legislation and best practice guidance.

We saw that staff were notified when policies were updated and ratified through the chairman and chief executive’s office team brief.

The trust had taken part in NHS Improvement’s 90-day falls collaborative aimed at reducing the rate of falls in their hospitals and sharing examples of best practice and innovation. We saw that the falls pathway created by the trust following this was evidence based.

**Nutrition and hydration**

At the inspection in 2015, we had concerns that compliance with the malnutrition universal scoring tool risk assessment (MUST) was low. We reviewed nursing care records at this inspection and found that compliance with the completion of the MUST remained concerning. At this inspection, we found 55% compliance in 18 sets of records.
We looked at the trust’s record keeping audit report from January 2017 to August 2017 and found that our findings were in line with the trust’s audits. The report showed compliance with completion of MUST risk assessments were between 29% and 81% for medicine and 40 and 80% for elderly care wards. This meant that there had been no improvement since our previous inspection.

The trust did not complete any other nutrition and hydration audits other than the record keeping audits of compliance with the MUST.

Most patients told us that they enjoyed the food on the wards and they were supported with their meals.

Protected mealtimes were promoted on the wards we visited. We saw that staff supported patients who needed assistance during our visit.

**Pain relief**

We saw from medicine administration charts that pain relief was given to patients and patients we spoke with told us that they received pain relief in a timely manner. However, although we saw pain scores recorded on NEWS charts we did not see any separate pain assessment charts which evaluated that pain relief had been effective.

On ward 19 staff used a dementia friendly picture board to assess patient’s pain scores.

The trust had not completed any pain audits in the twelve months prior to our inspection.

**Patient outcomes**

The trust performed worse than the England average in the 2015 national inpatient falls audit.

The trust did not submit data for this audit in 2016. However; South Tyneside was one of 19 trusts in England which took part in NHS Improvement’s 90-day falls collaborative aimed at reducing the rate of falls in their hospitals and sharing examples of best practice and innovation.

On one ward we visited, the manager told us that the implementation of the new falls initiatives had resulted in a reduction of falls from 22.6 falls per 100 bed days to 6.5 falls per 100 bed days.

Information provided by the trust indicated that a pilot, of new falls initiatives on two wards, during the 90 day collaborative had resulted in a reduction of falls on the participating wards and a 53% reduction in falls with harm trust wide.

Data provided by the national patient safety agency (NPSA) states that nationally there are 4.8 falls per 1000 bed days in acute hospitals. Figures provided by the trust indicated that the average number of falls was 9.4 between October 2016 and October 2017. This is a reduction from 10.6 prior to the implementation of new initiatives however, this has remained worse than the national average.

Nationally available data indicates that the trust performs worse than the England average for the following:

- Patients with lung cancer receiving all eligible secondary medicines.
- Emergency readmission and in hospital mortality following acute myocardial infarction.
- Emergency readmission following due to chronic obstructive pulmonary disease and bronchiectasis.
The trust was recognised as a national mortality outlier for patients with urinary tract infection. The trust produced an action plan which included a review of relevant patients' notes. The outcome of this was that there had been no preventable deaths. The trust held mortality review group meetings. We looked at the minutes of these meetings and saw that updates were discussed. However, it was noted, and documented in the minutes that there was minimal attendance from consultants.

Medical staff told us that they attended an audit meeting each Wednesday where audit results were discussed.

Junior nursing staff told us they were involved in collating data for local, ward-based audits and also acted as link nurses, for example, one member of staff told us they were the palliative care link nurse on the ward they worked on. We saw audit results were fed back to staff through team meetings.

The trust had completed an audit ‘the outcomes and management of acute kidney injury – initiatives to improve care for patients with renal disease’ in 2017. This audit had produced actions to improve patient outcomes, including improved education for patients, medical and nursing staff and the establishment of a renal clinic. There was a plan to re audit in 2018 to measure the results of the actions taken.

South Tyneside District Hospital’s endoscopy unit was awarded JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accreditation, which it has achieved every year since it was introduced in 2006.

Some therapists we spoke with told us that the trust focused on discharging patients rather than rehabilitation with long term goals and because of this, more patients were readmitted. We did not see any evidence of patient outcome measures being used by therapists, in patient’s records. We did not see goal setting in patient’s nursing care records.

**Relative risk of readmission**

**Trust level**

Between June 2016 and May 2017, patients at the trust had a lower than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Elective admissions:

- Patients in Medical Oncology had a lower than expected risk of readmission for elective admissions
- Patients in Gastroenterology had a higher than expected risk of readmission for elective admissions
- Patients in Clinical Haematology had a lower than expected risk of readmission for elective admissions

Non-Elective admissions:

- Patients in General Medicine had a higher than expected risk of readmission for non-elective admissions
- Patients in Cardiology had a higher than expected risk of readmission for non-elective admissions
- Patients in Diabetic Medicine had a higher than expected risk of readmission for non-elective admissions
Elective Admissions – Trust Level

Non-Elective Admissions – Trust Level

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 (01/06/2016 - 31/05/2017))

Sentinel Stroke National Audit Programme (SSNAP)

South Tyneside Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade insert latest grade D in latest audit, August 2016 and November 2016. The trust remained relatively consistent across four key performance indicators throughout the previous quarters.

South Tyneside Hospital
The trust made a temporary change to the model for acute stroke services in December 2016. There had been a stroke consultant vacancy since 2014. Clinical leaders and executives agreed that the service was no longer sustainable and a new temporary model was implemented, with all acute care for stroke patients in South Tyneside and Sunderland being centralised at City Hospitals Sunderland.

**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 which represents how each value compares to the England distribution for that audit year; quartile one means that the result is in the lowest 25 per cent, whereas quartile four means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 82% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in quartile two which was worse than the England average.

(Source: NHS Digital)
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 trust).

Between 2015/16, 36% of nSTEMI patients were admitted to a cardiac unit or ward at South Tyneside Hospital and 100% were seen by a cardiologist or member of the team compared to an England average of 96.2% and 55.8%.

The proportion of nSTEMI patients who were referred for or had angiography at South Tyneside Hospital was 94.2% compared to an England average of 83.6%.

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(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 81%, which was worse the audit minimum standard of 90%. The 2015 figure was not available.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 26.1%, this is better than the national level. The 2015 figure was not available.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 75%; this is similar to the national level. The 2015 figure was not available.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 71.4%; this is similar to the national level. The 2015 figure was 63%.

The one year relative survival rate for the trust in 2016 is 36.3%. This is not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls

The trust performed worse than the England average in the 2015 national inpatient falls audit.

The table below shows the trusts performance in assessing risk factors of falls and whether or not the trust had the appropriate interventions in place to prevent falls:
The trust’s performance was between 0-49% for three of the metrics in this audit: Delirium, BP and Vision, as stated in the inpatient audit this is where the trust would need to concentrate interventions and action plans. The remaining four metrics were between 50-79%; this is again below the England average.

The blue sparkline indicators show where the trust is performing well, Medication, Mobility aid and Continence CP are receiving better falls prevention approaches than the England average. Vision and call bell indicators however are worse than the average.

The trust did not submit data for this audit in 2016.

(Source: Royal College of Physicians)

**Competent staff**

**Appraisal rates**

Between July 2016 and June 2017, the trust had an appraisal rate of 80% for all medical staff which does not meet the trust appraisal completion target of 90%. This is an improvement from the previous year’s appraisal completion rate of 77%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

At the inspection in 2015, we had concerns that hospital appraisal data showed variability in compliance with annual appraisals, these ranged from 25% - 100% for nursing staff. Trust records showed 100% of doctors in the care group had received an appraisal in line with the GMC revalidation process.

At this inspection, information provided by the trust for seven wards showed that in October 2017, appraisal rates had improved with 82% of nursing staff having an up to date appraisal. Wards 5 and 19 had the highest rates of compliance with 97% and 100%. Ward 2, with 44% had the lowest rate.

At this inspection staff told us they had an up to date appraisal. Some staff gave examples of professional development they had identified as part of the appraisal process for example one registered nurse told us they were being supported to complete their mentorship training.

Junior doctors, nursing staff and a student physiotherapist told us they had attended the trust’s induction at the start of their employment. In addition to mandatory training, the staff told us they also had training on falls, NEWS and sepsis recognition.
A junior doctor we spoke with told us they had the opportunity to professionally develop at the trust and received regular supervision and training opportunities. A pharmacist we spoke with told us that they had been supported by the trust to complete further education.

Newly qualified staff we spoke with told us they had six months preceptorship with the trust.

**Multidisciplinary working**

All wards held a multi-disciplinary ‘huddle’ every morning. We observed one of these and found it to be an effective review and up date for each patient. Medical, nursing and therapy staff attended these. In addition to the discussions about each patient, the huddle was also used to discuss key communication issues such as lessons learned and trust updates.

Staff reported positive MDT working and gave examples of how closely they worked with colleagues from other disciplines, for example, the mental health liaison team and specialist nurses such as the tissue viability and falls nurses.

We attended the discharge team daily huddle. This meeting included members of the discharge team, social workers and therapists. All patients who were deemed medically fit were discussed at this meeting, the reasons for the patients not being discharged were highlighted and a plan to expedite discharge was agreed. Staff told us that this meeting had improved flow within the hospital.

We observed ward rounds on some of the wards and found that nurses caring for patients did not always take part in these, for example on the emergency admissions unit. Medical staff told us that they had concerns about this. We discussed this with the senior team who said they would look in to the reasons for this.

We attended a daily bed meeting. This meeting included representatives from all divisions of the trust. A brief on the daily situation reports (SITREPs) was given from each service representative. For medical wards and care of the elderly wards this included, any gaps in staffing levels, the current bed status, the number of definite and potential discharges, the current level of patients being boarded outside of their speciality area, the number of closed beds and the number of patients awaiting repatriation (transfer from another hospital outside the trust). This was an efficient and effective full hospital overview that informed the senior staff on call of any potential concerns about the delivery of care.

**Seven-day services**

The trust’s specialist medical consultants did not provide a seven-day on-site service. They were on site Monday to Friday from 8am until 8pm. An on call system was used outside normal working hours and at weekends with all on call consultants able to be on site within 30 minutes. There was a seven-day consultant presence on the emergency admissions unit.

The trust operated a seven-day service for radiography procedures including CT scans.

The trust pharmacy department provided a five-day service Monday to Friday 9am until 5pm and until lunchtime on Saturdays and Sundays. An emergency service was available outside of normal working hours.

The trust had a seven-day chaplaincy service and a chapel was also available on the ground floor of the hospital.
Access to information

Staff at the trust were able to access patients’ G.P. records electronically. This meant if the patient was not known to the hospital, staff could access information about the patient’s past medical history.

Patients’ medical records were stored on site; therefore, if a patient had a previous episode of care, staff could request the patient’s notes from the records department.

The extra-med electronic system was in use on all the wards. All staff were able to access all ward data. In addition the system could be used to send referrals, for example if a patient needed a referral for physiotherapy, occupational therapy or to a specialist nurse, this could be completed electronically.

Medical staff told us discharge information was sent electronically to patients’ G.P.s on the day of discharge.

We saw the trust had created a Working Arrangements and Key Contacts document for out-of-hours and holiday periods. We looked at the document created to support staff over the public holiday in August 2017. This document contained key information for staff including on call manager contacts, emergency pharmacy opening times, radiography and physiotherapy availability, doctors’ rotas and contact numbers for other services, for example infection control and safeguarding.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.

The Mental Capacity Act (MCA) is 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.

Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

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.

We saw that capacity assessments were completed for all patients where appropriate. Most staff we spoke with had a clear understanding about what would constitute a deprivation of liberty and were aware of when they would apply for an urgent authorisation. We saw that patients with an urgent authorisation in place were discussed at ward huddles; this included an update on when this needed to be renewed.

We saw staff on all wards obtaining consent before providing any care or treatments.

We looked at the trust’s policies for consent, deprivation of liberty and the mental capacity guidelines. We found that these were in date and contained appropriate references to legislation such as the mental capacity act, equality and diversity and the human rights act.

Staff completed MCA training as part of their mandatory training. Figures provided by the trust showed that 75% of medical staff and 68% of nursing staff were compliant with level 2 training.
Is the service caring?

Compassionate care

Friends and Family test performance
The Friends and Family Test response rate for Medicine at the trust was 33% which was better than the England average of 25% between September 2016 and August 2017.

Ward 2 had the highest scoring recommendation rate throughout the trust scoring 100% eight months out of 12.

Friends and family Test – Response rate between 01/09/2016 and 31/08/2017 by site

(Source: NHS England Friends and Family Test)

During our inspection we spoke with 38 patients and five relatives and carers, we received predominantly positive feedback from most people. One patient told us the care and compassion received from staff was outstanding.

We spoke to a patient who told us the staff were ‘lovely, they always introduce themselves and explain everything’. This patient said they were very satisfied with the care they received. Another told us staff were very considerate and respectful.

Other patients described the staff as ‘brilliant, friendly and great company’, patients told us that staff do their very best and are happy to do anything for the patients.

We spoke with four patients in the endoscopy and ambulatory care ward waiting room. All gave positive feedback about the service and the staff, with one patient saying, ‘They’re smashing; they can’t do enough for you here.’

We observed staff interacting with patients and relatives and saw that staff treated all patients with dignity and respect. Staff were caring and considerate to the needs of their patients.

Emotional support

Patients told us that they felt safe on the wards.

We spoke with a patient from an ethnic minority background who told us his dietary needs had been met and he had also been supported to pray.
Understanding and involvement of patients and those close to them

We observed staff explaining to patients what was happening when they were providing care but we did not see evidence in nursing care records that patients were involved in planning their care.

Staff on ward 19 told us patients’ relatives were invited as guests for Sunday lunch that was served in the day room.

We saw that conversations with relatives were documented in some records. We spoke with the relative of one patient who told us they were happy with the care their relative had received and they felt communication from staff was good.

Is the service responsive?

Service delivery to meet the needs of local people

Average length of stay

Trust Level

Between July 2016 and June 2017, the average length of stay for medical elective patients at South Tyneside Hospital was 3.1 days, which is lower than the England average of 4.2 days.

For medical non-elective patients, the average length of stay was 6.5 days, which is lower than the England average of 6.6 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in Cardiology is lower than the England average.
- Average length of stay for elective patients in Gastroenterology is lower than the England average.
- Average length of stay for elective patients in Respiratory Medicine is higher than the England average.

Average length of stay for non-elective specialties:

- Average length of stay for non-elective patients in General Medicine is higher than the England average.
- Average length of stay for non-elective patients in Stroke Medicine is higher than the England average.
- Average length of stay for non-elective patients in Cardiology is higher than the England average.

Elective Average Length of Stay – Trust Level

![Elective Average Length of Stay – Trust Level](image)
Non-Elective Average Length of Stay – Trust Level

*Data is the same at trust and site level.

(Source: Hospital Episode Statistics)

The trust had an emergency admissions unit, five medical wards that specialised in gastroenterology, diabetes, cardiology and coronary care, respiratory medicine, an oncology and haematology day unit, an ambulatory care unit and an endoscopy unit. In addition to these wards there was also an elderly care ward and two step-down wards, which had previously been community based. These two wards did not provide care for acutely ill patients but were utilised as a step down unit for patients who required more rehabilitation prior to discharge or who needed care at the end of their life.

The variety of wards meant that the needs of the local population were met.

The trust formed an alliance with a neighbouring trust in 2016; following this the trust’s stroke services were relocated to a single site. This meant that any local people who suffered a stroke were transferred out of their local area. However, at our inspection in 2015, we had concerns about the trust’s performance in the Sentinel Stroke National Audit Programme (SSNAP), the neighbouring hospital performed better in the SSNAP.

The endoscopy unit was offering evening appointments for people who may not be able to attend during normal working hours due to work commitments.

Meeting people’s individual needs

The ward environments were appropriate for the patients being cared for. We found the environment on ward 11 was particularly pleasant.

We saw some good examples of dementia friendly initiatives on a number of the medical wards but had concerns that this was not consistent across all areas. In some areas, we found that toilets and bathrooms had dementia friendly signage and contrasting colour schemes but again, this was not consistent.

On ward 19, the ward had a volunteer who provided diversional activities for two hours, three days per week. Staff told us they also encouraged families to come to the ward to help with feeding patients who needed assistance or encouragement. The ward also had a digital reminiscence monitor that was used to play films and music. This had also been used to video call patients’ relatives who lived out of the area and were unable to visit.

There were no specialist dementia nurses employed by the trust. There was a community based learning disability (LD) team. Staff were able to access this team, if they needed support, when caring for a patient with LD.

The trust had taken part in the national audit of dementia care in general hospitals 2016-2017. The results from this had been variable. These showed that South Tyneside scored in the top 50% of hospitals for assessment, carer rating of information and communication and overall carer rating of
patient care. The hospital scored in the bottom 50% for governance, nutrition, discharge and staff rating of information and communication.

We spoke with a patient from an ethnic minority background who told us his dietary needs had been met and he had also been supported to pray.

The trust had a seven-day chaplaincy service and a chapel was also available on the ground floor of the hospital. We did not see information about this service clearly displayed however, this information was available on the hospital website.

In the emergency admissions unit a Freephone telephone for patients’ use when booking taxis was available and clearly signposted.

Staff were able to access translation and interpretation services if required. Information was available on the trust intranet to support staff.

The trust’s electronic patient status system enabled staff to flag vulnerable patients, for example those living with dementia, so that this information was available to all staff.

On one ward there was a shower-room designated for male patients adjacent to a toilet designated for female patients. We also saw some male toiletries in a female designated shower. We were therefore concerned that the facilities may not be being used in line with single-sex guidance.

We also looked at the nursing assessment documentation and found that this did not support patient centred individualised care, as the paperwork was generic for all patients.

Access and flow

**Referral to treatment (percentage within 18 weeks) - admitted performance**

Trust’s referral to treatment time (RTT) for admitted pathways for Medicine was higher than the England average for the whole time period between September 2016 and August 2017.

Most recently the trust’s referral to treatment time (RTT) for admitted pathways for Medicine for August 2017, showed 95% of this group of patients were treated within 18 weeks versus the England average of 89%

(Source: NHS England)
Referral to treatment (percentage within 18 weeks) – by specialty

One specialty was above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic Medicine</td>
<td>98.2%</td>
<td>93.7%</td>
</tr>
</tbody>
</table>

At the inspection in 2015, staff we spoke with raised concerns about high numbers of ‘outlier’ patients boarded outside of their speciality area and how this influenced their workload. During this inspection, we found that the number of medical outliers was minimal. Medical staff did not raise any concerns about outliers and told us that the speciality team caring reviewed these patients daily for them.

The trust used a safer care bundle to ensure that all patients were reviewed each day and any delays were identified and escalated appropriately. The table below shows the medical patients who were cared for on surgical wards between 01 January 2017 and 31 October 2017. The information provided by the trust shows an improving picture, with the exception of August 2017.

### Medical Boarders on Surgical Wards 01/01/2017 - 31/10/2017

<table>
<thead>
<tr>
<th></th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Days</td>
<td>286</td>
<td>251</td>
<td>92</td>
<td>82</td>
<td>167</td>
<td>133</td>
<td>107</td>
<td>286</td>
<td>216</td>
<td>130</td>
<td>1750</td>
</tr>
<tr>
<td>Patients</td>
<td>72</td>
<td>67</td>
<td>39</td>
<td>39</td>
<td>48</td>
<td>45</td>
<td>37</td>
<td>77</td>
<td>56</td>
<td>50</td>
<td>530</td>
</tr>
</tbody>
</table>

When the trust had more than 100 patients with a length of stay of more than six days, an escalation meeting was held. We looked at the trust data for the week commencing 18 October 2017 and saw that there were 141 of these patients in the hospital. The highest numbers of patients (27) were on medical wards and care of the elderly, and the reason cited was awaiting clinical interventions that could only be provided in the hospital.

The hospital had a discharge lounge. This area could be used to release beds whilst patients were waiting for transport or medications prior to going home.

### Learning from complaints and concerns

#### Summary of complaints

Between August 2016 and July 2017, there were 42 complaints about medical care. The trust took an average of 53 days to investigate and close complaints, this is not with their complaints policy, which states complaints should be completed within 25 days.

- The majority of complaints related to all aspects of clinical treatment (61%)
- Ward 10 had the highest number of complaints with 71%.

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

We did not see information about how to raise a concern displayed on most of the wards we visited. However, patients and relatives we spoke with told us that they would speak to the nurse looking after them or the nurse in charge.)
Ward managers we spoke with were able to tell us how they dealt with complaints. We saw from minutes of meetings that complaints were discussed in some team meetings. Ward managers also said that complaints and concerns would be discussed at the morning huddles.

Following our inspection, the trust provided information which showed that they had improved the time taken to investigate, respond to and close complaints.

Is the service well-led?

Leadership

The medical and care of the elderly senior leadership team included a clinical director, business manager, matron and operational manager. Each ward and department had a ward manager and two deputies.

In addition to the clinical director, there was also a medical clinical lead for acute medicine and one for care of the elderly.

Nursing staff told us ward managers and matrons were visible, approachable and supportive. However whilst some staff said they were not aware who the senior leadership team was, ward managers and their deputies were aware of the senior team and told us that they were supportive.

Ward managers told us that they had a management supernumerary day each Wednesday. They attended meetings with the senior team on a regular basis and this included governance and business meetings.

Some managers that were not in medical or nursing roles felt that they were not always included in communication from the senior management team.

Vision and strategy

We spoke with the senior leadership team about the vision and strategy for medical services. The team told us that their priority was to maintain high quality sustainable care for the local population.

Most staff we spoke with were aware of the trust vision and values. We saw these displayed in ward areas. In addition, some wards had their own mission statements displayed.

Culture

All staff we spoke with, including doctors, allied health professionals and nurses told us that their senior staff were approachable and supportive. In addition to this, some staff told us that the human resources team were also accessible and helpful.

All staff said the ward environments were friendly. We saw positive working relationships between all grades of staff. Staff told us they prioritised patient safety, were team focused and ‘like a family’.

Staff told us teams were patient centred. On one ward, we were told they had regular team building days out.

We saw that compliment and thank you cards were displayed on the wards. Feedback about compliments was also shared in team meetings.
Governance

Ward managers told us that they attended divisional governance meetings that fed in to the corporate meetings. We saw minutes of these meetings and saw that patient safety and risks were shared and actions agreed.

The trust provided a copy of the clinical governance report for the medicine and elderly directorate. We looked at this and saw that all patient safety, quality and experience outcomes were reported within this document.

A medical consultant and a junior doctor we spoke with told us that they were invited to the divisional and corporate governance meetings.

Management of risk, issues and performance

Staff we spoke with on the wards were aware of the risks for their area. The trust provided a copy of the risk register for medicine and elderly care. We saw that this had overarching risks for the division such as nurse staffing and patient falls as well as risks specific to individual areas.

Each risk had an initial risk rating, a current risk rating, and a review date. We saw that some risks had remained moderate or high for more than three years. For example a risk relating to a lack of 24-hour telephone advice for oncology, had been on the risk register since March 2014.

We saw an example of an assurance audit. This audit included environmental spot checks, patient questions, staff questions and observation of any good practice. Following the audit, an action plan to address any issues or concerns was created and shared across clinical teams.

Information management

We raised concern in some areas about the security of patients care records. In some areas, records were stored in trolleys without locks in bay areas, ward corridors or in rooms that were also unlocked when not in use. We discussed this with the staff in the areas of concern during our visit. We reviewed this concern following our unannounced inspection. We spoke with seven ward managers who were all aware of the importance of security and confidentiality of records. This concern had also been discussed with the head of nursing at a ward managers meeting, Some managers we spoke with had taken interim measures to address the concern, others were submitting business plans for example to have swipe card access fitted to rooms where records were stored.

Staff completed information governance training as part of their mandatory training. Overall compliance for the service was 86% which was better than the trust target.

Engagement

During the week of our inspection, several ward managers told us that they had received the outcome of a recent staffing review. This had resulted in an immediate uplift in the planned registered nurse levels. One manager told us that they felt listened to and were delighted about the outcome of the review.
Junior doctors we spoke with told us that the trust was a good place to work and they would recommend South Tyneside as a place to work to others. They also said they had protected time to access to in house speciality training sessions and were supported by senior clinicians.

Some staff we spoke with told us they felt uncertain about the future due to the alliance with a neighbouring trust however, they told us their line managers were supportive.

Some staff raised concerns about the alliance with the neighbouring trust, telling us that they were uncertain about the future of their roles. Others told us that they felt ‘things would settle down’ once decisions about services had been made.

Information provided by the trust showed that staff were able to contribute their thoughts and ideas to the consultation programme. We also saw a public consultation document that gave the people who use services the chance to contribute their thoughts and feelings. There was a variety of options including public meetings, online and paper surveys, focus groups and a freepost address to send written correspondence. In addition, details of consultation events were detailed in the monthly chairman and chief executive’s office team brief.

The 2016 staff survey results indicated that the trust did not score significantly better on any questions, scored significantly worse on 17 questions and the scores show no significant difference on 71 questions, when compared to the 2015 survey. We saw staff survey participation rates and results displayed on some wards.

**Learning, continuous improvement and innovation**

Each week the trust consultants also did a grand round where all consultants saw all patients.

A member of pharmacy staff told us that they felt that progression opportunities within the trust were limited however; they were able to be involved in new ways of working. For example, pharmacists were providing input to the fall’s clinic.

We found very few dementia friendly initiatives on one ward. We discussed this with the staff on the ward who told us this had been identified but that improvements had been put on hold. We asked the senior leadership team about this and they told us that this was being progressed. Following our inspection, we saw minutes of a dementia friendly environment meeting which was held 05 October 2017. The minutes of this meeting identified that this work was progressing.

As part of the Trust’s on-going quality improvement strategy to increase dementia awareness, the trust has used Barbara’s’ Story, which was developed by another NHST trust in England in 2013, to educate staff in the importance of providing compassionate and effective care to those patients with dementia and their carers and family members. Barbara’s’ Story has been incorporated into educational programmes including the accredited preceptorship programme for newly qualified nurses, midwives and allied health professionals.

Ward 19 had been awarded the Elder-friendly Quality Mark from the Quality Mark project, a Royal College of Psychiatrists initiative.

Staff on ward two had adopted the NHS England initiative ‘Time to move: Get up, get dressed, keep moving’.

Staff on ward 10 told us they had been nominated for the trust carers of the year award.

South Tyneside District Hospital’s endoscopy unit was awarded JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accreditation, which it has achieved every year since it was introduced in 2006.
We spoke with the manager of the endoscopy unit who told us the service was trialling a pre-assessment service for patients. It was hoped this initiative would benefit patients, as it would give staff the opportunity to fully explain the procedure and therefore reduce cancellations and patients failing to attend for their appointments. The outcomes so far were reported as being positive.

The endoscopy unit was using double balloon enteroscopy; South Tyneside was the only hospital in the North East to offer this procedure. This was described as a procedure where no scope had gone before as it enabled endoscopists to visualise the small bowel using either a rectal or oral approach. The nearest NHS trust to offer this service was in South Yorkshire.

Outside normal working hours all emergency endoscopy procedures were performed in general theatres. The manager in the endoscopy unit told us the team worked closely with the general theatre staff and competency based assessments had been developed to support theatre staff.

The Gastroenterology team was recognised in the HSJ Awards 2016 as the best in the country for global impact on clinical research.

South Tyneside NHS FT was also leading on national study ‘B-ADENOMA’ which randomises consenting patients who have been scheduled for screening flexible sigmoidoscopy via the NHS English Bowel Scope Screening Programme.

The study aims to find out if using the colonscopic cuff EndocuffVision® will improve adenoma (polyp) detection rates and allow for easier polyp removal. Earlier detection and removal of these pre-cancerous polyps reduces the risk of bowel cancer developing.

South Tyneside was one of 19 trusts in England which took part in NHS Improvement’s 90-day falls collaborative aimed at reducing the rate of falls in their hospitals and sharing examples of best practice and innovation. On one ward we visited, the implementation of the new falls initiatives had resulted in a reduction of falls from 22.6 falls per 100 bed days to 6.5 falls per 100 bed days.

The Trust was chosen to share expertise and good practice after being identified as a top performer for lung cancer patient pathways by a national programme aimed at achieving earlier diagnosis of the disease.
Surgery

Facts and data about this service

The trust provides surgery services from ward seven (orthopaedics) and a surgical centre which includes inpatients and day surgery.

The trust has 135 inpatient beds.

(Source: Routine Provider Information Return (RPIR) – “Sites-Acute” tab)

The trust had 7,214 surgical admissions between June 2016 and May 2017. Emergency admissions accounted for 1,947 (26%), 4,409 (61%) were day case, and the remaining 858 (11%) were elective admissions.

(Source: CQC Insight)

During this inspection we visited the operating theatres and recovery area, the surgical centre which included the day surgery and in-patient unit, the orthopaedic ward (Ward 7) and the pre assessment unit. We spoke with 22 patients and relatives and 65 members of staff. We observed staff delivering care, and looked at 13 patient records and prescription charts. We reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

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

According to the data supplied by them the trust set a target of 90% for completion of mandatory training and had an overall training completion rate of 70%.

A breakdown of compliance for mandatory courses between June 2016 and July 2017 is shown below. However, the mandatory training data for medical staff provided by the trust is only for the team called “STDH General Surgery” it does not include any other surgical ward/team and no other core service. The trust did not provide information relating to any other surgical area.

The trust did not meet the completion target of 90% for three modules undertaken by medical & dental staff. Infection control exceeded the trust target and had a 100% completion rate. Resuscitation had the lowest completion rate of 64%.

For nursing mandatory training data the team/ward level data does not match the site level data, and the trust did not provide us with core service level breakdown.

The trust did not meet the completion target of 90% for all seven modules undertaken by nursing & midwifery staff. Resuscitation had the lowest completion rate of 62%.

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

Compliance rates for mandatory were worse than the last inspection of the trust.)
We observed an education and training board in theatre which listed all staff and the dates when training had been completed.

Some theatre staff reported training had been cancelled as a result of staffing shortages. Staff reported they did not feel training was given priority and they were not aware of any action to ensure training compliance was improved.

The orthopaedic ward staff were behind with e-learning training. Senior nurses told us schedules had been put in place with the onus staff to complete them.

Training was provided on sepsis via an e-learning package. This included aspects such as recognition of sepsis and screening for sepsis and treatment and management. One hundred percent of staff had competed this training on the surgical centre day unit.

**Safeguarding**

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

A breakdown of compliance for safeguarding courses between June 2016 and July 2017 for medical/dental and nursing/midwifery staff within surgical specialities and maternity is shown below:
The trust did not meet the 90% completion target for two safeguarding modules undertaken by medical & dental staff. Safeguarding adults level 2 had the lowest completion rate with 66%.

![Safeguarding Training by module](image)

The trust met the 90% completion target for two safeguarding modules undertaken by nursing & midwifery staff. Safeguarding adults level 2 had the lowest completion rate with 23%.

(Source: Trust Provider Information Request P18)

We reviewed safeguarding training compliance rates for individual wards and areas from the clinical governance report for September 2017. These figures were extremely variable (see table below). Senior nursing staff told us an action plan was in place for safeguarding training.

<table>
<thead>
<tr>
<th>Ward/Department</th>
<th>Completion %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical centre day unit</td>
<td>83%</td>
</tr>
<tr>
<td>Surgical centre inpatients</td>
<td>19%</td>
</tr>
<tr>
<td>Pre-assessment</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 7 (orthopaedics)</td>
<td>10%</td>
</tr>
<tr>
<td>Theatre</td>
<td>62%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>57%</td>
</tr>
</tbody>
</table>

Trust protocols and guidance on safeguarding were easily accessible. We reviewed the safeguarding policy which was in date. It referenced PREVENT, this provides staff with knowledge in order to recognise radicalisation of individuals, and female genital mutilation (FGM).

Contact details and the adult safeguarding alert flowchart were also included in the policy.

Staff we spoke with could describe what signs to look for and how they would escalate any safeguarding concerns. Senior nurses reported feeling confident that staff would escalate any concerns.

We saw evidence of safeguarding consideration during the safety huddles we observed.

The safeguarding advisers routinely attend safety huddles. The staff reported this was a valuable resource.

**Cleanliness, infection control and hygiene**

There were no cases of avoidable blood stream methicillin-resistant staphylococcus aureus (MRSA) at the trust between April 2016 and March 2017 and there had been no cases in the first quarter of 2017/2018. There had been five cases of clostridium difficile between April 2016 and March 2017 and no cases during the first quarter of 2017/2018.
Monthly audit data was collected on healthcare associated infections. This information was displayed in ward areas. For example the surgical centre day unit data from May 2017 to September 2017 showed compliance was 100%. This included areas such as catheter insertion, use of personal protective equipment (PPE) and hand hygiene.

It was noted in the clinical governance report for September 2017 that surgical centre inpatients unit had not returned audit data for October 2017 and September 2017. All the environments we visited were visibly clean and tidy and free from clutter. We observed staff using appropriate hand hygiene techniques. With the exception of one consultant in theatre and one consultant on the ward who were observed wearing wrist watches; staff were arms bare below the elbow in clinical settings.

The trust had a policy for MRSA screening for emergency patients. Elective patients were screened at pre assessment.

Single rooms were available for those patients requiring isolation. The surgical centre had opened in December 2016 and had increased the number of single rooms to 11 which staff reported as positive. We observed appropriate signage in place for patients requiring isolation.

The orthopaedic ward had beds 'ring fenced' for those patients undergoing elective joint replacements. This meant they were kept separate from urgent cases to further reduce infection risks.

Any patients taken to theatre with a known infection risk were kept in theatre to recover from their anaesthetic to enable them to be isolated.

There was a cleaning log in the anaesthetic room in theatre three although this had only been completed for 21 October and 29 October. We observed that equipment trolleys had disposable covers and curtains were also disposable with dates of when they had last been changed.

We checked commodes in ward areas and found them to be visibly clean with labels indicating they were clean and ready for use. Mattress and commode cleaning guidance was displayed in dirty utility rooms and information on the segregation of waste.

Alcohol gel was available at the entrance to wards and departments and at individual bed spaces. We observed good practice in relation to hand hygiene in all areas we visited. Patients reported they observed staff washing their hands and using alcohol gel.

From the notes we reviewed we saw that patients with a vascular access device had care plans in place with the date and reason for insertion. Ongoing monitoring of the site was recorded and prompts to remove when it was no longer required.

**Environment and equipment**

Resuscitation trolleys were easily located on main corridors in ward areas and theatre and in theatre recovery. Best practice is for resuscitation trolleys to be checked daily (Royal Collage of Anaesthetics – Resuscitation – Raising the Standard). We inspected resuscitation equipment in each of these areas and were assured that daily checks had been undertaken. On the surgical centre inpatient unit a rota was used to indicate whose responsibility it was to check the trolley each day.

The trolleys had tamper-proof seals; with permission we removed these to check the contents. With the exception of one wrapping on a laryngoscope which was torn, the contents were in date and sealed as required. One of the trolleys was dusty on top and we told the nurse in charge about this.
Anaesthetic equipment checks complied with ‘The Association of Anaesthetists of Great Britain and Ireland’ (AAGBI) guidelines. The difficult intubation trolley in recovery had an inventory but a record of daily checks could not be located.

An alert board was used in theatre to share information about new anaesthetic equipment. For example there had been changes to the defibrillator and instructions were displayed.

The wards had been reconfigured since the last inspection. The surgical wards had combined to a 42 bedded unit with day surgery located next door. The orthopaedic ward had reduced the number of beds to 21.

Wards reported having sufficient equipment to meet the needs of their patients, for example moving and handling equipment. Bariatric equipment could be obtained from storage if required.

All storage was clearly labelled in theatre and kept on shelves off the floor. All instruments were sterilised on site, no concerns were raised in relation to this and staff reported an on call service was available if required.

On the surgical inpatient unit we saw a notice to inform staff they had failed their sharps audit. One aspect of this was the soft close not been applied to sharps bins, we found three did not have this in place.

There was an identified locked cupboard in a locked room for control of substances hazardous to health (COSSH) in theatres. Formaldehyde was stored in a fuming cabinet with a chemical spillage kit next to it. However on Ward 7 we found the cleaner’s cupboard unlocked with detergent and sanitiser stored on open shelves.

Information provided by the trust indicated that all electrical devices were managed through a medical device management software system that contained an inventory for the trust. Theatre also had an equipment inventory list. We checked 39 pieces of equipment across surgical areas and theatre including infusion pumps and anaesthetic machines all had in date electrical safety testing.

Medical devices training was part of role specific training provided for staff.

Assessing and responding to patient risk

The national early warning score system (NEWS) was used in each ward area as a tool for identifying deteriorating patients. The documentation we reviewed across all ward areas showed accurate completion of NEWS scores and we saw evidence of raised NEWS scores being escalated appropriately.

Information of resuscitation audit by exception was included in the September 2017 clinical governance report. Ward 7 was highlighted as 80% was achieved. Audit data was red, amber and green (RAG) rated, a score of 80% would fall in to the amber category. Within the mandatory training data provided resuscitation was one of the lowest areas, with compliance at 62% for nursing and midwifery staff and 64% for medical and dental staff. We were not aware of any specific plans to address this.

There was a critical care outreach team who would come and support ward staff if a patient was deteriorating. They also reviewed patients who came to the ward from intensive care.

Staff gave us examples of when patients had deteriorated out of hours and they confirmed that the escalation process worked well and they felt supported by the medical and outreach team.
We were provided with data from the national early warning scores report from October 2017. In this patient observation charts were audited looking at 13 criteria such as patient details competed, have observations been carried out at appropriate frequency and has NEWS been correctly calculated. Overall scores for the surgical centre from May 2017 to October 2017 were above 98% indicating good compliance. The surgical centre inpatient unit did not submit data for two of the months.

For the same time period Ward 7 compliance was between 88% and 100%.

We also saw the use of the sepsis bundle in patient records. The sepsis bundle is a group of medical interventions to treat patients with a serious infection. Training was provided on sepsis and we saw information displayed on the sepsis bundle.

Any patients with a tracheostomy in situ had their own emergency box which was kept with them. This contained specific emergency equipment.

At the previous inspection concerns were identified in relation to patients requiring admission to the intensive care unit being cared for in recovery when beds were not available.

All the theatre staff we spoke with confirmed that this situation had significantly improved. If this situation arose an intensive care nurse would always stay with the patient. Since the last inspection a standard operating policy had been developed for managing critical care patients in recovery. This had been in place since October 2016. We reviewed a copy of this on site. It was very clear what the process would be if this situation arose and clear that the responsibility of the patient was with the critical care team and not recovery staff as had previously been the case.

The document also outlined what other plans needed to be put in place if the patients were expected to remain in recovery for over four hours.

The World Health Organisation’ (WHO) surgical safety checklist was in the process of being changed to have red flags added to particular steps. For example; is the surgical site marked? The slogan ‘we stop at red’ was being embedded to raise awareness of the need to pause at key moments within the safety checks.

During the inspection we observed various aspects of ten WHO safety checks in theatre. We found inconsistencies in terms of staff engagement, practices and quality of the checks. For example we observed a briefing led by a consultant who required some prompting from other staff. It was also felt the team made some assumptions during the checks due to the team knowing each other well.

The ‘stop before you block’ patient safety initiative was launched in 2010. It stated what steps should be taken in addition to the WHO safety checklist when a nerve block is being administered. These are, that prior to the insertion of the needle, the surgical site marking is visualised and the consent form is checked. If the patient is awake they can also be asked to confirm which side is being operated on.

We did not observe ‘stop before you block’ being utilised for a patient receiving a nerve block and when questioned, the anaesthetist was not aware of this initiative.

We observed two accountable-items checks, swabs were counted and checked with the count board for verification with the nurse and consultant. The instrument count was conducted when the patient was on a trolley waiting to go to recovery. A verification sheet was not used as the staff member stated they knew what there should be so did not require this.

On our second observation the staff member used the instrument checklist which came with the pack to check the instruments. The count board was again used to verify disposable items such as...
swabs and blades. It had been identified at the team brief that specialist equipment was required; despite this the equipment was not present. It was found prior to surgery commencing.

Theatre staff told us about another incident which occurred in June 2017 which was still being investigated. It had been verified that all equipment and instruments were present however when a specific instrument was required during the procedure it could not be found. The patient had to return to theatre the following day to have the procedure again.

We observed another team brief where all staff introduced themselves and their role. A comprehensive discussion of the patients on the list, including allergies and previous medical history took place as well as the equipment required and what surgery was to be undertaken. This information was recorded on a team briefing form.

We observed two ‘sign in’s in the anaesthetic room all members introduced themselves to patient and explained the procedure. All patient details and consent form were checked. The patients were also asked about fasting times. Only when all safety checks were completed was the ward nurse accompanying the patient allowed to leave and anaesthetic commence.

We observed two ‘sign outs’ with good engagement from whole team. Checks were completed before any staff left confirming correct swab counts; the recovery nurse was also present for this.

We reviewed re-audit data of WHO checklists from September 2017. This was a retrospective review of 463 WHO checklists from 1 May 2017 to 31 July 2017. The audit showed overall compliance had decreased on all components since the last audit.

With the exception of cardiology there were gaps in all stages for all specialities with compliance ranging from 82% to 100%.

We reviewed the recommendations and actions from this audit to try and improve compliance. These included targeted observations and improving the data quality.

The theatre manager gave us information about national safety standards for invasive procedures (NatSSIPs) and local safety standards for invasive procedures (LocSSIPs) which would also address some of the issues.

In 2014 the surgical never events taskforce report recommended a set of high level national standards of operating department practice. Based on this, individual departments were required to develop more detailed local safety protocols. NatSSIPs were published in 2015 to support NHS organisations. The overarching aim is to assist in providing safer care and reduce the number of patient safety incidents related to invasive procedures.

We saw an action log related to the use of NatSSIPs. This was red, amber, and green (RAG) rated for each area. For example handovers if team members changed during a procedure. A new form had been developed for the team brief to capture movement in and out of theatre. This data was to be reviewed and then the form adapted as needed.

We found that comprehensive risk assessments were completed at pre assessment; this was a nurse led service. All elective patients planned to have a general anaesthetic were pre assessed. There were systems in place to ensure further medical or anaesthetic review for any patients with identified risks.

Patient risk assessment documentation for falls, pressure areas, and nutrition were included in care records. We reviewed care plan documentation and risk assessments in 13 records and found these to be fully completed and updated as required.
A new falls risk assessment process was implemented across the trust in August 2017 supported by the falls teams. Data on falls and those which resulted in harm was collated and shared at monthly governance meetings. Data from the September 2017 governance report showed that Ward 7 and the surgical centre inpatients unit reported a lower number of falls than seven other wards in the trust.

**Nurse staffing**

The trust has reported their staffing numbers below for the period April 2016 to July 2017. The trust has 14.72 WTE fewer than required to provide safe and planned care.

<table>
<thead>
<tr>
<th>Ward/Site</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>282.89</td>
<td>268.17</td>
</tr>
<tr>
<td>Total</td>
<td>282.89</td>
<td>268.17</td>
</tr>
</tbody>
</table>

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

**Vacancy rates**

Between enter August 2016 and July 2017, the trust reported a vacancy rate of 5% in surgical care.

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

**Turnover rates**

Between enter August 2016 and July 2017, the trust reported a turnover rate of 2% in surgical care.

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

**Sickness rates**

Between enter August 2016 and July 2017, the trust reported a sickness rate of 6% in surgical care.

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

**Bank and agency staff usage**

The service used staffing acuity tools to review staffing establishments based on patient dependency. There had been a staffing review earlier in the year which facilitated an additional nurse in the evenings on the surgical day unit and Ward 7.

Electronic rostering was used with a safer nursing care tool to identify any gaps in staffing. The matron had oversight of this and attended the afternoon bed meeting to review staffing. However if the hospital was in escalation they would attend all three of the daily bed meetings.

Staff on the wards reported they felt staffing levels were appropriate for the patient numbers they cared for. During our inspection with the exception of one qualified nurse on one late shift, we saw that planned and actual staffing levels were achieved.
On the surgical centre inpatient unit they were still exploring different ways of working due to the size of the ward. Currently they were working in three teams; this enabled an appropriate nurse to patient ratios.

The rosters in theatre and the day surgery unit were done to reflect activity and composed in conjunction with theatre scheduling. A meeting took place each week to discuss activity six weeks in advance.

Whilst e-rostering was used in theatres managers told us it was a working progress to use the system more effectively. At the time of inspection rostering was done on paper then inputted into e-roster, rather than using the system to produce the roster.

Staff were able to access the roster from their mobile phones and could request five shifts per month.

Operating theatres staffing met the ‘Association for Perioperative Practice (AfPP) staffing recommendations. Theatre reported they had not used any agency nursing staff since May 2017. They had their own bank staff or staff doing additional shifts to cover any gaps. We reviewed two weeks of rotas in theatre (week commencing the 23 and 30 October) and saw that each week there were five shifts which had been covered by bank staff.

We received mixed views from theatre staff regarding staffing; this was as a result of a recent restructure and was focused around the number of band six staff. Staff told us covering the on call theatre rota for nursing staff was a challenge as there were not enough band six nurses to cover the rota. To mitigate a senior band five would be allocated. All staff reported that patient care was never compromised.

Wards handovers took place three times a day; informal handovers also took place as required throughout the day. In addition to this safety huddles took place in each area. These highlighted any patient safety issues.

**Medical staffing**

**Vacancy rates**

Between enter August 2016 and July 2017, the trust reported a vacancy rate of 15% in surgical care.

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

**Turnover rates**

Between enter August 2016 and July 2017, the trust reported a turnover rate of 4% in surgical care.

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

**Sickness rates**

Between enter August 2016 and July 2017, the trust reported a sickness rate of 2% in surgical care.

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

**Bank and locum staff usage**

The trust did not provide this information.
Staffing skill mix

Between June 2017 and June 2017, the proportion of consultant staff reported to be working at the trust was similar to the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the whole time equivalent staff working at South Tyneside NHS Foundation Trust

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>47%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>2%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>21%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

We reviewed medical staffing and spoke with consultants, middle grade and junior doctors. Medical cover was available on-site 24 hours a day. Consultants were available 24 hours and were on site between 8am and 6pm. On-call cover was provided at evenings and weekends.

The on call consultants were supported by on site registrars and foundation level doctors supported the wards.

Junior doctors reported always having support and access to senior colleagues when required.

In the medical notes we observed a weekend plan sticker which clearly communicated plans of care. It included diagnosis, co-morbidities, treatment to date and ongoing plans for example if blood tests were required.

On the orthopaedic ward patients were reviewed twice a week by the ortho-geriatric team.

The patients we spoke with reported visibility of doctors and being reviewed at weekends.

Records

We reviewed 13 sets of records across the wards. We found them to be completed appropriately and each contained completed risk assessments on topics such as skin integrity and falls.

We reviewed the elective care patient assessment document. This was very comprehensive and in line with the Royal College of Surgeons ‘Good Surgical Practice (2014).

Nursing and medical records in some areas were stored in open trolleys in corridors on the ward. This was not felt to be secure as they could potentially be accessed by anyone.

Laminated copies of basic record keeping standards were in each set of nursing notes. These reflected best practice as outlined by the nursing and midwifery council (NMC).
Medicines

Controlled drugs were appropriately stored with access restricted to authorised staff. We reviewed the controlled drugs records on surgical wards and in theatres including recovery. Accurate records and checks were completed in line with trust policy. Three monthly controlled drug checks were also done by the pharmacy department.

As wards had merged to form the surgical centre inpatient unit we found there were six controlled drugs registers in use. We discussed this with staff and whilst they recognised this as a risk, they reported there had been no time to combine the registers.

We observed administration of a controlled drug on a ward; appropriate checks and procedures were followed. In theatres three and four we found two incidences where the administration and discarded dose of a controlled drug had not been documented.

We observed Entonox and oxygen cylinders stored appropriately. Intravenous fluids and medicines were stored securely and weekly stock checks were undertaken.

Medication trolleys were locked and secured to the wall when not in use.

On Ward 7 the maximum temperature (exceeding eight degrees) was recorded on eight consecutive days and on a separate occasion for 13 days with no evidence of escalation. The ward sister was informed of this.

On the surgical inpatient unit fridge temperature monitoring was in place however there were some gaps. Theatre recovery had very recently had a new fridge installed. Staff were not aware any temperature monitoring was in place for this.

Pharmacy staff were allocated to clinical areas and provided cover Monday to Friday with an on call service at weekends. They clinically checked all prescriptions before they went to pharmacy to reduce errors. Pharmacy staff reported any minor issues with medication charts would addressed at the point they were identified with the relevant staff. Significant errors would be reported via an incident form such as errors involving insulin or anti-epileptic medication.

Junior doctors reported they received informal support and education around prescribing from pharmacy staff. Medicines reconciliation was done on the ward for each patient.

We spoke with pharmacists who audited medication charts and collated data centrally on a spreadsheet. Medication audit data was submitted monthly by ward areas. This data was included in the monthly clinical governance report. The report for September 2017 noted that Ward 7 had not submitted audit data.

We reviewed 13 medication record charts and found them fully completed with any omissions recorded with the reasons why. Those that had antibiotics prescribed had evidence of review in line with best practice guidelines.

The trust reported a high rate of 72 hour antibiotic review consistently achieving higher than 95% each quarter. The trust also had an app that allowed easy access to antibiotic protocols to support appropriate prescribing.
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. Between September 2016 and August 2017, the trust reported no incidents classified as never events for Surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in Surgery which met the reporting criteria set by NHS England between September 2016 and August 2017.

Of these, the most common type of incident reported was

- Slips/trips/falls meeting SI criteria with two (50% of total incidents).
- Treatment delay meeting SI criteria with one (25% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (25% of total incidents).

(Source: Strategic Executive Information System (STEIS))

We requested details of these four serious incidents; however the trust only supplied information relating to three out of the four.

Incidents were reported on an electronic system. All the staff we spoke with including medical staff were aware of how to report incidents and gave examples of what types of things they would report.

We reviewed information on 213 incidents reported by surgery from 1 May 2017 to 31 October 2017. 148 incidents (69%) were classified as no harm/near miss, 64 (30%) were classified as minor harm and one (1%) was classified as moderate harm. Themes of incidents were pressure damage and patient falls.
issues had previously been identified in relation to the reporting of pressure ulcers. Staff reported appropriate reporting of pressure ulcers was now in place. This had identified an increase in the number of pressure ulcers and an action plan was in place. A pressure ulcer collaborative had been established and the pressure ulcer panel reviewed any patients with multiple grade two pressure ulcers. A safety calendar was used to highlight incidences of pressure ulcers. For example on Ward 7 in September 2017 it had been identified that there had been a significant increase in the number of pressure ulcers to 11. This was investigated and found to be as a result of traction being used, it did also coincide with new mattresses being used but no link was found to this. The issues and learning were discussed at the ward meeting.

Incidents were monitored through the trust’s clinical incident review group. Information on incidents was shared in a variety of ways. This included monthly surgical specialties clinical governance meetings. We reviewed minutes of these and found incidents to be a standing agenda item. Team meetings, a trust wide safety brief and safety huddles were also used for disseminating information.

We observed a safety huddle in theatre conducted by the theatre lead. It was attended by band six staff and someone from each theatre. They discussed each theatre and their list as well as any acute cases. They then discussed any other news this included details of incidents and changes in practice.

We saw a clinical incident group review newsletter from summer 2017 displayed in a staff area. This explained what a never event was as well as details of never events in the trust and subsequent learning from these. It also made note of the human factors element in incidents.

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. We saw the duty of candour referenced in incident data. Staff we spoke with demonstrated an awareness of the duty and the importance of being open and honest when delivering care.

On the wards staff reported getting feedback from incidents and all felt there was a good culture of incident reporting, including near misses. Within theatre we received mixed feedback from staff. Some staff told us despite indicating on the electronic system they would like feedback they never received feedback from incidents. Some staff also said there were incidents that were not reporting as nothing was done about them so they had stopped completing incident forms.

Surgical specialties held monthly mortality and morbidity review meetings to review cases and share any learning. Information on reviews was collated electronically. It was noted in the September 2017 governance report that a deadline had been set for all reviews to be uploaded by November 2017. 0% of reviews were recorded within trauma and orthopaedics. General surgery had recorded 94%.

**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 17 new pressure ulcers, two falls with harm and one new catheter urinary tract infections between September 2016 and September 2017 for Surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at South Tyneside NHS Foundation Trust**

- **Total Pressure ulcers (17)**
- **Total Falls (2)**
- **Total CUTIs (1)**

(Source: NHS Digital)

We saw safety thermometer information displayed in ward areas. For example on the surgical unit harm free care from July 2017 to August 2017 was 90% to 100%.

**Is the service effective?**

**Evidence-based care and treatment**

Trust policies were based on guidance from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE). These were easily accessed on the trust's intranet under clinical policies. All staff were aware of guidance and how to access it.

New guidance was monitored through clinical governance meetings and we saw evidence of this in the clinical governance report we reviewed. Each piece of guidance had a named person responsible for reviewing it and updating trust polices as required. In the September 2017 report there were nine pieces of guidance that were overdue for review within the surgical directorate (excluding obstetrics and gynaecology).
We reviewed policies and found them to be in date and with version control and author identified. Care pathways were used for specific conditions for example the sepsis pathway had a link to the Royal College of Physicians acute toolkit, screening tool and care protocols including the sepsis six pathways.

An integrated pathway was in use for patients undergoing day surgery procedures this included pre assessment documentation assessing risk such as venous thromboembolism (VTE). Enhanced recovery pathways were in place, for example for patients undergoing elective joint replacement surgery.

Audits were undertaken in ward areas relating to the completion and accuracy of care bundles, the use of NEWS, medication and documentation. Information displayed showed there were gaps in each of these areas over the past three months indicating the audit had not been undertaken.

The surgical directorate participated in a number of national audits including the national hip fracture database and the national bowel cancer audit programme. From this good practice and areas for development were identified.

**Nutrition and hydration**

The Malnutrition Universal Screening Tool (MUST) was used to assess patients. We found these recorded and reassessed in the notes we reviewed. If required patients could be referred to the dietician for additional advice and support.

Protected mealtimes were in place this allowed patients to eat without disruption. We observed mealtimes and saw support was provided to patients if required. We also saw relatives supporting patients at mealtimes.

A variety of food choices was available to patients and we received positive feedback from patients with regard to the meals provided. Staff told us if there was a delay in getting elective patients a bed on the ward they could be provided with diet and fluids in recovery.

We saw policies and observed clear explanations regarding fasting times at pre-assessment which were in line with best practice.

There was a fasting policy and intravenous fluids would be commenced on an individual basis as required if patients were nil by mouth. Staff described the use of mouth care for patients who were unable to eat or drink.

We observed stickers in patient’s notes who were receiving nutrition via nasogastric tubes. This included the day and reason for insertion, the type of tube, measurement, aspirate pH and a confirmation that consent had been obtained.

**Pain relief**

For patients on enhanced recovery pathways there was a pain protocol in place. Staff told us the acute pain team had attended pre education classes and advised patients regarding pain relief. Pain relief for this patient group had been audited; as a result a new pain relief was being trailed with plans to re-audit to see if this had improved pain control.

Patients admitted with a fractured hip were administered a nerve block in the accident and emergency department to provide pain relief.
We saw evidence of pain scores in the documentation we reviewed. The patients we spoke with reported effective pain control and timely response to requests for additional pain relief. One patient told us they were ‘provided with pain relief immediately’.

**Patient outcomes**

**Relative risk of readmission**

**Trust level**

Between June 2016 and May 2017:

- Patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- General Surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.
- All patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- General Surgery patients at the trust had a lower expected risk of readmission for elective admissions when compared to the England average.
- Trauma & Orthopaedics patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.
- ENT patients at the trust had a higher expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Elective Admissions Chart]

*England Avg.*
Non-Elective Admissions – Trust Level

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 represents the opposite.

*The data for site and trust level is the same.

(Source: HES - Readmissions (01/06/2016 - 31/05/2017))

Hip Fracture Audit

In the 2016 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 10.8% which was worse than expected. The 2015 figure was 3.4%

The proportion of patients having surgery on the day of or day after admission was 75.7%, which was worse than the national standard of 85%. The 2015 figure was 76.7%

The perioperative medical assessment rate was 95.9% which failed to meet the national standard of 100%. The 2015 figure was 94.7%.

The proportion of patients not developing pressure ulcers was 93.8% which falls in the bottom 25% of trusts. The 2015 figure was 94.2%.

The length of stay was 25.6 days which falls in the bottom 25% of trusts. The 2015 figure was 27.6 days

(Source: National Hip Fracture Database 2016)

Orthopaedic consultants told us that the trust was actively addressing the drop in performance in relation to mortality figures. Multidisciplinary team reviewing took place with external representation from the British Orthopaedic Association.

Bowel Cancer Audit

In the 2016 Bowel Cancer Audit, 70.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was slightly worse than the national average of 69%.

The risk-adjusted 90-day post-operative mortality rate was 3.9% which was within expected range. The 2015 figure was 4.6%.

According to the data provided by the trust prior to inspection the risk-adjusted 2-year post-operative mortality rate was 34.1% which was worse than expected. The 2015 figure was 12.9%.

The risk-adjusted 30-day unplanned readmission rate was 5.8% within expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 54.2% which was within expected range. The 2015 figure was 54.3%.
The risk-adjusted 90-day unplanned readmission rate was 5.8% this was better than the national average of 10.1%.

(Source: National Bowel Cancer Audit)

National Vascular Registry
This trust did not complete this audit as they do not provide vascular surgery.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit
In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 18.9%.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit
In the 2016 National Emergency Laparotomy Audit (NELA), South Tyneside District Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 66 cases.

The South Tyneside District Hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 46 cases.

The South Tyneside District 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 30 cases.

The South Tyneside District Hospital achieved an amber rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 17 cases.

The risk-adjusted 30-day mortality for the South Tyneside District Hospital was within expectations based on 135 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures
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 hip replacements, performance was better than the England average.
For Knee replacements was better than the England average.
(Source: NHS Digital)

Information was collected on sepsis screening. During 2016 - 2017, the trust achieved a sepsis-screening rate of 81% on in-patient wards. In the first quarter of 2017/2018, this had improved to 96%.
During 2016 - 2017, 77% of patients with confirmed sepsis received their antibiotic within 60 minutes for in-patient wards. During the first quarter of 2017/2018 this had improved to 81%, however this still left a significant number of patients who did not receive antibiotics in a timely way.

Competent staff

Appraisal rates
Between August 2016 and July 2017 65% of staff within Surgery at the trust had received an appraisal compared to a trust target of 90%, this was however an improvement on the previous year’s appraisal completion rate of 60%.
(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

We reviewed appraisal data for individual areas from the September 2017 clinical governance report.

<table>
<thead>
<tr>
<th>Department</th>
<th>Completion Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical centre inpatients</td>
<td>81%</td>
</tr>
<tr>
<td>Surgical centre day unit</td>
<td>92%</td>
</tr>
<tr>
<td>Pre-assessment</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 7</td>
<td>63%</td>
</tr>
<tr>
<td>Theatre</td>
<td>44%</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>20%</td>
</tr>
</tbody>
</table>
On Ward 7 there were outstanding appraisals to complete; this had been impacted by a senior nurse from the ward being temporarily redeployed. They had now returned and they hoped this would enable appraisals to be completed.

We were not aware of any specific plans to address staff appraisals within theatres.

All new staff both medical and nursing attended a corporate induction when starting at the trust. A competency booklet was used to evidence learning. Newly qualified nursing staff underwent a six months preceptorship programme. We spoke with two new theatre staff who reported a very good induction and that they were supported for three months by an allocated a mentor.

Pre assessment staff received training in clinical history taking and examination, interpreting electrocardiograms (ECG's). We observed completed induction checklists for bank staff.

In addition to mandatory training there was role specific training on areas such as blood transfusion and conflict resolution. Staff reported they were encouraged to develop and attend additional training. For example in theatre a phlebotomy course was offered for a new operating department practitioner.

Theatre utilised their monthly clinical audit sessions to provide updates and training. We observed training on airway management and the use of diathermy during the inspection.

In theatre a skills matrix was used to identify learning needs and band six staff had responsibility/specialism in particular areas.

On the wards there were identified link nurses, for example, for colorectal surgery and continence. There was access to a range of specialist nurses including respiratory, breast care and diabetes; they could be contacted by phone or electronic referral.

The junior doctors we spoke with reported they were offered lots of learning opportunities both formal and informal, protected teaching was given each Tuesday. Doctors reported getting time in theatre to gain exposure and learning.

The trust supported nursing staff through the revalidation process. Revalidation is the new process that all nurses and midwives in the UK will need to follow from April 2016 to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practising.

### Multidisciplinary working

Staff told us, and we observed good multidisciplinary team working; for example on ward rounds between nursing and medical staff. We also saw evidence of this in the patient records we reviewed.

Daily multidisciplinary safety huddles took place each morning to discuss patient care and identify risks as well as to share other information. Physiotherapy and occupational therapy staff were aligned to ward areas for four months at a time which helped with continuity of care.

The trauma specialist nurses visited the ward daily to review patients and liaised with day surgery following trauma meetings if admissions for day case surgery were required. They also worked with the ortho-geriatric team who conducted twice weekly wards rounds.

We observed the routine follow up of a patient who had been discharged from intensive care by the outreach team. A comprehensive review was done and a plan put in place which was clearly articulated to ward staff.
The theatre manager was trying to build links with ward staff. The theatre and ward staff had attended workshops together and ward staff were invited to access any training provided in theatre.

The integrated discharge team included allied health professionals and hospital based social workers who were co-located. They also attended daily huddles on the wards.

There was a nurse led pre assessment service with an anaesthetic clinic held on Tuesday afternoons for any patients identified as high risk.

The outreach team followed up all patients discharged to the wards from intensive care.

**Seven-day services**

Daily consultant ward rounds took place. We saw evidence of reviews at weekends and the patients we spoke with confirmed this.

Staff provided examples of patients requiring emergency surgery or transfer to the intensive care unit out of hours and reported no concerns or delays with regards to this. We also saw evidence of such situations in some of the medical notes reviewed.

Physiotherapists provided treatment Monday to Friday. There was a weekend and on call service out of hours.

A pharmacist visited the unit Monday to Friday; the pharmacy was open seven days a week with a 24 hour on call service.

X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.

The day surgery unit was open Monday to Friday 8am to 8pm.

**Health promotion**

Support was available to support patients with smoking cessation we saw from notes this was discussed with patients as appropriate.

There were procedures in place to support patients withdrawing from drugs or alcohol and the pharmacist would advise and support in such situations.

On admission assessments over individual needs would take place and support would be provided as appropriate.

As appropriate the multidisciplinary team provided health and self-care advice to patients to enable them to manage their own conditions.

In patient areas we saw health promotion advice and information displayed. For example on the surgical centre inpatient unit there was information on a healthy diet and the importance of keeping hydrated.
Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

South Tyneside District Hospital reported that between August 2016 and July 2017 Mental Capacity Act (MCA) training has been completed by 36% of nursing & midwifery staff. Medical & dental staff had a completion rate of 15%.

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

We reviewed consent forms in patient records. Some staff did report that often consent took place on the day of surgery. The General Medical Council (GMC) guidance on consent: Patients and doctors making decisions together, states: “Give the patient time to reflect, before and after they make a decision, especially if the information is complex or what you are proposing involves significant risks”.

An audit undertaken at the trust from December 2016 of 59 consent forms found that 80% were consented the day of surgery.

We observed consent for a procedure being done at pre-assessment; this was very thorough with all risks clearly explained. The staff we spoke with demonstrated an understanding of consent, and would always seek consent from patients. We observed this in practice when staff were attending to patients.

Staff demonstrated an understanding of mental capacity and deprivation of liberty safeguards (DoLS). Junior doctors were aware of how to complete assessments and during an ortho-geriatric safety huddle we observed that consideration was given to patient capacity.

In two sets of notes where DoLS were in place we saw they included a comprehensive record with a completed mental capacity assessment. For these patients we saw that the appropriate consent forms were also used.

We found in one set of notes a DoLS was in place but we could find no evidence of a capacity assessment being completed. Discussions with staff highlighted this had not been completed. This was discussed with the nurse in charge who actioned this and the necessary forms were completed.

From the patient records we reviewed we saw delirium assessments were completed on admission and pre discharge.

Pre assessment staff received training in mental health crisis.
Is the service caring?

Compassionate care

Friends and Family test performance

The Friends and Family Test response rate for Surgery at South Tyneside NHS Foundation Trust was 26% which was worse than the England average of 29% between September 2016 and August 2017.

Friends and family test response rate at South Tyneside NHS Foundation Trust, by site.

Friends and family test information was displayed in ward areas. For example, on the surgical centre day unit data showed that for September 2017 98% of respondents would recommend the service, for August 2017 this was 100%.

The patients and relatives we spoke with were all positive about the care they had received. Patients described the staff as caring, one made the comment 'I can't fault anything the care has been excellent'.

During the inspection we observed interactions between staff and patients; these were consistently done in a kind and compassionate way. We saw information displayed on compassionate care in patient areas.

We observed a very anxious patient in pre assessment being told about things that could be put in place to help reduce their anxiety when they were admitted to hospital. These included the use of sedation and a numbing cream on their hand so they wouldn’t feel the cannula being inserted.

There were privacy and dignity link nurses and we observed the privacy and dignity of patients being maintained.

The majority of patients knew the names of the nurses and doctors caring for them.

We observed call bells being answered promptly and feedback from patients was that generally staff responded in a timely way. Only two of the 22 patients we spoke with reported a delay in getting assistance from staff.

Emotional support

There was a bereavement service, and multi faith chaplaincy services were available on site and staff could access these for patients.

Staff we spoke with felt able to provide support to relatives and visitors as well as to patients and felt this was an important part of their role. We observed theatre staff welcome patients into the anaesthetic room and provide assurance to patients in recovery.

Specialist nurses were also available to provide advice and support for patients.

Understanding and involvement of patients and those close to them

Patients and their families told us they were involved in discussions about their care and treatment. Patients said staff kept them informed of what was happening and that they had been given explanations from medical staff; we saw this whilst observing ward rounds. This involved pictures being drawn to further aid patients’ understanding of operations or procedures.
Staff showed a good awareness of patients with complex needs and gave examples of when they provided support for them and their families. During a ward round we observed that a consultant had spoken to a patient’s relative the day before to arrange them to accompany their relative when they went for a scan. The patient was living with dementia and it was identified that going for a scan may cause them some distress.

We also observed a ward round where a patient who was hearing impaired was given written details of what was discussed to ensure they had understood all that was discussed.

During the ortho-geriatric safety huddle we saw from discussions that conversations with family and the individual patients had taken place.

We saw information displayed on the carer’s charter and posters saying carers were welcome on our ward.

Is the service responsive?

Service delivery to meet the needs of local people

The surgical centre was spacious and had 11 single en suite rooms; this gave the ward greater flexibility and meant that generally side rooms were available for those who needed them.

The day surgery unit had designated areas for those waiting for surgery and post-operative patients. The service was nurse led with clear discharge guidelines.

The orthopaedic outreach team had been in place for approximately 18 months. This service was developed to support patients on discharge from hospital. Staff reported it had reduced length of stay however no formal audit had been completed.

The team comprised of a band six nurse and two training instructors. They supported both elective and non-elective patients. They inputted into pre education classes for elective patients and visited patients at home on the day of discharge and could provide support for up to a month.

There were no specialist dementia nurses employed by the trust; however there was access to learning disability liaison team. The staff we spoke with felt confident in caring for patients who may need additional support.

Average length of stay

Trust Level – elective patients

Between July 2016 and June 2017, the average length of stay for all elective patients at the trust was 3.6 days, which is higher compared to the England average of 3.3 days.

For General Surgery elective patients at the trust was 3.1 days, which is lower compared to the England average of 3.3 days.

For Trauma & Orthopaedics elective patients at the trust was 4.0 days, which is higher compared to the England average of 3.4 days.
Elective Average Length of Stay – Trust Level

(Source: Hospital Episode Statistics)

Trust Level – non-elective patients

The average length of stay for all non-elective patients at the trust was 6.4 days, which is higher compared to the England average of 5.1 days.

The average length of stay for General Surgery non-elective patients at the trust was 3.7 days, which is lower than the England average of 4.0 days.

The average length of stay for Trauma & Orthopaedics non-elective patients at the trust was 13.0 days, which is higher compared to the England average of 8.9 days.

The average length of stay for Cardiothoracic Surgery non-elective patients at the trust was 1.0 days, which is lower compared to the England average of 8.9 days.

Non-Elective Average Length of Stay – Trust Level

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The wards were accessible for people who used a wheelchair or walking aids. Disabled toilets and showering facilities were available in the ward areas we visited.

Assessments took place on admission or during pre-assessment to identify individual patient’s needs. This information was used to inform care planning. From speaking with staff and reviewing records we were assured that staff were aware and responsive to the needs of different people.

Different food choices were available and chaplaincy for different religions and faiths.

There were two side rooms on the day surgery unit; these were used for patients who were particularly anxious or were living with severe autism or a learning disability. Staff reported they would do all possible to support these patient groups. The ward sister ensured a nurse to patient ratio of 1:2 to enable additional support. Staff gave us an example of a patient who had never been out of their own environment and required several carers with them. Staff told us a
multidisciplinary team meeting was held to plan their admission. This enabled surgery to take place with as little distress to the patient as possible.

Staff felt they were proactive in planning for the needs of bariatric patients. This was identified at pre assessment so all necessary equipment could be obtained in advance of the procedure to avoid any delays.

Hip and knee replacement pre education groups helped identify any potential problems prior to admission and pre plan. For example, referrals to social services for additional support on discharge.

The integrated discharge team had access to the crisis team and worked with them to develop safer packages of care taking mental health needs into consideration.

There was a patient choice directive policy for those requiring temporary accommodation.

During a team brief in theatre it was noted that a patient required an interpreter and this had been arranged.

We observed an interpreter supporting a patient in the day surgery unit; any such requirements for elective admissions were identified at pre assessment.

**Access and flow**

**Referral to treatment (percentage within 18 weeks) - admitted performance**

Between September 2016 and August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was consistently higher than the England average. In the most recent month August 2017 the trust performance was 94% compared to the England average of 70%.

![Graph showing referral to treatment rates](image)

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

A breakdown of referral to treatment rates for Surgery broken down by specialty is below. Of these, one of specialties was above the England average.

**Above the England average**

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>92%</td>
<td>72%</td>
</tr>
</tbody>
</table>

Patients accessed the service either as a planned admission, through the emergency department or from GP referrals. All elective and some acute admissions were admitted to the day surgery unit into the recliner chair bay and given details of where they would be going post operatively.
Bed meetings were held three times a day to review capacity and demand.
Since the reduction of orthopaedic beds and the opening of the surgical centre staff reported the number of medical outliers on the surgical wards had significantly reduced. This was an improvement from the last inspection. As the numbers were smaller staff reported this was more manageable.

The integrated discharge team supported surgical wards if they had medical patients. They looked at admission avoidance as well as supporting safe discharges. Any patients readmitted within ten days of discharge would be reviewed by this team. The team told us audit data had been collected in relation to readmission but no particular trends had been identified.

The integrated discharge team had daily huddles where they reviewed delayed discharges and any issues in arranging packages of care. They felt an increased responsiveness from the social work team had helped improve discharge planning as well as the whole team being co-located.
At the time of inspection there were eight patients awaiting packages of care to support their discharge home within the trust.

The day surgery unit proactively managed the theatre list orders particularly with those patients on an afternoon list to ensure they have adequate recovery time to be able to go home.

Acute theatres were utilised for general surgery in the morning and trauma and orthopaedics in the afternoon. However if an acute patient required surgery for a different speciality we were told this could always be accommodated. The trauma specialist nurse helped to advise on the prioritisation of cases for theatre.

Uni-compartmental (partial) knee replacements were being done as day case procedures with the use of enhanced recovery pathways.

**Cancelled operations**

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.

Over the two years, the percentage of cancelled operations at the trust was consistently at 0%.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - South Tyneside NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Q2 2015/16</th>
<th>Q3 2015/16</th>
<th>Q1 2016/17</th>
<th>Q2 2016/17</th>
<th>Q3 2016/17</th>
<th>Q1 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

- This Trust — England
Over the two years, the percentage of cancelled operations at the trust was generally lower than the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Information had been collated locally on the day surgery unit. Data showed that out of 333 admissions in September 2017 there were six cancellations on the day. Most patients were given an alternative date prior to leaving the department.

Learning from complaints and concerns

Summary of complaints

Between August 2016 and July 2017 there were 35 complaints about Surgical Care. The trust took an average of 50 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be completed within 25 days.

- Ward 7 and Trauma & orthopaedics had the highest number of complaints all with 18%.
- 64% of all complaints related to all aspects of clinical treatment.

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

Following our inspection, the trust provided information which showed that they had improved the time taken to investigate, respond to and close complaints.

The senior management team stated they were developing a feedback process for complaints. Staff were not able to articulate what this was.

Staff told us they always attempted to resolve specific issues at the time and encouraged patients to speak out if they had concerns as early as possible.

Complaints and concerns were managed by the customer services department. We did not see information clearly displayed on how to contact this team in ward areas.

None of the patients we spoke with were aware of how to complain formally but many said they would speak to the ward sister.
Is the service well-led?

Leadership

Theatre staff were positive about the new manager who they described as very approachable. Staff also told us they felt listened to more and that things were actioned. The majority of staff told us they felt more supported and confident to escalate any concerns. This was an improvement from the previous inspection where a number of concerns had been identified in terms of leadership within theatre.

Across the wards and theatres the band six and seven roles (senior nurses) were being reviewed to look at roles and responsibilities within the teams.

There had been a restructuring in theatre whereby the number of band six and band seven nurses reduced. Some staff still felt ‘raw’ from this experience and were still in a period of adjustment. As a consequence of this staff reported some inconsistencies in terms of information sharing and functionality of team leaders.

The surgical centre inpatient unit was encouraging staff ownership and looking at having the ward manager in a supervisory role Monday to Friday due to the size of the unit. From our observations and reviewing the governance reports it was noted that local monthly audits had not been consistently submitted for the previous three months. Allowing more dedicated management time would help in areas such as this.

Ward and theatre managers reported good support from human resources with regards to the new sickness policy. All sickness reviews took place with human resource representation. We also spoke with a staff member who reported they felt supported returning to work following long term sickness.

There were two matrons in post who job shared although did have individual responsibility for different areas. We were assured that they worked consistently and kept in regular contact; however we were provided with a small number of examples from staff where they felt there had not been consistency in the information provided from matrons.

Vision and strategy

Staff were aware of the trust vision and values. We saw information displayed in the areas we visited. In addition some areas had their own mission statements displayed.

The trust had recently formed an alliance with a local NHS trust and introduced a series of clinical service reviews. Surgery was part of the next phase of a five year transformation of healthcare provision programme. This was focused on identifying new and innovative ways of delivering high quality care.

Whilst staff reported they were kept informed of any changes there was still a degree of uncertainty about the future. This was particularly noted in theatre where a number of staff were unhappy about things being changed without their involvement.

Culture

At the previous inspection concerns had been identified about the difficult working environment within theatre. We discussed this with the senior management team who acknowledged there
were issues in relation to culture and custom and practice. The clarification of roles and responsibilities had helped address some of these issues as well as ensuring processes for dealing with concerns were followed to give consistency.

There had been improvements in relation to the culture within theatres. Senior managers felt any issues were addressed at the point at which they occurred and that there was a zero tolerance approach to bullying and harassment.

However, we were still given recent examples of staff being shouted at and completing incident forms over behaviour they felt was not appropriate. It was a concern that following this some staff told us they were identified and confronted as a result. This meant not all staff felt they could always report incidents. However most staff confirmed that any behavioural issues would be verbally escalated to line managers and they felt assured that the individual involved would be spoken to.

Other small groups of staff spoke about issues within theatre teams that were impacting on their ability to do their job as information was not shared. They also told us that the rota sometimes had to take in to account certain staff who could not work together due to ‘personality clashes’.

Theatre staff had raised concerns over changes to the on call rota and the perceived lack of senior nurse support. The outcome of a grievance process was due to report immediately following our inspection.

From speaking with consultants they felt the culture in theatre had improved with clearer lines of management to escalate concerns. They also said direct conversations were taking place with individuals when issues were reported or witnessed.

Information on the staff well-being programme was displayed in areas we visited and staff knew how to access this although some said the timings did not fit well with shift patterns.

Theatre staff reported feeling valued within their department but not as much within the wider trust. It was hoped that by the manager developing relationships between theatre and the surgical wards to better understand each other’s roles and job pressures, this would improve.

In ward areas we observed senior doctors asking junior doctors if they needed any support. Junior doctors reported feeling very supported able to ask for advice. Nursing staff reported a positive culture and good working relationships between staff groups.

**Governance**

The Surgical Services directorate included critical care, endoscopy and maternity services. There was a clear governance structure with clear lines of responsibility and accountability.

The leadership team reported directly to the executive board, and systems were in place to allow information from them to be shared at ward level. Within theatre the cascading of information to teams was via the band six team leaders from monthly meetings with their manager.

We reviewed the clinical governance report for the surgical directorate. Patient safety, quality and experience outcomes were RAG rated within the document to highlight good practice and areas for improvement.

We reviewed monthly clinical governance meeting minutes and action logs and noted they were not particularly well attended. It was noted in the September 2017 minutes to ensure there was attendance from each area. There were ongoing actions in relation to staff appraisals and training compliance.
There were monthly mortality and morbidity meetings and clinical incident review group meetings. Feedback from medical staff was that the governance framework was clearer and speciality meetings were well established.

Management of risk, issues and performance

The surgical directorate risk register included risks from all of the clinical services. The senior leadership team reviewed risks at divisional governance meetings and the directorate risk register fed into the overarching register for all acute services.

The senior management team were confident that the restructuring within theatre had a significant improvement on the management of risk. The team brief and debrief had been revised utilising NatSSIPS and LocSSIPS to improve processes.

Incidents and sharing of information took place in all areas via daily safety huddles.

The service was engaged in national clinical audit programmes and there were local audits to monitor performance in areas such as documentation and infection prevention and control.

The directorate had not addressed all findings from the previous CQC inspection. This was particularly noted with regards to mandatory training and staff appraisals. Some areas of compliance were extremely low such as resuscitation and safeguarding training. This meant we could not be assured staff were up to date with the latest practices and guidance.

It was also found at the previous inspection that the World Health Organisation’ (WHO) surgical safety checklists had not been consistently completed. At this inspection we found varying practice and compliance, this was supported by audit data provided by the trust.

Information management

Staff could access information relating to polices and guidance electronically. The system was easy to navigate.

Staff received training on information governance and were aware of the importance of managing confidential patient information.

Engagement

Friends and family test information was displayed in ward areas. Staff in recovery said they received lots of patient feedback and patients reported it was a personal and friendly hospital. A suggestion box was in recovery information from which fed in to the ‘you said’ ‘we did’ initiative. This was also used for staff feedback. For example staff wanted a guide for gastroscopies, in response this was produced and we saw a copy in theatre.

We saw thank you cards and letters displayed in the entrance to ward areas. There was also a suggestion box in theatre for cost improvement ideas.

Staff in theatre had started a ‘tuck shop’; money raised from this was then used for staff. For example to send flowers if someone was off work due to sickness.

There was a staff forum to give the opportunity to meet the executive team.
Staff felt a degree of uncertainty about the future and particularly in theatres staff did not feel involved in decision making about changes in practice. Practices were being aligned to the partnership trust which made some staff feel undervalued for the work they had done.

**Learning, continuous improvement and innovation**

Senior managers and team leaders spoke about driving improvement and encouraging innovation. Team leaders felt they were supported in trying new ideas or ways of working.

During the inspection a new initiative was launched called Excellence Reporting. This prompted people to think who was excellent and what did they do, and how they could learn from them?

Staff could submit an excellence report and receive a letter of recognition from the chief executive.

The surgical team had developed the gall bladder service to enable symptomatic patients an operation within 48 hours.

The use of enhanced recovery pathways was enabling partial knee replacement surgery to be done as a day case procedure.

South Tyneside was one of 19 trusts in England which took part in NHS Improvement’s 90-day falls collaborative aimed at reducing the rate of falls in their hospitals and sharing examples of best practice and innovation.

The orthopaedic outreach service had evolved since the last inspection and was constantly responding to the changing needs of patients.

The work around NatSSIPS and LocSSIPS was ongoing to promote safer care for patients.

One pharmacist was a prescriber in acute pain and looking at developing an acute pain clinic in accident and emergency. Pharmacy staff were also exploring inputting into the pre assessment clinic.
Critical care

Facts and data about this service

The trust has six Critical Care beds. A breakdown of these beds by type is below.

**Breakdown of critical care beds by type, South Tyneside NHS Foundation Trust and England.**

<table>
<thead>
<tr>
<th>This trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult, 100.0%</td>
<td>Adult, 68.2%</td>
</tr>
<tr>
<td>Neonatal, 24.0%</td>
<td></td>
</tr>
<tr>
<td>Pediatric, 7.7%</td>
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</tr>
</tbody>
</table>

(Source: NHS England)

The critical care unit is a combined level two and level three facility. Level two care is for patients who require pre-operative optimisation, extended post-operative care, or single organ support. Level three care is for patients who require advanced respiratory support or a minimum of two organ support.

The unit has a four bed ward area and two side rooms. The unit provides four level three beds and two level two beds but is able to flex to meet demand. The unit can provide six level three beds if required.

South Tyneside District Hospital was previously inspected in May 2015. All five domains were inspected and an overall rating of requires improvement was given. Safe, effective, responsive and well-led were rated as requires improvement, and caring was rated as good.

The main areas of concern from the last inspection in May 2015 and the actions the trust were told they must take were:

- Implement an escalation plan approved by operating theatre and critical care nursing and clinical leads that ensures that appropriate support systems are available on a timely basis if critical care patients are nursed in recovery room.
- Conduct a full environmental risk assessment for the Intensive Therapy / High Dependency Unit (ITU) and take action to mitigate the risks posed by lack of storage space.
- Implement dedicated pharmacy support for the intensive care unit.

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

All of the staff we spoke with told us they either had completed, or expected to complete, their mandatory training before the end of the current year.

Mandatory training courses for medical and nursing staff included information governance, fire safety, infection control, and health and safety.

The trust set a target of 90% for the completion of mandatory training. Information provided to us by the trust showed compliance was variable for nursing staff. For example, 89% of nurses had completed moving and handling patients training and 78% had completed medical devices awareness training. However, only 52% had completed fire safety and 41% had completed conflict awareness training.

Compliance was also variable for medical staff. For example, 100% of doctors had completed moving and handling training and 95% had completed medical devices training. However, 70% had completed fire safety and 70% had completed health and safety.

Staff told us the trust had made changes to the availability of training courses. Staff previously had the opportunity to complete the majority of their training on one day. This had changed and staff told us it was now difficult to find time to attend classroom-based sessions. Some staff told us they completed their online training in their own time, outside of working hours.

Nursing staff told us the trust held individual staff members training requirements and compliance on the trust electronic staff records (ESR) system. Staff received updates via email and the ward manager told us they maintained oversight of mandatory training data within the unit. They were aware that compliance in some modules was low and explained nurse staffing constraints meant it was difficult to release staff from the rota.

Safeguarding

Safeguarding training completion rates
(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust had up-to-date safeguarding adults and safeguarding children policies, and staff knew how to access them on the trust intranet.

Staff we spoke with could explain what actions they would take if they had concerns about an adult, child, or young person. In most cases, nurses told us they would notify the ward manager or senior nurse in the first instance.

Staff told us there was a significant focus upon safeguarding within the trust. The trust set a target of 90% for the completion of safeguarding training and the majority of nurses had already completed safeguarding children level two (89%). However, compliance with safeguarding adults level two training was only 19%.

The majority of medical staff (95%) had completed safeguarding children level two however; compliance for safeguarding adults was lower at 65%.

Cleanliness, infection control and hygiene
The unit was visibly clean. There were handwashing facilities at the entrance to the unit and we observed staff and visitors using them appropriately upon entering and leaving the ward. Antibacterial hand gel dispensers were also available at various locations within the unit and at each bedside.

We saw personal protective equipment was readily available for staff to use and we observed staff using it appropriately. We also observed staff adhering to ‘bare below the elbow’ guidance, in line with national good hygiene practice.

The unit had an Infection prevention and control (IPC) link nurse and staff told us their level of involvement within the unit was good. Nurses followed IPC pathways if there was a need for the respiratory isolation of a patient. Although space on the unit was limited, nurses would use one of the two side rooms.

There was a comprehensive daily cleaning checklist and we saw evidence of appropriately completed documentation.

IPC was part of the trust’s mandatory training programme and the current compliance rate for nurses and healthcare assistants was 44%. Compliance for medical staff was higher at 70%.

The unit recorded no cases of Clostridium difficile (C.diff), methicillin resistant Staphylococcus aureus (MRSA), and methicillin sensitive Staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection.

The IPC audit and surveillance group carried out IPC validation audits every month. The audit assessed hand hygiene, the use of personal protective equipment (PPE), peripheral venous catheter (PVC) insertion and ongoing care, and urethral catheter insertion plus ongoing care.

- Staff maintained 100% compliance for hand hygiene, PPE and urethral ongoing care between April and October 2017.
- Results from PVC insertion and ongoing care fluctuated slightly which meant the IPC team completed a re-audit. Results from the re-audit showed compliance had improved to from 80% and 98% to 94% and 100% respectively.

**Environment and equipment**

At the previous CQC inspection, we found there was a significant shortage of storage space. For example, staff used the relative interview room to store clinical fluids and equipment. We found more equipment located in corridors and at the main unit entrance, which created a fire risk. The main four-bedded area was also cramped and cluttered and the patient shower facilities were not fit for purpose.

We told the trust it must complete an environmental risk assessment. Prior to this visit, we reviewed the assessment, which presented a range of options to mitigate the risks. During this visit, we found the trust had made appropriate improvements by creating a new storage cupboard and a dedicated room for relatives. The trust had also improved the shower facilities for patients.

The main four-bedded area had not changed and space was limited around each bed. The environmental risk assessment identified options to improve space, such as the use of smaller trolleys and reducing the number of beds from four to three. However, although there was no immediate solution, which did not compromise patient safety, we did see evidence of appropriate assessments to mitigate the risks. This included moving equipment that was not required into the storage cupboard when necessary.
Equipment on the unit conformed to national Guidelines for the Provision of Intensive Care Services (GPICS). The clinical lead was the lead intensivist for equipment.

The trust’s medical devices department was responsible for the maintenance of all devices and equipment. All life support and high-risk medical devices were serviced according to manufacturer’s instructions. All medium and low risk devices were safety checked on an annual basis.

Equipment we checked had been safety tested. Staff we spoke with told us they knew who to contact if they needed to report any faults and felt confident the system was robust.

The unit’s resuscitation trolley held appropriate equipment, which was suitable for the needs of critically ill patients. Staff updated a daily log to confirm the resuscitation and emergency equipment check was completed. We reviewed the logs and found no omissions.

Assessing and responding to patient risk

We saw evidence demonstrating medical and nursing staff completed comprehensive risk assessments for patients, in line with national guidance.

The critical care outreach team worked with staff across the hospital and was available 24 hours a day, seven days a week. This meant staff were able to mitigate risks to deteriorating patients and ensure prompt escalation in the event of a transfer to the ITU.

The outreach team recorded activity levels every month. Between January and September 2017, the team reported 905 patient contacts. Of these, 55 resulted in internal transfers to ITU and 28 external transfers to other specialist units in the region.

When patients required transfer to other intensive care units in the region, clinicians followed local transfer guidelines agreed through the North of England Critical Care Network, in which there was a specific transfer group.

Practitioners continually assessed patients through observations and monitoring of vital signs. Nurses and clinicians agreed individual parameters for each patient and determined the frequency of the observations by the patient’s condition and/or treatment.

The Sepsis 6 care bundle, for the management of patients with presumed or confirmed sepsis, was included within the ITU care bundle.

We attended a medical handover. Clinicians discussed each patient, highlighting all known risks, to ensure safe transition of clinical care from night to day shift.

Senior clinicians explained the unit was in the process of implementing new local safety standards for invasive procedures (LocSSIPs). The purpose of the standards is to help NHS trusts provide safer care and reduce the number of patient safety incidents. We did not see evidence of any current guidance.

Nurse staffing

The trust did not provide any data on the establishment for nurses working within critical care. (Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Information provided by the trust showed the budgeted whole time equivalent (WTE) for the unit was 32.39 and the total number of nursing staff was currently 25.80. The current Band 5
establishment was budgeted at 12.38 WTE with 8.87 WTE contracted staff. For Band 6 nurses, the figures were 16.41 WTE and 13.81 WTE respectively. Two Band 5 nurses were currently working as Band 6 nurses, covering maternity leave. Senior nurses explained recruitment was ongoing and the unit had recently appointed an additional band 6 nurse.

The unit used the trust e-rostering system and planned for five registered nurses on shift during the day and night, supported by a healthcare assistant (HCA). However, the current establishment of HCAs was 1.59 WTE, which meant there were not enough HCAs to cover the night shift.

Although nurse staffing met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients, and one nurse to two patients ratio for level two patients, nurses told us the unit was short staffed on a regular basis.

When there were enough nurses on duty, they were deployed elsewhere within the trust to cover shortfalls in nurse staffing on other wards. This included nurses from the critical care outreach team. This meant the trust could not ensure deteriorating patients on general wards received the right level of care from the specialist outreach nurses during shifts when they were asked to work elsewhere.

The unit did not collect data on this and the ward manager was unable to account for the number of times nurses had been asked to cover other wards. This meant to ward manager and senior nurses could not determine the impact of requests to provide support to other wards on the unit.

Staff did not display the patient dependency or actual staffing figures within the unit

We reviewed the duty rota from the previous five weeks in August and September 2017. There were 21 occasions where the rota showed less than five nurses during the day, and eight occasions at night. Those shifts were covered using overtime and critical care trained agency staff.

Staff told us the agency staff were a regular cohort of nurses, who were all familiar with working on the unit. The nurse in charge of the shift completed an induction with agency staff new to the unit, although we did not see documented evidence of this.

The trust had made changes immediately prior to the inspection to the way it recruited agency staff and some nurses expressed concerns. All nurses wishing to cover additional shifts had to register with the new agency and staff did not feel the new system was robust. For example, a request for agency staff to cover shifts from the previous week had not been met. The ward manager explained they escalated the risk to senior nurses who took immediate action. The unit was now able to request agency nurses 72 hours prior to the actual shift instead of the original 24 hours. The ward manager believed this would have a positive impact on the unit.

Managers and senior nurses told us the alliance with a local NHS trust could help improve the provision of nurse staffing on the unit. Although managers were in the early stages of discussions, they felt confident there was an opportunity for critical care nurses from the other trust to support the unit where possible.

The Royal College of Nursing (RCN) and GPICS recommend one member of nursing staff should be supernumerary and external to the nurse rota. The ward manager confirmed the unit did not meet this standard, as they were part of the nurse rota. They did not have any dedicated time for management duties and were unable to fulfil other non-clinical responsibilities.

The trust was in the process of recruiting two Band 6 deputy ward managers. However, the ward manager told us both positions would be included in the main nurse rota. To maintain supernumerary status, the ward manager felt the unit would have to rely on covering shifts through overtime.
At the previous CQC inspection in May 2015, the unit did not have dedicated pharmacy support and we told the trust it must implement this. The trust had taken appropriate action and appointed one WTE Band 8a pharmacist and one WTE Band 7 for the unit. Healthcare assistants, physiotherapists, and dieticians also supported the unit.

**Vacancy rates**

Between August 2016 and July 2017, the trust reported a vacancy rate of 8% for nurses in Critical Care.

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

**Turnover rates**

Between July 2016 and June 2017, the trust reported a turnover rate of 2% for nurses in Critical Care.

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

**Sickness rates**

Between July 2016 and June 2017, the trust reported a sickness rate of 6% for nurses in Critical Care.

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

**Medical staffing**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data.

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

Critical care had a designated clinical lead consultant and, together with consultants in intensive care medicine, led patient care within the unit.

A consultant was present on the unit between 8.00am and 6.00pm every day. Between 5.30pm and 8.30am, a consultant was available on call while a dedicated ITU registrar was available on site. The unit always had access to a practitioner skilled in advanced airway technique.

There were six WTE consultants within the critical care unit, one of whom was a recent appointment. Information provided by the trust showed a team of 10 middle-grade doctors supported the unit; however, a senior clinician explained there should be 13 in total. There were no trainee doctors.

Doctors from the unit and experienced locum doctors provided additional cover when required. Although we did not see any documented evidence of competency assessments, clinicians told us locum doctors completed a local induction to the unit and had the relevant skills and experience.

We observed a morning medical handover and noted the use of standardised handover procedures.

We saw evidence in patient records that twice daily consultant-led ward rounds were completed, which was in line with GPICS standards.
Vacancy rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust was unable to provide the appropriate data.

Turnover rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

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

Information provided to us by the trust showed between October 2016 and September 2017, the trust reported a turnover rate of 11.8% for medical staff in critical care.

Sickness rates
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template

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

Information provided to us by the trust showed between October 2016 and September 2017, the trust reported a sickness rate of 3.2% for medical staff in critical care.

Bank and locum staff usage
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

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

The trust did not provide details about bank and locum usage for medical staff in critical care.

Records
We looked at four patient records and found they were accurate, complete, legible, and signed and dated by relevant clinicians. Medical and nursing staff completed all relevant documentation in line with national guidelines and professional standards.

Each record included evidence of a consultant review prior to admission to the unit and the time of the decision to admit. Clinicians also used formal handover documents for patients stepping down from critical care.

We also found clear evidence of fluid state and balance, and review of in-dwelling lines, which staff completed three times a day.

Staff recorded all observations, including the frequency and we saw evidence of patient risk assessments, care bundles, and documented discussions with patients and relatives

We saw evidence of pathways in use. Examples included ventilator associated pneumonia and central venous catheter insertion.

Evidence of the involvement of allied health professionals was documented in care records, for example, physiotherapists, dieticians and the specialist nurse for organ donation. When applicable, staff told us involvement from the mental health liaison practitioners was also included although we did not see evidence of this in the four records we viewed.
Patient notes were stored securely at the bedside and there had been no incidences of a confidentiality breach.

The unit did not undertake care record audits to monitor and review the quality of documentation. Information governance was part of the trust’s mandatory training programme and the current compliance rate for nurses and healthcare assistants was 63% and 60% for medical staff.

**Medicines**

Medicines were securely stored and handled safely. Storage cupboards and fridges were tidy and locked. Staff recorded and monitored the minimum and maximum fridge temperature appropriately and explained the procedure they followed if there was a problem. This meant that medications were stored at the appropriate temperature.

We looked at four prescription charts. Overall, staff completed the charts accurately and the writing was legible. Staff recorded the date and their signature.

Staff documented patients’ allergies and medication that was omitted or not administered had a documented reason. We also noted staff followed appropriate guidelines when prescribing antibiotics and to reduce the risk of venous thromboembolism prophylaxis.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were appropriately stored with access restricted to authorised staff.

Staff checked stock levels every week and we saw no gaps in the documentation.

The dedicated unit pharmacists participated in daily ward rounds and helped prepare patients for relevant interventions. The pharmacist had introduced new changes within the unit, such as updating the drug chart, as the chart previously used did not reflect current national standards.

Other initiatives introduced to ensure safe medicines management included antibiotic and prescribing audits. The pharmacist explained the purpose of the audits was to standardise practice across the unit and in line with national guidelines. The pharmacist had identified a lack of local medicines guidelines for the unit and was currently developing them.

The pharmacist produced comprehensive quarterly reports that included a summary of medicine incidents, antimicrobial use by product, plus the top 20 medicines by quantity and cost. Information provided by the trust showed staff had reported four medicine errors between October 2016 and September 2017.

**Incidents**

The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using an electronic risk management reporting system. Medical and nursing staff told us they felt confident reporting incidents and near misses. Senior managers were also confident staff reported incidents appropriately.

Senior and local managers received a notification of every reported incident and told us they were discussed informally on an ad-hoc basis and more formally in governance meetings. Incidents were delegated to the ward manager for investigation.

We spoke with the ward manager who confirmed they had received RCA training for pressure ulcers but acknowledged they did not have the time to review incidents or complete RCAs.
However, we reviewed three investigation reports completed by a matron, with support from medical staff where applicable. The report included a detailed review and all appropriate actions.

Although the majority of staff we spoke with could not recall the last time they had reported an incident, the unit had reported 42 incidents between October 2016 and October 2017. The majority of incidents caused minor harm or no harm (86%). The remaining incidents (14%) caused moderate harm, and we noted staff took appropriate action in all cases.

During periods of increased demand within the unit, some patients (level two and level three) were nursed on the theatre recovery ward. The trust escalation plan stated staff must report every occurrence as an incident. Information provided by the trust showed four incidents reported between October 2016 and October 2017. The critical care outreach team cared for patients in three out of the four incidents. On that occasion, a practitioner from the on-call theatre emergency team cared for the patient together with an operating department practitioner (OPD). Outreach nurses told us some incidences had not been reported due to time and staffing constraints.

Information provided by the trust showed staff had reported only six incidents documenting out of hours transfers between November 2016 and October 2017. GPICS standards stipulate any out of hour transfers from critical care areas to the general ward should be documented as an adverse incident.

The clinical lead consultant attended trust-wide Clinical Incident Review Group meetings, chaired by the medical director. However, staff were unable to give recent examples of any lessons learned from reported incidents.

The clinical director chaired ITU mortality and morbidity meetings every month, although medical staff acknowledged attendance was not as good as it could be. We saw evidence that clinicians reviewed cases and documented appropriate actions. For example, clinicians agreed to develop a new protocol to document procedures for checking the position of central lines.

Staff we spoke with understood the duty of candour requirements. 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. We heard examples demonstrating where staff had applied the principles although we did not see any documented evidence.

**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.

Between September 2016 and August 2017, the trust reported no incidents classified as never events for Critical Care.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported zero serious incidents (SIs) in Critical Care which met the reporting criteria set by NHS England between 01 September 2016 and 31 August 2017.

(Source: Strategic Executive Information System (STEIS))
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 no new pressure ulcers, one falls with harm and zero new catheter urinary tract infections between September 2016 and September 2017.

Is the service effective?

Evidence-based care and treatment

The trust used a combination of national guidelines to assess and treat the needs of critically ill patients. These included guidance produced by the National Institute for Health and Clinical Excellence (NICE), the Intensive Care Society and Faculty of Intensive Care Medicine. Examples of those we looked at included guidelines on the management of acute sepsis, central venous catheter insertion, care of arterial lines and ventilator-associated pneumonia care bundle.

However, the unit did not adhere to all national standards such as NICE clinical guidelines 83. Patients did not receive rehabilitation care after critical illness.

Clinical guidelines and policies were reviewed at trust-wide clinical policy and practice assurance group meetings. Although the group was scheduled to meet every two months, staff told us only two out of six meetings had taken place so far this year. Similarly, the clinical policy and practice approval sub-group, which met monthly, had only held two out of ten scheduled meetings.

Policies and guidelines were accessible on the trust intranet and there was a dedicated ‘Intensive Care Unit’ page.

However, we found the unit lacked guidelines that were ITU-specific. For example, weaning for ventilation, withdrawal or limitations of treatment, medication regimes, and management of delirium, plus safe care guidelines (nursing), and blood glucose management in critical care. Guidelines we did see included the management of critical care patients in recovery and a policy for the admission, ongoing care, and discharge of ITU patients. The ward manager and clinical lead were aware of this. The clinical lead explained they had plans to strengthen the process to ensure the availability of more effective guidelines.

Although we did see evidence of some audit activity, we found the unit did not have a comprehensive programme of clinical audits to support and monitor compliance. For example, we reviewed care bundle audits, which included central venous catheter (CVC), ventilator-associated pneumonia (VAP), premature ventricular contractions (PVC) and urinary catheter. Each care bundle required ten audits per month and, although overall outcomes were positive, we saw evidence the unit had only completed two or three in the most recent month. Further information provided to us by the trust demonstrated the unit did not meet the required level of compliance. This meant the unit was unable to assure itself that nursing staff were appropriately following evidence-based national guidelines.
One of the ITU consultants was the unit audit lead. Recent medical audits included mortality within 24 hours of admission to ITU and acid prophylaxis. Outcomes from an audit based upon intensive care unit delirium led to the introduction of a new policy. Junior doctors also participated in leading audits. One doctor told us a recent audit about documentation had resulted in a change to the way doctors recorded information about patients.

We looked at 10 completed evidence-based risk assessments, which were all in line with national guidance.

**Nutrition and hydration**

Staff assessed patient’s nutritional and hydration needs using the malnutrition universal screening tool (MUST).

We saw in care records evidence that staff measured, recorded and analysed fluid intake and output.

The unit had a protocol for feeding patients who were unable to eat and were being fed by a nasogastric tube. This meant there was no delay in the feeding of patients if a dietician was not available.

A dedicated dietician visited the unit daily. They supported patients with nasogastric tubes and there was evidence of nutritional assessment and advice recorded in patient records.

**Pain relief**

Staff assessed and monitored patients’ pain and their responses to pain relief through routine observations. During ward rounds and at handover meetings, staff discussed each patient and their pain relief requirements. Medication was adjusted appropriately and staff recorded updates in the patient’s care record.

We saw evidence of pain assessment tools in use and staff recorded pain scores in patient records. Staff also used visual aids to ensure they identified and managed the pain relief needs of patients effectively.

Consultants and specialist nurses supervised the pain management of patients. Staff had access to a dedicated pain management nurse for support and advice whenever they needed to.

**Patient outcomes**

The unit did not regularly review the effectiveness of care and treatment through local audit. Although the unit produced data to determine patient outcomes, medical and nursing staff told us they did not always have time to focus on quality improvement. The ward manager was not supernumerary and felt this contributed to their inability to fulfil management duties, such as audit and quality improvement.

The unit regularly provided data to the Intensive Care National Audit and Research Centre (ICNARC), in line with recommendations from the Faculty of Intensive Care Medicine Core Standards.

**ICNARC Participation**
The trust has one unit that contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2015/16 Annual Report. More recent quarterly data may be available via the evidence grids. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Hospital mortality (all patients)**

For the Intensive Therapy Unit at South Tyneside Hospital the risk adjusted hospital mortality ratio was 0.9 in 2015/16. This was within expectations. The figure in the 2014/15 annual report was one.

(Source: Intensive Care National Audit Research Centre (ICNARC))

**Hospital mortality (for low risk patients)**

For the Intensive Therapy Unit at South Tyneside Hospital the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.8. This was about the same as the England average. The figure in the 2014/15 annual report was 0.8.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Data from the 2016/17 North Of England Critical Care Network quality report showed the unit was just above the regional average for unplanned readmissions to ITU within 48 hours. Trust performance was 1.3% compared to the network unit average of 1.2%.

**Competent staff**

Between April 2016 and June 2017 67% of staff within Critical Care at the trust had received an appraisal compared to a trust target of 90%, this was a deterioration compared to the previous year’s performance of 77%. However, managers were confident all staff would receive an appraisal by the end of the current year.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

The majority of medical and nursing staff told us they had received an appraisal within the last 12 months. Staff told us they were satisfied with the quality of the appraisal process and felt their performance was managed appropriately. Nurse revalidation was included within the appraisal process.

The unit met the GPICS standard that a minimum of 50% of registered nursing staff is in possession of a post registration award in critical care nursing. The current level of compliance was 66% with one more nurse scheduled to attend the next course in 2018.

At the previous inspection, we told the trust it should ensure there is dedicated educational support for critical care staff. The trust had recently appointed a new dedicated clinical nurse educator who worked at the unit two days a week. Their initial tasks included reviewing the current educational status and qualifications of all staff in preparation for the implementation of a new educational strategy. However, as the nurse educator had only been in post for less than three months, we did not have sufficient evidence to determine the impact of this role in addressing our previous concern.
In addition, staff commented upon the lack of available training and development for nursing staff. Although staff spoke positively about the dedicated clinical nurse educator, they were concerned they would still only have a limited amount of time for additional training and development. Nurses felt the standardisation of shifts across the trust had a negative impact on staff working in the ITU. They told us the combination of long day shifts (13 hours) with early and late shifts meant they were restricted for time available to them.

New members of nursing staff received an induction onto the unit, were allocated a mentor, and had a six-week supernumerary period before joining the main nursing rota. Once new nurse were operational, they were allocated a ‘buddy’ and completed a competency framework. Nurses described the preceptorship programme as practice-based during which new members of staff received ‘on the job’ supervision.

**Multidisciplinary working**

Our observation of practice, review of records and discussions with staff confirmed effective multidisciplinary team (MDT) working practices were in place.

Medical and nursing staff worked closely together and with other allied healthcare professionals. The unit had dedicated dieticians, pharmacists, and physiotherapists, who all visited patients daily.

The unit also worked closely with the organ donation service. We spoke with a specialist nurse for organ donation who told us the unit regularly contacted them and the referral rate was consistent.

The trust had created clear criteria for people who would and who would not benefit from admission to the critical care unit. Medical and nursing staff told us this worked effectively and had reduced the number of inappropriate admissions to the unit. We were unable to review any specific data in relation to this as the trust advised us it does not routinely collect this information.

Staff described good handover procedures within the critical care team, and we observed this in practice.

The critical care outreach team described positive relationships with medical and nursing staff working in wards across the trust. The team had regular involvement with staff caring for patients on medical and surgical wards, to ensure patients were reviewed appropriately.

The team also provided specialist training for nursing staff on general wards to ensure they cared for patients effectively. For example, the lead nurse had delivered training in tracheostomy care.

We heard examples of good liaison with the mental health liaison service. Nurses told us they received regular support from the Deprivation of Liberty standards lead and from the psychiatric team.

**Seven-day services**

There was consultant presence on the unit at weekends and they provided on-support for the dedicated ITU middle-grade and nursing staff out of hours

In the four patient records we reviewed, consultants assessed all patients within 12 hours of their arrival at the hospital. There was also evidence of ongoing review and consultants reviewed patients at least twice every day.

Patients had access to diagnostic services, such as x-ray and computerised tomography (CT) scanning, 24 hours a day, seven days a week.
The critical care outreach team, nurses and senior healthcare support workers who had advanced practice skills, were available 24 hours a day, seven days a week. They provided a supportive role to medical and nursing staff on the wards when they were caring for deteriorating patients or supporting patients discharged from critical care.

Physiotherapists and dieticians provided a seven-day service and reviewed critical care patients every day.

There was a minimum of five days cover from the dedicated unit pharmacy team.

**Health promotion**

Although patients on the unit were critically ill, staff told us they tried to involve them, where possible, in monitoring their own health. However, staff acknowledged nursing staff on the general medical wards provided the majority of additional support, such as smoking cessation, following discharge from the unit.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

The trust had a policy that outlined roles and responsibilities in relation to consent for examination, treatment, or hospital post mortem. The policy was due for review in February 2018. Staff could access the policy plus further information about capacity on the trust intranet, and we saw reference material and guidance in a folder at the nurse’s station.

Staff demonstrated a good understanding of the issues around consent capacity and deprivation of liberty safeguards (DoLS) for patients in critical care. They told us they would speak to the nurse in charge or a member of the medical team if they had concerns.

We saw evidence practitioners completed capacity assessments.

Between July 2016 and August 2017, the unit had made 13 DoLS applications. Staff could articulate the process and one nurse gave an example of when the team had considered DoLS. The team liaised with the DoLS lead about their key concerns and they agreed a decision not to make an application.

Staff understood the issues around restraining patients. Staff gave examples of the use of chemical and physical restraint. In all appropriate cases, the unit involved colleagues from the mental health liaison or psychiatric team. One nurse demonstrated sensitivity when expressing concern over the comfort of a patient who was wearing hand restraints. They took steps to ensure the padded mittens were not too tight to cause discomfort, and not too loose to pose a risk to staff.

**Mental Capacity Act and Deprivation of Liberty training completion**

(Source: Trust Provider Information Return)

The trust set a target of 90% for the completion of mental capacity act and DoLS training. Information provided by the trust showed only 30% of nursing staff and had completed the mandatory training. However, although below target, compliance was higher for medical staff at 65%.
Is the service caring?

Compassionate care

All staff we spoke with were very passionate about their roles and were clearly dedicated to making sure critically ill patients received the best patient-centred care possible. Throughout our inspection, we observed medical and nursing staff delivering compassionate and sensitive care that met the needs of patients, and their families.

We observed members of staff who had a positive and friendly approach towards patients and families. Although some patients were not fully conscious, staff explained what they were doing and took the time to speak with them at an appropriate level of understanding.

Staff were sensitive to patients who were in physical pain and discomfort. We also observed practitioners liaising gently and compassionately with a family whose relative’s treatment had been withdrawn.

Information provided by the trust showed results from the most recent and only submission of the Friends and Family Test survey collated between October and December 2016. Feedback was positive with 100% of families likely or extremely likely to recommend the service.

Although space was limited in the four-bed ward area, staff protected the privacy and dignity of patients. One family we spoke with praised nursing and medical staff for the dignified way they met the personal needs of patients.

Feedback from patients who had completed patient questionnaires praised staff for meeting their spiritual needs. One person described the unit as ‘an excellent place to recover’ while another commented staff were very considerate to their needs.

Emotional support

Families told us they felt staff understood the impact the patient’s condition and treatment had on them. One relative told us staff constantly offered reassurances and support throughout the treatment process.

Medical and nursing staff kept families informed at every stage and relatives told us they felt empowered to ask questions. Families also felt very confident their relative was receiving the best care possible.

There was a named nurse for each patient. Staff told us this helped them to build strong relationships with families and provide emotional support.

Understanding and involvement of patients and those close to them

Families we spoke with felt well informed about their relative’s condition and treatment. Medical and nursing staff communicated with families openly and checked their understanding of the facts that they presented. Feedback from a relative questionnaire described nurses as ‘superb’ who answered all of their questions and ‘explained everything’.

Families told us they saw medical and nursing staff regularly. One family described a consultant as ‘amazing’ and told us they were constantly checking on the patient, keeping the family informed and involved.
The unit provided patient diaries that captured all of the pertinent details during their stay on the unit. Staff encouraged family and friends to contribute to the entries and patients (or a family member) received a copy upon discharge.

Following patient feedback, the unit had changed the visiting times on the unit to introduce a 'quiet time'. This meant a period during the day in which there were no medical or nursing interventions. Feedback from a relative described visiting times as ‘brilliant’ and described quiet time as ‘excellent’.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Guidelines for the Provision of Intensive Care Services (GPICS) state Level 3 critical care units should have access to a Regional Home Ventilation and weaning unit. The trust worked collaboratively with the local tertiary centre and there was an appropriate referral process to transfer patients when there was a need.

GPICS also state patients discharged from intensive care units (ICU) should have access to an ICU follow-up clinic, to facilitate patients’ ongoing treatment and provide emotional and psychological support.

The unit did not comply with NICE Clinical Guidelines 83 by providing rehabilitation after critical illness. The outreach lead nurse told us they had developed a rehabilitation plan and had discussed this with the clinical lead with the aim of providing rehabilitation support for patients.

Although the unit was small, staff could make temporary arrangements for relatives to stay overnight with a patient. Staff explained they usually arranged for a comfortable chair to be positioned by the bedside.

The unit pharmacist was a member of the North of England Critical Care pharmacy network and participated in network audits to ensure the unit met the needs of local people. For example, a recent development included standardising infusions on a regional level with other local hospital trusts.

The medical team was not currently represented at the North of England Critical Care Network. The network promoted collaborative working with colleagues from critical care units across the region, focusing on operational delivery and agreeing evidence-based pathways. Managers explained the chief operating officer had previously attended some network meetings. However, the senior management and medical team felt it was more appropriate for the unit clinical lead to attend. The clinical lead spoke positively about engaging with the network and involving the unit in future meetings and collaborative working to meet the needs of local people.

The directorate business manager had completed a business case to develop a new ITU to improve the environment and create additional space. Although this did not come to fruition, additional storage space was identified and provided.

**Meeting people’s individual needs**

At the previous CQC inspection in May 2015, we noted the shower facilities for level two patients were not fit for purpose. The trust had taken appropriate action and during this visit, we saw
evidence of improvement. The new purpose built wet-room was larger and included an emergency call button.

Physiotherapists attended patients every day. Although they primarily focused on respiratory care, practitioners told us they also focused on rehabilitation and mobilisation whenever possible.

Nursing staff told us there were appropriate arrangements if they needed to request an interpreter and information was available on the trust intranet.

There was a folder in the relative’s waiting room, which included appropriate information about the unit, specifically the environment, equipment, visiting arrangements, an explanation about different staff roles, the provision of food and drink, and car parking.

Other leaflets in the relative’s waiting room included information about organ donation, pressure ulcers, health care records and the Friends and Family Test survey.

We heard examples from staff when patients received additional support from the mental health liaison and psychiatric support teams.

A clinician and a nurse from the critical care outreach team accompanied patients who required transfer to another hospital.

Information provided by the trust showed there were no mixed-sex breaches reported between August 2016 and July 2017.

(Source: RPIR Mixed sex P55)

Equality and diversity was part of the trust’s mandatory training programme and the current compliance rates was 85% and 95% for nurses and healthcare assistants, and medical staff respectively.

Access and flow

Bed occupancy

Between September 2016 and August 2017, South Tyneside NHS Foundation Trust has seen adult bed occupancy rates similar to or lower than the England average. January 2017 saw the lowest bed occupancy rates for the entire reporting period however in the latest month August 2017 trust performance rose above the England average.

Adult Critical Care Bed occupancy rates, South Tyneside NHS Foundation Trust.

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)
The unit had a policy for the admission, ongoing care, and discharge of ITU patients, published in February 2015 and scheduled for review in February 2018. It included admission criteria and discharge arrangements. A consultant intensivist made the overall decision to admit a patient to the unit, in collaboration with the patient’s clinical consultant.

Managers and staff told us improvements in patient flow across the hospital had achieved a positive impact within ITU. The trust held three daily bed management meetings to manage patient flow. Managers told us ITU - specifically the number of beds, safe staffing, and the timeliness of discharge - was included in each discussion and we observed this in practice during the inspection.

Managers told us these meetings had been instrumental in improving patient flow and the head of nursing had held workshops with site managers to strengthen the process. Managers felt this had contributed to the reduction of inappropriate admissions to the unit.

In the four records we looked at, staff had recorded the time of the decision to admit the patient to the unit and all patients arrived within four hours. This was in line with the GPICS standard.

Information provided by the trust showed four elective surgical procedures were cancelled due to a lack of critical care beds between October 2016 and September 2017.

At the previous inspection, we found the trust did not have appropriate arrangements in place when critical care patients were nursed in theatre recovery. We told the trust it must ensure appropriate support systems were available on a timely basis. During this visit, we noted the trust had introduced a new escalation plan and standard operating procedure. Managers and staff spoke positively about the changes. The critical care outreach team now cared for critically ill patients on the recovery ward.

Delayed discharges

For the Intensive Therapy Unit at South Tyneside Hospital there were 2,196 available bed days. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 1.7%. This meant that the unit was not in the worst 5% of units nationally. The figure in the 2014/15 annual report was 2.8%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

In 2016/17, the percentage of bed days occupied by patients with discharge delayed more than eight hours was 0.9%. This was better than the North of England Critical Care Network unit average of 3.1%. The trust had also demonstrated improvement since 2014/15 and 2015/15 where the percentage was 2.8% and 1.7% respectively.

(Source: North of England Critical Care Network Quality Review 2016/17).

Non-clinical transfers

For the Intensive Therapy Unit at South Tyneside Hospital there were 237 admissions, of which 0.5% had a non-clinical transfer out of the unit. This unit was within expected limits compared to the England average. The figure in the 2014/15 annual report was 0.3%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

In 2016/17, the percentage of patients transferred for non-clinical reasons to a critical care unit in another hospital was 1.2%, an increase of 0.7% from the previous year. This was worse than the North of England Critical Care Network unit average of 0.3%.

(Source: North of England Critical Care Network Quality Review 2016/17)
Non-delayed out of hours discharges to the ward

For the Intensive Therapy Unit at South Tyneside Hospital 10.9% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This unit was worse than the England average. The figure in the 2014/15 annual report was 8%.

(Source: Intensive Care National Audit Research Centre (ICNARC))

In 2016/17, the percentage of non-delayed, out-of-hours discharges to the ward was 5.2%. Although this was still higher than the network’s unit average of 1.8%, the trust had made an improvement from the previous year (10.9%)

(Source: North of England Critical Care Network Quality Review 2016/17).

Information provided by the trust showed that between August 2016 and July 2017 there were 30 out of hour transfers for level two patients and 23 moves for level three patients.

(Source: RPIR P52, Moves at night).

Learning from complaints and concerns

The trust had a complaints policy, which was accessible to staff via the trust intranet. Staff knew what actions to take when concerns were raised and this included trying to resolve problems as they occurred.

Between August 2016 and July 2017 there were no formal complaints about critical care.

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

We did not see any information leaflets on the unit about how to make a complaint.

Is the service well-led?

Leadership

There was a lead consultant for the critical care unit and a clinical director, although the latter also held clinical responsibility for all of the other services within the surgical services directorate.

There were two matrons, working job-share, one of whom held overall responsibility for nursing within the critical care unit. The matron visited the unit daily and nursing staff told us they had a visible presence.

The ward manager was not supernumerary. This meant they did not have any dedicated non-clinical time to fulfil management duties, as they were part of the nursing rota, delivering care to patients.

Managers acknowledged succession planning was a challenge. To mitigate the risk, the matron was in the process of recruiting two Band 6 deputy ward managers.

Nursing and medical staff spoke positively about managers and clinical leadership within the unit. Although the ward manager was constrained by their inability to access non-clinical time, staff commented that leadership was strong and patient care remained the primary focus. Nurses told us the ward manager maintained an ‘open door’ policy, which meant staff were encouraged to seek advice or raise concerns about any issues.
The senior leadership team told us leadership and development was a key priority. Although positive progress had been made in other services in this directorate, such as theatres, managers acknowledged staffing constraints within critical care meant nurses were limited in terms of leadership development.

Vision and strategy

The unit did not currently have a clear vision or strategy. The recent alliance with a local NHS trust had introduced a series of clinical service reviews to identify new and innovative ways of delivering high quality care. Managers explained the service review of critical care was in its infancy and the strategic development of the unit would be included in overarching programme of clinical service reviews.

The business manager confirmed they had previously submitted a business plan highlighting a series of improvements to the current critical care unit. However, they acknowledged the clinical service review had now superseded that original proposal.

Culture

Staff told us they felt valued and respected by local managers, describing them as approachable and supportive.

Staff felt the unit had an open and transparent culture. The majority of staff had worked on the unit for many years and were an established team. Newer members of staff told us they sought information and advice from more experienced colleagues and this supported their learning on the unit.

Medical and nursing staff told us they felt safe to acknowledge when they had made a mistake and they felt safe to challenge each other and medical staff. There were no reports of bullying or harassment and staff worked together collaboratively.

Medical staff told us managers and senior clinicians promoted equality and diversity and staff felt they were treated equally.

Governance

Critical care sat within the Surgical Services directorate. Other services within this directorate included trauma and orthopaedics, endoscopy, theatres, maternity, and obstetrics and gynaecology.

The surgical services directorate had a good governance structure with clear lines of responsibility and accountability. A triumvirate leadership team, who maintained overall management responsibility for critical care, was composed of a clinical director, a business manager, and a head of nursing for surgical services. The clinical director and head of nursing reported directly to the executive board, and the business manager reported to the divisional director for all acute services.

The critical care ward manager and clinical lead reported to the matron and clinical director respectively.

The directorate leadership team demonstrated a clear commitment to ensuring governance within the directorate was robust. However, managers did acknowledge there had been challenges.
within critical care. For example, although managers felt the governance arrangements within the directorate were good, and the flow of information from ‘ward to board’ was effective, there was room for improvement within the critical care unit.

However, there were no local governance arrangements, at unit level, in the form of team or ward meetings. Information was cascaded informally through face-to-face discussions on the unit, during handover meetings or via email.

We reviewed the previous three months’ directorate clinical governance meetings and noted that there had been no representative from critical care at any of them. The ward manager told us they received the minutes via email and shared them with the wider team.

The medical director chaired monthly clinical incident review group meetings (CIRG) and the medical director chaired monthly mortality review meetings.

The clinical lead was in the process of re-establishing a critical care clinical delivery group meeting. This was a recommendation made by the North of England Critical Care Network in the last unit appraisal, which was undertaken in June 2013. It was not clear if the unit had met the recommendation at any time, however managers assured us this action would be delivered.

We did not see any evidence of a comprehensive programme of clinical audit.

**Management of risk, issues and performance**

There was one risk register for the whole directorate. In addition to critical care, clinical services within the directorate included surgery and maternity. The senior leadership team reviewed risks at divisional governance meetings and the directorate risk register fed into the overarching register for all acute services.

Previous risks that managers had addressed within critical care included the need for a clinical nurse educator and improvements to the unit environment. We saw evidence managers had completed risk forms, recorded in the trust-wide risk management system.

Managers acknowledged the range of services within the directorate was diverse which meant the risk register was quite challenging to review in its entirety at divisional governance meetings. They told us they were reviewing the current process to strengthen the management of risks within the directorate.

Managers acknowledged current issues and risks within critical care included the nurse staffing concerns and lack of supernumerary status for the ward manager. They also acknowledged the lack of unit representation at the North of England Critical Care Network meetings.

Other risks and issues which managers did not appear to recognise was the potential under-reporting of incidents, the inability of the ward manager to complete incident investigations and root cause analysis, and the lack of clinical audits and ITU-specific guidelines.

However, the lack of governance arrangements within clinical care meant managers did not review risks with staff at unit-level. The clinical lead confirmed they had never once reviewed the risk register for the unit.

Although staff within the unit felt managers listened to them if they had any concerns, we did not see evidence of a formal system in which critical care staff could discuss them or receive feedback about current risks. Managers acknowledged this was an issue due to the lack of unit governance or team meetings.
Information management

Staff we spoke with told us they were able to access the information they needed to ensure they provided safe and effective care to patients. This included general policies and standard operating procedures, which were available on the trust intranet.

The intranet was available to all staff and contained links to trust-wide policies, safeguarding information and contact details for colleagues within the trust. This meant staff could access advice and guidance easily. All staff we spoke with knew how to access the intranet and the information contained within.

Senior managers told us they had access to good information technology systems to monitor and improve care. The trust's information team provided data that meet their needs in the shape of performance scorecards. Managers had worked with analysts to develop intuitive tools to interrogate data.

The information accessed by managers was stored in line with data security standards, for example, confidential and personal information pertaining to staff was protected through the of smart cards, issued only to staff with line management responsibilities.

Engagement

We found limited evidence of engagement within the unit.

Staff told us managers did not actively engage with them, or involve them in decision-making, and staff did not feel their views were reflected in the planning and delivery of services.

Staff told us although they knew about the alliance with another local NHS trust; they did not receive regular updates. In addition, they felt information about the current series of clinical service reviews was limited. However, staff acknowledged the chief executive and director of nursing had recently visited the critical care team and asked for their thoughts about current issues within the unit.

Although the unit pharmacist and critical care outreach team attended critical care network meetings, there was a lack of engagement from the clinical lead or ward manager. Senior managers were aware of this and told us they planned to strengthen those links. The chief operating officer had previously attended meetings and managers realised that a more appropriate and direct link to the unit should be involved.

There was limited evidence of engagement with patients and families. Staff provided questionnaires to patients and relatives and although we saw ‘thank you’ cards, they were not on display and we found them in a corner by the main entrance.

On speaking with staff, we were not made aware of any suggestions from patients that had led to improvements in the service.

Learning, continuous improvement and innovation

Senior managers spoke positively about driving and encouraging innovation, learning and continuous improvement across all services within the directorate, including critical care.

Nurses told us local managers encouraged them to share their ideas and suggestions for service improvement. For example, one of the nurses suggested changing a routine task usually
performed by the evening staff to the morning shift. They felt this would improve the quality of the service they provided.

The unit provided specialist therapies. These included citrate anticoagulation for continuous renal replacement therapy for critically ill patients with acute kidney injury, and neutrally adjusted ventilatory assist (NAVA) ventilation therapy. NAVA ventilation therapy facilitated faster and safer weaning which meant reduced patients' length of stay and morbidity.

Staff we spoke with struggled to articulate recent evidence of learning, continuous improvement and innovation. The majority of nursing staff told us their main area of focus was caring for patients.
Mental health services

Wards for people with a learning disability or autism

Is the service safe?

Safe and clean care environments
Safety of the ward layout

Staff did regular risk assessments of the ward environment. Environmental risk assessments were in place but did not include a detailed ligature point assessment throughout the building. However, staff were aware of the ligature risks within the building.

The ward layout did not allow staff to observe all parts of ward. The corridors on the ward formed a square with activity rooms, toilets and bathroom in the central area. Leading from this there was a relaxation room, lounge, dining room and kitchen. The service also had a self-contained room which was laid out as a studio flat with bed, lounge area and beverage bay.

The building was equipped to support people with complex health needs including patients who used wheelchairs and required assistance to move around the ward. Ligature anchor points were present throughout the building and included ceiling hoist tracking and hospital style beds. Ligature anchor points had been identified in the environment and each patient had an individual risk assessment in relation to ligatures. The fixtures and fittings were designed to meet the needs of the people who used the service and appropriate risk assessments were in place to mitigate the risks. No patients using the service had been identified as being at risk of ligature due to their mental health needs.

The ward did not comply with guidance on eliminating mixed-sex accommodation. Respite care was provided to both men and women at this service. Patient’s privacy and dignity was maintained as all bedrooms were en-suite and patients were supported by staff to use the adapted bathroom.

Fire safety was reviewed regularly and alarm systems tested. The last fire drill was carried out in June 2017.

Over the 12 month period from 1 August 2016 to 31 July 2017 the trust reported no mixed sex accommodation breaches.

Although the trust reported no same sex accommodation breaches, there was no lounge designated for female patients only. The majority of patients were supported by staff to move around the ward and staff could use the rooms available to provide an environment which met the patient’s individual needs. Quieter areas such as the “flat” or activity rooms were used to support patients who preferred a less busy environment. Staff ensured that patient safety, privacy and dignity were supported during their time on the ward.

Staff had access to alarms and patients had access to a nurse call system within bathroom and toilets. Staff alarms were present in the office area and available to staff. At the time of the inspection staff were not using the alarms. We asked staff if they used alarms within the ward. Staff told us that alarms were available if needed and would be worn if a risk had been identified such as supporting a patient with challenging behaviour.
Maintenance, cleanliness and infection control

All ward areas were clean, had appropriate furniture and were well-maintained. The ward was cleaned and maintained by a third party organisation. The ward manager reported no current issues with the cleaning or maintenance arrangements that were in place. Maintenance issues were addressed promptly when reported.

Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. The domestic supervisor visited the ward regularly to monitor the cleanliness of the environment and support the cleaning team. The ward manager was able to discuss any concerns regarding the cleanliness of the ward with the supervisor. Cleaning products and equipment were stored appropriately in a designated room.

Staff adhered to infection to infection control principles and handwashing facilities were available throughout the ward.

For the most recent Patient-led assessments of the care environment (PLACE) assessment (2017), the location scored better than the similar trusts for all four aspects overall.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Core service(s) provided</th>
<th>Cleanliness</th>
<th>Condition appearance and maintenance</th>
<th>Dementia friendly</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Tyneside District Hospital</td>
<td>Acute Wards for LD &amp; Autism Community based mental health services for LD or Autism</td>
<td>99.42%</td>
<td>96.75%</td>
<td>82.59%</td>
<td>91.14%</td>
</tr>
<tr>
<td>Trust overall</td>
<td></td>
<td>99.40%</td>
<td>96.84%</td>
<td>83.19%</td>
<td>91.50%</td>
</tr>
<tr>
<td>England average (Mental health and learning disabilities)</td>
<td></td>
<td>98.4%</td>
<td>94.0</td>
<td>76.7%</td>
<td>82.6%</td>
</tr>
</tbody>
</table>

Clinic room and equipment

The ward had a clinic room which was used to store medication and clinical equipment. There was no examination couch or emergency equipment located in the clinic room. The only emergency equipment located on the ward was a defibrillator which was located in the central office area. The defibrillator was regularly checked and these checks were recorded. An ambulance would be called for any medical emergency that occurred on the ward.

Equipment used on the ward including ceiling track and mobile hoists, hospital beds and pressure relieving mattresses was regularly checked and kept clean. Equipment and medical devices were maintained through contracted arrangements held by the trust.

Safe staffing
Nursing staff

Patients admitted to the ward were supported by registered nurses and healthcare assistants. Staffing levels had been agreed by the management team with a registered nurse and three healthcare assistants during the day and a registered nurse and one healthcare assistant during the night. Staff could be supported during the day by a clinical lead and members of the community learning disability team. During the night there was no additional support available,
other than the staff on duty. Staff told us that they planned the shift carefully to ensure that they could support patients’ needs safely when only two staff were on shift.

The ward was staffed through a day (07:30 to 20:45) and night (20:00 to 07:40) shift system.

Planned respite bookings were adjusted to reflect the needs of patients on the ward at that time. Rather than increase staffing levels, bed occupancy would be varied to match the needs of the patients requiring additional care.

The service used bank staff who knew the ward where shifts needed to be covered. Bank staff were experienced learning disability staff who worked in the ward or learning disabilities community team. In the last year agency staff had not been used to cover shifts on the ward. Activities were planned around the individual needs of patients and there was no evidence that activities were cancelled as a result of staff shortages.

Nursing staff were present in the communal areas of the ward supporting patients during the inspection. Patients received one to one time from nursing staff during their stay to support their care needs. There were enough staff to support the needs of patients during the day. During the night we were concerned that if both staff were supporting a patient there was no other staff available to support other patients at that time.

**Definition**

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

<table>
<thead>
<tr>
<th>Substantive staff figures</th>
<th>Trust target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of substantive staff</td>
<td>At 30 June 2017</td>
</tr>
<tr>
<td>Total number of substantive staff leavers</td>
<td>1 July 2016 - 30 June 2017</td>
</tr>
<tr>
<td>Average WTE* leavers over 12 months (%)</td>
<td>1 July 2016 - 30 June 2017</td>
</tr>
</tbody>
</table>

**Vacancies and sickness**

| Total vacancies overall (excluding seconded staff) | At 30 July 2017 | 0.84 | N/A |
| Total vacancies overall (%) | At 30 July 2017 | 5% | 10% |
| Total permanent staff sickness overall (%) | Most recent month (30 June 2017) | 0% | 5% |
| | 1 July 2016 – 30 June 2017 | 3% | 5% |

**Establishment and vacancy (nurses and care assistants)**

| Establishment levels qualified nurses (WTE*) | At 30 July 2017 | 7 | N/A |
| Establishment levels nursing assistants (WTE*) | At 30 July 2017 | 11 | N/A |
| Number of vacancies, qualified nurses (WTE*) | At 30 July 2017 | 0.84 | N/A |
| Number of vacancies nursing assistants (WTE*) | At 30 July 2017 | 0 | N/A |
| Qualified nurse vacancy rate | At 30 July 2017 | 5% | 6% |
| Nursing assistant vacancy rate | At 30 July 2017 | 0 | 5% |

**Bank and agency Use**
Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses) | 1 August 2016 – 16 August 2017 | 83.42 (13%) | N/A
---|---|---|---
Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses) | 1 August 2016 – 16 August 2017 | 0(0%) | N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses) | 1 August 2016 – 16 August 2017 | 7 (1%) | N/A
Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 August 2016 – 16 August 2017 | 548.17 (87%) | N/A
Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants) | 1 August 2016 – 16 August 2017 | 0 (0%) | N/A
Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants) | 1 August 2016 – 16 August 2017 | 2 (0.3%) | N/A

*Whole-time Equivalent*

This core service reported an overall vacancy rate of 5% for registered nurses at 30 July 2017.

This core service reported an overall vacancy rate of 0% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 5% as of 30 July 2017.

<table>
<thead>
<tr>
<th>Registered nurses</th>
<th>Health care assistants</th>
<th>Overall staff figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancies</td>
<td>Establishment Vacancy rate (%)</td>
<td>Vacancies</td>
</tr>
<tr>
<td>LD – Elmville S Tyne</td>
<td>0.84</td>
<td>7</td>
</tr>
<tr>
<td>Trust total</td>
<td>96.1</td>
<td>1499.6</td>
</tr>
</tbody>
</table>

Between 1 August 2016 and 16 August 2017, bank staff filled 16% of shifts to cover sickness, absence or vacancy for qualified nurses.

In the same period, agency staff covered 0% of shifts for qualified nurses. 2% of shifts were unable to be filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Available shifts</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts NOT filled by bank or agency staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD – Elmville S Tyne</td>
<td>100</td>
<td>16 (16%)</td>
<td>0</td>
<td>2 (2%)</td>
</tr>
</tbody>
</table>

*Percentage of total shifts*

Between 1 August 2016 and 16 August 2017, 75% of shifts were filled by bank staff to cover sickness, absence or vacancy for nursing assistants.
In the same time period, agency staff covered 0% of shifts. 7% of shifts were unable to be filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Available shifts</th>
<th>Shifts filled by bank staff</th>
<th>Shifts filled by agency staff</th>
<th>Shifts NOT filled by bank or agency staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD – Elmville S Tyne</td>
<td>100</td>
<td>75 (75%)</td>
<td>0</td>
<td>7 (7%)</td>
</tr>
</tbody>
</table>

* Percentage of total shifts

This core service had one (6%) staff leaver between 1 July 2016 and 30 June 2017.

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Substantive staff (30 June 2017)</th>
<th>Substantive staff Leavers</th>
<th>Average % staff leavers</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD – Elmville S Tyne</td>
<td>16.24</td>
<td>1</td>
<td>6%</td>
</tr>
<tr>
<td>Core service total</td>
<td>16.24</td>
<td>1</td>
<td>6%</td>
</tr>
<tr>
<td>Trust Total</td>
<td>2464.76</td>
<td>286.76</td>
<td>12%</td>
</tr>
</tbody>
</table>

The sickness rate for this core service was 3% between 1 July 2016 and 30 June 2017. The most recent month’s data [30 June 2017] showed a sickness rate of 0%.

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Total % staff sickness (at latest month)</th>
<th>Ave % permanent staff sickness (over the past year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD – Elmville S Tyne</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Core service total</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Trust Total</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

The below table covers staff fill rates for registered nurses and care staff during June, July and August 2016.

Monkton Hospital had not enough registered nurses for night shifts in July 2016. Planned versus actual staffing levels for the other months were within levels.

Key:

![Key image]

<table>
<thead>
<tr>
<th>Day</th>
<th>Night</th>
<th>Day</th>
<th>Night</th>
<th>Day</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>Care staff</td>
<td>Nurses</td>
<td>Care staff</td>
<td>Nurses</td>
<td>Care staff</td>
</tr>
<tr>
<td>Monkton Hospital</td>
<td>August 2016</td>
<td>94.7%</td>
<td>98.5%</td>
<td>97.5%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>July 2016</td>
<td>98.0%</td>
<td>98.0%</td>
<td>100.4%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>June 2016</td>
<td>100.4%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There were no medical staff working as part of the staff team on the ward. A visiting GP attended the ward each week and wrote prescription charts to allow patients’ medication to be administered.
Patients were encouraged and supported to attend their own GP to meet their health needs. However, the visiting GP would see patients where there was any difficulty in accessing their own GP during their respite admission. There was no on call doctor available to support this service.

Staff had received and were up to date with most mandatory training and compliance was above the trust average for all courses.

The compliance for mandatory training courses at 30 June 2017 was 96%. Of the training courses listed three failed to achieve the trust target and of those, none failed to score below 75%.

The core service failed to meet the trust training targets for Health & Safety with 84%, Information governance with 89% and Infection control with 89%.

**Key:**

<table>
<thead>
<tr>
<th>Training course</th>
<th>This core service %</th>
<th>Trust target %</th>
<th>Trust-wide mandatory training total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fire-Annual</td>
<td>100%</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Health &amp; Safety</td>
<td>84%</td>
<td>90%</td>
<td>69%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>89%</td>
<td>90%</td>
<td>87%</td>
</tr>
<tr>
<td>Infection Control</td>
<td>89%</td>
<td>90%</td>
<td>72%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>100%</td>
<td>90%</td>
<td>76%</td>
</tr>
<tr>
<td>Manual Handling – People</td>
<td>100%</td>
<td>90%</td>
<td>91%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>100%</td>
<td>90%</td>
<td>81%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>100%</td>
<td>90%</td>
<td>88%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 1)</td>
<td>100%</td>
<td>90%</td>
<td>87%</td>
</tr>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>92%</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Mental Capacity Act Level 2</td>
<td>100%</td>
<td>90%</td>
<td>46%</td>
</tr>
<tr>
<td>Core Service Total %</td>
<td>96%</td>
<td>-</td>
<td>78%</td>
</tr>
</tbody>
</table>

**Assessing and managing risk to patients and staff**

**Assessment of patient risk**

Staff had carried out risk assessments for all patients using the service using a recognised tool. We reviewed four care records and found clear risk assessments which linked to appropriate care plans. Risk assessments were reviewed regularly and at the commencement of each admission discussion regarding changes to risk took place and the risk assessment would be updated to reflect the discussion.

**Management of patient risk**

Staff identified patient risks and took action to reduce these. For example, where patients were at risk of pressure ulcers, pressure relieving mattresses were provided to reduce this risk. Staff responded to changing risks, on each admission any changes in risks were identified and care plans were updated to reflect changes. Staff also used the environment to reduce risks for example allocating the studio flat to patients with autism who may become distressed in the main communal areas. This gave the option to the patient to use their own lounge area if they preferred.
Staff provided a level of observation that was appropriate to the needs of the patients using the service. Care plans provided guidance to staff on the needs of the client and the level of support and observation that was required to keep patients safe.

There was evidence of some restrictions within the ward. Bedroom doors were locked during the inspection. Staff told us that when bedrooms were not in use the doors were locked. The complex needs of the patients using the service meant that most patients required the support of staff to access their bedrooms and other areas of the ward. Where a patient could access their bedroom independently the bedroom would not be locked. Non-patient areas such as the kitchen, laundry room and clinic room were kept locked. The main door to the ward was also locked to prevent unauthorised access and exit. All except one patient who used the service had Deprivation of Liberty safeguards authorisations in place. The patient who was not safeguarded by a Deprivation of Liberty safeguards authorisation had been assessed as having the capacity to make a decision to attend respite, understood the level of supervision and support provided and that they could leave if they wished. Staff had agreed a plan with the patient for contact to be made with the patient’s family if they wished to leave so that they could be offered appropriate support to return home.

**Use of restrictive interventions**

Staff knew the patients well and understood their needs. Staff did not use physical restraint on the ward. Staff were trained in using minimal touch techniques to support patients. Where any form of physical restraint was used this would be recorded as an incident and a care plan put in place.

Rapid tranquillisation was not prescribed for patients using this service.

There was no use of seclusion or long term segregation on the ward.

**Safeguarding**

Staff had received safeguarding training and could describe how to raise a safeguarding concern following the local procedure. Advice and support was available to staff from the trust safeguarding named nurse. Staff had not made any safeguarding referrals in the past 12 months.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines about how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

**Safeguarding referral data was given at provider level only.**

South Tyneside NHS Foundation Trust has submitted details of two serious case reviews commenced or published in the last 12 months, however none relate to this core service.

**Staff access to essential information**

Staff used electronic care records. All information to inform patient care was accessible to staff. Access to records was controlled using username and password log in details. We found that
daily progress notes were recorded in a database which prevented changes following the record being made. However, risk assessments, care plans and other documents were stored in a format which allowed them to be altered with no audit trail. Some documents were completed on paper, such as body maps. These would be scanned onto the electronic record.

**Medicines management**

Staff followed policies and procedures to ensure that patients continued to receive their prescribed medication during their stay on the ward. Prior to a patient’s admission staff would request a written update of prescribed medication from the patient’s GP. Staff would check that the patient’s medicines chart reflected the written confirmation from the GP. Where there was a change in prescribed medicines or a new chart needed to be written the ward’s visiting GP would make the required amendments. Patients brought their own medication supplies from home to the ward on admission. Ward staff recorded the medication received and checked that it had not exceeded its expiry date. The label on the medication was checked to ensure that it belonged to the patient and that the dose matched the medicines chart. On discharge, a record of the medicines returned to carers or family was made.

Medicines charts were completed to show when medicines had been administered. We reviewed seven medicines charts and found there were some medicines charts that did not have the patient allergy status recorded. We brought this to the attention of the ward manager during the inspection so that it could be rectified.

**Track record on safety**

There were been no serious incidents on the ward in the past 12 months.

There had been 18 incidents reported on the electronic incident reporting system between May 2017 and October 2017 in this service.

**Reporting incidents and learning from when things go wrong**

Staff knew what incidents to report and how to report them. There were very low levels of incidents in the service. The trust provided incident data for the period May to October 2017. There were 17 incidents recording during this time, seven of which related to patient behaviour. Examples of incidents included patients attempting to bite and nip staff and pull the hair of staff members.

Staff understood the Duty of Candour and were open when things went wrong. This is a legal duty on hospital, community and mental health services to inform and apologise to patients if there have been mistakes made in their care that have led to significant harm. Duty of candour aims to help patients receive accurate, truthful information from health providers. Staff maintained positive relationships with patients’ carers and families and were able to discuss any incidents or concerns regarding patients. There had been no incidents on the ward which met the criteria for the formal duty of candour to apply.

The service manager had oversight of all reported incidents and all incidents were discussed within staff supervision, team meetings and at the monthly communication meetings. Safe care leads and clinical leads from each service attended these meetings to share information, including risk and incidents.

Serious incidents were subject to a rapid review, and any incidents resulting in moderate harm or above were escalated to the clinical incident review group. This group was chaired by the Medical Director. The clinical incident review group produced a quarterly briefing for all staff which included information on lessons learned across the trust.
Learning was identified following incidents and actions developed and monitored to ensure they were completed.

The Chief Coroner’s Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no ‘prevention of future death’ reports sent to South Tyneside NHS Foundation Trust relating to this core service.

### Is the service effective?

We reviewed four care records on inspection. We found that assessments were completed in a thorough and holistic way to inform the development of care plans prior to patients using the service. Assessments included the physical healthcare needs of patients. Carers and families were very involved in the assessment process due to the complex needs of the patients using this service. Patients using the service lived at home with their parents or families who provided their care when not accessing respite care on the ward.

Care plans reflected the assessed needs and risks of the patients and the care and support required during their admission to the ward for respite care.

At the start of each admission an update to the patient assessment was completed to reflect any changes in the patients’ needs since the previous admission. Any changes in need or risk were then reflected in the patient's plan of care for their admission.

**Best practice in treatment and care**

The service did not provide assessment and treatment for people with learning disabilities. The care and treatment provided by staff on the ward was a continuation of the care and treatment patients received at home from carers, families and visiting professionals.

Staff liaised with community and primary care services which patients accessed at home and developed care plans which supported their continued care and treatment during their admission to respite care.

Staff ensured that patients had good access to physical healthcare when needed. Where patients were receiving treatments or interventions from community services these services would visit the patients on the ward, if this was required, to continue a consistent approach to care.

Patients were supported and encouraged to continue to use their own GP during the stay. If this was not possible staff could arrange for the visiting GP to see the patient on the ward.

Staff met the patients’ needs for food and drink including any special dietary requirements. Staff used the information from assessment, including specialist assessment from speech and language therapists to develop care plans. These care plans took the form of placemats and were kept in the kitchen. Each plastic coated placemat had a photo of the patient, the foods they liked and disliked, any specific dietary requirements, how the patient liked to sit to eat their meal and any aids or support they required while eating.

The service provided respite care and therefore was not comparable to assessment and treatment services for people with learning disabilities.

There was limited evidence of participation in national or local audits.
This core service participated in one clinical audit as part of their clinical audit programme 2016.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Audit scope</th>
<th>Core service</th>
<th>Audit type</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elmville Short Break</td>
<td>Learning Disabilities, Mental Health &amp; Substance Misuse</td>
<td>Other</td>
<td>Integrated Audit</td>
<td>03/10/2016</td>
</tr>
</tbody>
</table>

**Skilled staff to deliver care**

The team was formed of a clinical lead nurse, registered nurses and healthcare assistants who provided care and treatment in line with the patient’s care plans. The service provided respite care for people with learning disabilities and complex needs. The service did not provide assessment and treatment services and therefore did not have a multi-disciplinary team on the ward. Staff in the service worked with the wider multi-disciplinary or multi-agency team who supported patients in their own homes. The ward did have a contracted GP who visited the ward weekly. The role of the GP was mainly to write in medicines record charts to allow patients to have their medicines administered by the registered nurses on the ward. If requested by ward staff, the GP would see patients during their visit.

Staff had the relevant experience and qualifications to meet the needs of patients who used this service.

New staff joining the service were provided with an induction into the service and the needs of the patients using the service.

Staff attended monthly team meetings.

The trust appraisal process supported staff to identify their learning needs and develop their skills and knowledge. Staff we spoke with confirmed that the process was meaningful to them and identified their personal learning and developmental needs.

The trust’s target rate for appraisal compliance is 90%. As at 30 June 2017, the overall appraisal rates for non-medical staff within this core service was 72%. At the time of inspection the ward manager confirmed that all staff had completed their appraisal.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD – Elmville S Tyne</td>
<td>18</td>
<td>13</td>
<td>72%</td>
</tr>
<tr>
<td>Core service total</td>
<td>18</td>
<td>13</td>
<td>72%</td>
</tr>
<tr>
<td>Trust wide</td>
<td>2739</td>
<td>1846</td>
<td>67%</td>
</tr>
</tbody>
</table>

Staff had regular supervision which provided an opportunity to reflect and learn from practice. This was monitored locally by the clinical lead and was offered every four to six weeks in line with policy. The clinical lead provided data which showed that this had been met and additional sessions had been offered to staff (69 sessions were required for the period April 2017 to October 2017 and 77 sessions had taken place).
Nursing clinical supervision was monitored by ward managers and team managers across services. It was delivered in various forms due to the diverse range of services provided by the Trust for example observed practice, one to one supervision, group supervision, peer supervision. Reflective discussions are also part of one to one meetings with managers which are held every eight weeks as a minimum, reflective discussions are also part of yearly appraisal and the NMC revalidation processes. Work was in progress to look at how compliance rates can be monitored across the trust via Divisional Governance processes. Peer clinical supervision was in place for safeguarding issues.

Caveat: there is no standard measure for clinical supervision and trusts collect the data in different ways, it’s important to understand the data they provide.

Staff were able to access additional training to meet their role. Staff had attended additional training such as communication, dementia and positive behaviour support training.

The trust had policies and procedures in place to support managers to address the poor performance of staff in the team where this was necessary.

Multi-disciplinary and interagency team work
Staff attended meetings regarding patients arranged by the wider multi-disciplinary or multi-agency team who supported the patient at home. The ward team had a good working relationship with the community learning disabilities team who were based in the same building as the ward. The clinical leads of both the ward and the community learning disabilities team shared an office in the community team base and had an understanding of each of the clinical areas, providing cover for each other when required.

Staff worked well together as a team to support patients. Handovers took place at the start of each shift. Information in relation to any changes in risks or needs were discussed for each patient.

Staff worked with other agencies in relation to the provision of respite care admissions.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice
Patients using this planned respite service were not detained under the Mental Health Act.

Good practice in applying the Mental Capacity Act
Staff had a good understanding of the principles of the Mental Capacity Act.

The trust had a Mental Capacity Act policy in place which included the Deprivation of Liberty safeguards.

As of 30 June 2017, 95% of the workforce in this core service had received training in the Mental Capacity Act Level 1 and Level 2 training. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff made Deprivation of Liberty safeguards applications when required and monitored the progress of applications. All the patients who used this service had Deprivation of Liberty Safeguards authorisations in place.

The trust told us that six Deprivation of Liberty Safeguard applications were made to the Local Authority for this core service between 31 July 2016 and 1 August 2017.
The greatest numbers of Deprivation of Liberty Safeguarding applications was made in April and May 2017 with two in each of those months.

<table>
<thead>
<tr>
<th></th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Oct 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
<th>Feb 17</th>
<th>Mar 17</th>
<th>Apr 17</th>
<th>May 17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications made</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Applications approved</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Patient’s capacity to make decisions was assessed and recorded appropriately in the care records and we saw evidence of best interests decisions documented. Where a patient had a limited ability to express their needs and wishes, people who knew the patient well were involved in decision making.

**Is the service caring?**

**Kindness, privacy, dignity, respect, compassion and support**

Staff were caring, respectful and responsive when interacting with patients. We observed staff interaction with patients and carers or family members on their admission for respite care and saw positive interaction and discussion regarding patients and any changes in need since their last respite care admission.

Staff knew patients well, understood their individual needs and were able to provide support to patients who had significant difficulties in communicating their needs, likes and dislikes.

Staff supported the privacy and dignity of patients through the care and treatment provided. Staff said that they would raise concerns about any abusive behaviour or attitudes towards patients.

The 2016 PLACE score for privacy, dignity and wellbeing at the core service location(s) scored better than similar organisations.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Core service(s) provided</th>
<th>Privacy, dignity and wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Tyneside District Hospital</td>
<td>Acute Wards for LD &amp; Autism</td>
<td>85.19%</td>
</tr>
<tr>
<td></td>
<td>Community based mental health services for LD or Autism</td>
<td></td>
</tr>
<tr>
<td>Trust overall</td>
<td></td>
<td>85.75%</td>
</tr>
<tr>
<td>England average (mental health and learning disabilities)</td>
<td></td>
<td>83.7%</td>
</tr>
</tbody>
</table>

**The involvement of people in the care they receive**

**Involvement of patients**

As part of the admission process staff gave patients, families and carers information about the ward which included how to contact the service and make a complaint. Patients, families and carers were welcomed on the ward at each admission by the staff team. Patients could bring personal belongings for their bedroom during their admission.
Staff communicated with patients in an appropriate way, following speech and language therapy recommendations where these were present.

Patients had access to advocacy services if and when this was required and staff were aware of how to contact the service.

Involvement of families and carers

Patients who used the service lived at home and were supported by families and carers. The service provided respite care to families to allow them to continue to provide care at home. As family members were the main carers for patients using the service they were involved in every aspect of the patients assessment, care planning and discussion regarding any changes to the patients’ needs at the start of each admission.

Regular contact was maintained between staff and families and support was offered where required.

The ward operated a “you said we did” system for feedback from patients, families and carer and to share what action had been taken as a result of the feedback.

Is the service responsive?

Service Planning

The ward provided a planned respite care service; two beds were available for unplanned respite care. However only patients already accessing planned respite are could access these unplanned respite beds. Unplanned respite was specifically provided to support carers and families who required additional support due to unexpected issues such as illness. The service offered did not provide respite care for people with learning disabilities who received their care from paid carers.

Access and discharge

The service offered an agreed level of respite care to patients during the year. The level of respite was based on the number of patients accessing the service and the number of available nights. The service had the ability to use two beds for unplanned respite care due to a temporary change in family or carer circumstances such as illness.

This service provided care to patients to provide families and carers with a respite break. The maximum length of stay for patients in this service was normally two weeks. This would be to allow families or carers to go on holiday. Planned respite stays were normally shorter than two weeks.

Discharge and transfers of care

Patients accessing the service were not discharged unless their needs were no longer appropriately met by the service.
Facilities that promote comfort, dignity and privacy
The 2016 PLACE score for ward food at the locations scored better than similar trusts.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Core service(s) provided</th>
<th>Ward food</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Tynedside District Hospital</td>
<td>Acute Wards for LD &amp; Autism Community based mental health services for LD or Autism</td>
<td>94.2%</td>
</tr>
<tr>
<td>Trust overall</td>
<td></td>
<td>94.56%</td>
</tr>
<tr>
<td>England average (mental health and learning disabilities)</td>
<td></td>
<td>89.7%</td>
</tr>
</tbody>
</table>

Patients’ engagement with the wider community
During their period of admission for respite care patients participated in a range of activities on the ward and in the local community. The ward had their own minibus to support access to activities such as the cinema, shops and restaurants. On the ward a range of activities was available including a fully equipped relaxation room, arts and crafts equipment and games.

Meeting the needs of all people who use the service
The ward was fully accessible to people with complex health needs including patients who used wheelchairs. Ceiling track hoists were available in most bedrooms and the bathroom. All rooms had en suite facilities. A mobile hoist was also available to assist with the safe transfer of patients in areas where ceiling track hoists were not available. Staff had received additional training in meeting people’s communication needs and used individualised communication aids with patients on the ward.

Patients had access to a garden area off the ward and this was paved to allow access to people in wheelchairs.

Listening to and learning from concerns and complaints
There had been no complaints received regarding this service during the period April 2017 to October 2017. Staff worked with patients to understand their likes and dislikes. Information on how to make a complaint was contained within the welcome pack that was provided at the initial assessment prior to using the service. The views and concerns of carers were sought at each admission for respite care and staff responded to these. Carers we spoke with said they knew how to make complaints and felt able to raise issues with ward staff.

The trust received compliments from carers and families. During the period April 2017 to October 2017 staff received 28 compliments regarding the service they provided.

Complaints and compliments were reviewed and monitored by the clinical lead within the service.
Is the service well led?

Leadership
Staff spoke very highly of managers within the service and senior managers within the trust. Staff were passionate about their role, the service and working for the trust. Staff supported one another and there was a strong team spirit within the service.

Staff were confident to raise any issues with managers within the service and felt their views were valued.

Staff were aware of the duty of candour policy but there had been no incidents that required this policy to be followed.

There were effective structures in place to support communication in the service, including regular team meetings and monthly communication meetings.

Vision and strategy
Staff knew the trust’s vision and values. These were displayed within the service. Staff told us they felt an affinity to the values and that these were embedded in their practice.

Staff knew the most senior managers within the service and told us these managers were visible and supportive. Staff spoke highly of the service manager.

Culture
Staff morale was good and they felt well supported. Staff sickness rates and vacancy levels were low.

Governance
There were effective governance arrangements in place. Staff received regular supervision and appraisal in line with trust policy and valued these sessions. Mandatory training compliance was high, with most training programmes meeting the trust compliance target.

Staff had a good understanding of incident reporting processes, although the service had low incident rates. There were good systems in place to share learning from incidents across the trust.

Staff had a good knowledge of the Mental Capacity Act and safeguarding procedures and applied these when appropriate.

Management of risk, issues and performance
The service had an operational risk register which was monitored and overseen by the service manager. There was a clear escalation process for higher level risks to be included on the trust risk register. Risk registers were routinely reviewed quarterly at divisional clinical governance meetings. There was a monthly communications meeting involving clinical leads at which risks were discussed. At the time of the inspection there were no operational risks identified. The service had a business continuity plan in place, to respond to unexpected and significant events.

Information management
Staff used electronic care records. All information to inform patient care was accessible to staff. Access to records was controlled using username and password log in details. We found that daily progress notes were recorded in a database which prevented changes following the record being made. However, risk assessments, care plans and other documents were stored in a format which allowed them to be altered with no audit trail. We felt this could lead to information
governance issues. We raised these issues with the trust, and were assured that an electronic case management system was being introduced across the trust. This system was due to be implemented in the service in February 2018.

**Engagement**
Staff had a good understanding of local services and the needs of patients. Staff ensured that relevant external services continued to provide to support to patients during their periods of respite on the unit.

### Community mental health services for people with a learning disability or autism

#### Facts and data about this service

<table>
<thead>
<tr>
<th>Location/site name</th>
<th>Team name</th>
<th>Number of clinics</th>
<th>Patient group (male, female, mixed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monkton Hall</td>
<td>Community Learning Disabilities Team, Entrance B, First Floor – NE32 5NN</td>
<td>TBC</td>
<td>Mixed</td>
</tr>
</tbody>
</table>

South Tyneside NHS Foundation Trust provides community mental health services for people with learning disability or autism. The service provides specialist multi-disciplinary assessment and intervention to individuals aged 18 and over with learning disabilities with complex health care needs. The team also provides advice and support to the individual, their carer(s) and other professionals.

This is the first time the Care Quality Commission has inspected this service.

#### Is the service safe?

**Safe and clean environment**
The premises we inspected were mainly used as an office and administration base for staff working in the service. Occasionally, patients were seen on the premises. There were no treatment rooms or equipment in the premises.

The premises were clean and well maintained. Infection prevention and control audits were carried out and we saw reviewed completed audits.

Offices and meeting rooms were located on the first floor of the building. Visitors to the premises used an intercom system to contact staff for access to the building. Staff had swipe cards to access the building. There was a lift to the first floor and ramp access throughout the building into offices, meeting rooms and toilet facilities.

Meeting rooms did not have alarms fitted. Staff told us that any patients seen in the building would be assessed to identify any risks. If patients were identified as being a risk to themselves or others, they would be seen in meeting rooms near the reception and clinical leads office.

Fire evacuation chairs were available at the fire exits in the building.
Staff displayed team structures and trust values in the building. NHS Property Services and the trust’s fire officer regularly visited the premises. There was no log of fire safety checks located on the premises. The trust provided a copy of the fire safety check log after the inspection and this confirmed that weekly checks were taking place. Fire extinguishers had all been serviced in July 2017. Electrical appliance checks had been carried out in March 2017.

Safe staffing

The staff team was multi-disciplinary, including learning disability nurses, physiotherapist and physiotherapy assistant, occupational therapists, speech and language therapists, an acute and primary care liaison worker, health care support workers and administration staff. The team had evolved from a nursing specific team to a multi-disciplinary team. Whilst no specific formula had been used, the development of the team to include a wide range of disciplines had been informed by patient need.

There were two nursing staff assigned to cover the duty system during service operating hours. These nurses were available to respond to any patient crisis or urgent issues.

Staffing levels were adequate to meet the needs of the service. Sickness rates were low and below the trust target of 5%. Bank and agency staff were not used. There were no vacancies.

Definition

Substantive – All filled allocated and funded posts.

Establishment – All posts allocated and funded (e.g. substantive + vacancies).

<table>
<thead>
<tr>
<th>Substantive staff figures</th>
<th>Trust target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of substantive staff</td>
<td>At 30 June 2017</td>
</tr>
<tr>
<td>Total number of substantive staff leavers</td>
<td>0</td>
</tr>
<tr>
<td>Average WTE* leavers over 12 months (%)</td>
<td>10.71%</td>
</tr>
<tr>
<td>Vacancies and sickness</td>
<td>At 30 July 2017</td>
</tr>
<tr>
<td>Total vacancies overall (excluding seconded staff)</td>
<td>0</td>
</tr>
<tr>
<td>Total permanent staff sickness overall (%)</td>
<td>Most recent month</td>
</tr>
<tr>
<td>Total permanent staff sickness overall (%)</td>
<td>1 August 2016–30 July 2017</td>
</tr>
<tr>
<td>Establishment and vacancy (nurses and care assistants)</td>
<td>At 30 July 2017</td>
</tr>
<tr>
<td>Establishment levels qualified nurses (WTE*)</td>
<td>0</td>
</tr>
<tr>
<td>Establishment levels nursing assistants (WTE*)</td>
<td>0</td>
</tr>
<tr>
<td>Number of vacancies, qualified nurses (WTE*)</td>
<td>0</td>
</tr>
<tr>
<td>Number of vacancies nursing assistants (WTE*)</td>
<td>0</td>
</tr>
<tr>
<td>Qualified nurse vacancy rate</td>
<td>At 30 July 2017</td>
</tr>
<tr>
<td>Nursing assistant vacancy rate</td>
<td>0%</td>
</tr>
</tbody>
</table>
Bank and agency Use

<table>
<thead>
<tr>
<th>Shifts bank staff filled to cover sickness, absence or vacancies (qualified nurses)</th>
<th>1 August 2016 – 16 August 2017</th>
<th>0</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shifts filled by agency staff to cover sickness, absence or vacancies (Qualified Nurses)</td>
<td>1 August 2016 – 16 August 2017</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Qualified Nurses)</td>
<td>1 August 2016 – 16 August 2017</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Shifts filled by bank staff to cover sickness, absence or vacancies (Nursing Assistants)</td>
<td>1 August 2016 – 16 August 2017</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Shifts filled by agency staff to cover sickness, absence or vacancies (Nursing Assistants)</td>
<td>1 August 2016 – 16 August 2017</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Shifts NOT filled by bank or agency staff where there is sickness, absence or vacancies (Nursing Assistants)</td>
<td>1 August 2016 – 16 August 2017</td>
<td>0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Whole-time Equivalent*

This core service reported an overall vacancy rate of 0% for registered nurses at 30 July 2017.

This core service reported an overall vacancy rate of 0% for registered nursing assistants.

This core service has reported a vacancy rate for all staff of 0% as of 30 July 2017.

<table>
<thead>
<tr>
<th>Team</th>
<th>Registered nurses</th>
<th>Health care assistants</th>
<th>Overall staff figures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vacancies</td>
<td>Establishment</td>
<td>Vacancy rate (%)</td>
</tr>
<tr>
<td>155</td>
<td>0</td>
<td>14.5</td>
<td>0%</td>
</tr>
<tr>
<td>931867</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community LD Team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust total</td>
<td>96.1</td>
<td>1499.6</td>
<td>6%</td>
</tr>
</tbody>
</table>

NB: All figures displayed are whole-time equivalents

Between 1 August 2016 and 16 August 2017, there was no bank and agency data for community learning disability services for either qualified nurses or nursing assistants.

The service had used agency staff to cover a period in 2016 when there had been no speech and language therapist in the team. The permanent speech and language clinical lead and assistant had been recruited in April 2017.
The service had one (10.7%) staff leaver between 1 July 2016 and 30 June 2017.

<table>
<thead>
<tr>
<th>Team</th>
<th>Substantive staff (30 June 2017)</th>
<th>Substantive staff Leavers</th>
<th>Average % staff leavers</th>
</tr>
</thead>
<tbody>
<tr>
<td>155 931867 LD - Community LD Team</td>
<td>23.26</td>
<td>1</td>
<td>10.71%</td>
</tr>
<tr>
<td>Trust Total</td>
<td>2464.76</td>
<td>286.76</td>
<td>12%</td>
</tr>
</tbody>
</table>

The sickness rate for this core service was 3% between 1 July 2016 and 30 June 2017. The most recent month’s data [30 June 2017] showed a sickness rate of 4%.

The service operated across five ‘hubs’, each attached to a GP practice. Sickness rates for the service were low, and any staff sickness was managed within the team. For example, if there was a member of staff from one of the hubs absent due to sickness or annual leave, this would be covered from staff within another hub.

<table>
<thead>
<tr>
<th>Team</th>
<th>Total % staff sickness (at latest month)</th>
<th>Ave % permanent staff sickness (over the past year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>155 931855 LD - Admin/Management Team</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>155 931856 LD OT Styne</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>155 931857 LD Physio Styne</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>155 931867 LD - Community LD Team</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Core service total</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Trust Total</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

We reviewed caseload data for April to October 2017. There were between 340-400 patients on caseload each month. Staff managed caseloads of 16-20 patients. Staff told us that caseloads were manageable and patients were assigned to ensure the most appropriate member of the team had oversight of patient needs and treatment plans. The service did not have a waiting list.

A consultant psychiatrist from the local mental health trust worked into the team. This meant that there was good and timely access to psychiatry support when required.

A consultant psychiatrist from the local mental health trust worked into the team. This meant that there was good and timely access to psychiatry support when required.

The compliance for mandatory training courses at 30 June 2017 was 94%. Of the training courses listed three failed to achieve the trust target of 90% and of those, none failed to score below 75%.

The core service failed to meet the trust training targets for Health & Safety with 89%, Information governance with 81% and Infection control with 85%.
Assessing and managing risk to patients and staff

Assessment of patient risk

We reviewed 12 patient care records and found comprehensive risk assessments in all records. Staff considered and assessed risk regularly and this process started at the referral stage. We saw that risk assessment had been carried out when patients entered the service and were regularly updated. The referral form for the service included questions on any known risk, including any risks to lone working.

Staff discussed all new referrals in the fortnightly referrals meeting, including risk levels.

The service did not have an electronic case management system. All patient information and assessments were completed using ‘Word’ documents and were stored on a shared drive for staff to access. Staff flagged up patients with known risks by changing the name of the folder on the shared drive to include the word ‘RISK’. There were two folders on the shared drive which were not highlighted ‘RISK’, despite lone working risks being identified for these patients. We were concerned that staff may not be fully aware of the risks associated to individual patients, particularly if they did not regularly work with those patients. We raised this with the trust, and were assured that an electronic case management system was being introduced across the trust. This system was due to be implemented in the community learning disabilities team in February 2018.

All patients were assessed for risks to lone workers. Staff were aware of the lone working policy and had a good understanding of personal safety protocols. There was an effective system in place to monitor the location of staff and ensure that staff returned safely from visiting patients at home or in other community venues.

The service did not have a waiting list. New referrals were allocated to staff caseloads within 24 hours of receipt.
Management of patient risk

All patients with known and identified risks had a risk management plan in place. Staff demonstrated a thorough understanding of patients including risks.

The service had a ‘duty’ system during operating hours. Two nursing staff were allocated to manage the ‘duty’ system each day. This meant that staff were available to respond to urgent issues and patient crisis. This included any sudden deterioration in patient’s physical or mental health.

Safeguarding

All staff had completed training in safeguarding adults and children. Staff demonstrated a thorough understanding of safeguarding protocols and procedures and made safeguarding referrals when appropriate.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines about how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

From January to August 2017, the service made seven safeguarding referrals.

Staff access to essential information

The service did not have an electronic case management system. Patient information and assessments were completed using ‘Word’ documents and were stored on a shared drive for staff to access. Staff flagged up patients with known risks by changing the name of the folder on the share drive to include the word ‘RISK’. We found two patients where risks had been identified with the folder name did not reflect this. We were concerned that staff may not be fully aware of the risks associated to individual patients, particularly if they did not regularly work with those patients.

Staff used a database to maintain progress notes for each patient. These entries could not be amended once they were on the system. We were concerned that changes to patient records and information stored on the ‘Word’ documents could be changed without appropriate audit or restrictions in place. We felt this could lead to information governance issues.

We raised these issues with the trust, and were assured that an electronic case management system was being introduced across the trust. This system was due to be implemented in the community learning disabilities team in February 2018.

Medicines management

The service did not store, transport or dispense medication. Some patients required depot medication which was administered by nursing staff within the team. Depot medication is a special preparation of medication, which is given by injection. The medication is slowly released into the
body over a number of weeks. This medication was stored at patient’s homes. Nursing staff occasionally provided flu vaccinations to patients. Patient’s GPs provided the vaccinations and nursing staff could administer these. There was a patient group direction in place for this.

**Track record on safety**

South Tyneside NHS Foundation Trust submitted details of two serious case reviews commenced or published in the last 12 months, however none relate to this core service.

**Reporting incidents and learning from when things go wrong**

Staff had a good understanding of how to report incidents and what type of things should be reported. There were very low levels of incidents in the service. The trust provided incident data for the period May to October 2017. There were eight incidents recording during this time. Given the small number of recorded incidents there were no particular themes.

Staff understood the duty of candour. This is a legal duty on hospital, community and mental health services to inform and apologise to patients if there have been mistakes made in their care that have led to significant harm. Duty of candour aims to help patients receive accurate, truthful information from health providers.

The service manager had oversight of all reported incidents and all incidents were discussed at the monthly communication meetings. Safe care leads and clinical leads from each service attended these meetings to share information, including risk and incidents.

Serious incidents were subject to a rapid review, and any incidents resulting in moderate harm or above were escalated to the clinical incident review group. This group was chaired by the Medical Director. The clinical incident review group produced a quarterly briefing for all staff which included information on lessons learned across the trust.

**Is the service effective?**

**Assessment of needs and planning of care**

We reviewed twelve patient care records and found detailed and comprehensive assessments completed in all cases. The comprehensive assessment was a three part document, with the first two parts completed at initial assessment for all patients. The third part of the assessment was discipline specific, and would be completed by the relevant member of staff (nurse, occupational therapist, speech and language therapist or physiotherapist).

Staff used a range of appropriate assessment tools, specific to their particular disciplines.

Nursing staff used:

- Adaptive Behaviour Assessment System
- Continence Assessment Tool
- Motivation Assessment Scale
- Functional Analysis of Problem Behaviour
- Psychiatric Assessment Schedule for Adults with Developmental Disabilities
- Glasgow Depression Scale
• Glasgow Anxiety Scale
• Dementia Assessment Checklist
• Assessment for Adults with Developmental Disabilities
• Assessment of Cognitive Deterioration in LD
• Dementia Learning Disabilities Questionnaire
• Disability Distress Assessment Tool
• Epilepsy Care Pathway/Assessment Tool
• Malnutrition Universal Screening Tool
• OCD Assessment
My Pain Profile
• Social/Sexual Awareness Assessment

Speech and language therapists used:
• Assessment of Comprehension and Expression
• British Picture Vocabulary Scale
• Test for the Reception of Grammar
• Clinical Evaluation of Language Fundamentals
• Test of Problem Solving
• Test of Pragmatic Language
• Derbyshire Language Screen

Occupational therapists used:
• Assessment of Motor Processing Skills
• Sensory Integration Inventory

Assessments were regularly reviewed and updated to reflect the changing needs of patients. We saw a range of profession-specific assessments within the patient records we reviewed.

All patients had intervention plans in place, which were reflective of their needs and risks. Intervention plans were personalised, and included the views of patients. We saw evidence that intervention plans had been reviewed and updated.

Staff had access to patient records, all of which were stored electronically.

Best practice in treatment and care

Staff delivered treatment in line with relevant national guidelines. The trust had a committee to monitor adherence to national institute for health and care excellence guidance. Any new guidance was cascaded to appropriate teams through the trust’s governance facilitator to the relevant business manager. A ‘gap’ analysis was carried out for each new piece of guidance to identify any changes needed in service delivery. From this, action plans were developed and monitored to ensure compliance.

Patients had access to psychological therapies when needed. This was provided by a clinical psychologist from the local mental health trust who worked into the service.

Staff were skilled in assessing the needs of patients, including physical health needs. Nursing staff carried out routine physical health checks including blood pressure and weight monitoring. Patients were supported to complete health action plans and attend annual health checks with GPs. Due to the structure of the team being based within ‘hubs’ in GP practices, links with primary
care professionals were strong. This meant that staff ensured that patient's physical health needs were identified and appropriate interventions put in place.

Staff had good insight into the wider needs of patients, and those identified as requiring support for housing, employment or benefit advice were referred into appropriate local services.

Staff used a variety of outcome monitoring tools. These included the Glasgow anxiety and depression scales, psychological therapies outcome scale and patient motivation assessment scale.

This core service participated in one clinical audit as part of their clinical audit programme 2016.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Audit scope</th>
<th>Core service</th>
<th>Audit type</th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Tyneside Community Learning Disabilities Team</td>
<td>Learning Disabilities, Mental Health &amp; Substance Misuse</td>
<td>Other</td>
<td>Integrated Audit</td>
<td>03/10/2016</td>
</tr>
</tbody>
</table>

We reviewed the audit schedule for 2017 and saw the following audits had been complete:

- infection prevention and control audit
- audit of cognitive assessment process

The service manager also carried out regular audits of the quality of patient records and carried our regular observed practice sessions with staff.

**Skilled staff to deliver care**

The multi-disciplinary nature of the team meant patients had direct access to speech and language therapy, occupational therapy and physiotherapy alongside nursing interventions. Clinical psychiatry and psychology input was provided by the mental health trust.

Patients with speech and language difficulties had communication assessments carried out and communication plans in place.

Staff were passionate about their roles and the service, and were experienced and qualified.

Staff told us they valued supervision sessions and staff from different disciplines had strong and effective peer networks in place. For example, the speech and language clinical lead was a member of the North East Speech and Language Therapy association. This provided peer support and opportunities to share effective practice.

The service manager provided management supervision for all clinical leads for each discipline. Clinical leads provided supervision for their own staff. The trust provided service level data for supervision compliance. Between April and September, 95 staff supervision session had been scheduled, 115 sessions actually took place. Staff told us they asked for additional sessions if they felt these were needed, and line managers were responsive to these requests.

The target rate for appraisal compliance is 90%. As at 30 June 2017, the overall appraisal rates for non-medical staff within this core service was 93%.

There were only two members of staff who had not completed appraisals. These had been scheduled to take place.

Compared to the previous year, the core service achieved 100% compliance for all teams.
<table>
<thead>
<tr>
<th>Team name</th>
<th>Total number of permanent non-medical staff requiring an appraisal</th>
<th>Total number of permanent non-medical staff who have had an appraisal</th>
<th>% appraisals</th>
</tr>
</thead>
<tbody>
<tr>
<td>155 931855 LD - Admin/Management Team</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>155 931856 LD OT Styne</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>155 931857 LD Physio Styne</td>
<td>2</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>155 931867 LD - Community LD Team</td>
<td>16</td>
<td>15</td>
<td>94%</td>
</tr>
<tr>
<td><strong>Core service total</strong></td>
<td><strong>27</strong></td>
<td><strong>25</strong></td>
<td><strong>93%</strong></td>
</tr>
<tr>
<td><strong>Trust wide</strong></td>
<td><strong>2739</strong></td>
<td><strong>1846</strong></td>
<td><strong>67%</strong></td>
</tr>
</tbody>
</table>

Nursing clinical supervision was monitored by the service manager. This was delivered in a variety of forms including observed practice, one to one supervision, group supervision, peer supervision. Reflective discussions were also part of one to one meetings with managers which were held every eight weeks as a minimum. Reflective discussions were also part of the annual appraisal and NMC revalidation processes. The trust was looking at processes to monitor clinical supervision compliance rates across the trust via Divisional Governance processes.

### Multidisciplinary and interagency team work

The team comprised of staff from a range of different disciplines including learning disability nurses, primary care liaison worker, occupational therapy, speech and language therapy, physiotherapy and administrative staff. Psychiatry and psychology input into the team was provided by the local mental health trust.

All staff spoke very highly of the joint working arrangements and communication processes within the team between different disciplines.

Staff from different disciplines had a mutual respect for one another and all disciplines were highly regarded.

Staff from all disciplines attended a fortnightly referrals meeting, where new referrals into the service were discussed.

We observed a multi-disciplinary team meeting which was attended by an occupational therapist, community nurse, patient advocate, support worker, social worker, consultant psychiatrist, clinical psychologist and the service manager. All staff contributed to discussions and conversations were respectful and professional.

Staff attended monthly team meetings. We reviewed minutes of these meetings and found they were well attended by staff. Issues discussed at team meetings included:

- Feedback from the communication meeting
- Sharing good practice
- Operational challenges
- Risk management and incidents
- Health and safety
- Feedback from learning disability mortality reviews
- Friends and family feedback
Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 30 June 2017, the trust had not provided data relating to Mental Health Act training. Staff told us that they had received training, but could not recall when this had happened. Staff were aware of Community Treatment Orders (CTO) and how they were implemented and care planned, although there were no patients on CTO at the time of the inspection.

We reviewed twelve patient care records. Consent to treatment was documented in all records we viewed.

Good practice in applying the Mental Capacity Act

As of 30 June 2017, all staff had received training in the Mental Capacity Act Level 1 and Level 2 training. The trust stated that this training is mandatory for all core services for inpatient and all community staff and renewed every three years.

Staff demonstrated a thorough knowledge of Mental Capacity Act and could describe the five statutory principles of the act. Staff gave examples of different situations in which they might assess capacity.

We reviewed twelve patient care records and found good examples of capacity assessments that had been carried out. These were well documented, along with best interest decision meetings where appropriate.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We observed interactions between staff and patients. Staff were kind, caring and compassionate towards patients at all times. Staff clearly had a good understanding of the needs of individual patients and used appropriate communication techniques.

We observed a multi-disciplinary meeting and a care programme approach meeting. Staff attending these meetings used respectful and positive language when talking about patients. Discussions were patient focused and took into account patient preferences where appropriate.

We spoke to two patients and six family members of people who used the service. Patients and carers told us that staff were friendly, caring and helpful.

Involvement in care

The involvement of people in the care they receive

We reviewed twelve patient care records. All patients had an individualised intervention plan. There was evidence of patient involvement in all intervention plans we reviewed. Staff developed easy-to-read and pictorial care plans for service users where appropriate.

Patients were encouraged to provide feedback on the service. There was a ‘you said we did’ board within the service. At the time of the inspection all of the comments on this board were positive. Staff had responded by saying they would continue to provide the service in the way
patients liked. We reviewed previous comments and responses from March to May 2017. The only negative comments from patients and carers were in relation to patients not wanting to be discharged from the service. Patients and carers completed friends and families questionnaires quarterly. We reviewed the responses from May and August 2017. All responses were very positive, with no negative comments from patients and carers.

We spoke with six family members and two patients. All said that they felt involved in key decisions about the care of their loved one. Family members told us that communication with staff from the service was very good and they could speak to staff when needed.

Most people had copies of care plans. One family member said they did not have a copy of their loved one’s care plan

Patients and family members told us they were very happy with the service provided and that staff knew patients well.

Is the service responsive?

Access and waiting times

The service had a target of 15 days for referral to assessment. The trust provided data for the period July to September 2107. During this period there had been 290 referrals to the service, of which 275 (95%) had been assessed within 15 days.

There was no target for assessment to treatment, as treatment commenced on the day of assessment.

New referrals were allocated to a member of the team within 24 hours of the referral being made.

The service operated between the hours of 8.30am to 5pm, Monday to Friday. Staff were flexible in their working hours and if necessary, patients could be seen outside of these times. Patient appointments were almost never cancelled and usually ran on time. The service operated a duty system during operating hours, which was staffed by two nurses. These nurses dealt with any patient crisis or urgent issues.

The service had a ‘difficult to engage’ policy, to support patients who found it difficult to engage with the service. Staff were proactive in offering alternative appointments, considering alternative venues for appointments, considering communication issues and support needs to maintain patients within the service. Missed appointments were monitored by staff and alternatives offered to patients. For patients who struggled to keep appointments, staff would telephone ahead of the appointment as a reminder to patients.

Facilities that promote comfort, dignity and privacy

The premises were primarily an office and administrative base for the service. Occasionally patients were seen on the premises. Interview and meeting rooms were clean and well maintained. There was no patient information on general display within the building. Staff had access to a range of information in a variety of formats, which would be printed out on request. We were concerned that patients and carers may be unaware of the range of information available, so may not be proactive in requesting information.
Speech and language therapists within the team had supported the development of specific information leaflets to meet patient needs. For example, staff had developed an easy read information leaflet on managing diabetes for a patient with this condition. Staff had access to interpreter services, but this was rarely needed.

**Meeting the needs of all people who use the service**
Most patient appointments took place within patient’s homes or other community venues. The service was located on the first floor of the building. There was a lift to access the service and all walkways through the premises were ramped to facilitate wheelchair access. The building had disabled access toilet facilities.

**Listening to and learning from concerns and complaints**
The trust provided complaints data between 1 August 2016 and 31 July 2017, however none listed were for the core service.

This core service received 68 compliments during the last 12 months which accounted for 3% of all compliments received by the trust as a whole.

Patients and carers we spoke with said they knew how to complain, but had never needed to do so. Staff understood the complaints procedure and how to deal with any complaints, although this was not something they often dealt with.

**Is the service well-led?**

**Leadership**
Staff spoke very highly of managers within the service and senior managers within the trust. All staff were passionate about their role, the team, the service and working for the trust. There was a genuine respect for colleagues from different disciplines. Staff were very supportive to one another and there was a strong team spirit within the service.

All staff felt valued and that they played an important role in the team.

Staff were confident to raise any issues with managers within the service and felt their views were valued.

Staff were aware of the duty of candour policy but there had been no incidents that required this policy to be followed.

There were effective structures in place to support communication in the service, including regular team meetings, fortnightly referral meetings and monthly communication meetings.

**Vision and strategy**
Staff were aware of the trust’s vision and values. These were displayed within the service. Staff told us they felt a natural affinity to the values and that these were embedded in their practice.

Staff knew the most senior managers within the service and told us these managers were visible and supportive. Staff spoke very highly of clinical leads and the service manager.
Culture
Staff morale was very high and people were proud to work for the service. Staff worked in a supportive team environment. Staff sickness rates were low and there were no vacancies.

Governance
There were effective governance arrangements in place. Staff received regular supervision and appraisal in line with trust policy and valued these sessions. Staff requested additional supervision sessions if necessary and these were supported by managers.

Mandatory training compliance was high, with most training programmes achieving 100% compliance.

Staff had a good understanding of incident reporting processes, although the service had low incident rates. There were good systems in place to share learning from incidents across the trust.

Staff had a thorough knowledge of the Mental Capacity Act and safeguarding procedures and applied these when appropriate.

Management of risk, issues and performance
The service had an operational risk register which was monitored and overseen by the service manager. There was a clear escalation process for higher level risks to be included on the trust risk register. Risk registers were routinely reviewed quarterly at divisional clinical governance meetings. There was a monthly communications meeting involving clinical leads at which risks were discussed. At the time of the inspection there were no operational risks identified. The service had a business continuity plan in place, to respond to unexpected and significant events.

Staff had a good understanding of the key performance indicators for the service. The service manager maintained a performance wall within the service, which provided information on:

- Compliments/complaints received
- Referral to assessment data
- Sickness absence
- Incident data
- Safeguarding referrals

Information management
There was no electronic patient case management system within the service. Staff recorded progress notes for each patient on an electronic database. All other documentation was saved electronically on a shared folder which staff had access to. We were concerned that these documents could be amended without any clear audit process in place. The trust was implementing an electronic case management system into the service in February 2018 which would resolve this issue.
Engagement

Staff had a good understanding of local services and signposted or referred patients where appropriate.

Learning, continuous improvement and innovation

Staff were committed to continually improving the service to meet the needs of patients. The service had been involved in a pilot project for bowel screening for patients with learning disabilities. A protocol for screening had been developed which incorporated the role of GPs and the community learning disability team to support patients to access and complete bowel screening. This project was being assessed by the learning disability network and an outcomes report was awaited.

Staff had also developed a screening tool and checklist to identify possible hearing difficulties within the patient group. Any issues resulted in a referral to audiology services. These developments supported patients in relation to their physical health needs.