

Northern Lincolnshire and Goole NHS Foundation Trust

Quality Report

Diana Princess of Wales Hospital
Scartho Road
Grimsby
Lincolnshire
DN33 2BA
Tel: 01472 874111
Website: www.nlg.nhs.uk

Date of inspection visit: 17 October, 22 - 25
November 2016 and 8 December 2016
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust

Inadequate



Are services at this trust safe?

Inadequate



Are services at this trust effective?

Requires improvement



Are services at this trust caring?

Good



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Inadequate



Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a follow-up inspection of Northern Lincolnshire and Goole NHS Foundation Trust from 22 to 25 November 2016 to confirm whether the trust had made improvements to its services since our last inspection, in October 2015. We also undertook unannounced inspections on 17 October and 8 December 2016.

To get to the heart of patients' experiences of care and treatment we always ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

When we last inspected this trust, in October 2015, we rated the trust overall as 'requires improvement'. We rated safe, effective, responsive, and well-led as 'requires improvement'. We rated caring as 'good'. Scunthorpe General Hospital was rated as 'inadequate' overall, Diana Princess of Wales Hospital was rated as 'requires improvement' overall and Goole District Hospital was rated 'good' overall. In community services community adult services was rated as 'requires improvement' overall, end of life care was rated as 'requires improvement' overall, children's and young people's services was rated as 'good' overall with safe rated as 'requires improvement' and dental services was rated as 'good' overall.

Following the inspection in October 2015 there were six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These were in relation to staffing, safe care and treatment, dignity and respect, premises and equipment, good governance and need for consent.

The trust sent us an action plan telling us how it would ensure that it had made improvements required in relation to these breaches of regulation. At this inspection we checked whether these actions had been completed.

In November 2016 we inspected:

- Diana Princess of Wales Hospital
- Scunthorpe General Hospital
- Community Adult Services – safe and well led domains

- Community end of life care services – effective, responsive and well led domains
- Community children and young people's services – safe domain

We did not inspect Goole District Hospital as the services provided at this hospital were rated as good in October 2015. We carried out a follow up inspection of community services and looked specifically at the domains that were rated as 'requires improvement' following the October 2015 inspection.

We rated Northern Lincolnshire and Goole NHS Foundation Trust as 'inadequate' overall. Safe and well led were rated as 'inadequate', effective and responsive were rated as 'requires improvement' and caring was rated as 'good'. We rated Scunthorpe General Hospital as 'inadequate' overall. We rated Diana Princess of Wales Hospital as 'requires improvement' overall. We rated community services as 'good'.

Key Findings:

- There was insufficient management oversight and governance at Board, senior and middle management levels, of the identified risks and performance of the trust that has resulted in reoccurrence of patient backlogs and a deteriorating overall position with regard to referral to treatment times and patients waiting for follow up outpatient appointments and diagnostic tests in endoscopy.
- The trust had a Board Assurance Framework (BAF) and a corporate risk register in place, there were concerns that the risks recorded remained on the BAF for prolonged periods of time even after mitigations had been put into place. There were 24 risks recorded on the BAF of which many were rated as amber. There were concerns that the right assurances were not in place.
- There were concerns regarding the capacity and capability of the divisional management teams specifically with regard to the recognition, recording and mitigation of risks within the core services and ensuring timely action to address risks.
- We found poor leadership and oversight in a number of services, notably maternity services and urgent care. In these services leaders had not led and managed

Summary of findings

required service improvements robustly or effectively. In addition service leads had tolerated high levels of risks to quality and safety without taking appropriate and timely action to address them.

- There was some improvement in strengthening of governance processes across the trust. However, there were gaps in how outcomes and actions from audit of clinical practice were used to monitor quality in some services.
- Nursing and medical staffing had improved in some areas since the last inspection. However, there were still a number of nursing and medical staffing vacancies throughout the trust, staff turnover in some areas were particularly high especially in medical care, emergency departments, surgical services, and services for children and young people.
- The trust had systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care. However, a number of registered nurse shifts remained unfilled despite these escalation processes and we saw examples of wards not meeting planned staffing levels and high patient acuity not identified appropriately.
- There had been a lack of improvement since the inspection in 2015, areas of concern had not been fully addressed in a sustained way and there had been deterioration in a number of services. Safety processes were not always adhered to in some services.
- Assessing and responding to patient risk was inconsistent and did not support early identification of deterioration. This was particularly evident in the Emergency Department (ED) at Scunthorpe General Hospital (SGH), where the national early warning scores (NEWS) were not recorded in the majority of records we reviewed and in maternity services.
- Paediatric Early Warning Score (PEWS) was not in use in the ED at SGH and although used at DPoW, had not been consistently completed, following a review of records. We were not assured that the identification and escalation of deterioration in a child's condition would be recognised.
- The standard of documentation was variable, for example in ED across both sites we reviewed a total of 56 sets of patients' records (37 adults and 19 children) fully and found completion of documentation was variable and at times inadequate to ensure delivery of safe care.
- We found poor infection prevention and control processes and standards of cleanliness in the ED at SGH. Mandatory training rates in infection control were variable across the trust with low rates in the area where concerns were identified.
- In 2015, we said that the trust must ensure there is an effective process for providing consistent feedback and learning from incidents. During this inspection learning from incidents remained inconsistent and variable between directorates. Staff we spoke to, reported a varying standard of feedback and learning from incidents.
- We found inconsistent practice with regard to resuscitation trolley checks, fridge temperature checks and medication checks, across the trust.
- The trust had significant access and flow issues which had not changed since the inspection in 2015. The trust performance with referral to treatment times and management of capacity and demand had shown either no or minimal improvement since 2015. The trust was not meeting the 4-hour waiting time target in ED.
- Patient flow through the hospital remained an issue with a significant number of patients cared for on non-medical or non-speciality wards. A 'buddy ward' system was in place, however there was still confusion regarding which consultant should review which patient. Patients who were moved more than once could be under the care of different consultants during their stay in hospital.
- Not all management teams had a detailed understanding of the performance data, an ability to plan capacity to meet demands on services or credible recovery plans that would address the areas of concern.
- In 2015, we raised concerns regarding the numbers and reporting processes of mixed sex breaches. The trust had updated the policy for eliminating mixed sex accommodation, which was in line with Department of Health guidance (November 2010). However, the trust has continued to report mixed sex breaches in a number of core services. For example in medicine at Scunthorpe 14 mixed sex breaches had been reported.
- The trust participated in national and local audit programmes however trust performance was mixed

Summary of findings

across most of the core services with many showing performance that was worse than England averages. There was also variation in patient outcomes between the two hospital sites.

- The endoscopy unit had lost their Joint Accreditation Group (JAG) accreditation in August 2016 due to an audit that was not submitted within the necessary timescales and communication issues.
- In maternity services we had concerns regarding the completion of the K2 training package (an interactive computer based training system that covered CTG interpretation and fetal monitoring) for midwives and medical staff in maternity.
- Concerns remained regarding the organisational culture. There were a number of themes that emerged from discussions with staff relating to there still being a disconnection between the executive team and staff, there was a sense of fear amongst some staff groups regarding repercussions of raising concerns and bullying and harassment. Feedback from management teams had a more positive focus.

However,

- The hospital-level mortality indicator (SHMI) statistics from July 2015 to June 2016 showed that the SHMI remains in the 'as expected' banding with a figure of 110.
- The trust had taken action in some areas since the 2015 inspection, for example the trust had stopped using Band 4 nurses awaiting professional registration numbers within the registered nurse establishment.
- Improvements had been made across the community services for adults, children and young people's services and end of life care. There were robust safeguarding processes in place for both adults and children in community services.
- We saw pathways in place that complied with the National Institute for Health and Care Excellence (NICE) guidelines, professional and local guidelines.
- New roles had been developed including Assistant Nurse Practitioners and Acute Care Physicians.
- There were improvements in critical care services, there was a clear vision and governance processes were effective.
- There was a new management team in surgery that were able to demonstrate an understanding of the

challenges and the areas that required further improvement. They had only recently come into post and had not had sufficient time to implement the changes required to address the ongoing concerns.

- There were improvements in the ophthalmology service specifically with regard to the cancellation of clinics and clinical oversight of this process.
- The trust was in the process of expanding the nursing teams for people living with dementia and who had learning disabilities.
- Overall we observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful. Staff responded compassionately to pain, discomfort and emotional distress in a timely and appropriate way.

We saw areas of good practice:

- There was a new initiative called the virtual ward. Two health care assistants were available all day Sunday to Friday and half days on Saturdays. They were deployed to an elderly medical ward at the start of their shift, and then re-deployed to any area with short notice absence or where one to one patient care was required.
- A online call service run by the infant feeding co-ordinator was being offered to support breast feeding mothers within the community setting.
- The development of Advanced Midwifery Practitioners and Advanced Nurse Practitioners in gynaecology.
- There was a dedicated member of staff to manage interpretation and translation services which also included British Sign Language based at the Diana Princess of Wales hospital (DPoW).
- The trust had started to use "John's campaign" which was being trialled on four wards.
- A member of the speech and language therapy staff had received a Health Service Journal award for innovative work on voice banks.
- Podiatry services had developed training sessions for patients to care for their own feet if this was considered appropriate. Patients were discharged if this was successful and waiting lists had fallen. We were told that there was to be a cross site review of podiatry services to improve patient access.

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

Summary of findings

- The trust must ensure that appropriate numbers of staff, both medical and nursing, are available in line with national guidance and patient acuity and dependency, specifically within surgery, medicine, maternity, and to meet the needs of children and young people being cared for, on both the paediatric wards and in ED.
- The trust must improve the numbers of all staff receiving an annual appraisal and supervision, especially in children's wards, surgical areas and the ED, and the actions identified in the appraisals are acted upon.
- The trust must ensure that the service risk registers are regularly reviewed, updated and include all relevant risks to the service.
- The trust must monitor and address mixed sex accommodation breaches.
- The trust must continue to improve its paediatric early warning score (PEWS) system to ensure timely assessment and response for children and young people using services.
- The trust must ensure that, following serious incidents or never events, root causes and lessons learned are identified and shared with staff, especially within maternity and surgery.
- The trust must ensure that effective processes are in place to enable access to theatres out of hours, including obstetric theatres, and that all cases are clinically prioritised appropriately.
- The trust must ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist is implemented consistently especially within maternity and surgery.
- The trust must ensure there are effective planning, management oversight and governance processes in place, especially within maternity, ED and outpatients. This includes ensuring effective systems to implement, record and monitor the flow of patients through ED, outpatients and diagnostic services.
- The trust must ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medication are checked on a daily basis in line with the trust's policy.
- The trust must ensure that there are effective processes in place to support staff and that staff are

trained in the recognition of safeguarding concerns including all staff caring for children and young people receiving the appropriate level of safeguarding training and in outpatient services.

- The trust must ensure that actions are taken so enable staff to raise concerns without fear of negative repercussions.
- The trust must ensure that a patient's capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the Mental Capacity Act (2005).
- The trust must ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies.

Emergency and Urgent Care

- The trust must ensure that there are the appropriate systems in place to maintain the cleanliness of the ED at SGH to prevent the spread of infections.
- The trust must ensure that effective timely assessment and/or escalation processes are in place, including the use of the National Early Warning Score (NEWS) system, so that patients' safety and care is not put at risk, especially within ED.
- The trust must ensure that timely initial assessment of patients arriving at the ED takes place and that the related nationally reported data is accurate.
- The trust must ensure that ambulance staff are able to promptly register and handover patients on arrival at the ED.
- The trust must ensure that patients are assessed for pain relief; appropriate action is taken and recorded within the patients' notes.
- The trust must ensure that patients in ED receive the appropriate nursing care to meet their basic needs, such as pressure area care and being offered adequate nutrition and hydration and, that this is audited.
- The trust must ensure the checking of controlled drugs and the safe storage of medications used by the 'streaming' nurse in ED at DPoW hospital are in line with trust policy.

Critical Care

- The trust must audit compliance with NICE CG83 rehabilitation after critical illness and act on the results.

Summary of findings

- The trust must review and reduce the number of non-clinical transfers from ICU.

Maternity

- The trust must take steps to ensure that appropriate numbers of suitably qualified and experienced midwifery staff and medical staff are available to meet the needs of women being cared for by the service.
- The trust must ensure that labour ward coordinators are supernumerary.
- The trust must ensure that effective timely assessment and/or escalation processes are in place, including the use of the Modified Early Obstetric Warning Score (MEOWS).
- The trust must continue to improve obstetric skills and drills training among medical staff working in obstetrics.
- The trust must continue to improve midwifery and medical staff competencies in the recognition and timely response to abnormalities in cardiotocography (CTGs) including the use of 'Fresh eyes'.

Children and Young People's Service

- The trust must ensure the number of staff who have received training in advanced paediatric life support, is in line with national guidance and the trust's own target.

Outpatients and Diagnostic Imaging

- The trust must complete the clinical validation of all outpatient backlogs and continue to address those backlogs, prioritised according to clinical need.
- The trust must continue to take action to reduce the rates of patients who do not attend (DNA).
- The trust must continue to take action to reduce the numbers of cancelled clinics.
- The trust must continue to strengthen the oversight, monitoring and management of outpatient bookings and waiting lists to protect patients from the risks of delayed or inappropriate care and treatment.
- The trust must continue to work with partners to address referral to treatment times and improve capacity and demand planning to ensure services meet the needs of the local population.

There were also areas of poor practice where the trust should make improvements, which are detailed at the end of this report.

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Northern Lincolnshire and Goole NHS Foundation Trust

The trust provides acute hospital services and community services to a population of more than 350,000 people across North and North East Lincolnshire and East Riding of Yorkshire. Its annual budget is around £330 million, and it has 886 beds across three hospitals: Diana Princess of Wales Hospital and Scunthorpe General Hospital (each based in Lincolnshire) and Goole & District Hospital (based in East Riding of Yorkshire). The trust employs 5,364 members of staff.

We completed an inspection of the trust 22 - 25 November 2016, which included a review of progress made on the previous inspections in October 2015 and April 2014. We also carried out unannounced inspections on 17 October 2016 and 8 December 2016. We inspected all core services at both Diana Princess of Wales Hospital and Scunthorpe General Hospital. We carried out a focused inspection of the community services that had previously been rated as requires improvement in 2015. Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We did not inspect Goole and District Hospital. The trust had been inspected a number of times previously and a summary of the regulatory breaches is provided below.

We inspected the trust from 13 - 16 October 2015 and performed an unannounced inspection on 6 November 2015 and 5 January 2016. This inspection was to review and rate the trust's community services for the first time using the Care Quality Commission's (CQC) new methodology for comprehensive inspections. The acute hospitals had been inspected under the new methodology in April 2014. We therefore carried out a focussed inspection of the core services that had previously been rated as inadequate or requires improvement. Due to additional information the inspection team also inspected maternity services and caring across the core services included this inspection. We did not inspect children and young people's services

or end of life services within the hospitals. Additionally not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

Overall, in 2015, we rated the trust as requires improvement with DPoW hospital rated as requires improvement, SGH rated as inadequate and community services as requires improvement. The Trust was found in breach of the Health and Social Care Act (Regulated Activities) regulations 2014. These included: Regulation 10 (Dignity and respect), Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment), Regulation 15 (Premises and equipment), Regulation 17 (Good governance) and Regulation 18 (Staffing).

CQC carried out a comprehensive inspection 23 - 25 April and 8 May 2014 because the Northern Lincolnshire and Goole NHS Foundation Trust was placed in high-risk band 1 in CQC's intelligent monitoring system. The trust was also one of 14 trusts, which were subject to a Sir Bruce Keogh (the Medical Director for NHS England) investigation in June 2013, as part of the review of high mortality figures across trusts in England. Overall, Scunthorpe hospital was found to require improvement, although CQC rated it as good in terms of having caring staff.

At the comprehensive inspection in April 2014, DPoW hospital and Scunthorpe hospital were found in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Regulations 9 (care and welfare); 10 (governance); 22 (staffing) and; 23 (staff support). Additionally Scunthorpe hospital was also found in breach of regulation 15 (premises). CQC set compliance actions (now known as Requirement Notices) for all these breaches and the trust then developed action plans to become compliant. The majority of the trust's actions were to be completed by September 2014 and all actions by March 2015.

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Consultant, Chair of Inspection.

Summary of findings

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission.

The team included: CQC inspectors and a variety of specialists, namely, Chief Executive, Director of Nursing, Deputy Medical Director, Community Matron, Health Visitor, Physiotherapist, District Nurse, Consultant Paediatrician, Paediatric Nurse, Children and Young People's Nurse, End of Life Care Nurse Specialist, Critical Care Doctor, Critical Care Nurse, A&E Matron, A&E Sister,

A&E Nurse, Medicine Doctor, Medical Doctor in Training, Consultant Surgeon, Surgery Nurse, Theatre Nurse, Outpatients Nurse, Outpatients Manager, Midwife Matron, Obstetrician, Adult Safeguarding Named Nurse, Safeguarding Specialist, Equality and Diversity Specialist, Mental Health Act Reviewer, Consultant Radiologist, and experts by experience (people, or carers or relatives of such people, who have had experience of care).

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following eight acute, and three community core services at the trust:

- Urgent and emergency care.
- Medical care (including older people's care).
- Surgery.
- Critical care.
- Maternity and family planning.
- Services for children and young people.
- End of life care.
- Outpatients and diagnostics.
- Community services for adults.
- Community services for children, young people and families.
- Community end of life care.

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups (CCG), NHS Improvement, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held three local focus groups, prior to the inspection to hear people's views about care and treatment received at the hospital and in community services. We held a focus group especially for people with learning difficulties. We also held two similar focus groups, especially for people living with dementia, their families and carers. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the focus groups, Mencap Scunthorpe Gateway, Care4All Ltd and Alzheimer's Society in Scunthorpe and Grimsby.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, consultants, junior doctors and allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas. We observed how people were being cared for and reviewed patients' personal care and treatment records.

We carried out an announced inspection 22 - 25 November 2016 and unannounced inspections 17 October and 8 December 2016. The inspection team visited services at Scunthorpe General Hospital, Diana Princess of Wales Hospital and in the community.

Goole and District Hospital and the community dental service were not inspected during this inspection as they had been rated 'good' in each of the five domains at their previous inspection.

Summary of findings

What people who use the trust's services say

The trust's Friends and Family Test performance (% of people who would recommend the trust to friends and family) was generally better than the England average between August 2016 and July 2016. In the latest period, August 2016 trust performance was 97% compared to an England average of 95%.

In the CQC Inpatient Survey 2015, (published June 2015), the trust performed about the same as other trusts for all 11 questions, including questions about cleanliness, food, facilities and privacy, dignity and well-being.

In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for two of the 34 questions, in

the middle 60% for 25 questions and in the bottom 20% for seven questions. The question 'All staff asked patient what name they preferred to be called by' scored particularly low (52.57%) when compared to the top 20% of all trusts (67.1%) and the trusts 2013/14 figure (60.83%).

The trust performed about the same as the England average in the Patient-Led Assessments of the Care Environment (PLACE) 2016 for assessments in relation to food, facilities, cleanliness, privacy, dignity/wellbeing and facilities.

Facts and data about this trust

The trust was established as a combined hospital trust on 1 April 2001, and achieved foundation status on 1 May 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the trust became a combined hospital and community services trust (for North Lincolnshire). As a result of this the name of the trust was changed during 2013 to reflect that the Trust does not just operate hospitals in the region. The trust is now known as Northern Lincolnshire and Goole NHS Foundation Trust.

The trust provides acute hospital services and community services to a population of more than 350,000 people across North and North East Lincolnshire and East Riding of Yorkshire.

This trust has three hospital locations:

- Diana, Princess of Wales Hospital (DPoW).
- Scunthorpe General Hospital (SGH).
- Goole and District Hospital (GDH).

The trust has a total of 886 beds including:

- 441 Medical beds.
- 310 Surgical beds (272 inpatient, 38 day case).
- 64 Children's beds.
- 71 Maternity beds.

The trust employs 5,364 members of staff across acute and community services (as at September 2016), including:

- 604 Medical staff.
- 1,719 Nursing and midwifery staff.
- 2,103 Allied health professionals and other clinical staff.
- 2,016 Other non-clinical staff.

The trust has:

- 132,165 A&E attendances (August 2015 to August 2016).
- 96,576 Inpatient admissions (April 2015 to March 2016).
- 393,617 Outpatient appointments (August 2015 to July 2016).
- 454 Referrals to the specialist palliative care team (March 2015 to April 2016).
- 41,075 Surgical spells (April 2015 to March 2016).
- 2,133 Critical care bed days (February 2016 to July 2016).

The trust had 4,520 births between April 2015 to March 2016.

The trust reported 1,572 deaths between April 2015 and March 2016.

The trust's annual budget is around £330 million.

Summary of findings

Northern Lincolnshire comprises the populations of North Lincolnshire and North East Lincolnshire. These localities span the area south of the Humber River, bordering the East Riding area, South and Central Lincolnshire and South Yorkshire. There is a mix of very rural and urban areas with some heavy industrial areas. Northern Lincolnshire's population is getting older, and ageing faster than the national average.


- The health of people in North Lincolnshire is varied compared with the England average. Deprivation is lower than average, however about 19.8% (6,000) of children live in poverty. Life expectancy for both men and women is lower than the England average.

- The health of people in North East Lincolnshire is generally worse than the England average. Deprivation is higher than average and about 28.5% (8,500) of children live in poverty. Life expectancy for both men and women is lower than the England average.

The trust was last inspected 13 to 16 October 2015, with unannounced inspections on 6 November 2015 and 5 January 2016. The trust was then rated as 'requires improvement' overall, although it was rated as 'good' for having caring staff.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated safe as Inadequate because:</p> <ul style="list-style-type: none">• Maternity services and urgent and emergency care were rated inadequate for safe.• There had been a lack of improvement since the inspection in 2015, areas of concern had not been fully addressed in a sustained way and there had been deterioration in a number of services. Safety processes were not always adhered to in some services.• Assessing and responding to patient was risk was inconsistent and did not support early identification of deterioration. This was particularly evident in the Emergency Department (ED) at Scunthorpe General Hospital (SGH) where the national early warning scores (NEWS) were not recorded in the majority of records we reviewed. There was no paediatric assessment tool in ED at SGH to identify if a child's condition deteriorated. In maternity we saw delays in commencing Cardiotocography (CTG is used to record fetal heartbeat and uterine contraction during pregnancy), monitoring and lack of fresh eyes review. This was not in line with trust policy or national guidance.• The five steps to safer surgery procedures, including the World Health Organisation (WHO) checklist, was not consistently applied in surgical services. This had been identified as an area requiring improvement in 2015.• Nurse and medical staffing numbers were not always sufficient to meet the needs of the patients. Nurse staffing in the ED at SGH and Diana Princess of Wales (DPoW) did not meet planned numbers. Midwifery staffing at SGH did not meet planned numbers and the midwifery co-ordinator on occasion would have responsibility for a caseload of patients. Paediatric staffing in the high dependency unit did not meet the trust or national requirements and was not sufficient to meet the needs of the patient acuity. In medicine and surgery, planned nurse staffing numbers were not always achieved.• We saw examples of inconsistent learning from incidents, particularly evident in maternity services with the lack of learning from incidents regarding CTG monitoring and swab counts in maternity theatres. Duty of Candour (DoC) was not fully understood by all staff.	<p>Inadequate </p>

Summary of findings

- We saw poor infection prevention and control processes and standards of cleanliness in the ED at SGH. Mandatory training rates in infection control were variable across the trust with low rates in the area where concerns were identified, for example in ED training rates were 53%.
- Mandatory training rates were variable across the core services with many staff groups not meeting the trust target of 95%.
- Safeguarding systems and processes were variable. Safeguarding vulnerable adults and children was not given sufficient priority in the emergency department at SGH. The assessment for safeguarding adults and children was not robust. There were no clear systems and processes in place to protect children and vulnerable adults from abuse.

However:

- The trust had taken action in some areas since the 2015 inspection, for example the trust had stopped using Band 4 nurses awaiting professional registration numbers within the registered nurse establishment.
- Recruitment of nurses had recently improved since the inspection in 2015; this was particularly evident at the Diana Princess of Wales Hospital.
- On some wards shift co-ordinators were being piloted and work had been undertaken to review ward establishments to ensure ward managers had protected management time.
- New roles had been developed including Assistant Nurse Practitioners and Acute Care Physicians.
- Safeguarding processes were well understood in community services and training was up to date.

Duty of Candour

- The duty of candour (DoC) 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.
- The trust had an 'Openness and Duty of Candour Policy' which set out the process for duty of candour.
- We reviewed six root cause analysis (RCA) reports and saw that DoC had been applied in all six however, in two there was a delay in the provision of apology. We saw evidence that copies of the final reports were sent to the patient/relative.
- Not all junior nursing staff we spoke with were aware of the statutory duty of candour principles.

Safeguarding

Summary of findings

- The trust had policies and procedures in place for safeguarding children and adults. Both children's and adult policies were in date and provided staff with flowcharts to aid decision making and to ensure the correct processes were followed.
- Staff were aware of how to access the safeguarding policies and were clear about their safeguarding responsibilities. Staff knew how to contact the safeguarding team and felt they could access the team for support and advice. Information regarding how to contact the team was available to patients, visitors and staff on the entrance to each ward area.
- The trust reported good compliance with safeguarding training with 85% of staff trained in Level one adult safeguarding; 86% level one children's safeguarding; 88% level two children's safeguarding and 81% level three children's safeguarding training.
- Figures from the trust showed that overall 95.2% of staff working in community services had completed adult safeguarding training. Most teams had achieved 100% compliance. The lowest level of compliance was 92%. This meant that most staff had training to enable them to recognise and respond to safeguarding concerns.
- The ED departments had a system and process in place for the identification and management of adults and children at risk of abuse (including domestic violence). However at SGH this was not robust. The emergency department card only had a small one-line section which contained a tick box for child protection, cause for concern and no further action.
- The trust had named safeguarding midwife in post.
- Safeguarding level three training included female genital mutilation (FGM) training and training on child sexual exploitation (CSE). Staff were aware of the assessment for child exploitation and female genital mutilation. There was a female genital mutilation policy in place and this was easily accessible.
- Teenagers who presented to the pregnancy advisory service were referred to the safeguarding team.
- Safeguarding supervision compliance for community midwives was 38%.
- The 'failure to be brought' policy for outpatient consultations set out safeguarding concerns that could be raised due to parents or carers not bringing children and young people to planned appointments. It provided guidance on how to escalate and act on these concerns.
- In community children and young people's services, we saw that there was now a well-embedded safeguarding children supervision policy and that 100% of eligible staff had accessed three monthly supervision as outlined.

Summary of findings

Incidents

- The trust had an electronic reporting system in place and nursing and medical staff we spoke with could describe their roles in relation to the need to report, provide evidence, take action or investigate incidents as required across acute and community services.
- The trust had an incident reporting policy and procedure (2014) in place which clearly set out types of incidents, reporting procedures and responsibilities of managers with regard to reporting and investigation. There was a separate policy in place for the reporting and investigation of serious untoward incidents.
- The trust policies set out clearly that actions put in place will need to be monitored and reviewed to ensure they remain effective. At directorate level, monitoring of agreed action measures was undertaken via the appropriate directorate governance group.
- Between October 2015 and September 2016, the trust reported a total number of 9,652 incidents, of these 43 were classed as serious incidents (SI). The majority of incidents were reported as no (6,683) or low harm (2,878).
- In the staff survey, the percentage of staff witnessing potentially harmful errors, near misses or incidents in last month was 35% which was higher than the England average of 31%.
- During the inspection we reviewed six serious untoward incidents and the associated root cause analysis (RCA). All RCAs provided a clear timeline of events. There was a pre and post-mitigation risk rating which decreased following mitigation. Between October 2015 and September 2016 the trust reported two never events for the same period. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Action plans were in place with clear actions, leads had been identified for implementation of actions and there were clear timescales. There was evidence of completion of actions and dates of when submitted and ratified at directorate governance groups. There was a gap of two to four months before each full RCA was ratified. Two of the RCAs related to pressure ulcers had no date for when they had been reviewed by the pressure ulcer group (PUG).
- In 2015, we said that the trust must ensure there is an effective process for providing consistent feedback and learning from

Summary of findings

incidents. During this inspection learning from incidents remained inconsistent and variable between directorates. Staff we spoke reported a varying standard of feedback and learning from incidents.

- In surgery the directorate did not consistently learn from incidents, when things go wrong, or when things could be improved and take appropriate action to improve safety standards as a result. Repeat incidents had been reported and lessons learned had not consistently been implemented to prevent the incident from re-occurrence.
- The trust had not provided assurances of lessons learnt following three serious incidents in maternity services that raised concerns around CTG.
- The maternity service had not provided assurance that lessons had been embedded following a never event which related to a retained swab. We reviewed six sets of records of patients undergoing caesarean sections and instrumental deliveries and found that swab counts were not correctly documented in four sets. A re-audit of swab counts presented at the obstetrics and gynaecology clinical audit meeting in May 2016 provided limited assurance. At DPoW 66% of records had both swab checks fully completed. This was below the trust standard of 100%.
- Overall the majority of incidents across the trust were reported to the national reporting and learning system within the trust timescales of 60 days however there were incidents in medicine and surgery that took longer than 90 days to report.
- In 2015, we said that the trust must ensure that action was taken to address the mortality outliers and improve patient outcomes. However, not all services had initiated mortality and morbidity meetings, for example there were no specific surgical mortality and morbidity meetings. In medicine mortality meetings had been established and were held regularly. The senior management team told us that individual specialities discussed mortality as part of audit meetings however this information was not collated centrally within the directorate.

Staffing

- The trust used the safer nursing care tool as recommended by the National Institute for Health and Care Excellence (NICE) to calculate safe nurse staffing levels based on patients' level of sickness and dependency. There was an annual review of nurse staffing establishments with a 'table top' review six monthly. An acuity tool had been introduced in community services.

Summary of findings

- Nursing and medical staffing had improved since the last inspection, however there were still a number of nursing and medical staffing vacancies throughout the hospital. Staffing levels and skill mix in emergency, medical and surgical wards were below the actual planned levels at times despite the use of bank, agency and locums.
- We reviewed the safer staffing report to the trust board conducted for the six-month period to 30 June 2016. This set out staffing ratios for inpatient wards as one registered nurse to every eight patients with a minimum of two registered nurses on each shift. In paediatrics ward sisters/charge nurses would be supervisory. In the paediatric high dependency unit there would be one registered nurse to every two patients. On the paediatric wards for staffing was set out based upon the age of children.
- During the inspection we reviewed ward staffing levels and found that of the 38 wards 15 were reporting a planned versus actual staffing position of less than 80% and a further five wards less than 85%.
- Between October 2015 and September 2016, the trust reported a vacancy rate of 8% for nursing and midwifery and 24% for medical staffing; the core service medicine has the highest vacancy rate (14%) in nursing.
- The trust reported significantly below planned numbers for both consultants by 31.6 whole time equivalent (wte) and for other non-consultant grade doctors by 91.4 wte. In nursing and midwifery, the trust reported for Band 7 and below 168.6 wte below planned numbers and for Band 8 and above they were slightly above planned numbers by 1.9 wte.
- Between March 2015 and April 2016, the proportion of consultant medical staff reported to be working at the trust was lower than the England average and junior (foundation year 1-2) medical staff was higher than the England average. Consultant turnover was high in some areas with ED having consultant turnover of 52.3%.
- At the 2015 inspection there was a lack of protected time for ward managers and nursing staff who were co-ordinating a shift would also have the responsibility of a patient caseload. Ward baseline establishments had been reviewed and there had been some improvement to enable protected time for ward managers with the aim of 9.5 hours per week. In five high risk areas shift leaders had been implemented and were due for review in December 2016. A key performance indicator had

Summary of findings

been attached to the protected time for ward managers.

However, feedback from the focus groups indicated that due to the ongoing staffing difficulties, protected time for ward managers was still not achievable most of the time.

- There was a process in place to review and manage staffing on a twice daily basis with an assessment of patient acuity to support staff deployment to areas of greatest need. There was a clear escalation policy to support the reviews and a system of red flags for those wards where acuity was high. During the inspection, we saw examples where ward staffing was below planned numbers and patient acuity high was high however; the ward was not flagged as red but amber.
- Between August 2015 and July 2016, for nurse staffing, the trust reported a bank and agency usage rate that ranged between 0% and 4.1%. Urgent and emergency care had the highest average monthly usage (4.1%).
- Between August 2015 and July 2016, for medical staffing, the trust reported a bank and locum usage rate that ranged between 0.03% and 5.92%; the chart below shows the average locum usage by core services. Urgent and emergency care has the highest average monthly usage (5.92%).
- Assistant practitioner roles had been developed to support nursing establishments from 2017.
- At the 2015 inspection nurses who were awaiting their registration number had been rostered to cover qualified nursing shifts. At this inspection we saw that the practice had stopped and the trust confirmed that the Band 4 nurses awaiting registration were designated in healthcare assistant shifts until their registration number had been assigned.
- Acute care physicians had been developed at DPoW.
- Nurse staffing in critical care services met the Guidelines for the Provision of Intensive Care Services (GPICS) minimum requirements of a one to one nurse to patient ratio for level three (intensive care) patients and one nurse to two patients ratio for level two patients (high dependency).
- The planned staffing figures included a supernumerary clinical co-ordinator for Intensive Care Unit (ICU) for twelve hours during the day. At the time of the inspection there was not a supernumerary clinical co-ordinator during the night shift. GPICS standards state the supernumerary clinical co-ordinator should be on duty 24 hours a day.
- The medical establishment in ICU was 13 wte consultants. Six of these consultants were intensivists and seven were anaesthetists. The unit met GPICS requirements for medical staffing between Monday and Thursday 8am to 9pm as care was led by a consultant in intensive care medicine. However,

Summary of findings

the work pattern did not deliver continuity of care as the consultant changed on a daily basis. The service was actively recruiting additional intensivists to meet GPICS standards 24 hours a day, seven days a week as part of the critical care strategy.

- On the paediatric wards we observed that ward staffing was not in line with Royal College of Nursing guidance to treat the acuity of patients. There was no supernumerary senior nurse on night or weekend shifts. Only two Band 6 staff members were employed within the service. This meant that some night and weekend shifts were led by a Band 5 nurse, with no senior children's nursing cover on site. It was acknowledged in the safer staffing report for the six-month period to 30th June 2016 that the current funded nursing establishment was not sufficient.
- At the time of our inspection in paediatric services, Disney ward had 15 patients, of these, the ward staff had classed six children as requiring high dependency care due to clinical acuity, seven children were under two years old and two children over were two years old. Guidance states that there should be a nurse to patient ratio of 1:2 for high dependency patients, 1:3 for patients under two years old, and 1:4 for patients over two years old. The majority of these patients were being nursed in side rooms, which require additional nursing resource. At the time of our inspection, we saw that there were three registered nursing staff on shift. In addition to this staff also carried the emergency bleep for paediatric resuscitation. On Rainforest ward at DPoW, we saw three high dependency patients and six other children. Only two nurses (one Band 5 registered children's nurse and one of the ward's adult nurses) had been on duty and the ward had been closed to admissions due to a lack of suitably qualified staff to care for the number of patients.
- Data from November 2016 showed that at SGH 82.46% of shifts on the neonatal unit had been filled in accordance with British Association of Perinatal Medicine (BAPM) guidance on staffing numbers. This was greater than the national average of 57.91%. The service also identified that 90.19% of shifts had been staffed with appropriate 'qualified in specialty' nurses. This was also above the national average of 72.44%. Only 0.1% of shifts had been covered by a designated supernumerary team leader. This was below the national average of 22.91% and was not in line with the BAPM guidance.
- Data from November 2016 showed that at DPoW 62.5% of shifts on the NICU had been filled in accordance with BAPM guidance on staffing numbers. This was greater than the national average of 57.9%. The service also identified that 88.5% of shifts had

Summary of findings

been staffed with appropriate 'qualified in specialty' nurses. This was also above the national average of 72.4%. No shifts had been covered by a designated supernumerary team leader. This was below the national average of 22.9% and was not in line with BAPM guidance.

- The consultant cover in paediatrics did not meet the Facing the Future: Standards for acute general paediatric services (2015) in regard to consultants being present and readily available in the hospital seven days per week or the number of consultants on the rota.
- Staffing of the maternity service was reviewed using the Birthrate Plus® midwifery workforce planning tool in accordance with the recommendations and procedures outlined in the National Institute for Health and Care Excellence (NICE) safe staffing guidelines.
- The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour recommend a ratio of one midwife to 28 births (1:28). Information on the women's and children's reporting dashboard showed the midwife to birth ratio was 1:32. Subsequent information following our inspection showed this had improved to 1:30 following recruitment. Despite the challenges around staffing data provided by the trust showed that from November 2015 to October 2016, 99.9% of women received 1:1 care in labour.
- In community children and young people services health visiting caseloads remained higher than the national guidance (below 300) and it was unclear if the new acuity tool would address this.
- Children's therapy services had high caseloads. However, this was on the community risk register and actions had been taken to mitigate potential delays in children being treated.

Assessing and Responding to Patient Risk

- The trust used the national early warning score (NEWS) tool to identify deteriorating patients.
- The quality and consistency of assessments of patient risk and the response was variable across both of the acute hospitals. For example in ED at SGH national early warning scores (NEWS) were not completed, there was a lack of documented assessment of pressure areas.
- Paediatric early warning scores (PEWS) were not in use in the ED at SGH and there was no alternative assessment tool to identify deterioration in children however in DPoW the PEWS assessment tool had been implemented.

Summary of findings

- The internal audit department retrospectively reviewed 57 records in October 2016 in the surgical directorate. The results we reviewed showed good levels of performance with 96% compliance reported for the outcome measure 'vital signs recorded'. However, improvement (63% compliance) was required with completion of a management plan including, treatment, parameters and escalation of care.
- We saw from the Nursing Audits Interim Report (Quarter 1 2016), the trust audited 62 patient records on medical wards at Scunthorpe General Hospital against compliance with NEWS. The report identified that in all ward areas there was 100% compliance with vital signs being recorded in accordance with the NEWS, 100% compliance in documenting if observations were outside of the NEWS in all wards with the exceptions of Ward 16 and Ward 23; 100% compliance in actions taken being fully documented and all wards had 100% compliance with documenting the management plan with the exception of Ward 16 which scored 75%.
- Within maternity and gynaecology services staff used the modified early obstetric warning score (MEOWS) and the national early warning score (NEWS) respectively to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient's clinical condition was changing and prompted staff to get medical support if a patient's condition deteriorated.
- The trust audited MEOWS as part of their maternity documentation audit which was presented at the service clinical audit meeting in September 2016. The audit reviewed 247 sets of records and found 79% of women had a MEOWS completed immediately after delivery, 73% had a MEOWS completed between six and 12 hours post-delivery. The audit found if a woman required escalation, only 58% of records had evidence of appropriate referral and a management plan. The audit did not include an action plan.
- In maternity and gynaecology services an audit to assess compliance with the Five Steps to Safer Surgery including the WHO safety checklist for women undergoing surgical intervention showed that within gynaecology there was 38% compliance in all areas of the checklist. Within obstetrics, 38% of records were compliant with all aspects of the checklist. The audit stated that recommendations and an action plan were still to be agreed.
- Monitoring in maternity was not always initiated in line with trust guidance. Trust guidelines on CTG for continuous

Summary of findings

electrical fetal monitoring, stated an hourly systematic assessment of the CTG trace must be recorded and that every two hours the practitioner providing care must seek the assistance of a colleague to systematically review the CTG trace.

- We reviewed nine sets of records and found five (55%) sets had no evidence of hourly CTG reviews or 'fresh eyes' process had been completed. A further audit provided by the trust reviewed 66 cases and found 55 (83%) cases had fresh eyes reviews recorded every two hours.
- In the surgery division we saw that patient safety tools were not used consistently. The Five Steps to Safer Surgery including the World Health Organisation (WHO) checklist was not carried out consistently. Swab counts in theatre were not always performed as per the trust policy and best practice guidance. We saw two procedures where no instruments were counted.
- Staff did not complete formal risk assessments for each day case patient for blood clots (venous thrombosis). Day case admissions had no formal risk assessments for venous thrombo-embolism (VTE) completed during the admission. In three out of four cases we reviewed patients did not receive VTE assessments nor preventative treatments pre-operatively. In one case, this was rectified and the correct actions were carried out in theatre, in the other three cases no actions were completed despite equipment being available.
- The trust used a sepsis screening tool and pathway and the trust had a nurse consultant in post to support delivery of care for the deteriorating patient and a sepsis specialist nurse in post.
- The critical care outreach team was available 12 hours a day, seven days a week. Outside of these hours, the hospital at night team managed patients. The team supported patients stepped down from critical care and reviewed deteriorating patients alerted to them by ward staff. The team also delivered non-invasive ventilation outside of critical care in line with the trust policy.

Safety Thermometer

- The Patient Safety Thermometer is used to record the prevalence of patient harms at the frontline, 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.

Summary of findings

- Data from the Patient Safety Thermometer showed that the trust reported a prevalence rate of 187 pressure ulcers, 46 falls with harm and 53 catheter urinary tract infections between September 2015 and September 2016.
- In community adult services, harm free care over the three community nursing teams was above the England average of 95% for eleven months from September 2015 to August 2016. There was one month which was below 95%, which was in September 2015 at 94.2%.

Cleanliness, infection control and hygiene

- There were no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia reported between September 2015 and September 2016. Trusts have a target of preventing all MRSA infections, so the trust met this target within this period. Additionally, the trust reported 11 MSSA infections and 24 clostridium difficile infections over the same period.
- The trust had an Infection Control Policy in place.
- The medical director was the director of infection prevention and control, supported by an assistant director of infection prevention and control.
- There was an Infection Prevention and Control Committee chaired by a non-executive director.
- The trust had a policy for screening surgical patients for MRSA. Emergency and elective patients undergoing surgical procedures and fitting the national criteria were tested for MRSA. We reviewed compliance rates with screening and noted 97% compliance against a target rate of 95% during the reporting period April to October 2016.
- Hand washing facilities and antibacterial gel dispensers were available at the entrances of wards and there was signage encouraging visitors and staff to wash their hands.
- We observed staff complying with bare below the elbows policy, correct handwashing technique and use of hand gels in the clinical areas we visited. Trust audit data showed variable compliance with hand hygiene.
- Clinical areas participated in monthly environmental audits, which were carried out by the quality matrons. The audits focused on 12 key elements; these included infection control practice and observation of hand hygiene, environment, waste disposal and sharps safety and decontamination. We looked at a random sample of these in medicine and found compliance was good in most areas. Actions were documented if compliance fell below the required level. Low compliance was seen in a number of areas including ED with the lowest monthly recording of 67% in June 2016.

Summary of findings

- The emergency department at SGH had generally poor levels of cleanliness and infection control practices. The environment was visibly dirty and dusty. During the inspection we saw that the floors had debris and dust in areas. Several equipment trolleys were dirty and dusty. We checked 10 patient trolleys and they were very dirty. There was no evidence cleaning had taken place of any of the patient equipment or patient bays. We raised this with the chief nurse at the time of inspection. Sharps disposal bins were overfilled. At the unannounced inspection, we saw that the sharps disposal bins were still overfilled. Cleaning schedules showed that the resuscitation room had not been cleaned since April 2016.
- Staff in ED at SGH did not routinely carry out mattress audits. We were told they were checked and cleaned between patients. On inspection, we checked three mattresses and found one was split and had holes in it, leading to the foam inside being contaminated.
- Cleanliness and infection control practice in the ED at DPoW was of a higher standard compared to SGH. The emergency department was visibly clean and tidy. We saw cleaning in progress during the visit. Most of the equipment had 'I am clean' labels attached documenting the time and date when it was last cleaned. Hand hygiene was audited on a monthly basis. The audit results for December 2015 to August 2016 showed 100% compliance. In April 2016 there was no audit performed. We viewed monthly cleaning audits from December 2015 to August 2016 and the overall score was between 88% and 100%.
- In medicine we reviewed the audits for acute medical unit (AMU) and cardiology day case unit between January 2016 to August 2016 and found overall compliance between 86% and 100%.
- At the time of the inspection the intensive care unit (ICU) did not have facilities for isolation. This was recorded on the risk register and senior staff were working with the infection control team. When patients were repatriated from other critical care units, staff requested the repatriating trust completed a MRSA screen prior to transfer and this was discussed with the microbiologist. Pods to provide isolation facilities were due to be fitted in January 2017.
- The estates department had fitted additional sinks in ICU; however, the unit did not comply with Department of Health building regulations (HBN02). This was recorded on the risk register.

Medicines

Summary of findings

- In 2015, we said that the trust must ensure the safe storage of medicines within fridges, specifically in regard to temperature and stock control. During this inspection, we saw that, medicines fridges were secured. Temperature records however were not always completed in accordance with national guidance and trust policy. We saw examples of when fridge temperatures had fallen outside of the recommended range and ward staff had taken no action. In theatres we saw fridges were not able to be locked, staff we spoke with said there were no keys to lock them. Staff in theatres however did take prompt action when a fridge temperature was outside the range.
- Controlled drugs were managed appropriately. Record keeping and balance checks were completed as per trust policy.
- Patient group directives (PGDs) were in use and there was a robust system in place to ensure they were managed appropriately. PGDs are written instructions that allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked PGDs used by the nursing team and found they were being used effectively to support patient access to medicines in a timely way.
- Prescription pads were stored securely and appropriate records maintained in accordance with national guidance.
- All intravenous infusions were stored in their original boxes or in appropriately labelled containers.
- During the inspection of ED at DPoW we observed the streaming nurse at the reception desk with a bag of medicines which included codeine, paracetamol and ibuprofen. This was not secure and was left on reception if the nurse left the desk. We advised staff to lock this safely in a cupboard. When we returned on the unannounced inspection, the medicine bag was open at the reception desk.

Records

- We reviewed records across a number of core services and saw that record keeping was of a variable standard. However, generally, the documentation was legible, we saw that most entries were dated and signed. Patient records were stored in notes trollies that could be locked, or were stored in secure areas. However, on the paediatric wards the majority of records we reviewed did not contain a legible signature from medical staff or their GMC number. This meant that it was not always possible to identify which member of medical staff had made an entry in the records. This was not in line with General Medical Council guidance on record keeping.

Summary of findings

- Electronic boards were available on all wards visited, which provided easy access for staff to key information, for example, flags for dementia, post-operative confusion, patient acuity and discharge plans. This system had expanded since our last inspection and now included the theatre management system.
- The trust used an intentional rounding tool. Intentional rounding involves nursing staff using predetermined questions to ask patients on a regular basis about care needs and checking the patient environment to ensure that it is clean and uncluttered and that everything is in reach of the patient. We saw that these were in place and used effectively in a number of areas.
- In ED however across both sites we reviewed a total of 56 sets of patients' records (37 adults and 19 children's) fully and found completion of documentation was variable and at times inadequate to ensure delivery of safe care. For example, we could not tell if nursing care was actually given because of nursing care was not documented as being given in any of the 56 records. This included no record of pressure ulcer assessment or pressure care given and no documentation if the patient had been offered or given food or drinks whilst in ED. Four patients had a falls assessment completed.
- We were told on the unannounced inspection that they had introduced care rounds documentation we reviewed a further seventeen sets of records and found the documentation in eight of the seventeen however completion of the record remained inconsistent.
- The trust completed a report in August 2016 that reviewed 41 patient records on medical wards. The audit reviewed that risk assessments were completed appropriately. The results showed that the majority of patients were commenced on pressure area pathways and followed. Moving and handling assessments were completed on most wards with the coronary care unit receiving 75% and C1 Holles 86%.
- We saw limited evidence of advanced care planning for patients approaching the end of their life. The trust was in the process of implementing end of life care documentation that would support staff in the care and treatment of patients approaching the end of their life. We did not see this documentation in use on any of the wards we visited at DPoW.
- The Family Nurse Partnership (FNP) covered North Lincolnshire and Goole. Families in the Goole area had generic electronic records. This meant that universal health visiting teams could access the records. Families in North Lincolnshire were not on the same unit on the electronic record system as the FNP, therefore records were not transferable. This situation had been

Summary of findings

escalated, but was not seen to be a concern so no further action had been taken. This did not adhere to the National Health Visiting Service Specification March 2014, which states 'providers will ensure that all staff have access to sharing information to safeguard or protect children'.

- Records reviewed in community services were legible and up to date. They included clear plans about interventions. We saw that these included appropriate information from external agencies such as social care.
- We saw a trust wide record-keeping audit for community service teams. Seven hundred records were audited against ten compliance measures during 2015/2016. Compliance rates varied but some improvement was noted in key areas which included 99% compliance for records completed contemporaneously and 100% of written records were accessible for audit and linked to NHS numbers. They were legible and written in accordance with professional guidance for example the Nursing and Midwifery Council record keeping for nurses.

Environment and Equipment

- The trust had a policy for maintaining equipment which outlined the process to follow when repairs to equipment were needed. We checked equipment such as hoists, infusion pumps and machinery during our inspection and found them to be serviced correctly and the dates recorded appropriately.
- During the inspections of 2014 and 2015 we raised concerns regarding the lack of a dedicated room at ED in Scunthorpe that was specifically designed to allow for the safe assessment of patients who attended with a mental health condition. At this inspection there was a dedicated room identified for patients with mental health conditions however we observed a patient on a trolley in the room, there was oxygen tubing which was a ligature risk.
- During the previous inspection in October 2015 of maternity services we found the checks of emergency equipment were not being done consistently. During this inspection we found gaps in daily checking of emergency resuscitation equipment for adults and babies.
- We found inconsistent practice with regard to resuscitation trolley checks across the trust. In maternity we inspected two advanced resuscitation trolleys on the inpatient area. On one of the advanced resuscitation trolley check records, we saw checks were not recorded on the 07 October and from the 10 to

Summary of findings

14 October 2016. On the second trolley the equipment checks had not been recorded from the 09 to 13 November 2016. In medicine a review of the monthly matron audits showed gaps in checks across several wards.

- Resuscitation equipment on Disney ward (paediatrics) had not been consistently checked in the previous three months; it had not been checked on 12 days in September, but had been checked on every day in October 2016 and 21 of 23 days in November 2016.
- A system was in place for the security of the maternity units on both hospital sites. Access to the Neonatal ICU and Disney ward was via swipe card or buzzer system. CCTV was available to staff to monitor access and identify visitors before being allowed in
- Equipment for bariatric patients was available and staff we spoke with were aware of how to access this.
- We saw that children and young people were placed on adult theatre lists. They were anaesthetised in the same area as adults, and were recovered in shared recovery bays with adults, with a curtain separating them. However, there was a risk that children in recovery would be able to see adult patients being transported and recovered. This process was not in line with Royal College on Anaesthetist standards (Standards for Children's Surgery, 2013) or Royal College of Nursing guidance.

Mandatory Training

- At the time of inspection the overall mandatory training rates were 85%. The trust had a mandatory training target of 95% which is higher than many other trusts.
- Mandatory training rates were variable across the core services and for the different mandatory training modules.
- For medical and dental staff mandatory training rates had not been achieved in any of the core mandatory training modules. The highest achieved was 88% in bullying and harassment and the lowest was 57% for moving and handling. Resuscitation training rates were also low at 62%.
- Mandatory training rates for nursing and midwifery staff were slightly better with a number of core mandatory training modules meeting and exceeding the trust target, these included moving and handling, medicines management and bullying and harassment. The remaining nine modules did not meet the trust target of 95% with the lowest scores were for resuscitation training at 77% and fire training at 78%.

Major incident awareness and training

- The trust had a major incident policy; this was accessible to staff on the trust intranet.

Summary of findings

- Staff we spoke with had an understanding of their roles and responsibilities with regard to any major incidents.
- In August 2016, there had been a 'table top' exercise to test the major incident policy. The trust had to implement the major incident policy following a cyber-attack in 2016; they were commended by external stakeholders on their response to the incident.
- There was a designated store for major incident equipment in both emergency departments that contained specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- We saw business continuity plans for teams within adult community services. Community staff in both nursing and therapy teams were aware that these were in place for events such as adverse weather. Most staff told us that they would report to their nearest base. Managers told us that business continuity plans were on the intranet.

Are services at this trust effective?

We rated effective as Requires Improvement because:

- The trust participated in national and local audit programmes however trust performance was mixed across most of the core services with many showing performance that was worse than England averages. There was also variation in patient outcomes between the two hospital sites.
- The endoscopy unit had lost their Joint Accreditation Group (JAG) accreditation in August 2016 due to an audit that was not submitted within the necessary timescales and communication issues.
- In 2015, we said that the trust must continue to improve on the number of fractured neck of femur patients who receive surgery within 48 hours. Internal trust data we reviewed indicated that surgery was still not occurring consistently within 48 hours.
- We were not assured that patients in the ED at SGH were offered suitable nutrition and hydration. Out of 33 sets of notes, only one had documented that a patient had a drink of water.
- Medical device training was not consistent across the trust and we saw examples of poor and good practice.

Requires improvement



Summary of findings

- In maternity services we had concerns regarding the completion of the K2 training package (an interactive computer based training system that covered CTG interpretation and fetal monitoring) for midwives and medical staff in maternity.

However:

- We saw pathways in place that complied with the National Institute for Health and Care Excellence (NICE) guidelines, professional and local guidelines.
- The hospital-level mortality indicator (SHMI) statistics from July 2015 to June 2016 showed that the SHMI remains in the 'as expected' banding with a figure of 110.
- Protected meal times were in place and we observed that patients were provided with their meals promptly and with assistance where needed.
- Patients who required a Deprivation of Liberty Safeguards (DoLS) in place were correctly completed with the appropriate urgent and standard DoLS applications.
- The critical care service had taken action on the issues raised in the 2015 inspection. For example, patient outcomes, specifically mortality and early re-admissions, had improved and were in line with similar units. A clinical educator had been appointed and was due to start in January 2017 and staff demonstrated an improved understanding of restraint and consent and worked in line with the trust's policy.
- There had been an increase in the number of patients who died in their own home due to increased recognition of patients who were in their last days of life and seven day working practices in the specialist palliative care team, therapies and equipment provision. There had been a significant decrease in those patients who had died in hospital.

Evidence based care and treatment

- We saw pathways in place that complied with the National Institute for Health and Care Excellence (NICE) guidelines, the Royal College of Emergency Medicine's (RCEM) clinical standards for emergency departments, the Intensive Care Society (ICS) and the faculty of intensive care medicine (FICM) the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines.
- The trust participated in the national RCEM audits so it could benchmark its practice against other emergency departments. The last sepsis audit we saw was the Royal College Emergency Medicine (RCEM) severe sepsis shock in adults in 2013 to 2014. Five standards were below 70%, we saw no evidence of a re-

Summary of findings

audit. When we asked we were told it was not re-audited as it was already embedded. However, we saw an example that this was not the case during our inspection of the department, when we saw a patient with suspected sepsis. The paramedics had pre-alerted the department and the patient was queuing in the corridor for 50 minutes, without an assessment. We raised this with the staff in the department.

- The trust was part of the Intensive Care National Audit and Research Centre (ICNARC).
- The trust were in the process of implementing the 'Care in the Last Days of Life' document that had been developed to replace the Liverpool Care Pathway Documentation. The records audit completed in May 2016 showed that the new documentation was used in 90% of the records audited. However, data provided by the trust indicated that between August 2015 and July 2016, of the 761 patients who had died in this hospital only 75, less than 10%, had been cared for using the Care in the Last Days of Life document.

Patient outcomes

- The trust participated in national and local audit programmes however trust performance was mixed across most of the core services with many showing performance that was worse than England averages.
- The hospital-level mortality indicator (SHMI) statistics from July 2015 to June 2016 showed that the SHMI remains in the 'as expected' banding with a figure of 110.
- The trust had three active mortality outlier alerts as at October 2016. This total includes one open alert currently being considered for follow up by CQC's expert panel and two alerts already approved for follow up. Alerts were for the following: Acute Bronchitis, Cardiac Dysrhythmias and Septicaemia (except in labour).
- The trust had a screening for sepsis CQUIN from April 2015 to March 2016 this showed on average 62% of patients were adequately screened. The percentage of patients given timely antibiotic treatment was on average 48%.
- The endoscopy unit had lost their Joint Accreditation Group (JAG) accreditation in August 2016 due to an audit that was not submitted within the necessary timescales and communication issues. The unit had an action plan in place to meet the actions required for reaccreditation. The trust was liaising closely with JAG and the process for reapplying for JAG accreditation was underway; audits had been submitted in October 2016 and the trust was awaiting the outcome.

Summary of findings

- We reviewed several RCEM audits, trust performance was variable and overall worse or in line with the England average. In the 2015 RCEM audit for assessing cognitive impairment in older people, the site was in the lower quartile compared to other hospitals for three of the six measures and was between the upper and lower quartiles for one of the six measures. In the 2015 RCEM audit for initial management of the fitting child, the site was in the lower quartile compared to other hospitals for three of the five measures and was in between the upper and lower quartiles for two of the five measures. At SGH the fundamental standard of having an early warning score documented was not met.
- In the 2015 RCEM audit for mental health in the ED, the site was in the upper quartile compared to other hospitals for one of the eight measures, in the lower quartile for five of the eight measures and between the upper and lower quartiles for the other two. The trust had met the fundamental standard for having a dedicated assessment room for mental health patients at DPoW but not for SGH. Neither ED had met the fundamental standard for having a documented risk assessment taken.
- In the 2015/16 RCEM audit for Procedural Sedation in Adults, SGH was in the top 20% compared to other hospitals for two of the seven standards and was in the middle 50% for the remaining five standards.
- In the 2015/16 RCEM audit for Vital Signs in Children, SGH was in the bottom 20% compared to other hospitals for two of the six standards and in the middle 50% for the remaining four. The hospital did not meet either of the two fundamental standards set by RCEM.
- As a result of audit findings we saw action plans in place identifying improvements to be made. However, we did not see evidence actions had been effectively implemented for example the RCEM audit for vital signs in children (July 2016) action was for all children to have vital signs recorded using the paediatric early warning scores (PEWS) score, unless seen for an injury. On reviewing the notes, no PEWS scores were completed.
- The trust showed variable performance between the two acute sites in a number of audits. In the Heart Failure Audit, 2015, DPoW scored better than the England average for three of the four standards however, SGH scored worse for all four standards relating to inpatient care.
- In the National Diabetes Inpatient Audit 2015, SGH scored better than the England average in six metrics and worse in 11 metrics. The indicator regarding "All or most staff know enough

Summary of findings

about diabetes” had the largest difference versus the England average (37.1% compared to the England score of 65.5%). At DPoW, the site scored better than the England average in 14 metrics and worse than the England average in three metrics.

- In the Sentinel Stroke National Audit Programme, the trust’s overall performance was high, although discharge processes had deteriorated in both team and patient centred indicators dropping from A to C and thrombolysis remained consistently low compared to the other indicators.
- In the national emergency laparotomy organisational audit (NELA) 2015, at DPoW achieved a green rating (>70%) for one measure, an amber rating (50-79%) for four measures and a red rating (>49%) for five measures, at SGH achieved a green rating (>70%) for three measure, an amber rating (50-79%) for one measures and a red rating (>49%) for six measures.
- In 2015, we said that the trust must continue to improve on the number of fractured neck of femur patients who receive surgery within 48 hours. Internal trust data we reviewed indicated that surgery was still not occurring consistently within 48 hours. Current compliance showed the proportion of patients having surgery on the day or day after admission was 62.5% at SGH and was 74.1% at DPoW, which does not meet the national standard of 85%, this had improved however on the 2015 result of 58.1% and 69.9% respectively.
- We reviewed the ICNARC data for the intensive care units at both SGH and DPoW from 1 April 2015 to 31 March 2016; the risk adjusted acute hospital mortality ratio was 1.19 at SGH and 1.12 at DPoW. This was in line with similar units.
- Trust patient reported outcome measures (PROMs) from April 2015 to March 2016, showed that for the majority of indicators the trust performed in line with the England average.
- The proportion of patients not developing a pressure ulcer was 100%, which falls in the best 25% of all trusts. This was an improvement on the 2015 score of 99.5%.
- The National Neonatal Audit Programme (NNAP) included two questions that applied to maternity services. The 2015 report indicated that the hospital was achieving 95% compliance with recording babies’ temperature within an hour of birth; this was below the target of 98%. The hospital achieved 95% compliance for the percentage of mothers receiving a dose of antenatal steroids; this was above the target of 85%.
- In the 2015 National Neonatal Audit the hospital met or was above the NNAP standard/benchmark for three of the four indicators and was below the NNAP standard/benchmark for the remaining indicator.

Summary of findings

- In children's and young people's service a survey was completed for a two week period in July and August 2016 to act as a baseline for annual comparison of parent/carer satisfaction with Children and Young People's Services in North East Lincolnshire. The results and comments recorded show that overall there is high level of satisfaction with all services.
- The trust participated in the End of Life Care Audit – Dying in Hospital: National report for England 2016. The trust scored the same as the England average for one clinical quality indicator, better for two and worse for three of the indicators. The trust met seven of the eight organisational indicators.
- There had been an increase in the number of patients who died in their own home due to increased recognition of patients who were in their last days of life and seven day working practices in the specialist palliative care team, therapies and equipment provision. There had been a significant decrease in those patients who had died in hospital.

Nutrition and hydration

- A Malnutrition Universal Screening Tool (MUST) was used on the wards and uploaded onto the patient electronic system identifying the risk. The computer system would identify when a reassessment was required. We observed that patients' MUST scores were completed.
- Protected meal times were in place and we observed that patients were provided with their meals promptly and with assistance where needed. Drinks were provided at meal times and between meals; we saw that drinks were placed within patients' reach.
- Fluid balance charts we reviewed were kept up to date.
- We were however not assured that patients in the ED at SGH were offered suitable nutrition and hydration. Out of 33 sets of notes, only one had documented that a patient had a drink of water; therefore we were not assured patients had adequate nutrition and hydration whilst they were in the emergency department for a long period of time. We also observed practice and saw that not all patients were routinely offered food or drinks.
- Two audits of end of life care records completed in October 2015 and May 2016 showed that not all patients were being assessed for their nutrition and hydration needs however, during our inspection we saw nutrition and hydration assessments in most of the care records we looked at. If patients were assessed as high risk of malnutrition or dehydration food and fluid charts had been implemented.

Summary of findings

- The United Nations Children's Fund (UNICEF) baby friendly initiative is a global accreditation programme developed to support breast feeding and promote parent/infant relationships. The service was level two accredited and was due to be assessed in January 2017 for level three accreditation.
- There was a strong culture of comfort requirements at the end of life and staff we spoke with were clear that nutrition and hydration needs were led by the patient's condition.
- Specialist palliative care staff told us they provided advice to other staff about nutrition, hydration and regular mouth care to promote comfort at the end of life.

Pain relief

- The trust's guideline and observation chart for the management of pain, agitation, delirium and sedation had been approved in June 2016.
- We saw examples of effective assessment of pain using a pain scoring tool and appropriate pain management and review.
- However in ED at SGH we reviewed 18 sets of adult records, 13 patient records did not have a pain score recorded, and ten patient records of the 18 records indicated pain relief had been administered. It was not possible, from the records, to determine if the remaining eight patients required pain relief. Of the 11 paediatric records, ten had no pain score recorded; six had a record of analgesia being administered. In one record there was a pain score documented as a level eight but there was no record that analgesia had been administered. This means that in the adult records five patients were given analgesia but who had not had a pain score and in the paediatric records six paediatric patients had no pain score but had analgesia administered.
- The 2015/2016 national care of the dying in hospital audit showed that 86%, 55 of the 77 patients audited had a pain assessment completed in the last 24 hours of their life. Of these 87% of the patient records had documented evidence that the patients' pain was controlled.

Multidisciplinary working

- The frail elderly assessment team (FEAST) was in place in Scunthorpe at the inspection in 2015. At this inspection we saw this team working effectively as part of the multi-disciplinary team, they attended ED seven days each week (Monday to Friday 8am -8pm and 8am – 4pm at weekends) to review patients and facilitate supported safe discharge, liaising with the community teams. At DPoW this service was provided by the 'core care-links' team.

Summary of findings

- There were established multi-disciplinary team (MDT) meetings for discussions of patients on cancer pathways. MDT meetings included attendance from specialist nurses, surgeons, anaesthetists and radiologists. Consultants from the trust also attended specialist MDT at the local tertiary hospital when they had made referrals.
- The trust had a number of link nurse roles for specific areas including tissue viability.
- We saw examples of teams working across acute and community services for example in respiratory medicine strong links were in place with community services with the introduction of specific respiratory pathways. Respiratory nurse specialists worked with the respiratory medical team and also with nurses on the main respiratory ward. They worked closely with their colleagues in the community to provide support for patients after they are discharged from hospital.
- There were transition arrangements in place for children with diabetes and epilepsy with joint clinics established. In the last CQC children's survey in 2014 the trust scored 8.4 for the question 'Did the members of staff caring for your child work well together?', this was about the same as other trusts.
- Clinical review meetings were held each week at the local hospice between the palliative care consultant and the palliative care team to discuss all referrals made to the hospital and community specialist palliative care teams. Staff told us they found the meetings were well attended and ensured they were informed about needs of the patients.

Competent Staff

- In 2015, we said that the trust must continue to improve against the target of all staff receiving an annual appraisal and supervision and that actions identified in the appraisals are acted upon. Between April 2016 and August 2016, the percentage of staff within the trust who had received an appraisal ranged between 14 and 100%. Occupational health services and the technical division had the lowest appraisal rates at 50%. The core services reported rates of between 73% and 88% however we were told at inspection that the ED at Scunthorpe was at 54%.
- Medical staff appraisals in the core services were the lowest in the women's & children's division at 65% with the highest in pathlinks at 81%. The overall lowest appraisal rate was in the medical director's office at 14%.

Summary of findings

- The trust had processes in place for consultant validation; there is a ratio of one appraiser to six appraisees. The medical director was the revalidation officer and there was a revalidation assistant in post. The trust had an electronic system to support the revalidation process.
- The trust had processes in place to support nurse revalidation.
- The trust had a preceptorship programme in place and newly trained and overseas nurses completed most of their mandatory training at an induction programme called 'Care Camp'. Care camp was a two week hands-on clinical education programme to ensure that all staff received the same training and had been in place since before the inspection in 2015.
- Competencies to support the assistant practitioner in nursing role had been developed based upon the Calderdale framework.
- The trust had a mentorship programme in place for student nurses.
- Medical device training was not consistent across the trust and we saw examples of poor and good practice. In ED medical device training was not planned but delivered on an ad-hoc basis. Nurses were not assessed on competencies for each piece of equipment and there was no clear record of medical device training or assurances staff were competent to use each piece of equipment. However in the intensive care units the service kept records of staff training for specialist equipment. We saw examples of specific competency training for example for non-invasive ventilation and coronary care competencies. Specific ward based induction was undertaken on the surgical wards and departments this involved training on specific issues and equipment used on the area.
- Nurses on intensive care units completed a local competency package; this was based on the national competency framework for adult critical care nurses. The service had successfully recruited a clinical educator who was due to commence their post in January 2017.
- All midwives said they had a designated supervisor of midwives (SOM). Staff confirmed they had access to a SOM for advice and support 24 hours a day.
- In maternity services we had concerns regarding the completion of the K2 training package (an interactive computer based training system that covered CTG interpretation and fetal monitoring) for midwives and medical staff in maternity. The timescale for completion was 30 October 2016. Training data provided by the trust showed to date 35% of medical staff and

Summary of findings

38% of midwifery staff at SGH and 86% of medical staff and 15% of midwifery staff at DPoW had completed the training. This was particularly pertinent as it had been identified as a theme in a number of serious incident investigations.

- End of life and palliative care was provided by well-trained and competent staff. There were 5.2 whole time equivalent specialist palliative care nurses covering North Lincolnshire community and one palliative care consultant.
- Supervision was in place for Specialist Palliative Care Team (SPCT) nurses by psychology staff. This offered staff the opportunity to reflect on their practice and discuss their own welfare needs.

Seven-day services

- The National Institute for Health and Care Excellence (NICE) guidelines state that palliative care services should ensure provision to visit and assess people approaching the end of life face-to-face in any setting between 9am and 5pm, seven days a week. Provision for bedside consultations outside these hours is considered to be high-quality care by NICE. The guidelines also state that specialist palliative care advice should be available, at any time of day or night, which may include telephone advice.
- The specialist palliative care nurses employed by the external provider were available seven days per week from 9am-5pm providing services to patients at DPoW. SGH did not have seven-day access to specialist advice. There was no out of hours telephone advice service available.
- The chaplains offered a seven-day service but were unable to achieve this due to the low numbers of chaplains employed by the trust.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust had policies in place for consent and Mental Capacity Act which were in date.
- Between October 2015 and September 2016 Mental Capacity Act (MCA) training has been completed by 86% of staff.
- In paediatric services we saw that Gillick competence was in place. The 'Gillick Test' helps clinicians to identify children aged less than 16 years who have the legal capacity to consent to medical examination and treatment. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions.

Summary of findings

- We observed consent being obtained in line with the trust policy.
- There was a system to ensure consent for termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We reviewed three sets of records and found women were correctly consented for the procedure and forms were signed by two doctors.
- Mental Capacity Act assessments were completed and in place identifying why the patient did not have mental capacity. We saw that capacity assessments and possible DoLS applications were discussed at nursing handovers.
- Deprivation of Liberty training had been completed by 82% of staff. Staff said they linked with the mental health teams to support them in the completion of the forms and we spoke with staff that had completed them. Staff completed an incident form for patients that required a DoLS.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). During the inspection the trust had patients subject to a DoLS authorisation. However, the electronic patient system and the internal database did not routinely flag up applications waiting for assessment or those authorisations about to expire.
- During our inspection, we looked at 13 do not attempt cardiopulmonary resuscitation (DNACPR) forms. Two forms indicated that the patient lacked capacity. We were not able to find any evidence within the notes that formal capacity assessments had been completed for these patients.
- In community end of life care the service completed an audit of DNACPR forms completed from September 2015 to December 2015. Fifty-four deceased patient notes were reviewed and all patients had a DNACPR form completed before they died. Of the 54 completed, 20 (37%) of the forms were completed by the SPCT. The audit showed that discussions with patients and their families were documented in the patient record.
- The trusts resuscitation policy stated that it is essential that a discussion with relevant others takes place where a patient lacks capacity. We found that patient records did not always evidence that these discussions had taken place, in both cases, we could see no evidence that deprivation of liberty safeguards or best interest had been considered.
- At the inspection in 2015 we raised concerns regarding the use of a CCTV monitor at DPoW in the coronary care unit, at the time there was no process for ensuring patient consent. At this inspection we saw that the trust's policy and information was displayed outside the room to inform patients and relatives that the monitor was in use but no recordings were made. We

Summary of findings

were told that verbal consent was taken and documented in the patient's notes however, we reviewed the patient's record that was in the room at the time of inspection but no consent was documented regarding the CCTV monitor. It was identified on the unit's improvement board that staff needed to document within the patient's record regarding consent for the CCTV.

- At the inspection in 2015 we raised concerns regarding the use of a baby monitor in use in the ICU at SGH. At this inspection the monitors were still in use, however, a notice was now on display outside both side rooms informing patients and their relatives about the monitors in line with trust policy. Staff we spoke with told us they informed patients and their relatives that the monitor was in use, the reasons for it and recorded this in the patient notes.

Are services at this trust caring?

We rated caring as good because:

- Overall we observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- Feedback from patients and relatives was generally positive about the way staff treated them.
- The trust's Friends and Family Test performance (% recommended) was generally better than the England Average between August 2016 and July 2016.

However:

- We did observe patients being cared for in the ED at SGH with a lack of care and compassion.

Compassionate care

- Overall we observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- The trust's Friends and Family Test performance (% recommended) was generally better than the England Average between August 2016 and July 2016. In the latest period, August 2016 trust performance was 97% compared to an England average of 95%. However in outpatients friends and family data

Good



Summary of findings

had shown a decreasing trend in satisfaction from 96% likely to recommend the service in January 2016 to 73% in October 2016. This figure had increased to 80% would recommend in November in comparison to the national average of 93%.

- In the Cancer Patient Experience Survey 2015, the trust was in the top 20% of trusts for two of the 34 questions, in the middle 60% for 25 questions and in the bottom 20% for seven questions.
- The question 'All staff asked patient what name they preferred to be called by' scored particularly low (52.57%) when compared to the top 20% of all trusts (67.1%) and the trusts 2013/14 figure (60.83%).
- Patient-led assessments of the care environment (PLACE) 2016 for the trust showed privacy, dignity, and well-being scored 84.4%, which was better than the 83.8% England average level.
- The trust received 103 responses to the CQC Survey of Women's Experiences of Maternity Services 2015. Results were similar to other trusts for 15 out of the 16 indicators relating to care received during labour and birth, staff during labour and birth and care in hospital after birth. The other indicator was better than other trusts (raising concerns and having it taken seriously).
- During the inspection we spoke with over 80 patients, 14 parents, two young people, and 11 women. We found that generally patients and relatives told us that staff were friendly, helpful and had a good attitude. They told us that staff had empathy and provided good care. Overall patients told us they were treated with compassion and respect.
- During the unannounced inspection, we carried out a short observational framework for inspections (SOFI) on a number of wards across both hospital sites. We observed good interactions between staff and patients. Patients responded positively to staff and it was clear from the patient's facial expressions that they enjoyed this interaction. Staff talked to patients regularly to see if there was anything they needed.
- The neonatal intensive care unit (NICU) at SGH had a 'quiet hour' every day to allow parents time to spend with their baby uninterrupted by medical or nursing staff. Parents told us that they found this very helpful in spending quality time with their child.
- We had concerns regarding the level of care given to patients in the ED at Scunthorpe, we saw examples where care had been delayed, we observed staff did not always show an

Summary of findings

encouraging, sensitive and supportive attitude to people. We observed care in the ED at DPoW and saw that this was different and that patients' needs were attended to in a kind and compassionate manner.

- The trust's urgent and emergency care Friends and Family Test performance (% recommended) was generally worse than the England average between November 2015 and October 2016. In latest period, October 2016 trust performance was 74.2% compared to an England average of 86.0%. We spoke to the relatives of a patient who was approaching the end of their life and they said that their relative had received outstanding care. They told us that they felt the unit leader was exceptional, that shift changes are seamless and every member of staff had been compassionate and professional without exception. The family also praised the cleaning and catering staff saying that they were also excellent. The family told us that 'staff check on us all the time' and that their relative had received authentic and genuine care.

Understanding and involvement of patients and those close to them

- In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts for all 11 questions.
- CQC's Survey of Women's Experiences of Maternity Service 2015. Showed results similar to other trusts for questions relating to involvement in decisions about care. The trust scored 8.5/10 for being involved in decisions about their care during labour and birth and score 8.1/10 for partner being involved as much as they wanted.
- Patients and relatives we spoke with told us that staff answered their questions fully or if they did not know, they would go and find out the answer. Medical staff had explained things to them in a way they could understand and they provided an example of medical staff drawing pictures to explain issues to the patient.
- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risks and benefits of treatment.
- In critical care the diary we saw at the 2015 inspection was still in use to ensure that relatives were involved and could make entries in the diary.
- In critical care staff we spoke with knew the procedure for approaching relatives for organ donation when treatment was being withdrawn.
- The NICU used a 'parent's journal' in which both staff and parents were encouraged to write and share information about

Summary of findings

a babies development, including stories, comments or concerns. We observed that of the six journals we saw, these were only around 20% complete. Staff acknowledged that they would like the journals to be utilised more to increase information sharing and participation between staff and parents.

- Women using the trust's maternity services said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby. Partners said that they felt involved in their partners care and treatment and had things explained appropriately.
- In a trust audit carried out in May 2016, only 40% of the records indicated that there had been communication with the patient to inform them they were in the last days of life however, 100% of records showed that discussion had taken place with the patient's family.
- In outpatient services, there was a variable response. Patients and relatives we spoke with told us about a lack of continuity of care and doctors having differing opinions and giving different information. A relative told us her elderly relative was treated well when in the department but not getting appointments on time felt like they did not matter.
- The majority of patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.

Emotional support

- A multi-faith chaplaincy service was available for patients to access during their stay.
- Counselling was provided prior to surgery for cancer or potential stoma colorectal patients.
- Clinical nurse specialists (CNS) supported patients diagnosed with cancer and provided them with written and verbal information; patients were offered contact details of the CNS team.
- Play specialists were available during week days to support children.
- Staff said perinatal mental health risk assessments took place for pregnant women at the booking appointment, throughout pregnancy and during the post-natal period.
- There were no specific counselling services for women who had experienced pregnancy. However, staff said women were given a contact number and could contact the clinic at any time for support and advice

Summary of findings

- The critical care service did not have access to psychological support or counselling services. Staff could refer patients to their GP for support following discharge.

Are services at this trust responsive?

We rated responsive as Requires Improvement because:

- The trust had significant access and flow issues which had not changed since the inspection in 2015. The trust performance with referral to treatment times and management of capacity and demand have shown either no or minimal improvement since 2015.
- Services did not always meet patients' needs. Patients were not always able to access services for assessment, diagnosis or treatment when they need them. There were long wait times and waiting list management for both outpatient and inpatient services remains reactive and continue to lack management oversight.
- There were significant numbers of medical patients being cared for on surgical wards. Moves out of hours were identified and there were concerns regarding the arrangements in place with regard to consultant cover for patients who were moved to surgical wards.
- In 2015 we raised concerns regarding the numbers and reporting processes of mixed sex breaches. The trust had updated the policy for eliminating mixed sex accommodation, which was in line with Department of Health guidance (November 2010). However the trust has continued to report mixed sex breaches in a number of core services. For example, in medicine at SGH 14 mixed sex breaches had been reported.

However:

- There were improvements in the ophthalmology service specifically with regard to the cancellation of clinics and clinical oversight of this process.
- The trust was in the process of expanding the nursing teams for people living with dementia and who had learning disabilities.

Service planning and delivery to meet the needs of local people

- The trust worked closely with external partners and stakeholders through a number of forums including contract monitoring board and a number of work streams supporting the sustainability transformation programme.

Requires improvement



Summary of findings

- There were a number of services that were being developed in collaboration with other local providers and tertiary referral services to ensure patients could be seen locally wherever possible.
- Capacity and demand plans were carried out at speciality level across the trust and a lead for capacity planning had been appointed. We were told that capacity plans were based upon consultant job plans; however, at the time of inspection consultant job plans were being reviewed.
- The trust was working with the 'NHS Improvement Intensive Support Team to ensure the trust had recovery plans in place to achieve the referral to treatment time standards and to address other waiting list issues.
- The department had joined the North Yorkshire and Humber Trauma Network. Trauma networks are set up to deliver specialist treatment to patients with major trauma such as severe heads injuries within a specified geographical area. A requirement of being part of the network to improve and share best practice. The department submit data to the Trauma Audit and Research Network (TARN) on an annual basis.

Meeting people's individual needs

- Between July 2015 and July 2016, there were 466 patients with learning disabilities that had been admitted to either SGH or DPoW.
- The trust had a quality matron who was the trust lead for learning disability patients; staff could contact the staff member through the hospital switchboard. The trust was in the process of recruiting to two full time posts to support people with learning disabilities.
- In the ED if a patient with learning disabilities had previously attended this would be flagged on the ED system known as symphony, we saw this in place at the inspection.
- Staff used a telephone interpreting service to communicate with patients who did not speak English. Staff said the system worked well. Face to face interpreters were also available and there was access to British Sign Language (BSL) interpreters.
- Prior to the inspection, we held focus groups for patients with a learning disability and their carers; who were generally positive about the care they had received at this trust.
- We saw that when patients required bariatric equipment this was easily accessible.
- The wards and departments were accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available.

Dementia

Summary of findings

- Between August 2015 and July 2016 there were 1,434 patients admitted to DPoW and 1,587 patients admitted to SGH with a diagnosis of dementia.
- The trust had a non-executive director identified as a lead for learning disabilities and dementia.
- The trust had a Dementia Delivery plan in place which identified outstanding actions and plans following the 2012 National Dementia Audit.
- We reviewed patient led assessment of the care environment (PLACE) results for DPoW and noted they were 50.6% for dementia, which was worse than the 75.8% England average for 2016. The scores for disability were also worse with 65.7% being scored for the site against a national average of 78.5%.
- We held focus groups for people living with dementia and their carers who had attended services at DPoW and SGH. During these focus groups a number of concerns were raised regarding their experiences of out-patient appointments, they felt that environment in outpatients was unsuitable, appointment times or days offered lacked flexibility and choice, there was a lack of understanding by some staff about dementia and there was no support offered to carers. However there were also very positive experiences shared by the group with some patients and carers describing excellent care particularly as inpatients.
- At the inspection in 2015 there was a matron in post whose role was partly dedicated to dementia and learning disabilities. We noted and commended the commitment of the individual to the development and delivery of a patient focussed service for these groups of patients. However we also raised concerns regarding the workload of the matron. The trust had approved and was in the process of appointing to two further full time posts to strengthen the team at DPoW and SGH.
- We were told that dementia training was on the trust's "essential training" list. The trust reported that at the time of the inspection 72% of staff had completed tier one dementia training and 50% of staff had completed tier two training.
- The trust had an education and training strategy for dementia care in place
- There was no flagging system in place to enable patients living with dementia to be identified on admission to the trust. However on the wards patients were easy to identify using the WebV electronic system. In medicine staff could tell us which patients on the wards were living with dementia and this was identified within their record.
- In November 2016 the trust carried out an audit of the use of "My life" booklets (equivalent to patient passports) which have been in place for two years however the results were not

Summary of findings

available at the time of inspection. We reviewed a booklet during the inspection and saw that they included: what is important to me; how best to support me; eating and drinking; support for personal care; etc. Patients take a copy of “My life” home and a copy is kept in the care notes.

- Some staff took on a dementia friendly role and felt passionate about this responsibility. This included encouraging others to learn more about dementia.
- The trust had started to use “John’s campaign” which was being trialled on four wards.
- A number of wards provided specialist equipment for people with dementia for example on Amethyst ward at DPoW they provided “rummage boxes”. In the emergency department they used covers for plaster casts for people with dementia with the aim of reducing damage to the casts.
- A small number of areas had undertaken work to improve the environment for patients who were living with dementia. ED and outpatients were in the process of raising funds to enable refurbishment of a cubicle and consulting room to be dementia friendly.

Access and flow

- The trust performance with referral to treatment times and management of capacity and demand have shown either no or minimal improvement since 2015.
- The trust had external support to work with them to develop recovery plans and improve trust performance for cancer performance and referral to treatment times particularly in key areas like ophthalmology and maxillofacial surgery.
- Access to services and patient flow through the hospital however, remained an issue across a number of services resulting in long waits for treatment, backlogs of people waiting for outpatient and inpatient services and patients being cared for on non-medical or non-speciality wards.
- The main reason for delayed transfer of care at the trust was ‘waiting further NHS non-acute care’ (40%), followed by ‘completion of assessment’ (21.2%). This was recorded between August 2015 and July 2016.
- Bed occupancy was below the England average between Q3 2014/15 and Q4 2015/16.
- The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. Between August 2015 and July 2016 the department breached the standard in all months. As at July 2016, the trust wide position for the four-hour wait was 91.5%.

Summary of findings

- Between November 2015 and October 2016, the monthly percentage of patients waiting between four and 12 hours in the ED, from the decision to admit until being admitted for this trust, was worse than the England average for six out of the 12 months (January 2016 to June 2016).
- Information provided by the trust showed that during the six month period of February to July 2016 682 medical patients had been internally transferred between 10pm and 8am at SGH. At DPoW there were 626 patients who were moved wards after 10pm from February 2016 to July 2016, with over 130 patients in the month of February 2016, the amount had begun to reduce but increased to 115 patient moves in July 2016. We observed in stroke meeting minutes that a patient was sent to the ward at 12 midnight.
- Information provided to us by the trust showed that between April and September 2016 there were 38 medical outliers on non-medical wards. This figure does not include patients outlying on non-speciality medical wards, for example a patient with an endocrine problem being cared for on a stroke ward. A 'buddy ward' system had been agreed for medical outliers. However, we found that patients did not always go to the buddy ward and this caused confusion about which consultant was looking after which patient.
- Staff we spoke with and records we reviewed showed that medical outliers were not assessed regularly and were at risk of delays in their care due to being transferred to different wards and consultants. We saw an example of a patient being moved to three different wards and being under the care of three different consultants.
- The trust performance of meeting referral to treatment times (RTT) for patients admitted for treatment within 18 weeks of referral had been worse than the England overall performance since June 2016. Data for October 2016 showed 73.7% of patients were treated within 18 weeks versus an England performance of 75.5%.
- In medicine for admitted pathways performance was worse than the England overall performance. Figures for October 2016 showed 74.9% of this group of patients were treated within 18 weeks. Over the time period, RTT performance had deteriorated ranging between 80-89% to between 70-79% while the England average has remained fairly consistent at 91-93%. This was worse than at the last inspection. The trust had not been compliant with the 18 week referral to treatment indicator since June 2015.
- Three medical speciality areas were above the England average for admitted referral to treatment times; these were general

Summary of findings

medicine 100%, rheumatology 100% and thoracic medicine at 96.2%. Three speciality areas were below the England average for admitted referral to treatment times; these were dermatology at 25%, cardiology 69.7% and gastroenterology 86.7%.

- Two week breaches were still occurring in endoscopy. We reviewed the endoscopy activity report and found between April 2016 and November 2016 there were 387 breaches in urgent and two week waits for endoscopy. There were 2,194 patients waiting for a follow up appointment.
- We saw in the JAG action plan actions to address the two and six week breaches in endoscopy. Actions included; providing additional capacity at weekends and weekly monitoring of activity. The target date for completion was December 2016 and this was amber on the action plan indicating they were on target to achieve this.
- Staff in the cardiac catheter laboratory told us that procedures were often cancelled on the day. This was an issue at the previous inspection and had not improved. Staff recorded how often cancellations occurred and from the 4 November to 23 November 2016, 17 procedures had been cancelled on the day; of these 11 were due to no time. There were 15 cancellations in October 2016. We were told there was an action plan in place to understand and address the issue of cancellations.
- Trauma and orthopaedics and ophthalmology were performing below the national average with data 63.2% (67.2% national) and 72.6% (78.7% national) respectively. Urology, ear nose and throat, general and oral surgery were all performing above the national average, with data ranging from 79% to 82.9% (national data ranged from 70.3% to 80.2%).
- Theatre usage within the trust ranged from 0% to 95.4% during the period of May 2016 to July 2016. Data for this site was lowest at 63% overall usage. Theatres five and six reported 0% in May and June 2016, after which they had utilisation rates of 80%). The trust had a target for theatre utilisation of 93%.
- We reviewed on the day cancellation rates April 2016 to June 2016, at DPoW for clinical and non- clinical reasons 98 patients had their operation cancelled on the day for clinical reasons and 134 for non-clinical reasons. However, when both sites are added together and compared against last year's data this shows that the trust cancelled more patients in April 2016 to June 2016 282 patients for clinical reasons against 240 patients in March 2015 to May 2015. This was reflected in cancellations for non-clinical reasons 236 April 2016 to June 2016 against 180

Summary of findings

March 2015 to May 2015. We discussed this with the senior management team who were aware of the number of cancellations, and said that a number of them were due to the industrial action by junior medical staff in April 2016.

- The trust shared information with us that two surgical patients waited over 52 weeks for treatment one in general surgery and one in urology November 2016.
- In 2015 we raised concerns regarding the numbers and reporting processes of mixed sex breaches. The trust had updated the policy for eliminating mixed sex accommodation, which was in line with Department of Health guidance (November 2010). However the trust has continued to report mixed sex breaches in a number of core services. For example in medicine at Scunthorpe 14 mixed sex breaches had been reported.
- The ambulatory care unit (ACU) opened in September 2015 and it made a positive impact to patient flow on the SGH site.
- We saw that there was an unscheduled care team of which included a rapid assessment time limited service (RATL) which aimed to prevent hospital admissions where appropriate and supported rapid discharge from hospital. This included the rapid response equipment service and social work team who gave advice and supported families.
- The trust had bed management teams on the acute sites to co-ordinate patient flow across the hospital. There were regular operational meetings throughout the day to review patient demand, bed availability and staffing pressures. A new role was being piloted in medicine called a 'care navigator' to improve the flow of patients at the point of discharge. The post holder attends ward rounds, obtained patients scan results and expedited discharge medication to support.

Learning from complaints and concerns

- Between September 2015 and August 2016 there were 471 complaints about the trust. The trust took an average of 57 working days to investigate and close complaints. Of these 99 were closed within 30 days.
- The trust had an up to date policy and procedure for the management of complaints, concerns, comments and compliments which clearly set out the processes to be followed when responding to complaints and roles and responsibilities.
- Information for patients on how to make a complaint was evident within clinical areas. There was information on the trust website on how to make a complaint.
- The most common complaint theme was regarding clinical treatment; this was the most common theme for the majority of

Summary of findings

core services. Medicine is the core service with the highest number of complaints (26.3%) and Diana, Princess of Wales Hospital is the site with the highest number of complaints (50%).

- Reports for the assurance committees provided qualitative and quantitative information, identified themes and trends from complaints and detailed any changes to practice as a result of complaints investigations.
- We were told learning from complaints was shared widely across the trust via the Patient Experience Group.
- Staff we spoke with gave a mixed picture of learning from complaints with some staff saying they were informed of the learning whilst others, particularly junior staff, told us they were not.
- The trust had carried out a Complaints Handling Survey which showed that overall people reported that the role of the complaints facilitator was helpful. However out of 70 responses 35 respondents felt the written response from the trust did not answer all of the questions and 33 people out of 72 responses did not feel confident that the trust would act on lessons learned from the complaint.

Are services at this trust well-led?

We rated well-led as inadequate because:

- Urgent and emergency care, surgery and outpatients were rated as inadequate for being well led.
- There is insufficient management oversight and governance at Board, senior and middle management levels of the identified risks and performance of the trust that has resulted in reoccurrence of patient backlogs and a deteriorating overall position with regard to referral to treatment times and patients waiting for follow up outpatient appointments and diagnostic tests in endoscopy.
- The trust had a Board Assurance Framework (BAF) and a corporate risk register in place, there were concerns that the risks recorded remained on the BAF for prolonged periods of time even after mitigations had been put into place. There were 24 risks recorded on the BAF of which many were rated as amber. There were concerns that the right assurances were not in place.
- We had concerns regarding the capacity and capability of the divisional management teams specifically with regard to the recognition, recording and mitigation of risks within the core services and ensuring timely action to address risks.

Inadequate



Summary of findings

- We had significant concerns in a number of core services as strategies were not well developed.
- We did not feel that all management teams had a detailed understanding of the performance data nor did we see credible recovery plans that would address those areas of concern.
- We were not assured that the concerns raised at the inspection in 2015 had been addressed at pace to ensure that services across the trust were safe and of high quality.
- We had concerns regarding the overall culture of the organisation in a number of areas, specifically we saw examples which did not contribute to a positive organisational culture.
- We found poor leadership and oversight in a number of services, notably maternity services and urgent care. In these services leaders had not led and managed required service improvements robustly or effectively. In addition service leads had tolerated high levels of risks to quality and safety without taking appropriate and timely action to address them.

However:

- There were improvements in critical care services, there was a clear vision and governance processes were effective.
- There was a new management team in surgery who were able to demonstrate an understanding of the challenges and the areas that required further improvement. They had only recently come into post and had not had sufficient time to implement the changes required to address the ongoing concerns.
- There had been improvements across community adult services, community children and young people's services and notably in end of life care services. The leadership team in end of life were committed and had a clear vision for the service.

Leadership of the trust

- The trust had a Board of Directors, there are five Care Groups covering acute and community services. Each Care Group is led by an Associate Chief Operating Officer, Associate Medical Director and Associate Chief Nurse. Within the Care Groups services had a clinical lead.
- The Chair had only recently been appointed and was able to articulate a clear need for a change in leadership approach and the need for further work to develop capability and capacity across all of the management teams.
- There is insufficient management oversight and governance at Board, senior and middle management levels of the identified risks and performance of the trust that has resulted in

Summary of findings

reoccurrence of patient backlogs and a deteriorating overall position with regard to referral to treatment times and patients waiting for follow up outpatient appointments and diagnostic tests in endoscopy.

- We were not assured that the concerns raised at the inspection in 2015 had been addressed at pace to ensure that services across the trust were safe and of high quality. This was particularly evident in surgery, accident & emergency and maternity services. However, we did see improvements in critical care, community services and end of life services.
- We found poor leadership and oversight in a number of services, notably maternity services and urgent care. In these services leaders had not led and managed required service improvements robustly or effectively. In addition service leads had tolerated high levels of risks to quality and safety without taking appropriate and timely action to address them.
- In outpatient services there had been improvements with some of the specific processes regarding ophthalmology. There remained a lack of management oversight of the recurrent backlogs and deteriorating trust performance across a range of access and performance indicators and access targets.
- The hospital lost their Joint Accreditation Group status due to communication issues and an audit not being submitted correctly.
- There was a new management team in surgical services who was seen to have a clear vision for the service however improvements under the previous management team had been slow and required improvements still needed to be implemented.
- Senior staff told us that there was a lack of support for children's services at board level.
- The trust had undertaken further work to strengthen clinical leadership since the last inspection with the development of a number of Associate Medical Directors however this still need further development.
- An in house programme was being developed for Clinical Leads that focussed on providing them with practical leadership skills. However we were unable to determine the impact of the programmes at the time of our inspection.
- There was an acknowledgement that there has been a lack of board development, this was recognised by the Chair and since commencing in post had set out the requirements for board development.
- The trust had appointed an Associate Medical Director for Strategy and Planning.

Summary of findings

- Since the last inspection, the trust had received support from an Improvement Director. Following the inspection, the trust recognised the need for a more holistic improvement plan and this was in progress.
- At the 2015 inspection we raised concerns regarding the lack of visibility of the executive team. The trust was undertaking leadership walk rounds and executive directors and non-executive directors had 'adopt a ward'.
- In the staff survey the trust had scored worse for the support from immediate managers (3.63 vs England average 3.7).
- Between October 2015 and September 2016, the trust reported a sickness rate of 5%; Pharmacy had the highest sickness rate (8%).
- Between October 2015 and September 2016, the trust reported a turnover rate for nursing and midwifery of 15%; Trust wide services (wards/services not covered by a core service) had the highest turnover rate (29%). Between October 2015 and September 2016, the trust reported a turnover rate for medical staff of 31%; End of life care had the highest turnover rate (55%) and trust wide services the lowest (0%).

Vision and strategy

- The trust had a five year strategic plan for the period 2014 to 2019. The strategic plan set out the values and vision of the trust with the patient at the centre. We were told the vision and values had been developed with staff across the organisation in 2012 to 2013 although staff awareness of it remained variable.
- The Strategic Plan identified the key strategic risks and was underpinned by a number of supporting strategy and operational documents including the 2015 to 2016 operational plan. The trust operational plan had been in place since 2014 and was due for review 2016, this set out both quality and financial plans.
- The trust had previously developed the Healthy Lives Healthy Future strategy, this now formed part of the Sustainable Transformation Plan for Humber Coast and Vale of which the trust was a key partner.
- The Director of Nursing was in the process of developing a Nursing Strategy that was based upon the values of the organisation and would take the form of a pledge. The strategy was linked to the ten key commitments for nursing and the Six 'C's'. This was currently in draft form and had been submitted to the Quality and Patient Experience Committee and Nursing and Midwifery Forum (NMAF) for comment. An extended NMAF was planned for December 2016 to develop key performance indicators for the nursing strategy.

Summary of findings

- A clinical strategy was being developed with service reviews in progress at the time of the inspection these would be embedded in the overarching strategy and we were informed that this would be ready by December 2016. The strategy was being developed with the involvement of the clinical leads from the services.
- We had significant concerns in a number of core services as strategies were not well developed. The lack of detailed service strategies had been raised at the 2015 inspection. The clinical strategy for surgical services did not make detailed reference to national reports and recommendations, the trust values and strategy, or have clear deadlines for actions. We discussed this with the senior management team who were aware of the issues and said that this document was a list of immediate priorities to focus on, and as they were new in post, they required further time to populate and embed all of the actions required.
- The vision and strategy for emergency and urgent care created since our last inspection in July 2015 was still in its infancy. The vision did not encompass key elements such as compassion, nursing care, patient safety and quality. Not all staff were aware of, or understood the vision and strategy for the department. However in critical care and children and young people's services we saw well developed strategies underpinned by mission statements and business objectives.
- A multi-agency group had been set up to devise and implement an end of life care strategy that encompassed the whole of the local health economy. We looked at the document and found that the vision and purpose of the strategy was to ensure that appropriate care was provided in the appropriate setting at the right time, and to ensure that access to care was seamless and easy, and that the patient's needs and wishes were central.
- The trust had an Information Management and Technology Strategy, the trust were in year three of the strategy at the time of inspection. At the previous inspection had implemented the WebV Clinical Portal, this had been expanded to include a new theatre system.

Governance, risk management and quality measurement

- There was a governance framework and systems in place to support staff to identify and review risk and incidents and to ensure effective escalation of risk from the clinical areas through to the trust board. At the 2015 inspection we were

Summary of findings

concerned that the governance framework had not been implemented consistently across all core services. Since the 2015 inspection the trust had reviewed and strengthened the governance framework.

- There were a number of board assurance committees; these were chaired by non-executive directors (NEDS), the Quality and Patient Experience Committee (QPEC) which focussed on outcomes; the Trust Governance and Assurance committee (TGAC); the Mortality Performance and Assurance committee (MPAC); the Resources committee and; the Audit committee. There was however duplication of discussion between the QPEC and TGAC, this was acknowledged by the NEDs.
- QPEC identify annual themes, we were told that current themes focussed on community, surgery and maternity services. The agenda for QPEC is set two weeks prior to the meeting by the Director of Nursing, Medical Director and Chair of the committee.
- The trust had a Board Assurance Framework (BAF) and a corporate risk register in place, there were concerns that the risks recorded remained on the BAF for prolonged periods of time even after mitigations had been put into place. There were 24 risks recorded on the BAF of which many were rated as amber. There were concerns that the right assurances were not in place. We were told that risks would not be rated as green until the evidence provided demonstrated sustainability. There were no dates for completion of actions on the BAF.
- The BAF was reviewed quarterly in conjunction with the corporate risk register at the Trust Governance and Assurance Committee (TGAC). A report is submitted to the board quarterly.
- At this inspection we remained concerned that risks were not always identified or had robust controls in place, we saw evidence that this had resulted in harm or sub-optimal care of patients. For example, the backlog of ophthalmology outpatients and the cluster of serious incidents in maternity services. Risk scores on the corporate risk register did not always change following the mitigation, we were told that the actions to mitigate the risks may not impact quickly and therefore the risk rating would remain the same.
- Risk registers held at care group and service level were variable in the accuracy of reflecting current risks. We had concerns regarding the capacity and capability of the divisional management teams specifically with regard to the recognition, recording and mitigation of risks within the core services and ensuring timely action to address risks.
- In a number of services such as urgent care, maternity and services for children and young people key risks were not fully

Summary of findings

understood, recorded, escalated or mitigated effectively. During our inspection senior members of staff for maternity services, were unable to highlight the risks identified above. In particular, staffing and lack of escalation procedures were not identified as risks on the services risk register.

- However we saw risks in surgery and critical care services were discussed at the governance meetings and escalated appropriately.
- Care groups held governance meetings as part of the trust governance framework we reviewed a sample of governance minutes across the core services and saw that they were generally well attended. Issues discussed included incidents, complaints, patient safety alerts, mandatory training, serious incident and RCA action plans and the risk register. Previous actions were reviewed and monitored.
- Safety days in critical care and surgery took place bi-monthly.
- The trust had a performance management framework in place that served to support and hold to account divisional management teams. The trust had a special measures process for those divisions whose performance was deteriorating. Trust performance was discussed weekly with the Executive team. The trust had external support from the NHS Improvement Intensive Support Team who had supported the trust to develop an overarching performance committee. There were improvement plans and trajectories in place however performance against national indicators were deteriorating, backlogs of patients had recurred and there continued to be a lack of management oversight and control.
- A monthly quality and performance report and a report on the delivery of sustainability programme to ensure there is robust governance around the delivery of financial responsibilities are submitted to the board. We reviewed the Performance Compliance Reports for May, June and July 2016, the reports focussed on the trust's key performance measures and provided an indication as to whether performance was improving or deteriorating.
- The trust and core services had access to a wide range of data however we were concerned that the data did not always accurately reflect performance. We did not feel that all management teams had a detailed understanding of the performance data nor did we see credible recovery plans that would address those areas of concern. An example was the disparity in the published time to initial assessment of patients arriving in ED and the lack of recognition on the part of the management team regarding the published data. The one minute performance had been published for over a 12 month period. In

Summary of findings

addition patients brought in by ambulance staff to ED were not booked in to the department until handover was carried out. We spoke to management teams regarding this practice and they informed us they thought this practice had been stopped some months previously.

- We did not see a consistent approach to learning and dissemination of learning from incidents and staff in some areas told us that they had not received feedback from incidents. There was evidence of lack of learning from incidents particularly in maternity services.
- Quality impact assessments were carried out and there was a process in place for these to be reviewed by the Director of Nursing and Medical Director. We were told that all changes in nurse staffing are signed off by the Director of Nursing prior to implementation.

Culture within the trust

- We had concerns regarding the overall culture of the organisation in a number of areas; specifically we saw examples which did not contribute to a positive organisational culture.
- We heard from staff of ongoing concerns regarding the relationship between management teams with specific concerns being raised regarding the lack of engagement with staff by middle management teams.
- There was variation in the level of clinical engagement across the trust.
- Feedback from focus groups and interviews presented significant variation in how staff perceive the culture of the trust. There were a number of themes that emerged from the discussion relating to a disconnection still between the executive team and staff, there was a sense of fear amongst some staff groups regarding repercussions of raising concerns and bullying and harassment. Feedback from management teams had a more positive focus.
- We raised concerns at inspection regarding the trust approach to the application of the disciplinary process. We saw on a surgical ward at DPoW a poster that stated staff would be subject to a disciplinary process if they did not complete the required tasks with regard to legionella. We were informed that this had been put up by a band five staff nurse. We were told of other examples of staff receiving automated letters informing them of possible disciplinary action if actions were not carried out.
- Staff told us that they would receive written warnings for failures to complete standardised daily clinical checklists. Guidance stated that the trust had a zero tolerance approach to

Summary of findings

checks being missed. However, staff told us that did not take into account times of increased patient need, shortage of staff, or other circumstances meaning that checks were not completed. This impacted on morale.

- In the staff survey 2015 the percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse was better than the England average (19% vs England average 35%)
- In the 2015 staff survey, the surgical health group had scored joint second highest directorate for experiencing harassment, bullying or abuse from staff in the last 12 months with 32% of surgical staff completing the survey, 14% of surgical staff completing the survey said they had reported harassment, bullying or abuse. The surgical directorate also scored the second lowest score when asking staff what percentage reported good communication between senior management and staff.
- The recently appointed Director for People and Organisational Change planned a cultural survey in January 2017 which will be used to develop more focussed action plans
- In the 2015 staff survey the trust performed better than other trusts in recognition and value of staff by managers and the organisation (3.33 vs England average 3.43); and the percentage of staff reporting errors, near misses or incidents witnessed in the last month (93% vs England average 90%)
- In the staff survey, 2015 staff recommendation of the trust as a place to work or receive treatment was lower than the England average (3.51 vs England average 3.75)
- However during the inspection staff we spoke with in a number of services told us they were happy in their work, felt supported and valued by their immediate and directorate managers. They felt able to raise concerns and that the culture on both units was open and honest.
- In critical care staff morale had been affected by the movement of nurses from ITU to the wards to cover shortfalls in staffing. Staff had raised their concerns and spoke positively of the changes the new leadership had made, for example, ensuring the moves were fairly distributed and the change to expectations of nurses when moved to the wards to ensure they were not working outside of their competency.

Equalities and Diversity – including Workforce Race Equality Standard

- As part of the Workforce Race Equality Standard (WRES) programme we have added a review of the trusts approach to equality and diversity to our well led methodology. The WRES

Summary of findings

has nine very specific indicators by which organisations are expected to publish and report as well as put action plans into place to improve the experiences of its Black and Minority Ethnic (BME) staff.

- The trust had an Equality and Diversity Policy in place however further work was required in ensuring equality and diversity was embedded in the trust.
- We saw that new policies had an equality impact assessment.
- With regards to the Equality Delivery System (EDS2), the equality objectives, policies and strategies were out of date and there was little evidence that outcomes for protected groups, within the workforce were routinely monitored.
- The Public Sector Equality Duty (PSED), the publication duty (due in January of each year) which shows how a trust meets the requirements of the Equality Act had not been met.
- We were not assured that the trust is compliant with its contractual compliance in relation to equality and diversity. However, it is not possible to say whether the trust is meeting its obligations under the Public Sector Equality Duty (PSED) because of the lack of evidence. This was because the published data on their website was out of date and only covered BME not the other protected characteristics. The equality objectives on the website were dated March 2012/13 and also the WRES data was Apr13-March15. Did find in the Board reports on the website WRES data for 15/16, but again this pertaining to BME and no other groups.
- The 2016 WRES report pertaining to this trust was published on its website. However, the data within this report does not completely reflect the data set out within the Trust's 2016 WRES report to external stakeholders or the national 2015 Annual NHS Staff Survey data which is publicly available online.
- The Director of People and Organisational Effectiveness was aware of gaps in the trust's Equality and diversity responsibilities, however we were told that the trust was presently out to advert for a Equality & Diversity Lead post to push the equality agenda forward. The trust was undertaking a gap analysis for Equality & Diversity.
- The trust did have a Lesbian Gay Bisexual and Transgender (LGBT) staff network however it had only recently been established and at the time of inspection had met once.

Fit and Proper Persons

Summary of findings

- The trust was aware of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust policy covered pre-employment checks in accordance with NHS Employers pre-employment check standards including: two references, one of which must be most recent employer; qualification and professional registration checks; right to work checks; proof of identity checks; occupational health clearance; disclosure and barring service (DBS) checks (where appropriate); search of insolvency and bankruptcy register; search of disqualified directors register.
- During the 2015 inspection we identified gaps in the documentation of the director's files that were reviewed. At this inspection we saw that the trust had taken action to improve the process. We reviewed the annual declaration in respect of compliance with the Fit and Proper Persons Test dated September 2016. This set out the standards against which the trust measured itself for meeting the requirements of this regulation, the evidence required and the assurance. The trust had pre-employment checks in place for use by the recruitment team.

Public engagement

- The trust had a Patient Experience strategy covering the period 2015-18, this document was accessible via the trust website.
- Patient stories were discussed at the Trust Board every month.
- In a number of core services, we saw examples of engagement with patient groups including Maternity Led Group; Young Carers Forums; PLACE inspection; Cancer group and the Multiple Sclerosis Forum.
- In the staff survey 2015 the trust scored worse than the England average for the effective use of patient/service user feedback (3.51 vs England average 3.69).
- There was a Board of Governors who were very committed to the trust and participated in trust wide walk rounds. However, the governors were not fully aware of the scope of their role and function, for example they were unaware that it was within their remit to request the presence of trust external auditors to the Council of Governors.
- In children and young people's services a 'pants and tops' system to allow children to feed back on the care they received. Children filled out 'pants' templates and said what they did not

Summary of findings

like, or filled in 'tops' templates to say what they did like. At the time of our inspection, completed templates were displayed on the ward. However, these had not been updated since August 2016.

- The trust had held dying matters roadshows at a number of venues in May 2016. This had been advertised as an event to provide advice and sign posting to members of the public on all aspects of planning end of life care, bereavement, dying, organ donation and will writing.

Staff engagement

- The trust had a joint negotiating consultative committee (JNCC) which was very well attended and we were told that there was a focus on developing a partnership approach for this committee.
- The trust had a cohesive staff side team who told us they worked well with the executive team however, there was still further improvement required with regard to how the organisation took steps to ensure staff were engaged.
- In the NHS Staff Survey 2015, the trust performed better than other trusts in two of the 34 questions, about the same as other trusts in 18 questions and worse than other trusts in 14 questions.
- The trust response rate was worse than the England average (34% vs England average 41%).
- The trust performed worse than other trusts in a number of areas that related to staff engagement and the trust engagement score of 3.69 placed the trust in the bottom 20% of trusts. The trust also scored lower for organisation and management interest in and action on health and wellbeing (3.47 vs England average 3.57), staff feeling able to contribute towards improvement at work (67% vs England average 70%) and staff satisfaction regarding flexible working opportunities (41.44% vs England average 49.3%).
- However, although lower than the England average there was a high percentage of staff agreeing that their role makes a difference to patients (87% vs England average 90%).
- Monthly briefings took place to keep staff up to date with events across the trust.
- Staff in children and young peoples' services told us that they did not always feel that their views were sought before changes were made. However, the majority of staff told us that they understood the nature of changes being made to services, for example in a change in NICU staffing.

Innovation, improvement and sustainability

Summary of findings

- There was a new initiative called the virtual ward. Two health care assistants were available all day Sunday to Friday and half days on Saturdays. They were deployed to an elderly medical ward at the start of their shift, and then re-deployed to any area with short notice absence or where one to one patient care was required.
- A skype service run by the infant feeding co-ordinator was being offered to support breast feeding mothers within the community setting.
- The development of Advanced Midwifery Practitioners and Advance Nurse Practitioners in gynaecology.
- There was a dedicated member of staff to manage interpretation and translation services which also includes British Sign Language based at the DPoW.
- In 2016 the community midwifery team were nominated for the provision of an education programme aimed at expectant teenage mums and fathers.
- The two week intensive care camp for newly qualified staff and overseas nurses was innovative. It gave staff a good grounding in the behaviours and values the trust expected and highlighted differences in practices between other countries and the UK.
- There was a new award in the trust in recognition of clinical areas that had achieved and maintained all of the trust's quality standards for at least 12 months. Critical care had been the first unit to receive the gold award.
- The trust held an annual 'Best Practice Day for End of Life Care' conference for the third year in 2016. Staff we spoke with who had attended this told us that it was valuable and that they cascaded the learning to other members of their teams.

Overview of ratings

Our ratings for Scunthorpe General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Overview of ratings

Our ratings for Diana Princess of Wales Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Our ratings for Northern Lincolnshire and Goole NHS Foundation Trust

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

Overview of ratings

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	N/A	N/A	N/A	Good	Good
Community health services for children, young people and families	Good	N/A	N/A	N/A	N/A	Good
Community End of Life Care services	N/A	Good	N/A	Good	Good	Good
Overall Community	Good	Good	N/A	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure that appropriate numbers of staff, both medical and nursing, are available in line with national guidance and patient acuity and dependency, specifically within surgery, medicine, maternity, and to meet the needs of children and young people being cared for, on both the paediatric wards and in ED.
- The trust must improve the numbers of all staff receiving an annual appraisal and supervision, especially in children's wards, surgical areas and the ED, and the actions identified in the appraisals are acted upon.
- The trust must ensure that the service risk registers are regularly reviewed, updated and include all relevant risks to the service.
- The trust must monitor and address mixed sex accommodation breaches.
- The trust must continue to improve its paediatric early warning score (PEWS) system to ensure timely assessment and response for children and young people using services.
- The trust must ensure that, following serious incidents or never events, root causes and lessons learned are identified and shared with staff, especially within maternity and surgery.
- The trust must ensure that effective processes are in place to enable access to theatres out of hours, including obstetric theatres, and that all cases are clinically prioritised appropriately.
- The trust must ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist is implemented consistently especially within maternity and surgery.
- The trust must ensure there are effective planning, management oversight and governance processes in place, especially within maternity, ED and outpatients. This includes ensuring effective systems to implement, record and monitor the flow of patients through ED, outpatients and diagnostic services.

- The trust must ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medication are checked on a daily basis in line with the trust's policy.
- The trust must ensure that there are effective processes in place to support staff and that staff are trained in the recognition of safeguarding concerns including all staff caring for children and young people receiving the appropriate level of safeguarding training and in outpatient services.
- The trust must ensure that actions are taken so enable staff to raise concerns without fear of negative repercussions.
- The trust must ensure that a patient's capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the Mental Capacity Act (2005).
- The trust must ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies.

Emergency and Urgent Care

- The trust must ensure that there are the appropriate systems in place to maintain the cleanliness of the ED at SGH to prevent the spread of infections.
- The trust must ensure that effective timely assessment and/or escalation processes are in place, including the use of the National Early Warning Score (NEWS) system, so that patients' safety and care is not put at risk, especially within ED.
- The trust must ensure that timely initial assessment of patients arriving at the ED takes place and that the related nationally reported data is accurate.
- The trust must ensure that ambulance staff are able to promptly register and handover patients on arrival at the ED.
- The trust must ensure that patients are assessed for pain relief; appropriate action is taken and recorded within the patients' notes.

Outstanding practice and areas for improvement

- The trust must ensure that patients in ED receive the appropriate nursing care to meet their basic needs, such as pressure area care and being offered adequate nutrition and hydration and, that this is audited.
- The trust must ensure the checking of controlled drugs and the safe storage of medications used by the 'streaming' nurse in ED at DPoW hospital are in line with trust policy.

Critical Care

- The trust must audit compliance with NICE CG83 rehabilitation after critical illness and act on the results.
- The trust must review and reduce the number of non-clinical transfers from ICU.

Maternity

- The trust must take steps to ensure that appropriate numbers of suitably qualified and experienced midwifery staff and medical staff are available to meet the needs of women being cared for by the service.
- The trust must ensure that labour ward coordinators are supernumerary.
- The trust must ensure that effective timely assessment and/or escalation processes are in place, including the use of the Modified Early Obstetric Warning Score (MEOWS).
- The trust must continue to improve obstetric skills and drills training among medical staff working in obstetrics.
- The trust must continue to improve midwifery and medical staff competencies in the recognition and timely response to abnormalities in cardiotocography (CTGs) including the use of 'Fresh eyes'.

Children and Young People's Service

- The trust must ensure the number of staff who have received training in advanced paediatric life support, is in line with national guidance and the trust's own target.

Outpatients and Diagnostic Imaging

- The trust must complete the clinical validation of all outpatient backlogs and continue to address those backlogs, prioritised according to clinical need.
- The trust must continue to take action to reduce the rates of patients who do not attend (DNA).

- The trust must continue to take action to reduce the numbers of cancelled clinics.
- The trust must continue to strengthen the oversight, monitoring and management of outpatient bookings and waiting lists to protect patients from the risks of delayed or inappropriate care and treatment.
- The trust must continue to work with partners to address referral to treatment times and improve capacity and demand planning to ensure services meet the needs of the local population.

Action the hospital SHOULD take to improve:

- The trust should review and strengthen the role of the Council of Governors ensuring they are fully aware of their role and function.
- The trust should ensure the structural work in ITU at DPoW is completed within the planned timescales.
- The trust should continue to address the areas where they do not meet the Guidelines for the Provision of Intensive Care Services (2015), for example, supernumerary nurse, medical staffing and work patterns that deliver continuity of care.
- The trust should ensure that patients are assessed for delirium in line with national guidance.
- The trust should monitor the number of patients ventilated outside of critical care.
- The trust should review the formal processes in place to collect patient or relative feedback.
- The trust should identify a Board level lead for paediatric services.
- The trust should ensure that access to breast milk fridges is risk assessed and secured.
- The trust should complete a risk assessment to ensure that the two bedded rooms on Rainforest ward are safe to use for patients.
- The trust should take steps to ensure that an appropriate environment and staff are available for children and young people receiving anaesthesia and recovering from surgery, in accordance with national guidance.
- The trust should ensure that it completes risk assessments concerning the risks posed by the ward environment to children requiring Child and Adolescent Mental Health Services (CAMHS), at both sites.
- The trust should take steps to ensure that appropriate numbers of play specialists are available in accordance with the national framework.

Outstanding practice and areas for improvement

- The trust should take steps to ensure that appropriate transition pathways are in place for children and young people moving from paediatric to adult services.
- The trust should ensure that medical records are appropriately completed by medical staff.
- The trust should ensure that staff complete Mental Capacity Act training.
- The trust should ensure that mandatory training rates are improved for all staff.
- The trust should take steps to improve its staff and public engagement activities.
- The trust should ensure that resuscitation equipment is regularly checked and tested consistently and in line with trust policy.
- The trust should ensure that clinical supervision is regularly recorded and monitored. The trust should ensure that Patient Group Directives (PGDs) for nursing staff are completed and up to date.
- The trust should ensure that the amount of medical patients cared for on non-medical wards is reduced and ensure that a robust system is in place to review their care.
- The trust should reduce the amount of patients that are moved late at night.
- The trust should review the current availability of chaplaincy support for patients and staff.
- The trust should ensure that the roll-out of the last days of life document and the completion of the deceased patient audit is prioritised to evidence patient outcomes.

- The trust should review the provision of an out of hours service to support staff caring for end of life patients when the specialist palliative care team are not available.

Community Adults

- The trust should assure itself that there is effective learning and sharing of lessons across community teams.
- The trust should ensure that community staff are compliant with mandatory training in line with the trust targets.
- The community teams should continue to develop strategies and visions for their services.

Community Children's and Young People Services

- The trust should continue to embed the acuity tool to provide equity of caseloads across the health visiting teams.
- The trust should review compliance with the National Health Visiting Service Specification (March 2014) to ensure all staff have access to sharing information to safeguard or protect children. The trust should monitor children's therapy service provision and review mitigating actions.

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the trust be placed into special measures.

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>How the regulation was not being met: We found that on occasion, people's right to privacy and dignity was compromised.</p> <p>The trust must:</p> <ul style="list-style-type: none">• Ensure that mixed sex accommodation breaches are monitored, addressed and reported. Regulation 10(1).• Ensure that the number of non-clinical transfers from critical care units are reviewed and reduced. Regulation 10(2)(a).
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>How the regulation was not being met: Some patients did not have clearly documented when they lacked capacity to make decisions which was not accordance with the Mental Capacity Act (2005).</p> <p>The trust must:</p> <ul style="list-style-type: none">• Ensure that a patient's capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the 2005 Mental Capacity Act. Regulation 11(1) and (3).
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p>

Requirement notices

How the regulation was not being met: Care and treatment was not always provided in a safe way for patients.

The trust must:

- Continue to improve its paediatric early warning score (PEWS) system to ensure timely assessment and response for children and young people using services. Regulation 12(2)(a) and (b).
- Ensure that effective timely assessment and/or escalation processes are in place, including the use of the National Early Warning Score (NEWS), and Modified Early Obstetric Warning Score (MEOWS), so that patients' safety and care is not put at risk, especially within ED. Regulation 12(2)(a) and (b).
- Ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medication are checked on a daily basis in line with the trust's policy. Regulation 12(2)(g).
- Ensure the checking of controlled drugs and the safe storage of medications used by the 'streaming' nurse in ED at DPoW, hospital are in line with trust policy. Regulation 12(2)(g).
- Ensure that there are the appropriate systems in place to maintain the cleanliness of the ED at SGH to prevent the spread of infections. Regulation 12(2)(h).
- Ensure that ambulance staff are able to promptly register and handover patients on arrival at the ED. Regulation 12(2)(i).

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met: Systems and processes were not always operated effectively to assess, monitor, improve services, and mitigate any risks relating the health, safety and welfare of people using services and others.

The trust must:

- Ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies. Regulation 17(2)(a).

Requirement notices

- Ensure it audits compliance with NICE CG83 rehabilitation after critical illness and acts on the results. Regulation 17(2)(a). Ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist is implemented consistently within surgical services Regulation 17(2)(a).
- Ensure that effective processes are in place to enable access to theatres out of hours, including obstetric theatres, and that all cases are clinically prioritised appropriately. Regulation 17(2)(a).
- Ensure that timely initial assessment of patients arriving at the ED takes place and that the related nationally reported data is accurate. Regulation 17(2)(a).
- Ensure that service risk registers are regularly reviewed, updated and include all relevant risks to the services. Regulation 17(2)(b).
- Ensure there are effective planning, management oversight and governance processes in place, especially within maternity, ED and outpatients. This includes ensuring effective systems to implement, record and monitor the flow of patients through ED, outpatients and diagnostic services. Regulation 17(2)(b).
- Complete the clinical validation of all outpatient backlogs and continue to address those backlogs, prioritised according to clinical need. Regulation 17(2)(b).
- Continue to take action to reduce the rates of patients who do not attend (DNA). Regulation 17(2)(b).
- Continue to take action to reduce the numbers of cancelled clinics. Regulation 17(2)(b).
- Continue to strengthen the oversight, monitoring and management of outpatient bookings and waiting lists to protect patients from the risks of delayed or inappropriate care and treatment. Regulation 17(2)(b).
- Continue to work with partners to address referral to treatment times and improve capacity and demand planning to ensure services meet the needs of the local population. Regulation 17(2)(b).
- Ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions. Regulation 17(2)(e).
- Ensure that, following serious incidents or never events, root causes and lessons learned are identified and shared with staff, especially within maternity and surgery. Regulation 17(2)(f).

Requirement notices

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met: There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of patients using the services. Not all staff were receiving the support, training, professional development, supervision and appraisals that were necessary for them to carry out their role and responsibilities.

The trust must:

- Ensure that appropriate numbers of staff, both medical and nursing are available, in line with national guidance and patient acuity and dependency, specifically within surgery, medicine, maternity, and to meet the needs of children and young people being cared for on both the paediatric wards and in the ED. Regulation 18(1).
- Ensure that labour ward coordinators are supernumerary. Regulation 18(1).
- Ensure that there are effective processes in place to support staff and that staff are trained in the recognition of safeguarding concerns including all staff caring for children and young people receiving the appropriate level of safeguarding training. Regulation 18(2)(a).
- Ensure that the number of staff who have received training in advanced paediatric life support is in line with national guidance and the trust's own target. Regulation 18(2)(a).
- Continue to improve obstetric skills and drills training among medical staff working in obstetrics. Regulation 18(2)(a).
- Continue to improve midwifery and medical staff competencies in the recognition and timely response to abnormalities in cardiotocography (CTGs) including the use of 'Fresh eyes'. Regulation 18(2)(a).
- Improve the numbers of all staff receiving an annual appraisal and supervision, especially in children's wards, surgical areas and the ED, and that actions identified in the appraisals are acted upon. Regulation 18(2)(a).

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met: Care and treatment of patients in ED did not always meet their basic care needs.

The trust must:

- Ensure that patients in ED are assessed for pain relief; appropriate action is taken and recorded within the patients' notes. Regulation 9(1)(a) and (b).
- Ensure that patients in ED receive the appropriate nursing care to meet their basic needs, such as pressure area care and being offered adequate nutrition and hydration and, that this is audited. Regulation 9(1)(a) and (b).

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

Why there is a need for significant improvements

During our inspections carried out on 9 November 2016, 22 to 25 November 2016 and 8 December 2016 we found that:

1. Staffing shortages and a lack of escalation processes were putting patients at risk.
2. There was a lack of patient assessment and/or escalation of patients identified as being at risk was resulting in patients' safety being compromised.
3. Following serious incidents in maternity, root causes and lessons learned were not always identified, therefore risks were not mitigated and changes to practice not embedded.
4. There was insufficient management oversight and governance of the identified risks.

Where these improvements need to happen

Scunthorpe General Hospital
Diana Princess of Wales Hospital, Grimsby