

Northern Lincolnshire and Goole NHS Foundation Trust

Quality Report

Diana Princess of Wales Hospital
Scartho Road
Grimsby
Lincolnshire
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Date of inspection visit: 13 – 16 October 2015, 6
November 2015 and 5 January 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

Requires improvement 

Are services at this trust safe?

Requires improvement 

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?

Requires improvement 

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Northern Lincolnshire and Goole NHS Foundation Trust from 13 – 16 October 2015 and performed an unannounced inspection on 6 November 2015 and the 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 been 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.

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 therefore did not inspect children and young people's services or end of life services within the hospitals at the follow up inspection. Additionally not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected. We inspected the effective domain in A&E and the minor injuries unit as it had not been rated in the previous inspection. We inspected diagnostic imaging services across all three sites as these had not been previously inspected in 2014.

At the inspection in April 2014 we found the trust was in breach of regulations relating to patient care and welfare, staffing, premises, staff support and governance.

Overall at the October 2015 inspection we rated the trust as "required improvement" overall. The trust was rated as "good" for being caring. The trust was rated "required improvement" in the domains of safe, effective, responsive and well-led. The core service of outpatients was rated inadequate at Scunthorpe General Hospital (SGH) and Diana Princess of Wales (DPoW) hospital. There was evidence of harm to patients within the outpatient services because of poor management of the follow up appointment system. There were no significant concerns identified within the diagnostic services we inspected where we found patients were protected from avoidable harm and received effective care.

The community services we rated as good for dentistry and children's services with community health services for adults and end of life care, rated as required improvement. Scunthorpe General Hospital was rated inadequate overall, Diana Princess of Wales Hospital was rated as required improvement overall and Goole Hospital was rated as good overall.

Our key findings were as follows:

- We were assured by the quality of the governance arrangements in place. However, we were significantly concerned that these governance arrangements were not either widely understood, applied or embedded to ensure the delivery of high quality care.
- We found within the trust there had been improvements in some of the services and this had meant a positive change in some of the ratings from the previous CQC inspection notably within critical care at Diana Princess of Wales hospital. However we found that the services in A&E at Scunthorpe, outpatients and surgical services had either not improved or had deteriorated since our last inspection.
- There were significant gaps in the medical rotas for some specialities: both A&E and critical care services were not staffed in line with nationally recommended levels of consultants and A&E was not staffed to the trust's own recommended levels. The medical cover overnight at Scunthorpe was delaying care and treatment of some patients.
- Whilst the trust was actively recruiting to nursing posts, there remained a high number of nursing posts vacant on a significant number of wards and other services. Shift co-ordinators on each ward also had a cohort of patients to care for. On most wards there were two registered nurses overnight; frequently one of these would be bank or agency. We saw examples of delayed care and staff who were not familiar with ward environments and specialities. This was raised at the time of inspection and the trust are undertaking a review of nurse staffing and developing the shift co-ordinator role.

Summary of findings

- There was a backlog of patients requiring outpatient follow up and high levels of clinic cancellations resulting in patients being cancelled on multiple occasions. There was a lack of clinical involvement in the cancellation process and a lack of clinical validation of the patients who were waiting for follow up appointments.
- There was lack of oversight and accountability of the outpatient processes and associated backlogs with actions slow and lacking sufficient senior managerial involvement at core service level. The issues regarding outpatient backlogs was raised at the inspection. The trust took immediate action and provided monitoring information which indicated that all 30,000 patients in the backlog had been reviewed and validated by 31 December 2015.
- There were gaps in learning from incidents in almost all acute and community services. There were systems and processes in place to support the dissemination of learning. However staff told us that they did not receive or access feedback/learning from incidents. We were therefore not assured that learning from incidents was effective.
- At the time of the inspection the trust was a mortality outlier for deaths from acute bronchitis and cardiac dysrhythmias.
- The Summary Hospital-level Mortality Indicator (SHMI) for the trust was 111 which was higher than the England average (100) in June 2014. For the period July 2014 – June 2015 the SHMI was 109.7 which was within the ‘as expected range’ nationally. The SHMI is the ratio between the actual numbers of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.
- The Hospital Standardised Mortality Ratio (HSMR) was 99.2 which was similar to the England ratio (100) of observed deaths and expected deaths.
- Staff were not aware of how to record minimum and maximum temperatures for medication fridges; what the recommended range was or that this was necessary for safety and efficacy of medicines. We saw several examples where a temperature had been recorded outside of recommended range but no action had been taken.
- There was not sufficient resource identified including specialist staff, training and systems in place to care for vulnerable people, specifically those with learning disabilities and dementia. However, there was a highly motivated and compassionate quality matron who had the lead for dementia and also learning disabilities.
- There had been managerial change within critical care which was beginning to have a positive impact with regard to development of the service. There had been significant improvements in the delivery and location of high dependency services at the DPoW hospital since the initial comprehensive inspection of 2014.
- At our inspection in April 2014 we found that not all clinical staff who required level 3 safeguarding of children training had received it. At this inspection, we found that clinical staff were now in the process of being trained up to level three in safeguarding children. However, the numbers of staff who had received the level three training was below the trust’s 95% target. The records provided to us by the trust showed that no medical staff in the emergency department had undertaken level three safeguarding children training.
- Community nurses were not aware of policies and procedures in relation to the management and disposal of controlled drugs in patients’ own homes. Staff we spoke with used different methods to dispose of drugs that were no longer required by a patient.
- There appeared to be a disconnect between acute and community services. Staff told us that the community services staff voice was not heard at board level and many did not feel they were part of the trust.
- There was no trust specific end of life strategy or related performance indicators to measure the success of the end of life care services. We saw that national guidelines were used by staff however it was not possible to tell if patients’ preferences at end of

Summary of findings

life were met, as outcomes such as preferred place of care, were not measured. However, the trust were part of the wider health economies' strategic groups for end of life care.

- Community dental services were effective and focused on the needs of patients and their oral healthcare.
- There was a lack of evidence that an acuity tool was used to allocate caseloads to health visitors and staff were not aware that there was not a designated doctor for the looked after children's team. Additionally three-monthly safeguarding supervision had not been taking place for health visitors, which did not meet guidance.

We saw several areas of outstanding practice including:

- The dental health education team developed a package of resources offering oral health promotion support and training to dental practices in the North Lincolnshire region. This online learning package enabled dental professionals to earn continuing professional development hours as part of the General Dental Council requirements to maintain their registration. They could also use the resources to take part in a strategy called 'making every contact count', aimed at improving the community's oral health.
- There was a highly motivated and compassionate quality matron who had the lead for dementia and also learning disabilities.
- The development of a pressure sore assessment tool known as a 'pug wheel' to support staff in the accurate identification of pressure damage. This had been developed by the tissue viability team.
- The Frail Elderly Assessment and Support Team gave elderly patients, immediate access to physiotherapy / occupational therapy assessment as well as nursing and medical assessment. Social services would also be involved in assessment with the aim of providing immediate treatment / assessment and initiation of community based care or services. The aim of this service was that patients should be able to return to their usual place of residence with the support of community services.

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

Action the trust MUST take to improve acute services:

- The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance, taking into account patients' dependency levels. This must include but not be limited to: medical staff within the emergency department (ED) and critical care, nursing staff within ED, medicine and surgery. It must also include a review of dedicated management time allocated to ward co-ordinators and managers. It must ensure adequate out of hours anaesthetic staffing to avoid delays in treatment. The trust must ensure there are always sufficient numbers of radiologists to meet the needs of people using the radiology service.
- The trust must ensure that the significant outpatient backlog is promptly addressed and prioritised according to clinical need. It must ensure that the governance and monitoring of outpatients' appointment bookings are operated effectively, reducing the numbers of cancelled clinics and patients who did not attend, and ensuring identification, assessment and action is taken to prevent any potential system failures, thus protecting patients from the risks of inappropriate or unsafe care and treatment.
- The trust must ensure that all risks to the health and safety of patients with a mental health condition are removed in Scunthorpe emergency department (ED). This must include the removal of all ligature risks, although must not be limited to the removal of such risks. The trust must undertake a risk assessment of the facilities (including the clinical room and trolley areas, but not be limited to those areas), with advice from a suitably qualified mental health professional.
- The trust must ensure that the recently constructed treatment rooms at Scunthorpe ED that were previously used as doctors' offices are suitable for the treatment of patients on trolleys. This must include ensuring that such patients can be quickly taken out of the room in the event of an emergency.

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- The trust must ensure that staff at core service/ divisional level understand and are able to communicate the key priorities, strategies and implementation plans for their areas.
- The trust must improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform.
- The trust must ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation, especially in relation to critical care and ensuring the equipment is included in the trust replacement plan.
- The trust must ensure it acts on its own gap analysis of maternity services across the trust to deliver effective management of clinical risk and practice development.
- The trust must have a process in place to obtain and record consent from patients and/or their families for the use of the baby monitors in critical care and for the use of CCTV in coronary care.
- The trust must ensure the safe storage and administration of medicines including the storage of oxygen cylinders on the intensive care unit at DPoW hospital. The trust must ensure staff check drug fridge temperatures daily and record minimum and maximum temperatures. Additionally it must ensure staff know that the correct fridge temperatures to preserve the safety and efficacy of drugs and what action they need to take if the temperature recording goes outside of this range. Patient group directions for medications within ED must be reviewed and in date.
- The trust must ensure equipment is checked, in date and fit for purpose, including checking maternity resuscitation equipment and critical care equipment is reviewed and where required, included in the trust replacement plan.
- The trust must ensure that action is taken to address the mortality outliers and improve patient outcomes in these areas.
- The trust must ensure there is a robust process for providing consistent feedback and learning from incidents.
- The trust must review the validation of mixed sex accommodation occurrences, ensure patients are cared for in an appropriate environment and report any breaches.
- The trust must ensure the reasons for Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) are recorded and is implemented in line with best practice within surgical services.
- The trust must ensure the Five Steps for Safer Surgery including the WHO check list is consistently applied and practice is audited.
- The trust must review the effectiveness of the patient pathway from pre-assessment through to timeliness of going to theatre, and the number of on the day cancellations for patients awaiting operations.
- The trust must ensure policies and guidelines in use within clinical areas are compliant with NICE or other similar bodies.
- The trust must ensure there are adequate specialist staff, training and systems in place to care for vulnerable people specifically those with learning disabilities and dementia.
- The trust must stop including newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses on duty.
- The trust must ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours The trust must ensure that staff, especially within surgery, have appraisals and supervision, and that actions identified in the appraisals are acted upon.

Action the trust MUST take to improve community services:

- The trust must ensure three-monthly safeguarding supervision takes place for health visitors.
- The trust must ensure all staff are up to date with appraisal and mandatory training.

Summary of findings

- The trust must ensure it has an end of life care vision and strategy in place supported by key performance indicators that reflects national guidance and ensure staff are included in the development of these.
- The trust must have effective systems in place to assess, monitor and improve the quality of the end of life care services, including auditing preferred place of care and other patient outcomes.
- The trust must ensure that all community equipment is tested for electrical safety and evidence is available to show that equipment is serviced in line with manufacturers recommendations.
- The trust must ensure that all substances which could be harmful are stored appropriately, specifically within the Ironstone Centre.
- The trust must ensure that procedures for managing controlled drugs in patients' homes are standardised and all staff follow guidelines for the safe management and documentation in relation to controlled drugs.
- The trust must ensure that record keeping meets all appropriate registered body standards.

Additionally there were other areas of action identified where the trust should take action and these are listed at the end of each report.

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. It became a foundation trust in 2007. Its annual budget is around £330 million, and it has 843 beds across three hospitals: Diana Princess of Wales (DPoW) Hospital at Grimsby in North East Lincolnshire and Scunthorpe General Hospital in North Lincolnshire and Goole & District Hospital (based in the East Riding of Yorkshire). The trust employs around 5,200 members of staff.

According to the Local Health Profile, the health of people in North Lincolnshire and North East Lincolnshire is generally significantly worse than the England average. The health of the population in East Riding of Yorkshire is generally better than the England average, apart from the number of women smoking at the time of delivering a baby and the level of recorded diabetes. North East Lincolnshire is in the most deprived quintile, and North Lincolnshire is in the fourth most deprived quintile, compared to other Local Authorities (LAs) in England. A significantly greater proportion of children live in poverty compared to the England average in both these areas. East Riding of Yorkshire is less deprived, being in the second quintile of LAs and proportionately fewer children live in poverty compared to the England average.

CQC carried out a comprehensive inspection between 23 and 25 April and on 8 May 2014 because the Northern Lincolnshire and Goole NHS Foundation Trust was placed in a 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. The community service provision at the trust was not visited as part of this inspection. Overall, this trust 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: Jan Filochowski, Clinical and Professional Adviser at CQC; NIHR; Commonwealth Fund and IHI

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included: CQC inspectors and a variety of specialists, namely, Community Trust CEO/Director,

Community Children's Nurse Manager, Community Matron, Health Visitor, School Nurse, Dentist, Community

Paediatrician, Physiotherapist, District Nurse, Child Safeguarding Lead Nurse, EOLC Matron, Critical Care Doctor, Critical Care Nurse, A&E Nurse, Medicine Doctor, Medicine Nurse, Surgeon, Anaesthetist, Surgery Nurse, Theatre Nurse, Ophthalmic Nurse – Outpatients, Midwife Matron, Midwife, Consultant Obstetrician, Child Safeguarding – Trustwide, Clinical Director, Diagnostic Radiology Doctor, Junior Doctor, Student Nurse, and experts by experience (people (or carers or relatives of such people), who have had experience of care).

Summary of findings

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?

A comprehensive inspection was carried out to review and rate the trust's community services for the first time using CQC's new methodology, all of the community services were inspected. In addition there was also an acute hospital focused inspection to follow up our concerns from the 2014 inspection. We did not inspect across the whole acute service provision; we focused on the areas defined by the information that triggered the need for the focused inspection. Therefore not all of the core services or the five domains: safe, effective, caring, responsive and well led were reviewed during the inspection. The inspection team inspected the following acute core services at the trust and four community services:

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

- Community dental services
- Community health services for adults.

We did not inspect the core services for hospital based children and young people and for hospital 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), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch organisations.

We held two focus groups, especially for people with learning difficulties, prior to the inspection to hear people's views about care and treatment received at the hospital and in community services. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, 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, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out an announced inspection on 13 – 16 October 2015 and unannounced inspections on 6 November 2015 and the 5 January 2016.

What people who use the trust's services say

The NHS Friends and Family Test results (FFT) results between July 2014 and June 2015 indicated the

percentage of patients who would recommend the trust's services was consistent with, or better than, the England average apart from in December 2014 and March 2015 when it was lower than the England average.

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The results of the Care Quality Commission In-Patient Survey (2014) showed the trust scored 8.0 in answer to the question: 'Did doctors talk in front of you as if you weren't there?' which puts it amongst the worst performing trusts for that question. But it scored higher for the question: 'Did a member of staff answer your questions about the operation or procedure?' (8.7 in 2014 compared to 8.2 in 2013) and the question: 'Do you feel you got enough emotional support from hospital staff during your stay?' showed improvement (6.9 in 2014 compared to 6.6 in 2013).

The Patient Led Assessments of the Care Environment (PLACE) scored the trust just above the England average for privacy, dignity and well-being (87, England average 86).

Between 2010-11 and 2014-15 there was a year on year increase in the number of written complaints in this trust. The number fell in 2014-15, with the trust receiving 448 complaints in that year. Data received from the trust for the period between September 2014 and August 2015 shows the most common complaint subjects included: 'all aspects of clinical treatment' (70%); 'communication/information to patients (written and oral)' (10%); 'attitude of staff' (under 10%); and 'appointments, delay/cancellation (out-patient)' (less than 10%).

Facts and data about this trust

The trust was established as a combined hospital on April 1 2001 by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust. It achieved Foundation trust status on May 1 2007 and on April 1 2011 it took over community services primarily in the North Lincolnshire area under the 'Transforming Community Services' agenda.

The trust has 772 general and acute beds and 71 maternity beds. There are approximately 400 beds at Diana, Princess of Wales (DPoW) hospital, 380 at Scunthorpe General Hospital (SGH) and up to 55 at Goole hospital.

The trust employs 5,214.64 WTE staff across acute and community services. The staff are split into the following broad groups:

- 1,389.20 WTE Nursing
- 3,322.86 WTE Other

The trust's inpatient admissions (April 2013 – March 2014) were 107,403. There were 389,327 outpatient attendances (total attendances). Accident and Emergency had 137,841 attendances.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Summary</p> <p>We rated safe as “requires improvement” for the following reasons:</p> <p>We had significant concerns about staffing within the trust, both nursing and some elements of medical staffing. The trust was proactively recruiting staff and had put a number of incentive schemes in place. However, there remained a high level of agency use and in some instances shifts were not filled. The level of consultant cover for the emergency departments was poor, especially at weekends, as was anaesthetic cover out of hours.</p> <p>There were seven serious incidents in outpatients between September 2014 and the time of the inspection and these had resulted in patient harm. Five of these were in ophthalmology and two in other outpatient specialties (one in breast services and one in respiratory). The root causes of these incidents included delayed treatment due to cancelled appointments and failure to follow up in a timely manner. Staff in almost all acute and community services told us that they did not always receive or access feedback/learning from incidents. We were therefore not assured that learning from incidents was effective.</p> <p>We found there was no dedicated room in Scunthorpe emergency department specifically designed with safety measures in place that would allow for the safe assessment of patients who attended with a mental health condition. Other rooms that had been converted to treatment rooms were unsafe for patients on trolleys. Within critical care, essential equipment such as beds, mattresses and ventilators was old and described by staff as not fit for purpose. 28 pieces of equipment required for direct patient care were out of date.</p> <p>There had been a shortage of registered community nurses for two years. This had led to increased reporting of missed visits, medication errors and staff stress. Harm free care in four of the five community nursing teams was worse than the England average of 95% in August, September or October 2015. In one team it was 87%, 8% lower than the England average. Mandatory training compliance in community services was variable, with one service only achieving 33% compliance for resuscitation training. This was not identified as a risk and we did not see any plans in place to address this.</p> <p>Health visiting caseload numbers were often above recommended maximum levels and the number of complex cases for each health</p>	<p>Requires improvement </p>

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visitor varied. In addition, there were staffing concerns within therapy services highlighted on the community risk register. The looked after children's team were not aware of who the designated doctor was.

Duty of Candour

- The Director of Performance Assurance was the trust's lead for duty of candour. It was monitored through the trust governance and assurance committee. Duty of candour (DoC) was included in the trust's Serious Untoward Incident Policy.
- The trust had in place a long standing Being Open Policy which was endorsed by the trust board. The policy had been amended to include the new statutory duty of candour.
- These requirements were communicated with staff via a range of mechanisms including the trust's intranet, email, posters / leaflets and within training.
- The trust used the on-line Datix incident reporting system and a prompt had been included for staff reporting incidents to remind them of the duty of candour requirements.
- We were told there was a weekly validation and monitoring of incidents to ensure that these requirements were being met. There was also a prompt within the serious incident management checklist.
- During the inspection we reviewed five serious incidents and associated root cause analyses and we saw evidence that duty of candour had been applied.
- Template letters were in place to assist staff with the duty of candour requirement.
- A key performance indicator (KPI) had been agreed and performance was monitored via the integrated performance / KPI arrangements.
- The trust had recently commissioned an external review of its arrangements for managing serious incidents and the duty of candour requirements. No significant gaps were identified and the review noted areas of good practice. Some areas were suggested for further strengthening the trusts arrangements and these were being addressed.
- The complaints team monitored implementation of duty of candour.

Safeguarding

- There was a safeguarding adults policy and guidance which was in date and due for renewal in 2017.
- The Executive board lead for safeguarding was the Director of Nursing.

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- There was a head of safeguarding who was the strategic and operational lead; their role covered both children and adult safeguarding. The role included leading the safeguarding team within the trust that had the remit for safeguarding children, safeguarding adults, looked after children (two teams) and PREVENT.
- PREVENT is part of the Government's strategy to stop people becoming terrorists or supporting terrorism and is now a statutory duty. The trust's training strategy / plan has been amended to ensure that all staff within the trust undergo a level of Prevent training every three years. For the majority of staff this was embedded into the safeguarding children training. PREVENT was also a safeguarding KPI for the trust set by commissioners from 2015 onwards.
- A report on "Themes and Lessons Learnt from NHS Investigations into Matters Relating to Jimmy Savile" was published in February 2015. The trust reviewed the recommendations relevant to providers and provided a gap analysis and action plan to the board in June 2015. Six of the nine identified actions were completed or on target in November 2015.
- There were six serious case reviews for children in 2014-15.
- The trust's annual safeguarding report indicated that the number of safeguarding adult cases that the trust investigated was rising in number and systems were being developed to allow for improved tracking and for trend analysis.
- General trends from recent investigations in 2015 highlighted issues of poor nursing care, lack of co-ordinated discharge and poor communication / record keeping. In particular, during 2014-2015 additional issues of poor care planning; lack of nutrition and hydration; failure to provide medication as prescribed; and; ineffective escalation, have all been noted and action plans put in place to address these areas.
- The trust plan for 2015 was to increase the number of ward areas with swipe access systems to ensure a safe environment and increased uptake of the Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DOLS) training for staff. We saw that improvements had been made in both increasing swipe access for ward areas and staff training rates. Although the trust had still to meet their trust target of 95%. This work was to include earlier identification of patients' needs and to take account of the increased number of DOLS assessments that were required to assist in promoting patient safety.
- The National Health Visiting Service Specification 2014-2015 which was published in March 2014 states health visitors must receive a minimum of three-monthly safeguarding supervision

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of their work with their most vulnerable children and babies. This must be done by a colleague with expert knowledge. Staff told us this was currently taking place six monthly. Within the health visiting teams three-monthly safeguarding supervision had not been taking place, managers were aware of the guidelines and told us there had not been the capacity to provide the relevant training. We were told by the senior management team this had now been addressed and three-monthly supervision would now begin.

- The Looked after children (LAC) team was not aware of who was the designated doctor or medical strategic lead for the service. There was a named doctor who worked with the LAC team. Information provided by the trust following the inspection demonstrated there was a clinical lead for the LAC team. This information had not been communicated to the staff at the time of inspection.
- At our inspection in April 2014 we found that not all clinical staff who required level 3 safeguarding of children training had received it. At this inspection, we found that clinical staff were now in the process of being trained up to level three in safeguarding children. However, the numbers of staff who had received the level three training was below the trust's 95% target. The records provided to us by the trust showed that no medical staff in the emergency department had undertaken level three safeguarding children training.

Incidents

- There was an incident reporting policy and procedure in place, which was within date and due for further review in November 2017. The policy clearly defined risk, the purpose and benefits of reporting, fair blame culture, definitions of types of incidents, an easy to follow list of triggers, reporting actions, duties and responsibilities. Reporting of incidents was through the datix system with a management review (the handler) within one day. The handler is responsible for the initial coding and grading of the level of risk. To support the grading a matrix was included within the policy. The policy also covered root cause analysis and follow up.
- The incident reporting policy and procedure was supported by a policy for dealing with serious incidents. This policy was within date, due for review in November 2017. The process was clearly set out. When incidents were raised they were scored against degree of harm caused. For serious incidents a root cause analysis was performed using the National Patient Safety Agency (NPSA) guidelines. The policy identified the need for immediate and subsequent actions and discussed the need for

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duty of candour. The sharing of learning was identified within the policy at a trust wide and directorate level. At the end of the policy there was a summary checklist of actions taken, a risk grading matrix and flow chart identifying the process and timeframes to be met.

- The trust reported more incidents per 100 admissions than the England average 10.1 per 100 admissions compared to England average of 8.4.
- The trust reported 10,834 incidents for the period July 2014 to June 2015 of which 7009 were low or no harm. There were three never events in the trust between August 2014 and July 2015, all of which related to a surgical/ invasive procedure. trust-wide 66 serious incidents (SI) had been reported between August 2014 and July 2015, 27 were pressure ulcers and eight were unexpected deaths. Serious incidents were reviewed at a collaborative meeting with the commissioning groups to provide additional assurance, this was attended by the medical director and other senior members of the trust as required.
- There were seven serious incidents in outpatients between September 2014 and the time of the inspection and these had resulted in patient harm. Five of these were in ophthalmology and two in other outpatient specialties (one in breast services and one in respiratory). The root causes of these incidents included delayed treatment due to cancelled appointments and failure to follow up in a timely manner. Although the trust had investigated these incidents, it was unclear whether the actions the trust had put into place to prevent any future incidents occurring were effective. Staff we spoke with were unaware of any changes to systems and processes as a result of learning from incidents.
- Staff we spoke with in almost all acute and community services told us that they did not always receive or access feedback/ learning from incidents. We were therefore not assured that learning from incidents was effective. The trust had launched a campaign called 'ASK' to encourage staff to seek feedback from incidents however in medicine none of the staff we spoke to were aware of it.
- We reviewed five other serious incidents and the associated root cause analyses (RCAs). We found that the general quality of the investigations, subsequent RCA and report were good, although there were variations in the quality of the final report. The action plans were appropriate, with SMART objectives. Evidence of actions taken was reviewed; we were told the governance team did not close an incident until they received the evidence of completion of any required actions.

Summary of findings

- There were 232 pressure ulcers and 80 falls with harm recorded in the Patient Safety Thermometer between July 2014 and July 2015. Community services reported twenty-one serious incidents. The majority of these (fifteen) were pressure ulcer incidents.
- There was an active drive to reduce the harm caused by poor tissue viability (TV) leading to pressure ulcers. There was a team of four whole time equivalent TV nurses led by a quality matron. A business case had been approved to move to seven day working from April 2016. Specific training had been added to the trust's "Compliance list" since July 2015 so attendance had increased and was 52% for nursing staff at the time of the inspection. The team had developed two successful initiatives to improve earlier detection of potential pressure ulcers. This included the use of pocket mirrors and the PUG wheel (Pressure Ulcer Group). The PUG wheel had been presented at the European wound management conference in spring 2015 and the national patient safety conference in summer 2015. It also won the internal "Shine" award in October 2015. There were 232 grades 2, 3 and 4 pressure ulcers reported between July 2014 and July 2015.
- Data from the trust indicated that the number of pressure ulcers peaked from December 2014 – March 2015 and then had a downward trajectory with the number of grade three and four pressure ulcers decreasing. Staff told us this was in line with increased training and awareness of staff.
- In maternity there was a "Maternity Services Trigger List" which staff followed for incident and near-miss reporting. Examples of triggers included: missed child protection issues; readmission of a baby to the service; caesarean section; and compromised staffing levels.
- We found the trust had four action plans following serious case reviews. A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. The review looked at recommendations and actions with an identified lead and a time scale. We saw that the actions were being monitored to ensure they were met.

Infection prevention and control (IPC)

- Handwashing facilities were available throughout the wards and we observed hand gel dispensers at the entrance to wards, each bay and side room. Hand hygiene audits were carried out by the trust to monitor practice and compliance was generally

Summary of findings

very high for example audits showed 100% compliance in A&E, surgery and critical care. However in the A&E department at Scunthorpe, hand hygiene audits were not carried out every month.

- Between June 2014 and April 2015, there was one case of MRSA bacteraemia in this trust, which had occurred in February 2015.
- There were 27 cases of Clostridium Difficile and 17 cases of MSSA between June 2014 and April 2015, with rates per 10,000 bed days similar to the England average.
- From April to October 2015 there had been 16 cases of clostridium difficile (from an agreed maximum trajectory of 21 for the full year); following root cause analysis four of these were from lapses of care within the trust.
- There were two cases of Legionella within the trust in May 2015. The Health and Safety executive issued six improvement notices for which the trust produced action plans. The action plans were ongoing at the time of the inspection and were being monitored by the Health and Safety Executive. In response the trust created a compliance team within the Estate and facilities directorate to monitor this and other risks. Water checklists used for recording flushing of water systems we reviewed were complete. Water coolers were in place on the ward however there was no evidence of flushing or testing of these was available on the ward environment.
- Infection control training was compliant with over 90% achievement at trust level. However the directorate of medicine, which included A&E were at 76% compliance at the time of inspection.
- A local IPC audit tool, FLO (FrontLine Ownership) had been developed to review ten key areas of IPC. In critical care at Diana Princess of Wales Hospital (DPoW) the audit had identified poor storage as a concern however in outpatients infection prevention and control audit was 98%.
- The role of Director of Infection Prevention and Control (DIPC) had recently passed to the new deputy CEO position.
- A weekly Infection Prevention Control challenge meeting had been set up to improve IPC across the organisation. Membership included the CEO, DIPC, microbiologist and facilities management.
- Environmental cleaning schedules were available and displayed. The patient led assessment of the care environment (PLACE) results for cleanliness showed the trust scored slightly worse at 95.57% compared to the national average of 97.57%.

Summary of findings

- Equipment cleaning assurance labels provide assurance to patients that re-usable patient equipment was clean and ready for use. During the inspection we saw cleanliness labels were available and used.
- Across a number of core services, we found that airway management equipment was not in sealed sterile packaging. This equipment should be kept in sealed packaging to keep it sterile.
- In surgery, compliance with the patient isolation policy was variable. Rooms used for isolation of patients had the door left open and standard precautions and hand hygiene policies were not always followed due to sinks being cluttered and difficult to access. Sharps bins were seen overflowing and in one area, ward 11, a sharps bin had been in use for over a year.

Environment

- At our inspection in April 2014 we found there was no dedicated room in Scunthorpe emergency department (ED) specifically designed with safety measures in place that would allow for the safe assessment of patients who attended with a mental health condition. This was a breach of Royal College of Emergency Medicine (RCEM) guidance. At this visit, we found there was still no room designed for this purpose; staff showed us two general rooms that were used if required for this purpose. Neither of these rooms had safety measures such as a second door for emergency exit, or an emergency alarm. They also had ligature points that could be used by a person with suicidal ideation to harm themselves. There were coat hooks, leads for monitors and electrical leads that posed a risk of avoidable harm. There were also bandages and plastic aprons that could be used to make a noose. We informed the trust of our concerns and following the inspection they provided us with an action plan to address these specific issues and to improve the care for patients with mental health conditions.
- Following our last inspection the trust had altered three doctors' offices so they could be used as treatment areas at Scunthorpe ED. However, the doors had not been widened so as to allow the safe transfer of patients on trolleys in the event of an emergency. Staff told us that it took time to get the trolleys out of the rooms and they had to be manoeuvred in a certain way. We informed the trust of our concerns that the rooms were unsafe. They responded by providing us with an action plan to prevent acutely ill patients using these rooms. They also told us they would be widening the doors to improve the speed with which patients could be taken out of the room in an emergency.

Summary of findings

- There was no separate treatment area for children and young people within Scunthorpe ED apart from one clinic room. However, this room was also used for the treatment of adult patients by GPs, and other health care professionals.
- At Scunthorpe ED there was one single entrance for patients brought in by ambulance and those walking in to be booked-in at reception. This meant that the privacy and dignity of patients with serious injuries was compromised.
- In Scunthorpe critical care unit we found 28 out of date consumables in the equipment store. The consumables were required for direct patient care, for example, suction catheters, artificial airways (endotracheal tubes) and invasive devices (central venous catheters). The expiry dates were from earlier in 2015.
- The ageing beds on the critical care unit had been on the risk register since 2009. Staff told us they were not fit for purpose as they did not have the ability to weigh patients and frequently broke down. Incident reporting data submitted by the trust supported this. Following the inspection the trust told us that funding was not available for replacement in the 2015/16 capital programme.
- In one community location, we found a cupboard and two storerooms containing hazardous substances unlocked.

Medicines

- There was a lack of oversight regarding the use and review of Patient Group Directions (PGDs). PGDs were reviewed by the Medicines and Therapeutics Group but were the responsibility of each individual clinical area. We were told the day to day management of this was “difficult”. There was no assurance at trust level and all information was held at ward level. Only the individual wards/departments had lists of those people authorised and trained to operate under the PGD.
- At the unannounced inspection, we spoke with staff and checked a number of medicine fridges. All but one fridge had gaps in the recording of temperatures. Many staff we spoke with were not aware of how to record minimum and maximum temperatures, what the recommended range was or that this was necessary for the safety and efficacy of drugs. This was raised as a concern with the Trust at the comprehensive inspection in 2015 and they told us action would be taken. However, we found similar concerns remained at the unannounced inspection in November 2015.
- The chief pharmacist understood the risk posed by the poor recording and management of fridges across the trust and told us that there had been actions included in the action plan

Summary of findings

following the Safe and secure handling of medicines re-audit March 2015. However the recorded action to include the information in the June 2015 newsletter has not been completed. The trust were not able to find any newsletter that this had been included in.

- Whilst there was a requirement to check the expiry dates on medicines within fridges we found this was not being routinely recorded. In two instances we found out of date medicines, one at DPoW hospital and one at Scunthorpe hospital.
- In community settings, we found limited evidence that controlled drugs were managed appropriately in patients' homes and staff did not fully understand the processes they should follow when patients no longer need their medications. This meant that controlled drugs were not managed safely.
- There was a good approach to the issue of availability of medicines keys on wards by the use of electronic keys.

Mandatory training

- The trust required high compliance rates of 95% for mandatory training and levels of training had improved since the last inspection.
- The 2014 staff survey indicated that the percentage of staff receiving job-relevant training, learning or development in last 12 months was 82% compared with a national average of 81%.
- Mandatory and statutory training was at 89% across the trust in September 2015 (amber RAG rating in September's board papers). As at November 2015, the average percentage of staff across the trust who were verified as compliant with their mandatory training was 92%. However, this masked significant variation between directorates and individual services. The medicines directorate was the lowest at 79%.
- Figures for medical staff completing their mandatory training were much lower than nursing staff, for example, training figures for the surgery and critical care directorates included 78% of nursing staff and 51% of medical staff were up to date with resuscitation training and 76% of nursing staff and 49% of medical staff were up to date with fire training.

Nursing and other clinical staffing

- There were widespread issues with staff shortages. The trust were aware of these and had a number of strategies in place to improve staff recruitment and retention.
- Information provided by the trust indicated it had taken the decision to set the nursing establishment so that there was a ratio of one registered nurse to every seven patients during the day. In addition to this, the trust told us that each ward had one

Summary of findings

band 6 and one band 7 nurse. We were informed that the trust had developed its own model for setting staffing establishments; the model was based on the Safer Nursing Tool for assessing acuity and professional judgement.

- The trust had put in place a number of national and international recruitment initiatives. However, it was not achieving vacancy targets for medical, nursing (registered and unregistered) and allied health professional vacancies which were all red RAG rated in the September 2015 board papers. The nursing vacancy rate was: registered 12.8% and unregistered 6.1%. There was an improvement in the October figures; the vacancy position across registered nursing was 9.07%, with approximately 15% of these being within the medical directorate and over 10% within the surgical and critical care directorate.
- Evidence from the inspection identified that on many wards when nursing staff were acting as ward co-ordinators/shift leaders they were included in the staffing figures and were not supernumerary. This meant they were caring for a cohort of patients as well as co-ordinating the ward. For example, ward C1 Hollies at DPoW hospital had 26 beds with planned staffing levels of four RNs and four health care assistants on duty during the day and two registered nurses (RNs) and three health care assistants (HCAs) overnight. The patients had high dependency needs (levels 1a and 1b). From Saturday 31 October to Saturday 7 November 2015 there were staff shortages every day, some of which were filled by bank staff. On the 1, 2, and 3 November each morning shift only had three RNs on duty. In Scunthorpe A&E 22% of registered nurse posts were vacant at the time of inspection.
- Following the inspection the trust told us there was a review underway regarding the role of ward co-ordinators for completion in December 2015 and to be presented to the executive team in February 2016.
- Most wards we visited had two RNs on duty overnight. In some areas these were shared between wards. We had particular concerns about the trauma and orthopaedic wards at Scunthorpe hospital. We saw evidence of three registered nurses being allocated for duty across both wards, one nurse was allocated to each ward with the other nurse floating between the two wards. When full these wards had 32 patients spread over two floors. On reviewing staffing rosters for 28 night shifts we saw three registered nurses had been on duty on 19 occasions. Agency staff made up part of the three RN shifts on 14 occasions.

Summary of findings

- In Scunthorpe A&E a registered children's nurse was not on duty on every nursing shift. Although there were two registered children's nurses employed in the department they were only able to cover for 48 hours a week. National guidance from the Royal College of Paediatrics and Child Health recommends all emergency departments receiving children have a lead registered children's nurse and sufficient Registered Children's Nurses to provide one per shift. The position at DPoW was different due to there being a separate children's A&E area staffed by registered children's nurses.
- Midwifery staffing was 1:29 births which was just above the national recommended staffing of 1 midwife to 28 births.
- Monthly staffing reports to the board indicated that the trust was achieving fill rates for shifts of over 80% for the majority of the time, however there was a heavy reliance on agency and bank staff to deliver this.
- For night duty, out of 37 wards on the board report for November 2015, only six had a fill rate of 90% or above of permanent staff, 19 wards had a fill rate of 80% or above for permanent staff. With agency/bank staff these figures improved with only five wards having less than 90% of the RN shifts filled.
- For day duty in November 2015 there were 11 wards below 80% fill rate for RNs across the trust. This improved to only three below 80% after the use of agency and bank staff. Of particular concern was wards 3, 17, 23 and C6, wd2 where the day fill rate ranged from 76% to 83.2% after agency bank staff were used.
- The board papers from August 2015 indicated there were 20 community nurse vacancies. The trust risk register showed this had resulted in an increase in missed visits to patients and an increase in medication errors. The October 2015 vacancy position across community registered nursing had improved and was at 4.2%. Staff told us there was between 140-150 patients on the caseload, which was an increase of 30% over the last three years.
- During the inspection, concerns were raised that newly qualified recruited nurses awaiting their professional registration were being counted in the numbers for registered nurses (RNs) on duty. During the unannounced inspection we were made aware that a memo had been circulated to Matrons since the inspection, advising managers not to roster newly qualified nurses awaiting their registration as registered nurses if less than two substantive qualified RNs were on duty.

Summary of findings

- Critical care was not meeting service standards for nurse staffing. A supernumerary senior nurse was not available 100% of the time as a clinical coordinator. The clinical educator post had been vacant for eighteen months at the time of our inspection.
- The trust had mandated clinical supervision for all registered nurses. Prior to the inspection compliance with supervision stood at 60%. The trust told us that this process would become more robust as the processes for revalidation of nurses was embedded.
- The trust had recently set up a “Care Camp” for the induction and skill development of staff.
- Personal development review rates generally were on an amber RAG rating across the trust in September 2015.
- The trust was within its own target for sickness absence.
- The most common reason for requesting temporary staff was staff vacancies with internal and external expenditure on temporary staff increasing month on month. The share of bank and agency usage was higher than the national average at 6.8% compared to 6.1%
- The senior management team were aware of the staffing issues, were collectively working on new role development such as Band 4 theatre assistant roles, and advanced care practitioner roles. However, we were told that some of these developments would take 2 years to implement.
- In community end of life services there was a Macmillan healthcare team made up of 32 healthcare support workers who were band 2, 3 and 4. The band 4 support workers planned the rota for their ‘patch’ and dealt with day-to-day issues. They ensured close liaison took place with the community nurses. Staff told us further funding was being sought to expand the band 4 role.
- We reviewed data on caseloads for therapy staff (physiotherapy, occupational therapy and speech and language therapy) numbers varied from two to 114. There was 1.6 whole time equivalent (WTE) physiotherapy cover for the area. We were told current caseload was approximately 180 children. This was on the risk register as a moderate risk, a business case to increase the establishment had been unsuccessful, so an action to develop joint pathways to work more efficiently was recommended.
- Lord Laming’s report in 2009 on the protection of children in England stated that health visitor caseloads should be no more than 300 children. We were told by the management team

Summary of findings

caseloads for each visitor were between 300 and 350, meaning the recommendations were not always achieved. We saw evidence of a spreadsheet which supported this; in October 2015 two teams had a caseload greater than 300 (309 and 341).

Medical staffing

- The trust had proportionately more junior medical staff and fewer consultant level staff than the England average.
- There were more middle career doctors and less registrars (28% compared to 38% nationally)
- Junior doctor made up 22% of the medical workforce compared with 15% nationally. Eighty-six percent of posts had been filled by the Deanery in August 2015.
- Out of hours medical cover had improved within critical care since the last inspection. However, it was still not meeting standards. A consultant intensivist was not available seven days and week and medical staff rotas did not promote continuity of care.
- We found the A&E departments across both hospitals that the service was not staffed in line with nationally recommended levels of consultant cover, or to the trust's own levels. Staffing levels provided by the trust for July 2015 showed an establishment of 4.89 whole time equivalent (WTE) emergency department consultants. There were 1.89 WTE in post which left a variance against establishment of 3 WTE. The rotas showed there were two whole time equivalent locum consultants working in the department. In addition in Scunthorpe there was one Associate Specialist doctor that also supported the consultant rota.
- We reviewed 13 weeks of medical rotas for the emergency department for the period 2 November 2015 to 31 January 2016. We found that between Monday to Friday there was a consultant presence in the department for seven to 12 hours. However, on Saturdays and Sundays consultant presence in the department was only for three hours with on call cover at other times. There was also a reduced consultant presence in the department on bank holidays.
- Medical cover at night was one registrar, with two junior doctors; a foundation year 1 (FY1) grade covered all of the medical wards and an SHO (Senior House Officer) worked in the clinical decision unit. They were supported by a consultant on call. The registrar was also responsible for covering the stroke unit and accident and emergency. During the unannounced inspection, there was evidence of delayed treatment and care due to the high workload of the junior doctor who was unable to see all patients on the wards in a timely manner.

Summary of findings

- In surgery there were 10 whole time Consultant vacancies across the surgical specialities however surgical rotas ensured seven day 24 hour cover.
- The critical care unit at Scunthorpe did not meet the requirements of the Core Standards for Intensive Care (2013) for medical staffing. For example, twice daily ward rounds did not take place at the weekend and consultant work patterns did not deliver continuity of care as the consultants covered one day at a time.
- There were six consultant obstetricians with an on call arrangement of 1:6. Figures showed a consultant was on site between the hours of 9am to 7pm Monday to Friday, and Saturday 9am to 2pm. Consultant on call cover was then provided Monday to Friday 7pm to 9am, and at the weekend 1pm to 9am (with an overlap of 1 hour between 1 – 2pm). This was in line with the Royal College of Obstetricians and Gynaecologists (RCOG) best practice standard for consultant labour ward cover.
- There were ten unfilled vacancies for medical staff in radiology. However, the department was managing this shortfall and had plans to recruit radiologists from abroad. We found there was no detrimental effect on the care and treatment patients received due to the shortage of medical staff in radiology.

Records

- In 2014, the trust was asked to ensure the reasons for do not attempt cardio respiratory resuscitation (DNACPR) decisions were recorded and were in line with good practice guidelines. DNACPR records we reviewed during the inspection showed mixed compliance in terms of discussion with family members to put the DNACPR in place. We observed that no review of the DNACPR decision had taken place post-operatively when the emergency situation may have changed. This was also the case when patients were diagnosed medically fit, or when they were transferred between hospitals. It is recognised, as good practice to record further discussions throughout the patient's hospital stay. There was no consistent approach to completing DNACPR records.
- We reviewed records across the core services in acute and community locations and found them to be overall up to date and complete. However in community we saw both paper and electronic records, in use simultaneously). Audit of records had been carried out in community which showed variation in

Summary of findings

standards of record keeping and areas requiring improvement. Documents such as early help assessments had to be scanned into system one as there was no facility to input directly in to the electronic system.

- We raised a concern about records from system one being printed out for a children's and young people's multi-disciplinary team meeting then collected in for shredding at the end of the meeting. This was due to some members of the team not having access to system one records. This was raised with the management team at the time of inspection; they were not aware of this practice but said they would take immediate action to stop this practice as there was a risk of confidential information being accessed.
- Electronic records could be accessed remotely by the use of laptops, these could only be accessed by use of a smart card. We were told getting internet access could be an issue when working outside of the office depending on the location, staff said this had improved with the use of laptops. System one was a standing item on all of the meeting minutes we reviewed.

Assessing and responding to patient risk

- We observed the use of an electronic system called WebV to manage and monitor patients. We saw nursing staff measuring observations at patient's bedsides and entering them onto an electronic device. The system was used in conjunction with the National Early Warning Score (NEWS) and allowed staff to monitor whether patients were receiving timely repeat observations and whether their condition was improving, stable or deteriorating. Web V incorporated a range of icons which made it easy for health professionals to see risks associated with each patient, such as if a patient was suffering from dementia or confusion or if they were at high risk of falls. It was easy to see at a glance whether any risk assessments were incomplete.
- There was a system for assessing ambulance patients that arrived in the A&E departments although we found in Scunthorpe that when the department was busy there was a delay in the assessment taking place. Ambulance crews told us that on such occasions they had to go round to the nurses' station in the majors' area to find a nurse to assess the patient. We observed this when we visited the department.
- At Scunthorpe, telemedicine was used out of hours for stroke services, this meant that the on call consultant could see and speak to the patient from home.
- In 2014, the trust was asked to ensure the World Health Organisation Safety Checklist (WHO) was fully embedded and

Summary of findings

audited appropriately in theatres. Internal audits in 2014 showed compliance with WHO audits below 62%. Audits of retrospective documentation we reviewed during this inspection showed 88% compliance in February 2015; however, in August 2015 the trust's own level of assurance had dropped to "limited". During the inspection, we observed two WHO checklists taking place we noted variable compliance with one being undertaken appropriately and one where new staff entering the theatre were not being introduced during the list. The name of the person completing the record has been removed from the WHO audit document which decreased accountability. The trust told us this was to encourage full team responsibility for completion.

- In theatres on both acute sites there was a lack of formal processes for identification of allergies and also changes to theatre lists.
- Concerns were raised during the inspection and corroborated with discussion with staff over the pre-assessment process and the staffing levels. No anaesthetic support was offered to pre-assessment and few pre- assessment pathways were available. This resulted in patients being listed for day case operations when they were unsuitable and required overnight stay. An increasing number of surgical cases were cancelled, due to inappropriate pre-assessment. The senior management team were aware of the issue and "improvement of the service" was noted in the theatre action plan.
- The trust had developed a deteriorating patient team to enable rapid response, this team included a Nurse Consultant, the Critical Care Outreach team, vascular nurse and a sepsis nurse.
- The service used the Modified Early Obstetric Warning Score (MEOWS). This assessment tool enabled staff to identify and respond to the need for additional medical support if required. The MEOWS identified directions for escalation, and staff were aware of the appropriate action to take if patients scored higher than expected. We looked at completed charts; the documentation had been completed appropriately.

Major incident awareness and training

- There was variable awareness of major incident preparation and policy. For example in surgery, staff we spoke with were not aware of any major incident scenario training sessions being carried out in the previous year. However, in critical care, staff were able to articulate the requirements in the event of a major incident or disruption to business continuity.

Summary of findings

Are services at this trust effective?

Summary

We rated effective as “requires improvement” for the following reasons:

Although the majority of policies reviewed during the inspection were within date there were a number that were out of date across medicine, maternity, critical care and emergency care. Out of date policies had been raised in the 2014 inspection but actions to address this had not been fully completed. In critical care however there were processes in place to ensure timely review of policies and guidelines and all were in date within the unit.

The trust’s quality accounts indicated that overall the trust was 82.8% compliant with NICE guidance at the end of March 2015. However, within a performance dashboard from the surgery and critical care group dated May 2015 there was just over 50% of NICE guidance adopted. In July 2015 there were 31 of 54 (approximately 57%) sets of NICE guidance which were fully compliant.

The trust had variable performance with regard to patient outcomes.

In the critical care units baby monitors were used. There was no information displayed to patients or relatives to inform them that a monitor was in use and there was no evidence of staff obtaining consent from patients or relatives to this in the two records we reviewed. This was raised as a concern during the inspection and at the unannounced inspection a draft Privacy Impact Assessment for the use of the monitors had been developed and was due to be ratified at the trust governance and assurance committee on 16 November 2015. Information for patients and relatives was displayed in the side rooms. There was no record of consent to the monitor being used in the record we reviewed.

Evidence based care and treatment

- Care and treatment was delivered in accordance with evidence based practice and national guidance.
- NICE and other best practice guidance was risk assessed by clinical teams and discussed at the local business unit/ directorate governance groups. Gap analyses of guidance were undertaken and implementation prioritised based on risk.
- The trust’s quality accounts indicated that overall the trust was 82.8% compliant with NICE guidance at the end of March 2015. However, within a performance dashboard from the surgery and critical care group dated May 2015 there was just over 50% of NICE guidance adopted. In July 2015 there were 31 of 54 (approximately 57%) sets of NICE guidance which were fully

Requires improvement



Summary of findings

compliant. Treatment provided did not always reflect current evidence-based guidance, standards and best practice. In surgery, implementation of best practice guidance was variable, with less than 60% of policies compliant with current National Institute for Health and Care Excellence guidance.

- The trust had realigned its stroke pathways following national best practice and created hyper-acute stroke beds at Scunthorpe hospital with step down and rehabilitation beds at DPoW hospital.
- The endoscopy unit at DPoW hospital was nationally accredited by the JAG (Joint Advisory Group). There was an action plan in place to work towards the unit at Scunthorpe being JAG accredited.
- Overall policies that we reviewed were in date however we did identify a number that were out of date. We had identified in the 2014 inspection that policies within critical care required updating; this had not been fully completed by the time of this inspection. There were also policies out of date within surgery, medicine, maternity and emergency care; we were told plans were in place to review these.
- An effective NICE-based oral health toolkit had been developed and was in use within schools.
- We found that there was a named respiratory consultant to manage patients with non-invasive ventilation (NIV). A maximum of four NIV patients were cared for on Ward 22. The recommended minimum staffing ratio of one qualified nurse to every two patients was met and there was additional support from the specialist outreach team.
- In response to the national withdrawal of the Liverpool Care Pathway (LCP) in July 2014, the trust had developed a 'my future care' document. This was based on national guidance and supported the delivery of individualised end of life care.
- There was no trust specific end of life strategy or related performance indicators to measure the success of the end of life care services. However, the trust were part of the wider health economies' strategic groups for end of life care. The diagnostic department undertook a range of national statutory audits to demonstrate compliance with the radiation regulations. For example, diagnostic imaging had a procedure for the use of diagnostic reference levels (DRLs). We saw that the RPA audited DRLs; records reviewed showed compliance was good overall.
- UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breastfeeding and promote parent/infant relationships. The health visiting service

Summary of findings

was currently accredited to stage two, which meant the service had demonstrated assessment of staffs knowledge and skills. Staff told us they attended training on this. We reviewed a trust audit on UNICEF baby friendly imitative from July 2015. The audit identified areas for improvement, for example of the 20 people interviewed, 60% had adequate knowledge on how to attach the baby to the breast, so this was identified as an area for improvement.

- The healthy child programme (HCP) is the main universal health service for improving the health and well-being of children. This is done through health and development reviews, health promotion, parenting support and screening and immunisation programmes. The health visitors and Family Nurse Partnership followed this initiative and delivered it to the 0-19 age range.

Patient outcomes

- Levels of hospital mortality are measured in a number of ways nationally. The SHMI (Summary Hospital-level Mortality Indicator) is an indicator which reports on mortality at trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI for this trust was at 112.5 at the end of May 2015, with a particularly marked increase in North Lincolnshire in the Scunthorpe hospital area where the out of hospital SHMI was 130 vs. the in hospital SHMI of 105. Work was underway with community and primary care partners to address this, which was being led by the newly appointed palliative care consultants. Data released at the end of January 2015 covering the time period July 2014 – June 2015, indicated a slightly improved trust score of 109.7 which was within the ‘as expected range’ nationally..
- The Hospital Standardised Mortality Ratio (HSMR) is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell, compared to the expected number of in-hospital deaths. The HSMR was increasing from 104 at the end of March 2014 to 110 at March 2015.
- In hospital crude mortality to the end of June 2015 was 1.51%; 1,626 deaths in 107,488 discharges, compared with 1.43% to the end of June 2014; 1516 deaths in 105,997 discharges.
- At the time of the inspection the trust was a mortality outlier for deaths from acute bronchitis and cardiac dysrhythmias.
- Patient outcome data for the ITU was variable; the mortality ratio was worse than the critical care network average data.

Summary of findings

- Scunthorpe General Hospital scored well in the Stroke Sentinel National Audit Programme, with an overall score of B (on scale of A – E, with E being the worst) for April – June 2015 admissions
- Data from the trust showed that preliminary results received for 2014-2015 data for the Myocardial Ischaemia National Audit Project indicate secondary preventions medications were now above or equal to the latest average results.
- Performance in the National Diabetes Inpatient Audit (2013-14) was mixed, with the hospital performing better than the England average in 11 areas and worse in nine. We saw that action plans were in place to further improve these services.
- The stillbirth rate and the induction of labour rate were higher than the national average at DPoW hospital.
- In a Royal College of Emergency Medicine (RCEM) 2014-15 audit of mental health provision Scunthorpe Emergency Department (ED) scored worse for one of the fundamental standards and met the other. The audit found that the emergency department did not have a: “Dedicated assessment room for mental health patients.” This ED also scored worse for five of the six developmental standards. These standards were: “History of patient’s previous mental health issues taken and recorded; Mental state examination taken and recorded; Provisional diagnosis documented; Assessed by mental health practitioner within one hour; and details of any referral or follow-up arrangements documented.”
- In the April 2013 – December 2014 Trauma Audit and Research Network (TARN) report it was found that the outcomes for trauma patients had improved in comparison with the 2012-13 audit.
- In end of life care we saw that national guidelines were used by staff however it was not possible to tell if patients’ preferences at end of life were met, as outcomes, including preferred place of care, were not measured.
- In 2014, we asked the trust to ensure there was an improvement in the number of patients with fractured neck of femur who received surgery within 48 hours. At this hospital 71.4% of fractured neck of femur patients had surgery within 48 hours in 2014, compared to the England average of 87.3%.
- National hip fracture audit data for 2014 showed Scunthorpe hospital (SGH) performed better than the England average on most of the indicators. However, there had been deterioration in performance at SGH in six of the areas reported on in 2014 compared to 2013, including the proportion of patients having surgery on the day or after the day of admission which was lower (64.9%) than the England average (73.8%) and lower than in 2013 (71.4%).

Summary of findings

- The trust had taken part in the 2013-2014 National Care of the Dying Audit (NCDAH) and achieved three out of seven organisational key performance indicators (KPIs). These were in the areas of access to information, education around end of life and having protocols for medicines.
- The trust was worse than the England average for access to specialist palliative care, board representation for end of life care, the promotion of privacy and dignity at end of life, and the feedback process for bereaved relatives.
- Information about the outcome of peoples' care at end of life was not routinely collected or monitored. For example, there were standard audits of infection prevention and control, catheter audits, hand hygiene audits, and documentation/ records audits; however, we did not see specific audits of preferred place of care, the outcomes of advanced care planning or bereavement audits.
- DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) is a UK NHS training course for people with type 2 diabetes that helps people to identify their own health risks and to set their own goals. Nurses and dieticians from the community teams ran half-day courses for diabetic patients in the community to improve a person's management of their disease.
- Breastfeeding initiation rates were 51%, this was worse than the England average which is 73.9%. Those mothers still breastfeeding at six months drops to 6%.
- Therapy Outcome Measures (TOM) are a way of measuring children's health needs at the start of their patient journey, working with them and their family to meet these health needs, then evaluating to hopefully demonstrate an improvement. We were told TOM's were a work in progress, they were part of the allied health professional specification and key to achieving them was patient pathways.

Multidisciplinary working

- Throughout the inspection there was evidence of good multidisciplinary working.
- The trust was working with its partners to improve discharge and prevent unnecessary admissions. For example in North Lincolnshire the Better Care Fund investment was being used by partners to expand a community service. The Rapid Assessment Time Limited Service (RATL) would provide a fast community response, seven days a week, 24 hours a day, to mainly elderly or frail people who were in urgent need of care

Summary of findings

and it would see staff responding to the most urgent calls within one hour and preventing hospital admissions where it was safe to do so. Staff worked directly with the A& team, social services and mental health teams.

- There was a Skin Integrity Board which worked across the trust, other local providers and the two commissioning groups. Initiatives to improve tissue viability were shared and implemented.

Competent Staff

- At the end of November 2015, the trust achieved an overall 78% compliance with Performance Appraisal and Development Reviews (PADRs), an increase compared to October, which was 74%. Compliance varied by directorate with the surgery and critical care being the lowest at 63% of PADRs completed. A senior nurse for the emergency department told us that the percentage of nurses who had received appraisals was at 51%, against a trust target of 90%. They told us they had changed the timing of when they did appraisals which would allow them to improve the percentage of staff that had an appraisal within the year.
- Appraisals could not be signed off until the training on the trust's "Compliance training" list had been completed which ensured staff had the relevant training for their roles and improved compliance rates.
- The medical director was the responsible officer for the revalidation of doctors working within the trust. There was a system in place to manage the process and monitor any deferrals.
- Each of the 234 permanent employed medical staff and 66 short-term contracts in the previous year was allocated an appraiser and had to have an appraisal every year. In September 2015, the national medical staff appraisal rate was 81.4% with the trust's rate at 90%. Where required appropriate steps were put in place for lack of engagement with the appraisal process.
- We found two gynaecology patients had been admitted to the antenatal ward and were being nursed by midwives that did not have the relevant skills and experience, as some were not dually qualified in general nursing. The midwives were potentially compromising their professional registration by doing this. We were told this happened approximately twice per month. It was brought to the attention of the provider who told us they had acted immediately to address the situation.
- The Kirkup report gap analysis across the trust had identified the need for a Clinical Risk Midwife and a Practice Development

Summary of findings

Midwife, and the management team were working to address these shortfalls. However, although the management team were working on this, neither posts had been appointed. The clinical educator post within critical care was also vacant. These gaps may have impacted on staff training and development.

- Midwives had statutory supervision of their practice, and staff confirmed they had access to a supervisor of midwives for advice and support 24 hours a day. Information provided by the trust showed that 98% of 223 midwives had completed their annual supervisory review. Figures showed the supervisor to midwife ratio was 1:15 and this was in line with the national guidance of 1:15.
- Community palliative care staff were providing a range of training to support staff in caring for people at the end of life. The team also planned to deliver 'SAGE & THYME'® training to a range of community staff. The SAGE & THYME® model was developed by South Manchester NHS Foundation trust. Its purpose was an aide-mémoire to train all grades of staff on how to listen and respond to patients or carers who were distressed or concerned.

Seven Day Services

- Gastroenterology consultants were on site at the weekend and there were plans in place to introduce a formal seven day on-call bleed rota across the hospitals at Scunthorpe and Grimsby. This had been raised as a concern at the initial inspection in 2014.
- In 2014 the trust was asked to ensure availability of emergency theatre lists at Scunthorpe hospital. We observed that access to emergency theatre lists had improved and was now offered seven days a week for part sessions. At the weekend, trauma and emergency lists were joint. Staff working in orthopaedics told us that on some occasions this made it difficult for orthopaedic cases to access theatre in a timely manner.
- In critical care, consultants completed a ward round once a day at the weekend which was not in line with the twice a day recommendation from the Core Standards for Intensive Care (2013).
- General radiology provided a 24-hour seven-day service with core hours from 8.30am to 5pm and reduced staffing (2 radiographers and 1 HCA) outside these hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Summary of findings

- Staff we spoke with understood the principles of consent including the Gillick Competency Guidelines where relevant, which relate to obtaining consent from children and young people.
- The trust compliance with MCA training was 83% in September 2015.
- Training records provided by the trust for medicine at Scunthorpe and Goole hospitals showed good levels of training for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) for nursing staff. Eighty eight per cent of nursing staff attended Mental Capacity Act training and 89% attended Deprivation of Liberty Safeguards training. However training attendance was not so good for medical staff with only 38% attending both Mental Capacity Act and Deprivation of Liberty Safeguards training.
- In critical care at Scunthorpe and DPoW hospitals, staff told us baby monitors were used in the side rooms in case the patient could not use the call bell but could hold their hand up or make some noise. Staff told us the monitor was turned off or covered during personal care to maintain patients' privacy and dignity. There was no information displayed to patients or relatives to inform them that a monitor was in use and there was no evidence of staff obtaining consent from patients or relatives for this, in the two records we reviewed. CCTV was also used in the coronary care unit at DPoW hospital. Staff showed limited understanding of the need to obtain consent for the use of these monitors. We raised this at the time of inspection and the trust responded to say they would act on our concerns.

Are services at this trust caring?

Summary

We rated caring as "good" for the following reasons:

People in community services were treated with kindness, dignity, respect and compassion while they received care. Patients and their relatives spoke positively about the care they received in the community. We observed interactions between staff and patients and saw staff found ways of making the experience of care as easy as possible for people. Relatives could record aspects of care in a diary in critical care, for example and staff told us this enabled them to review relatives' experience of care and learn from it.

We saw and heard of some outstanding examples of care and involvement of patients who were dying, and difficult conversations were done in a sensitive understanding way. Staff were compassionate and understanding of people as individuals.

Good



Summary of findings

This trust had a higher response rate in the Friends and Family Test than the England average and a high proportion of patients who would recommend the service. The response rate for Scunthorpe General Hospital was 43.8% between July 2014 and June 2015.

Compassionate care

- Generally, this trust had a similar performance to others in the Cancer Patient Experience Survey 2013/14, although they performed in the bottom 20% for seven of the questions. These were: patient's family definitely had the opportunity to talk to doctor; got understandable answers to important questions all/most of the time; hospital staff did everything to help control pain all of the time; given clear written information about what patients should / should not do post discharge; family definitely given all information needed to help care at home; patient definitely involved in decisions about care and treatment and; hospital staff gave information about support groups. Of these seven, six scores had deteriorated since the previous survey.
- Results from the 2015 patient-led assessments of the care environment (PLACE) were similar to the England average for cleanliness and privacy and dignity. There has been a marked improvement in scores relating to food, from 64 in 2013 to 86 in 2015 which is almost at the national average of 88. Facilities scores were below average.
- Results from the CQC inpatient survey 2014 were similar to other trusts, although they were amongst the worst performing trusts for the question about doctors talking in front of the patient as if they were not there.
- Results from the Friends and Family Test (FFT) were similar to the England average between July 2014 and June 2015 and response rates were variable across the trust. For example in medicine at Scunthorpe the response rate was 43.18% between July 2014 and June 2015. However in May 2015, the trust remained in the bottom 50% of reporting trusts for friends and family tests. The trust response rate was 21.7% compared to the national average of 39.3%. We looked at data that was available from the FFT and found the following comments:

"Very friendly, helpful, chatty, Enjoy seeing them all. A credit to the NHS."

"Very nicely treated, made to feel safe and welcome."

"Nurses are very friendly and professional. Always competent and know what they are doing. - Never let down."

"The nurses have shown decent dignity, kindness and sincerity. I have always been pleased to see them"

Summary of findings

- We received some negative comments while on inspection, which included a patient on ward 24 who told us that although the nurses were good and efficient there were not enough of them. They said that when patients press the buzzer it can take a long time for them to respond and a patient was left for 20 minutes on the toilet that morning. Another patient said that sometimes the nurses talk very loudly at night and this disrupts sleep.
- We saw issues of privacy and dignity around a gentleman who had exposed himself whilst catheterised. Two doctors, one nurse and one housekeeping assistant had all passed by the gentleman and no action was taken. This was raised with the ward manager who took immediate action.
- When we asked patients and relatives in outpatients whether they understood their care and treatment, the responses were mixed.
- We viewed feedback from patients and relatives in the community that included comments about how caring staff were and how safe patients felt in their care. Comments included,

“Macmillan carers do what the title says - they care. Never rushed but always efficient and friendly.”

“The team are caring, compassionate and nothing is too much for them.”

“Everyone was very caring. Professional and obviously well trained.”

Understanding and involvement of patients and those close to them

- All the patients and relatives we spoke to told us they had been kept informed of their treatment and progress and that they were involved in the decisions made by the medical team.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- Nurses on the critical care units started a diary for patients in consultation with their relatives. Staff and relatives made entries in the diary during the patient's stay on the unit.
- Women we spoke with who were using maternity and gynaecology services stated they had been involved in decisions regarding their choice of birth and felt supported by staff.
- In community end of life services the ‘my future care plan’ included prompts for patients about choices and decisions they

Summary of findings

might wish to make before and for after they died. This advanced plan was recorded so staff were aware of patient decisions. The last days of life document also included prompts for discussing issues of care with patients and relatives.

Emotional support

- We saw examples of where staff provided emotional support to patients. For example in critical care at Scunthorpe one member of staff followed a patient through the organ donation process and attended the funeral. They wanted to understand the process to enable them to support families in the future.
- In critical care staff told us of the frustration delayed discharges caused them because of the psychological effect it had on patients. There were no patient toilet or washing facilities on the unit and there was limited space for patients to walk around.
- Specialist palliative care nurses were trained in advanced communication skills and the clinical psychologist offered a range of therapies to end of life patients in clinics or in their own homes. Therapies included compassion focussed therapy and acceptance therapy. If the clinical psychologist were not available, their manager would see patients in times of crisis.
- There were policies and procedures in maternity for supporting parents in cases of stillbirth or neonatal death. This included referral to the Blue Butterfly group, which was facilitated by the chaplaincy and offered support to families following bereavement.
- The trust had a chaplaincy service which supported patients and relatives across the trust
- Staff in the community clinics told us that they build relationships with patients who had long term conditions and were able to provide emotional support. We saw this when we observed staff in clinics interacting with patients who they had seen on a number of occasions.
- Staff in the community stroke service told us that stroke patients had mood screening and a psychologist was available within the team.

Are services at this trust responsive?

Summary

We rated responsive as “requires improvement” for the following reasons:

Requires improvement



Summary of findings

The trust had a backlog of 30,000 patients who were requiring outpatient follow up across a number of core services, this had resulted in patient harm in a small number of patients. There were multiple cancellations of appointments resulting in delays to follow up.

During our inspection, we observed and saw evidence of a number breaches of the national policy for mixed sex accommodation on both sites which compromised a person's right to privacy and dignity. None had been reported nationally as is the requirement.

The emergency department failed to meet the needs of mental health patients, with patients having to wait in unsuitable accommodation that was unsafe. The lack of a designated room for mental health patients had been raised at the previous inspection in 2014 and following a Royal College of Emergency medicine audit into provision of mental health. We informed the trust of our concerns and following the inspection they provided us with an action plan to address these specific issues.

The use of monitors in critical care and coronary care compromised the privacy and dignity of patients.

There was no learning disability strategy in place at the time of the inspection. Strategic aims were being developed and a non-executive board lead identified. There was not sufficient resource identified including specialist staff, training and systems in place to care for vulnerable people, specifically those with learning disabilities and dementia. A highly motivated and compassionate quality matron had the lead for dementia and also learning disabilities.

Access and flow performance was variable across the trust

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.

Service planning and delivery to meet the needs of local people

- There was an ongoing strategic review of the configuration and sustainability of health and social care services across the geography of North and North East Lincolnshire called "Healthy Lives, Healthy Futures" (HLHF). The trust were working closely with external partners on developing a model of care that addresses the challenges across the health economy. The Healthy Lives, Healthy Future programme is focussed on

Summary of findings

developing models of care which involve providers across the community bringing together primary, community and acute care to ensure services provided are sustainable and financially viable.

- Capacity and demand planning is undertaken at divisional level. We were concerned regarding the robustness of the capacity planning across a number of core services including outpatient requirements due to the current situation of a backlog of patients. The senior medical team in surgery were unaware of how many pre-assessment appointments were required to assess correctly the number of patients being referred however, they were undertaking a capacity and demand assessment.. They were also unaware of the length of time each operation required and whether enough theatre time was available.
- The critical care service worked with leads from the other directorates in the trust to plan service delivery. We saw evidence of this in the minutes of the critical care provision group meetings.
- Following the 2014 inspection the trust was required to address the high rates of patients not attending their outpatient appointments. Since then outpatients had introduced a reminder system using text messages for patients and the ophthalmology department was piloting call reminders, to ensure patients were aware of their appointments. We were told that the did not attend rate should improve as a result. However the management team were unaware whether the did not attend rate had actually improved in their department or not.
- The trust had developed clinical pathways with other providers to ensure patient access to tertiary referral services.
- The Rapid Assessment Time Limited Service (RATL) had been developed to provide a fast community response, seven days a week, 24 hours a day, to mainly elderly or frail people who are in urgent need of care. The service was an expansion of the existing unscheduled care team and would see staff responding to the most urgent calls within one hour and preventing hospital admissions where it was safe to do so. Seven additional members of staff were being recruited to the team. This was a joint initiative between North Lincolnshire Clinical Commissioning Group and the trust.
- In October 2015 the Specialist Palliative Care Team (SPCT) had recently begun to provide a seven day service, from 9am to 5 pm, this was to support the other community based services and the GP out of hour's service, with the intention of reducing the number of unnecessary admissions to hospital.

Summary of findings

Meeting people's individual needs

- Between April 2013 and May 2015, 50% of delayed transfers of care were due to the patient waiting for further NHS non-acute care which equated to 6,620 discharges. A further 30%, equivalent to 3,960 discharges, were because the patient was waiting for the completion of an assessment.
- During our inspection, we observed and saw evidence of a number breaches of the national policy for mixed sex accommodation on both sites which compromised a person's right to privacy and dignity. None had been reported nationally as is the requirement. Mixed sex breaches occurred within the Acute Medical Unit (AMU) at DPoW hospital and it was unclear how these formally assessed and reported. We raised this with the trust and they confirmed that in December 2015, following their validation, the trust was declaring breaches in respect of five patients on AMU. In terms of the other patients affected, this equated to 28 breaches.
- At Scunthorpe hospital's critical care unit we saw 10 forms completed by staff from 13 March 2015 to 2 November 2015 declaring a breach. We were told by staff a breach was only declared if it was after 24 hours and the patient was not waiting for a speciality bed. We raised this with the trust and were told it was only declared a breach after 24 hours and they were clinically justified as they were waiting for speciality beds. At our unannounced inspection intensive care staff in DPoW hospital told us they had reported an occurrence on 2 November 2015 where a patient had experienced a 75 hour and 45 minute delay. The senior management were unaware of this.
- The three largest ethnic minority groups in the area served by the trust were Polish, Lithuanian and Latvian. Where an interpreter was required, the trust in the majority of instances used a telephone service.
- The trust had a list of approved interpreters both independent and agency based (including sign language) where it was physically impractical to use the telephone service, for example, endoscopy, ultrasounds.
- All ward and departmental staff had the responsibility to ensure that requests for face to face interpreters were booked through the Patient advice and liaison service (PALS) at least five days prior to an appointment. If requests were urgent PALS would try and seek a resolution to ensure the service was provided.
- The trust had recently appointed its first two palliative care consultants who were working with other local services to improve choice of place of death and responsiveness for patients requiring end of life care.

Summary of findings

- The CCTV policy was due for review in May 2014 and was therefore out of date.
- Following the inspection the trust told us they were putting in place a privacy impact assessment for the use of cameras. They were still in use at the time of the unannounced inspection and the Privacy impact assessment was in draft form. We reviewed two patients' notes and found there was nothing recording any discussion or consent to the use of these observation methods.
- The 2014 staff survey showed 74% of staff having had equality and diversity training in the last 12 months. This had decreased but remained much better than the national average of 62%.
- The needs of people of faith were met by a multi-faith team in the hospital, which was contactable on a 24 hour basis throughout the year. This team could obtain support from representatives of the different religious faiths.
- The outpatient service did not have reliable systems and processes in place to meet the needs of different patient groups, including those in vulnerable circumstances or with additional needs, such as those living with dementia or a learning disability. There was a reliance on the GP referral letter to identify whether patients have specific needs.
- The Looked After Children (LAC) team told us they try to be flexible with appointments to ensure attendance from young people. This is done by offering appointments after school hours or in school holidays. They also liaised with community dental clinics and made local arrangements for LAC to be seen up to the age of 21.
- The health visiting teams told us they had developed the system of having a daily 'duty worker' who was office based. They answered the telephone and dealt with day to day tasks meaning the rest of the team could focus on their caseload.
- The "Frail Elderly Assessment and Support Team" gave elderly patients, immediate access to physiotherapy / occupational therapy assessment as well as nursing and medical assessment. Social services would also be involved in assessment with the aim of providing immediate treatment / assessment and initiation of community based care or services. The aim of this service was that patients should be able to return to their usual place of residence with the support of community services.

Meeting people's individual needs: Learning disability

- The trust was not meeting all the requirements for people with learning disabilities.

Summary of findings

- There was no learning disability strategy in place at the time of the inspection. Strategic aims were being developed and a non-executive board lead identified.
- There was not sufficient resource identified including specialist staff, training and systems in place to care for vulnerable people, specifically those with learning disabilities and dementia. A highly motivated and compassionate quality matron had the lead for dementia and also learning disabilities. Until 2014 there had been one registered nurse working one day a week covering Scunthorpe hospital. There was also a part-time post (three days per week) working at DPoW hospital but this post which was externally funded and was due to end within eight weeks of the inspection.
- There was a speech and language therapist (SALT) who was a clinical specialist for community adults with learning disabilities and they worked closely with the quality matron and across the sites.
- The two leads worked effectively together to support patients wherever possible. Patients in the community already known to the SALT have care plans in place. For some patients joint visits were arranged to ensure care plans were in place to meet each person's needs.
- We were told the number of patients with learning disabilities accessing services across the trust was increasing and that a business case to increase support for such patients was to be developed.
- Patients with recognised learning disabilities were flagged through the trust's IT system when they were admitted to hospital. However, there was no routine notification / reporting system to the quality matron to inform them of an admission. The matron had to review each ward's information on the IT system to see where patients were.
- The trust's staff worked with community health and wellbeing co-ordinators from another provider to support patients with a learning disability.
- Many patients came into hospital with a "My Health book" which was designed to support carers to meet their needs and included information on such things as communication, medicines, physical ability and support needs. These books were reviewed annually with the patient's GP.
- At the time of the inspection training uptake was low; there was a lack of trainers and training for learning disabilities was not on the trust's compulsory "Compliance training" list. There was no e-learning in place for learning disability.

Summary of findings

- Work was to start in November 2015 to develop a film about the pathways through outpatients from the GP visit onwards. Staff were working with the patient group “The Thinkers” to develop this resource and its use.
- Ward champions for learning disabilities were going to be recruited.
- There was no audit system in place to monitor performance in relation to meeting the needs of those with learning disabilities. For example, there was no audit of bowel care. However, the matron was able to give us excellent examples of where a person’s care had been adjusted to meet their needs.
- Risks identified by staff included: lack of learning disability liaison nurse(s) and ensuring everyone had an understanding of consent and capacity, especially consultants.

Meeting people's individual needs: Dementia

- There was a delivery / action plan dated 2014-15 that has been updated from the 2010 National Dementia Audit Delivery Plan to deliver outstanding actions throughout the trust as identified in the 2012 National Dementia Audit (published 2013) in place to improve caring and support for people living with dementia.
- There was no full time nurse specialist in place for dementia care. A highly motivated and compassionate quality matron had the lead for dementia and also learning disabilities. The other quality matrons supported the lead for dementia together with a number of dementia champions.
- There were quality indicators in place to ensure patients were screened, received the appropriate assessment and were referred to specialist services if required. These indicators were achieved for 2014-15.
- Indicators in place for 2015-16 were for 90% of patients aged 75 and over admitted as an emergency to be asked the dementia case finding question, and for 90% of the above patients scoring positive on the case finding question, to have a further risk assessment.
- The trust had a target that 45% of all relevant staff to have received dementia awareness training by December 2015. In May 2015 this target had been exceeded and 49% of staff had completed this training.
- Dementia training uptake was good. There were three levels of training in place for staff; the first level was for all staff who were likely to come into contact with people who had dementia, level two was for clinicians and level 3 more specialised. The training was also on the trust’s “Compliance training” list which meant that staff could not have their appraisal signed off until the training had been completed.

Summary of findings

- There were specific quality targets relating to dementia within the quality accounts for both 2014-15 and 2015-16.
- The trust were a national exemplar at DPoW hospital for home from home.
- The environment within two orthopaedic ward bays at DPoW hospital had been made redeveloped to take into account the needs of people with dementia.

Access and flow

- Referral to treatment (RTT) performance for non-admitted patients had fallen since April 2013, but had remained above the 95% standard and the England average throughout this period.
- Referral to treatment performance for incomplete pathways had been between 96-98% since April 2013, which was above the standard of 92% and the England average.
- Data submitted by the trust showed performance against the eight national and local cancer targets was compliant in six out of the eight categories in July 2015. The two categories which were not compliant were;
 - 62-day wait urgent GP referral to treatment was 80.42% against the national standard of 85%
 - 62-day wait consultant screening service was 84.62% against the national standard of 90%.
- In June 2015 there were approximately 30,000 patient episodes identified in a backlog, about 11,000 of these were ophthalmology patients. These patients had not been clinically assessed and there was no system in place to record how many follow up appointments had been cancelled. There had been serious incidents declared with evidence of patient harm as a result of delayed follow up. We asked the trust to take immediate action: the trust provided monitoring information following the inspection that indicated all patients in the backlog had been reviewed by 31 December 2015.
- All cancer waiting time measures had been consistently higher than the England average since Q1 2013/14. This meant patients waited less than the national average for their appointments.
- During this inspection visit, we found the 'did not attend' (DNA) rates and cancellation rates in outpatients had not improved since the last inspection in April 2014.
- We reviewed the trust's 'Referral to treatment access policy' and found that the trust target for outpatient clinic cancellation and did not attend rates was 6%. Between September 2014 and August 2015, the did not attend rate was 10.3%. The level of list

Summary of findings

cancellations in outpatients remained high and had increased since the 2014 inspection; the cancellation rate was 21% in 2014-2015 and increased to 22% between April and September 2015

- In ophthalmology during the same period the DNA rate was 8.0%, this amounted to 2115 patients. The clinic cancellation figures in ophthalmology for September 2014 to August 2015 were 23.9% There were high numbers of on the day patient cancellations and on the day hospital on the day cancellations. There had been no significant improvement in follow up appointments being timely.
- We observed clinics being cancelled by administrative staff with no clinical oversight of the process. Patients were contacted systematically and appointments cancelled with no clinical prioritisation.
- We raised concerns regarding the current position in outpatients at the time of the inspection with the trust. When we did the unannounced inspection, the trust had put measures in place to prevent this from happening again. Information was now collected on what stage patients were at in their care pathway. If any clinics required cancelling or reducing then the decision to do this, and which patients to cancel, was that of the consultant and not the administration staff.
- Information regarding bed moves between April 2014 and March 2015, indicated that across the medical service for the trust 48% of patients were moved once during their stay, 13% were moved twice, 3% three times and 2% of patients were moved four or more times. This equated to 336 patients across both hospital sites being moved four or more times during their hospital stay. Evidence from the Royal College of Physicians has shown that every ward move increases patient length of stay. There was a 1% improvement of numbers of patients being moved two and three times during their stay from the previous year.
- A&E data showed that between April 2015 and October 2015 a total of 2,212 patients waited more than 30 minutes to be handed over from ambulance crew to A&E staff. Over the same period 422 patients waited over one hour before handover. In October, the month of our inspection 78 patients waited between one and two hours to be handed over, whilst three waited over two hours.
- Ambulance crews told us that they had experienced extended waits to hand over patients. They said short handovers were

Summary of findings

completed on arrival and full handovers once the patient was transferred to the emergency department team. They recounted occasions when they had continued to treat patients whilst they were on ambulance trolleys in the corridor.

- The trust had revised the acute stroke care pathway with the hyper-acute service based at Scunthorpe however staff reported that it was difficult to re-patriate back to DPoW hospital in Grimsby due to lack of bed capacity.
- It was also apparent that inpatients were not always checked to see whether any preparation was required for the proposed intervention. For example, patients could be cancelled due to medications not being stopped or specific blood test, such as INR, not having been carried out. Patients had been found at the last minute to have clotting times that were not in the safe range for the procedure to go ahead. The manager in this area told us that cancellations and delays were very frequent and happened every week.
- Bed occupancy for women's services 2014-2015 was between 41.4% - 55.1%. This was lower than the England national average of 60% and in line with the Royal College of Midwives recommendations.
- In radiology we observed there was a bottleneck of inpatients waiting for escorts to take them back to the ward areas in the main general X-ray waiting area. There were no other issues identified with access and flow within the radiology departments visited; waiting rooms did get full, but the patient flow was maintained.

Learning from complaints and concerns

- Between 2010-11 and 2014-15 there was a year on year increase in the number of written complaints in this trust. The number fell in 2014/15, with the trust receiving 448 complaints in that year.
- Data provided by the trust indicated that the average number of working days taken to process a complaint until it closed was 61. The trust's own target was to acknowledge complaints within three working days, to put together a resolution plan with five days and to close complaints within 65 days.
- Other trust data indicated that the average number of working days since complaints were received was 68 using data up to 19 September 2015.
- Not all executive staff were aware of the trust's complaints timescales and compliance with this. We were told that 80-90% were completed within 30 days.

Summary of findings

- It was noted that the time period of 65 days was much longer than most other trusts. We were told this was to ensure that all complainants were offered at least one face to face meeting as a part of this process.
- We reviewed a sample of five complaints which demonstrated that the complaints process had been followed and there was evidence of action plans. The complaint reviewer felt that the complaints lacked empathy however quality overall was satisfactory.
- Ninety-four of the 636 complaints were reopened which equated to 15%.
- Following the Keogh review and CQCs last inspection the complaints process was changed. The team has a senior Band 8 clinical lead and the approach was changed to offer more face to face meeting with complainants. The complaints staff we spoke with were passionate about their role and said the face to face contact was improving outcomes for both the complainant and the trust.
- The complaints team maintained a tracking system of all the complaints and lessons learnt. For example, a patient complained about intravenous cannulation in A&E so lights were purchased and alarms were purchased for nurses to help remind them when specific time sensitive medication was due.
- The lead nurse for complaints also attends the safeguarding forum and reviews complaints for any safeguarding issues or clinical incidents that should be reported and investigated.
- All complaints were seen by the medical director and chief nurse. Complaint responses were signed off by the CEO or deputy CEO.
- Complaint data was monitored through the quality and patient experience committee to the board.
- The complaint facilitators had received specific externally accredited training for their role.
- There is also non-executive director challenge within the complaints process.
- 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.

Are services at this trust well-led?

We rated well-led as “requires improvement” for the following reasons:

- We were assured by the quality of the governance arrangements in place. However, we were significantly

Requires improvement



Summary of findings

concerned that these governance arrangements were not either widely understood, applied or embedded to ensure the delivery of high quality care. We did not see sufficient evidence of improvement in some areas from the initial comprehensive inspection in April 2014 to the focussed inspection across a number of core services. For example in the emergency department at Scunthorpe there had been minimal progress in relation to improving the environment and in outpatients there had been significant a backlog of patients requiring further outpatient appointments and examples of harm as a result of multiple cancellations.

- The trust had in place values, a vision and a five year strategic plan. There has been significant challenge to deliver sustainable services within the local health and social care community. To address this the local health and social care community were developing a “Healthy Lives, Healthy Futures” (HLHF) programme, to deliver a sustainable model. However there was no vision or strategy at some core service levels across both acute and community settings. There was no trust specific end of life strategy or related performance indicators to measure the success of the end of life care services.
- In 2014, we said the trust must take action to ensure that there were sufficient qualified, skilled and experienced staff, particularly in surgical areas. During this inspection, we found substantial and frequent shortages of nursing staff and an increased number of agency staff being used. The trust had run a significant recruitment campaign but the skill mix and retention of new staff remained an issue. Appraisal rates for staff had improved since 2014, however still did not meet internal compliance targets and levels of compliance was variable.
- There was a governance framework and systems in place to support staff to identify and review risk and incidents. However we were concerned that not all risks were identified or had robust controls in place which had resulted in harm or sub-optimal care of patients. We did not see a consistent approach to learning and dissemination of learning from incidents and staff told us that they had not received feedback from incidents. There was evidence of lack of learning from incidents across the core services inspected, in medicine, surgery and emergency medicine we were not assured that there was dissemination of learning from incidents.

Summary of findings

- 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.
- There was a lack of accountability at middle and senior management levels regarding outpatient processes and governance which resulted in lack of challenge and monitoring. Concerns regarding outpatient waits and did not attend rates had been raised in the 2014 inspection however progress to address concerns had been slow with little impact on the current outpatient position.
- The Chief Executive Officer (CEO) of the trust had been appointed on a part-time basis to lead the HLHF programme work. The trust had recently created a deputy CEO role so that, whilst the CEO remained the accountable officer, the leadership of the trust on a day to day basis was shared with the deputy CEO. There were concerns regarding the sustainability of the current leadership arrangements.
- There had been a lack of ongoing meaningful staff engagement. Staff told us of low morale and a lack of communication with management. Senior staff had recognised this and were putting actions in place to improve engagement.

Vision and strategy

- The trust had a five year strategic plan 2014-19. The strategic plan set out the values and vision of the trust with the patient at the centre of the values. We were told the vision and values had been developed with staff across the organisation in 2012-13 although staff awareness of it was variable.
- The Strategic Plan identified the key strategic risks and was underpinned by a number of supporting strategy and operational documentations including the 2015-16 operational plan.
- The trust and its strategic partners had recognised for some years the challenge within this geographical area to provide sustainable services for the local population and that this could not be delivered by any one organisation in isolation.
- This recognition was a driver in 2014 to changing the structure of the community wide sustainability programme and appointing one accountable officer to lead the programme which was called “Healthy Lives, Healthy Futures” (HLHF). There

Summary of findings

were seven work streams including: in hospital model, out of hospital model, IT, workforce, finance, engagement and estates. A plan was to be finalised and sent to Monitor in December 2015.

- The annual business planning process for the trust was revised in April-May 2015 to ensure it linked to HLHF and each of the trust's clinical groups.
- An estate strategy was in draft form at the time of the inspection. This was being reviewed in light of work ongoing for the HLHF strategy to rationalise estate across the trust and other health and social care partners.
- The trust did not have a workforce strategy in place at the time of inspection. In quarter four of 2015/16 the trust was going to use a workforce planning toolkit to do a high level analysis by directorate to identify the staff and grade mix required and benchmark this against similar trusts. This would then form the foundations of the trusts workforce plan. The plan was to introduce the toolkit and develop it during the 2016-2017 workforce planning cycle.
- There was a Chief Nurse Strategy dated 2012-2015. The aim of which was to develop a culture that placed quality at the heart of everything that staff did, to deliver a positive patient experience and to improve outcomes. The strategy was to be reviewed annually through the Quality Patient Experience Committee (QPEC) and the Nursing Midwifery Advisory Forum (NMAF).
- The trust set quality priorities each year as described in the Quality Accounts for 2014-15, most of which were locally agreed. These were set under the headings of clinical effectiveness, patient safety and patient experience and many have been carried forward to 2015-16. The draft 2015-16 Quality Priorities were discussed at the trust's governor and non-executive director (NED) briefing sessions in February 2015 as well as at the board's Quality and Patient Experience Committee.
- There was limited evidence that staff within community services were aware of any vision or strategies for their services. Going forward we were told this would be developed through the Healthy Lives Healthy Futures work-streams.
- There was a lack of vision and strategy for end of life care. During interviews this was recognised by the board and service leaders. Plans were in place to develop a performance framework and strategy. However, an end of life care lead had recently been appointed on the trust board and senior leaders were involved in developing an end of life care strategy. The trust had also acknowledged the need for senior clinical

Summary of findings

leadership and had recently appointed its first two palliative care consultants. Whilst the team were very positive and work had started there was more to do before the impact for patients could be evidenced.

- The trust's vision for maternity services was; 'Every woman and child in our locality is healthy and happy;' Their mission statement was, 'To provide safe, effective and leading edge care to the population we cover through nurturing high performing teams that prioritise patient experience'; and their strategic objectives.
- The trust had an equality statement for 2014-2017.

Governance, risk management and quality measurement

- There was a risk management framework and systems in place to identify risk. There was risk training in place for staff together with processes to share learning from incidents and complaints. All risks had a risk owner and an associated sub-committee responsible for assurance that the risk was being managed.
- However, not all risks were identified or had robust controls in place which had resulted in harm or sub-optimal care of patients. Additionally, the trust was slow to address concerns when raised through the governance system, there was a lack of clinical oversight and auditing of practice.
- Examples of poor risk management included the poor identification and management of outpatients, specifically the backlog of patients awaiting appointments that were not within the referral to treatment time national targets. There was a lack of an effective process around prioritising and cancelling appointments, a lack of ownership of the problem at middle and senior management which meant a lack of monitoring and challenge at these levels. The appointment system was seen as an administration process.
- We raised concerns regarding outpatient backlogs at the time of inspection with the executive and senior management teams particularly as there had been concerns raised at the time of the initial comprehensive inspection with regard to a relatively high did not attend rate, combined with a significant number of outpatient appointments cancelled in the six weeks prior to the 2014 inspection due to lack of medical cover alone.
- We raised our concerns at the October 2015 inspection and following the inspection we formally wrote to the trust asking them to address the outpatient concerns. The trust responded and provided monitoring information that indicated all 30,000 patients in the backlog had been reviewed and validated by 31 December 2015.

Summary of findings

- We reviewed the critical care risk register and found there had been significant delays in taking actions on issues that have affected patient and staff safety within ITU. Ageing and failing beds had been on the risk register since 2009, ventilators that require more frequent repairs and would not be supported by the manufacturer in 2017 had been on the risk register since 2010 and failing mattresses had been on the risk register since 2013. In all cases there were limited controls in place. Medical staffing, particularly out of hours cover, was not on the risk register. Informal arrangements were in place for consultants to be requested to come in if required, however, the management team were unable to give evidence of any formal plans to mitigate against the risk to a potential delay in patient care. The management team were unaware of the concerns regarding equipment, due we were told, to a focus on strategic development of the unit.
- Additionally, during the inspection, a number of mixed sex breaches, which impacted on a person's privacy and dignity, were also identified. These had been raised by ward/service staff but not recognised as a breach by senior staff or reported nationally.
- There were a number of board committees, chaired by non-executive directors, which oversaw various aspects of quality, governance and risk management: 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 were risk management processes in place at a trust level with a clear link between the Trust assurance framework (TAF) and the risk register. There was an annual self-assessment of the TAF by the board which was externally facilitated. The strategic risk register and TAF were presented to the board quarterly. They were reviewed more frequently at the TGAC.
- The QPEC invited operational staff to attend for specific items. We were told this helped to ensure board to ward engagement and understanding of the issues facing the services and the trust.
- The trust's governance structure was managed through its clinical groups each of which had a governance group; community and therapies; women and children's; surgery and critical care; medicine; diagnostics, pharmacy and central operations and; Path Links.

Summary of findings

- Each of the trust's business groups had a risk register and a named risk and governance facilitator to support the work of the group. There were also complaints and quality facilitators linked to each group.
- There was an overarching quality development plan, which was routinely presented to the board and its committees. It was a high level monitoring tool to ensure that all regulatory requirements, including from CQC, were identified, actioned and mitigated.
- Monitor had assessed the trust as an elevated risk for its governance with regard to its finance and sustainability position and had enforcement action in place; the trust had a financial sustainability risk rating of two and the governance risk rating was red.
- At the time of the inspection the budget forecast for 2015-16 was a deficit budget of £29mt. During the course of the year the trust had applied for a support loan from the department of health (public divided capital fund) which was successful in securing £15m.
- The Strategy and planning group was responsible for the co-ordination of business proposals and responsible for confirming and challenging the content of business cases.
- There was a significant cost improvement plan (CIP) in place to support the requirements of Monitor and to manage the allocated budget. There were quarterly chief executive challenge meetings to review the CIP and the sustainability actions. The CIP for nurse staffing equated to £3.5m of which circa £2m would be achieved.
- Quality impact assessments were completed at the time of initial presentations of outline business cases and CIPs, then a more developed one if the business case progressed. These were signed off by both the medical director and chief nurse.
- There were announced and unannounced quality monitoring visits to clinical and non-clinical areas by senior managers, which were documented. The visits covered such areas as the environment, cleanliness, training and feedback from staff.
- There had been external reviews of the quality governance system, both trust-wide and at clinical group level. In April 2015 there was an external review of quality governance within clinical groups against Monitor's quality governance framework. No concerns were noted but some recommendations for further improving the trust's arrangements were noted. These actions were being progressed as part of the trust's Quality Development Plan (QDP).

Summary of findings

- In May 2015 there was an external review of board assurance and self-certification. The outcome of which was; “significant assurance with minor improvement opportunities”. An action plan was developed in response to the two recommendations made.
- In July 2015 there was an external diagnostic undertaken of the trust’s arrangements for managing serious untoward incidents and the duty of candour requirements. Some areas were suggested for further strengthening of the trust’s arrangements and areas of good practice were noted.
- Senior community staff we spoke to knew about the risk register and could explain the risks for community services although at a more senior level there appeared to be limited action taken to address or mitigate the risks.
- There was a lack of staff time within maternity to effectively address governance and quality assurance. There was no clinical risk midwife or practice development midwife in post at the time of the inspection. A trust gap analysis of the Kirkup Report had identified the need for these posts. We were told by management that they were preparing business cases to address these gaps.
- The trust was setting up monthly/rolling quality and safety days for each directorate to learn lessons and add a continuous focus to quality and safety. They were clinically led and had been in place for some time in the women and children’s division. Surgery had implemented them in 2015 and they were being developed for medicine and community services.
- There were four quality matrons across the trust, all of which were involved in the monthly quality review of each ward area and in addition each matron took a lead in specific areas, for example, dementia.
- There was a Mortality performance and assurance committee (MPAC) who met regularly. There were seven working groups focussing on mortality case reviews using a structured judgement technique, thematic analysis and a planned programme of improvements to care. The groups were based on the top six crude mortality areas: respiratory, cardiology, infection/sepsis, gastroenterology, cancer and stroke, plus a cross cutting process group. Each group had clinical leadership and involvement and had developed a programme of action. All groups reported to monthly meetings in their clinical area as well as to the Mortality performance and assurance committee (MPAC), a sub-committee of the trust board.

Leadership of the trust

Summary of findings

- The Chief Executive Officer took on a health and social care patch wide part-time role (2-3 days per week), to be the lead officer, for the 'Healthy Lives, Healthy Futures' work in October 2014. In early 2015 it was proposed that this role continue for another 1-2 years. In light of this in March 2015 board took decision to appoint a full-time deputy CEO. A risk assessment paper was reviewed by the board prior to this decision being taken. There was concern regarding the sustainability of the current management structure.
- The Chief Nurse had recently been appointed as Deputy Chief Executive Officer to support the Chief Executive to lead on the strategic partnership working. Following this there had been a recent internal appointment to the Chief Nurse post.
- The deputy stated that 80% of this role is leading the organisation as the CEO but not as the accountable officer and the other 20% as shifting the profile and reputation of the organisation. However line management of the executives remained with the CEO with day to day operational responsibility sitting with the deputy CEO.
- There had been a lack of stable medical leadership; a new medical director (MD) had early in 2014 brought in a new model for medical leadership. This MD left in 2015 and an assistant MD took up the temporary position of medical director in April 2015 and was made substantive in July 2015. We received positive feedback from key partners and staff within the trust about the new appointment.
- There was a clinical leaders forum and clinical leaders had attended development workshops through a university in 2014.
- We were concerned at the limited progress regarding the improvements needing to be made following the initial 2014 comprehensive inspection particularly regarding staffing levels that remain significantly low particularly in surgery. Staffing levels were raised at the time of the inspection specifically in relation to the lack of shift co-ordinators. In addition, we also had concerns regarding staffing in community adult and children's services which were inspected for the first time.
- Non-executive board members we interviewed gave good examples of where they had provided constructive challenge and affected change. For example, a key performance indicator was introduced through the non-executive led Quality and Patient Experience committee to reduce the number of non-clinical bed moves. They were aware of organisational risk and how this was managed through the various governance processes.
- Staff from each of the community services we inspected commented on the lack of visibility of the senior team.

Summary of findings

- The trust's NHS Staff Survey (2014) results indicated it had a worse than expected response rate 30% against a national rate of 42%. The trust scored worse than expected on effective team working, percentage of staff reporting incidents and near misses, feeling secure about raising concerns, contribution to improvements at work and use of patient feedback to inform decision making. They also scored worse than the England average on structured appraisals, support from their immediate line manager, whether staff would recommend the trust as a place to work or receive treatment and for overall engagement. However, these indicators were an improvement on the 2013 score. The trust scored better than expected on six indicators that included; staff being satisfied that their role made a difference to patients and being satisfied with the quality of care they could deliver.
- We found there was a disconnect between the trust board and staff in the community. Staff were proud of the care they were able to give and received positive feedback from patients, families and carers; they told us senior managers did not acknowledge this.

Culture within the trust

- To emphasise the focus on quality and safety a patient story is heard at every board meeting and every Quality and Patient Experience committee.
- There were concerns regarding the level of integration between the community and acute services and across the two acute hospital sites. Community teams told us that they did not feel part of the acute trust. In A&E there were differences between the two departments and there was a lack of clinical integration.
- Staff morale within surgical areas of the hospital was mixed. All staff we spoke with were positive about colleagues, they spoke about the environment being patient focused, and an open and honest culture. However, staff said they felt deflated due to the staffing levels. Staff we spoke to said they were proud of the teams and their colleagues.
- There was an ongoing clinical administration review which aimed to improve processes to make the trust more responsive to patient needs. However, many staff raised concerns with us regarding the impact it was having on staff morale.
- Students we spoke to felt supported in their roles during placements.

Summary of findings

- Morale in critical care varied across staff groups with themes being around changes to clinical leadership and working patterns, delayed discharges and being moved off the unit to cover gaps in staffing on the wards.
- There was a positive learning culture especially in the Macmillan healthcare team; staff told us there were opportunities for development and training. Four community nurses told us pressure of work meant they could not always attend end of life training.

Fit and Proper Persons

- 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.
- In addition there was a self-declaration form for existing and new board members to complete. We saw copies of these in the files we reviewed.
- We reviewed the personnel files of seven directors on the board; one of which was appointed since the regulation came into force. The files indicated that most of the relevant checks had been done. Only two of the seven files had two references on file and these were not dated for one of the directors. DBS checks were not evidenced in four of the files. We also reviewed the personnel files of the non-executive directors (NEDs). The checklist in the file indicated that it was not a trust requirement to have DBS checks for the NEDs. The lack of DBS checks for NEDs meant that the trust would not have been fully assured regarding the suitability of the individuals for the role.

Public engagement

- There was a patient experience strategy which was due for renewal; a revised version was out for feedback at the time of the inspection.
- Patient stories were presented at the start of each board meeting.

Summary of findings

- In the last year, the trust had merged its vision and values group with a patient experience group to form a new Patient and staff experience group. We were told this was so the trust could more closely triangulate patient and staff experience. According to the terms of reference dated March 2015, this met monthly and reported to the quality and patient experience committee. Complaints and Friends and Family test information were standing items on the agenda of the group.
- As part of their role the quality matrons covered all wards and talked with ten patients about their experience of care on each ward every month. Feedback from this and the rest of the monthly nursing dashboards and environmental audits undertaken were discussed at the Nursing and Midwifery Forum.
- The trust had a council of governors which met 4-6 times a year. Governors told us they had good relationships with the senior team and mostly felt they were listened to. They had full access to the monthly quality and mortality reports and were given detailed briefings on specific issues as required.
- The trust's governors raised some concerns with us that corroborated our findings during inspection, for example delayed episodes of care in ophthalmology. Concerns were also raised about the lack of internal ward reviews that had been completed and then shared with the governors and poor communication with patients. They also complimented the revised stroke pathway.
- A group of 17 patients had been recruited to form a patient panel. The group were mainly from the trust's foundation trust membership. The group had met and the role was being developed. For example, a member had inputted into the development of the revised gastro-intestinal (GI) care pathway.
- There was a cancer patient involvement group which met monthly.
- The trust had a membership of over 11,000, which included 6,000 staff and over 5,000 of which were members of the public. Foundation trusts are required to have a membership to help ensure direct participation of local communities in their health service.
- The Maternity Services Liaison Committee was run by a group of parent representatives who worked with midwives, doctors, healthcare professionals and commissioners to guide and influence maternity services at North and North Lincolnshire. The Chair told us the trust were open and honest with the MSLC and part of their role included attending clinical governance meetings and development of maternity guidelines.

Summary of findings

- The Family nurse partnership had a Facebook page for their clients to access.

Staff engagement

- The trust had mixed results on the NHS Staff Survey (2014). They had a low response of 305 compared to 425 nationally and this was worse than the previous year. Of the 30 indicators reviewed, six were better than the national average, ten were worse than the average and the rest were similar to the average. The overall score for the trust was 3.63 out of five compared to the England average of 3.75. They scored 3.5 out of five on the question about whether staff would recommend the trust as a place to work or receive treatment, which is worse than the England average, but an improvement on their 2013 score.
- We were told that the chief executive undertook a monthly 'Chief Executive Briefing' session that staff could attend in order to hear current issues from within both the trust and the local health community.
- Visits to wards and departments were undertaken by both directors and non-executive directors of the trust which gave staff an opportunity to engage and share their views. Not all staff were aware of these visits.
- The trust has in place a staff recognition and award scheme called "Shine".
- The trust was developing an "Employment framework" with six objectives, all of which were linked to the Healthy Lives Healthy future work streams and included a focus on staff retention.
- Senior staff and board members we interviewed recognised that engagement with staff had been lacking, but was now being brought into focus and was integral to the employment framework being developed. It was acknowledged that consultation about job changes had been the main engagement with staff and this required improvement going forward.
- The trust was using an in-house staff morale barometer which was completed quarterly. This showed lower than expected levels in September 2015 and had a red RAG rating. In May 2015, all trust staff were invited to take part and participate in the barometer survey. The response rate was 321, which was less than 5% of staff.
- The trust had a website, Facebook page and twitter account to engage with staff through.
- A weekly bulletin was published sharing up to date news about the trust with staff.

Summary of findings

- Exit interview data indicated dissatisfaction in a number of areas including engagement with trust values, dissatisfaction with management team, unable to cope with workload. Results were better for team working and feeling valued.
- There had been a recent staff consultation regarding an administration review. A lack of meaningful engagement with staff had led to significant anxieties being raised amongst the affected staff. Staff we spoke with said the consultation had not been handled well, that there was a lack of communication and engagement. Many, particularly at the DPoW hospital, did not know who their manager was and said that morale amongst staff was very low and they were not valued.
- There was a staff side committee in place which senior HR staff attended together with senior managers from finance. The CEO routinely provided a briefing to the committee. It was commented that the committee would benefit from more executive presence.

Innovation, improvement and sustainability

- Following on from the 2014 comprehensive inspection the trust had set out their improvement plan for addressing the concerns raised and services that required improvement. At the 2015 inspection we found within the trust there had been improvements in some of the services and this had meant a positive change in some of the ratings from the previous CQC inspection, notably within critical care at Diana Princess of Wales hospital. However we found that the services in A&E at Scunthorpe, outpatients and surgical services had either not improved or had deteriorated since our last inspection.
- We also found there had been limited progress since 2014 to ensure that there were sufficient qualified, skilled and experienced staff, particularly in surgical areas. During the 2015 inspection, we found substantial and frequent shortages of nursing staff and an increased number of agency staff being used. The trust had run a significant recruitment campaign but the skill mix and retention of new staff remained an issue.
- The facilities for mental health patients had not been improved on the Scunthorpe site following the 2014 inspection and the audit of mental health provision by the Royal College of Emergency Medicine.
- Improvement of outpatient processes had lacked pace and sufficient transformation to minimise the number of clinic cancellations and the did not attend rates had not improved

Summary of findings

from the 2014 comprehensive inspection. The concerns regarding outpatient services was raised at the time of this inspection and the backlog of patients has significantly reduced.

- Improvements had been achieved in critical care services with the relocation of the High Dependency Unit (HDU) leadership and there had been significant changes to the management of patients on HDU since our inspection in 2014. Some progress had been made to cross site working and standardisation of care across both sites.
- Appraisal rates for staff had improved since 2014, however still did not meet internal compliance targets and levels of compliance was variable across divisions.
- There was an initiative based on “Dragon’s Den” where staff can put forward innovative ideas to improve care. These were judged by senior staff and a small grant awarded to the winners. For example, the tissue viability team developed new methodology to improve early identification and treatment of pressure ulcers.
- The trust were part of the team which developed the joint agreement “Tackling violence and antisocial behaviour in the NHS” with NHS Protect, the police and the crown prosecution service.
- The IT team who created the trust’s “WebV” virtual ward system collected the Medipex Innovation award at the Yorkshire and Humber NHS Innovation Awards, and were finalists in the EHI 2015 awards in the Digital Health trust or Health board of the Year category.
- The service had successfully secured funding of £36,550 from the Nursing Technology Fund. A national fund which the Prime Minister established in 2012 to support nurses, midwives and health visitors to make better use of digital technology. These monies provided a bespoke Web V ‘virtual ward’ system and flat screen computers were installed in all ward. We saw these in use on the delivery suite and as they were relatively new, staff were still learning the technology during daily use.
- At the Royal College of Midwives award in 2014, the midwifery team were recognised twice for promoting a ‘normal birth experience’ and were finalists in the ‘supervisor of midwives team’ category.
- The “Frail Elderly Assessment and Support Team” gave elderly patients immediate access to physiotherapy / occupational therapy assessment as well as nursing and medical assessment. Social services were also involved in assessment with the aim of providing immediate treatment / assessment

Summary of findings

and initiation of community based care or services. The aim of this service was that patients should be able to return to their usual place of residence with the support of community services.

Overview of ratings

Our ratings for Diana Princess of Wales

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	N/A	Requires improvement	N/A	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Scunthorpe General

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	N/A	Requires improvement	Inadequate	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Overview of ratings

Our ratings for Goole and District

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	N/A	Good	N/A	N/A	N/A	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community Health services For Adults	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Community services for children, young people and families	Requires improvement	Good	Good	Good	Good	Good
End of Life Care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Community Dental Services	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Our ratings for Northern Lincolnshire and Goole NHS Foundation Trust

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

Overview of ratings

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Urgent and Emergency and Outpatients & Diagnostic Imaging.
2. When we inspected the Minor Injuries service at Goole hospital in April 2014, we rated it as 'good' for safe, caring, responsive and well-led. At that time CQC's methodology did not include rating the effective domain. We therefore only inspected the effective domain at this inspection, so a rating could be given.
3. When we inspected Urgent and Emergency care at Scunthorpe hospital in April 2014, we found it required improvement in relation to being safe, effective, responsive and well led. We therefore looked at these domains at this inspection. We did not inspect caring as it was rated as 'good' at the last inspection.
4. When we inspected Urgent and Emergency care at Diana, Princess of Wales hospital in April 2014, we found it required improvement in relation to being safe, effective and responsive. We therefore looked at these domains at this inspection. We did not inspect caring or well-led as these were rated as 'good' at the last inspection.

Outstanding practice and areas for improvement

Outstanding practice

We found a number of examples of outstanding practice:

- The end of life care service had specific elements of outstanding practice that included the team provided end of life training to care home and home care staff to help them support patients at the end of their lives more effectively and all community nurses were trained to verify expected death, and senior nurses were trained to sign DNACPR (do not attempt cardiopulmonary resuscitation) forms to record patients' wishes about what to do if they needed reviving.
- The tissue viability team had developed two successful initiatives to improve earlier detection of potential pressure ulcers. This included the use of pocket mirrors and the PUG wheel (Pressure Ulcer Group). The PUG wheel had been presented at the European wound management conference in spring

2015, the national patient safety conference in Summer 2015. It also won the internal "Shine" award in October 2015. The number of grade three and four pressure ulcers had decreased whilst the number of grade two ulcers reported had increased in line with increased training and awareness of staff.

- The "Frail Elderly Assessment and Support Team" gave elderly patients immediate access to physiotherapy / occupational therapy assessment as well as nursing and medical assessment. Social services would also be involved in assessment with the aim of providing immediate treatment / assessment and initiation of community based care or services. The aim of this service was that patients should be able to return to their usual place of residence with the support of community services.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve acute services:

- The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels. This must include but not be limited to: medical staff within the emergency department (ED) and critical care, nursing staff within ED, medicine and surgery. It must also include a review of dedicated management time allocated to ward co-ordinators and managers. It must ensure adequate out of hours anaesthetic staffing to avoid delays in treatment. The trust must ensure there are always sufficient numbers of radiologists to meet the needs of people using the radiology service.
- The trust must ensure that the significant outpatient backlog is promptly addressed and prioritised according to clinical need. Ensure that the governance and monitoring of outpatients'

appointment bookings are operated effectively, reducing the numbers of cancelled clinics and patients who did not attend, and ensuring identification, assessment and action is taken to prevent any potential system failures, thus protecting patients from the risks of inappropriate or unsafe care and treatment.

- The trust must ensure that all risks to the health and safety of patients with a mental health condition are removed in Scunthorpe emergency department. This must include the removal of all ligature risks, although must not be limited to the removal of such risks. The trust must undertake a risk assessment of the facilities, including the clinical room and trolley areas, but not be limited to those areas, and do this with advice from a suitably qualified mental health professional.
- The trust must ensure that the recently constructed treatment rooms at Scunthorpe ED that were

Outstanding practice and areas for improvement

previously used as doctors' offices, are suitable for the treatment of patients on trolleys. This must include ensuring that such patients can be quickly taken out of the room in the event of an emergency.

- The trust must ensure that staff at core service/divisional level understand and are able to communicate the key priorities, strategies and implementation plans for their areas. The trust must improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform.
- The trust must ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation, especially in relation to critical care and ensuring the equipment is included in the trust replacement plan.
- The trust must ensure it acts on its own gap analysis of maternity services across the trust to deliver effective management of clinical risk and practice development.
- The trust must have a process in place to obtain and record consent from patients and/or their families for the use of the baby monitors in critical care and for the use of CCTV in coronary care.
- The trust must ensure the safe storage and administration of medicines including the storage of oxygen cylinders on ITU at DPoW hospital. The trust must ensure staff check drug fridge temperatures daily and record minimum and maximum temperatures. Additionally it must ensure staff know that the correct fridge temperatures to preserve the safety and efficacy of drugs and what action they need to take if the temperature recording goes outside of this range. Patient group directions for medications within ED must be reviewed and in date.
- The trust must ensure equipment is checked, in date and fit for purpose including checking maternity resuscitation equipment and that critical care equipment is reviewed, and where required, included in the trust replacement plan.
- The trust must ensure that action is taken to address the mortality outliers and improve patient outcomes in these areas.
- The trust must ensure there is an effective process for providing consistent feedback and learning from incidents.
- The trust must review the validation of mixed sex accommodation occurrences, ensure patients are cared for in an appropriate environment and report any breaches.
- The trust must ensure the reasons for Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) are recorded and is implemented in line with best practice within surgical services
- The trust must ensure the Five Steps for Safer Surgery including the WHO check list is consistently applied and practice is audited.
- The trust must review the effectiveness of the patient pathway from pre-assessment, through to timeliness of going to theatre and the number of on the day cancellations for patients awaiting operation.
- The trust must ensure policies and guidelines in use within clinical areas are compliant with NICE guidance or guidance from other similar bodies and that staff are aware of the updated policies, especially within maternity, ED and surgery.
- The trust must ensure there are adequate specialist staff, training and systems in place to care for vulnerable people specifically those with learning disabilities and dementia.
- The trust must stop including newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses on duty.
- The trust must ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours. The trust must continue to improve against the target of all staff receiving an annual appraisal and supervision, especially in surgery, and that actions identified in the appraisals are acted upon.

Action the trust MUST take to improve community services:

Outstanding practice and areas for improvement

- The trust must ensure three-monthly safeguarding supervision takes place for health visitors.
- The trust must ensure all staff are up to date with appraisal and mandatory training.
- The provider must ensure it has an end of life care vision and strategy in place that reflects national guidance and ensure staff are included in the development of these.
- The provider must have effective systems in place to assess, monitor and improve the quality of the end of life care services including auditing preferred place of care and other outcomes for patients.
- The trust must ensure that all community equipment is tested for electrical safety and evidence is available to show that equipment is serviced in line with manufacturers recommendations.
- The trust must ensure that community equipment and environments are cleaned in line with cleaning schedules.
- The trust must ensure that all substances which could be harmful are stored appropriately, specifically within the Ironstone Centre.
- The trust must ensure that procedures for managing controlled drugs in patients homes are standardised and
- The trust must ensure that record keeping meets all appropriate registered body standards.
- The trust should introduce critical care specific morbidity and mortality meetings.
- The trust should continue to improve on its mandatory training targets to achieve its own compliance level of 95% and specifically ensure that staff have a better understanding of the assessment of capacity and the use of restraint (including chemical restraint).
- The trust should continue to work towards delivering care and treatment that is in line with national guidance and Core Standards for Intensive Care.
- The trust should undertake work in a reasonable time-frame that will lead to the creation of separate waiting and treatment areas for children in the Scunthorpe ED that are safe and secure.
- The trust should undertake work in a reasonable time-frame that will lead to the creation of separate entrances in Scunthorpe ED for patients self-presenting with minor injuries or illnesses, and those conveyed by ambulance with serious injuries.
- The trust should review access and flow through the Scunthorpe angiography catheterization lab to reduce last minute cancellations, delays and wasted appointments.
- The trust should review patient flow through the Scunthorpe short stay ward to ensure this does not have an impact on the flow of patients through the clinical decisions unit.

Action the trust SHOULD take to improve acute services:

- The trust should evaluate the medical review of outlying medical patients on surgical wards to improve consistency of cover arrangements and prevent unnecessarily delayed discharges.
- The trust should evaluate the arrangements for consultant cover of the AMU to ensure a consultant reviews all patients daily, irrespective of length of stay.
- The trust should as a matter of urgency address the continuing gap in clinical education in critical care.
- The trust should review patient flow and reduce the number of delayed discharges from ITU.
- The trust should ensure the lock on the intravenous fluids room in maternity at Scunthorpe hospital is in working order to ensure safe storage of the fluids.
- The trust should review the use of pressure relieving equipment and preventative blood clot equipment within theatres.
- The trust should ensure the premises and location of the ophthalmology department is suitable for the purpose for which it is being used.
- The trust should ensure there is sufficient space and seating for patients and their supporters in the outpatients departments.

Outstanding practice and areas for improvement

- The trust should strengthen the support provided to nuclear medicine technologists by the ARSAC (administration of radioactive substances advisory committee) licence holder.
- The trust should ensure IR(ME)R training is mandatory for radiology staff.

Action the trust SHOULD take to improve community services:

- The trust should ensure consistency with the role of the health visitor link to GP practices.

This section is primarily information for the provider

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: there were breaches of the national policy for mixed sex accommodation which compromised a person's right to privacy and dignity. Patients privacy and dignity was compromised by the use of baby monitors and CCTV on critical care and CCU at DPoW hospital.</p> <p>The trust must:</p> <ul style="list-style-type: none">• review the validation of mixed sex accommodation occurrences, to ensure patients are cared for in appropriate environment and report any breaches. Reg 10(1)• ensure that patients' privacy and dignity is maintained if the baby monitors and CCTV and in use. Reg 10(1)

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: There was no review of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions post-operatively when the emergency situation may have changed or when patients were diagnosed medically fit, or transferred between hospitals. Consent was not been obtained/ recorded from patients and/or their families for the use of the baby monitors in critical care and for the use of CCTV in CCU at DPoW hospital.</p> <p>The trust must:</p>

This section is primarily information for the provider

Requirement notices

- ensure the reasons for do not attempt cardio respiratory resuscitation (DNACPR) decisions are recorded and in line with good practice within surgical services. Reg 11(1)
- have a process in place to obtain and record consent from patients and/or their families for the use of the baby monitors in ITU and CCTV in CCU at DPOW hospital. Reg 11(1)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met: care was not always provided in a safe way as policies and guidelines were not all compliant with national guidance; there were risks to the health and safety of patients with a mental health condition at Scunthorpe emergency department; some clinical rooms at Scunthorpe ED were not suitable for the treatment of patients on trolleys: not all equipment was checked or where required included in the trust's replacement plan; fridge temperatures were not effectively monitored to preserve the safety and efficacy of drugs; there were not suitable arrangements in place in order to ensure the proper and safe management of medicines in people's homes.

The trust must:

- ensure policies and guidelines in use within clinical areas are compliant with NICE guidance or guidance from other similar bodies and that staff are aware of the updated policies, especially within maternity, ED and surgery. Reg 12(1)
- ensure that all risks to the health and safety of patients with a mental health condition are removed in Scunthorpe emergency department. This must include the removal of all ligature risks, although must not be limited to the removal of such risks. The trust must undertake a risk assessment of the facilities, including the clinical room and trolley areas, but not be limited to those areas with advice from a suitably qualified mental health professional. Reg 12(2)(a),(b),(d)&(e)

This section is primarily information for the provider

Requirement notices

- ensure that the recently constructed treatment rooms at Scunthorpe that were previously used as doctors' offices are suitable for the treatment of patients on trolleys. This must include ensuring that such patients can be quickly taken out of the room in the event of an emergency. Reg 12(2)(d)
- ensure equipment is checked, in date and fit for purpose including checking maternity resuscitation equipment and critical care equipment is reviewed and where required included in the trust replacement plan. Reg 12(2)(e)&(f)
- ensure the safe storage of medicines within fridges, specifically with regard to temperature and stock control. Reg 12(2)(g)
- procedures for managing controlled drugs in patients' homes are standardised and all staff follow guidelines for the safe management and documentation in relation to controlled drugs. Reg 12(2)(g)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

How the regulation was not being met: in the community setting not all cleaning substances were stored in line with legislation and not all equipment was tested or serviced.

The trust must:

- ensure that all cleaning substances are stored in line with current legislation and guidance, specifically within the Ironstone Centre. Reg 15(1)(a)
- ensure all community equipment is tested for electrical safety and equipment is serviced in line with manufacturers recommendations. Reg 15(1)(e)

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 operated effectively to: assess,

Requirement notices

monitor and improve the quality and safety of services; assess, monitor and mitigate risks relating to the health and safety of patients; maintain some community records in line with recognised guidance and; seek and act on feedback from relevant persons.

The trust must:

- ensure that staff at core service/divisional level understand and are able to communicate the key priorities, strategies and implementation plans for their areas. Reg 17(2)(a)
- ensure the five steps for safer surgery including the World Health Organisation Safety Checklist (WHO) is consistently applied and practice is audited in theatres. Reg 17(2)(a)
- review the effectiveness of the patient pathway from pre-assessment, through to timeliness of going to theatre and the number of on the day cancellations for patients awaiting operation. Reg 17(2)(a)
- ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours. Reg 17(2)(a)
- ensure it has an end of life care vision and strategy in place that reflects national guidance and ensure staff are included in the development of these. Reg 17(2)(a)
- have effective systems in place to assess, monitor and improve the quality of the end of life care services including auditing preferred place of care and other outcomes for patients. Reg 17(2)(a)
- ensure that the significant outpatient backlog is promptly addressed and prioritised according to clinical need, ensure that the governance and monitoring of outpatients' appointment bookings are operated effectively, reducing the numbers of cancelled clinics and patients who did not attend, and ensuring identification, assessment and action is taken to prevent any potential system failures, thus protecting patients from the risks of inappropriate or unsafe care and treatment. Reg 17(2)(a)&(b)
- review the rate of cancellations of outpatient appointments and rates of 'did not attend' at Goole and take action to improve these in order to ensure safe and timely care and to meet the trust's own standards of 6%. Reg 17(2)(a)&(b)

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- ensure it acts upon its own gap analysis of maternity services across the trust to deliver effective management of clinical risk and practice development. Reg 17(2)(a)&(b)
- ensure that action is taken to address the mortality outliers and improve patient outcomes in these areas. Reg 17(2)(a)&(b)
- ensure there is an effective process for providing consistent feedback and learning from incidents. Reg 17(2)(b)
- ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation, especially in relation to: staffing; critical care and ensuring the essential equipment is included in the trust replacement plan. Reg 17(2)(b)
- ensure that record keeping meets all appropriate registered body standards. Reg 17(2)(c)
- seek and act on feedback from patients in radiology at Goole in order to evaluate and improve the service. Reg 17(2)(e)
- improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform. Reg 17(2)(e)

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 skilled, qualified and experienced staff deployed and not all staff received appropriate training, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform.

The trust must:

- ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels. This must include but not be limited to: medical staff within ED and critical care, nursing staff within ED, medicine

Requirement notices

and surgery. It must also include a review of dedicated management time allocated to ward coordinators and managers. It must ensure adequate out of hours anaesthetic staffing to avoid delays in treatment. The trust must ensure there are always sufficient numbers of radiologists to meet the needs of people using the radiology service. The trust must stop including newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses on duty. Reg 18(1)

- continue to improve against the target of all staff receiving an annual appraisal and supervision, especially in surgery, and that actions identified in the appraisals are acted upon. Reg 18(2)(a)
- ensure there are suitable arrangements in place for health visitors to receive three-monthly safeguarding supervision. Reg 18(2)(a)
- ensure there are adequate specialist staff, training and systems in place to care for vulnerable people specifically those with learning disabilities and dementia. Reg 18(1)