

Northern Lincolnshire and Goole NHS Foundation Trust

Diana Princess of Wales Hospital










Quality Report

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Date of inspection visit: 17 October, 22 - 25
November 2016 and 8 December 2016
Date of publication: 06/04/2017

This report describes our judgement of the quality of care at this hospital. 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 hospital	Requires improvement	
Urgent and emergency services	Requires improvement	
Medical care (including older people's care)	Requires improvement	
Surgery	Requires improvement	
Critical care	Good	
Maternity and gynaecology	Requires improvement	
Services for children and young people	Requires improvement	
End of life care	Good	
Outpatients and diagnostic imaging	Inadequate	

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

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

In November 2016 we inspected:

- Diana Princess of Wales Hospital
- Scunthorpe General Hospital
- Community Adult Services – safe and well led domains
- Community end of life care services – effective, responsive and well led domains
- Community children's and young people's services – safe domain

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

We rated Northern Lincolnshire and Goole NHS Foundation Trust as Inadequate overall. Safe and well led were rated as 'inadequate', effective and responsive were rated as 'requires improvement' and caring was rated as 'good'.

We rated Diana Princess of Wales Hospital as requires improvement overall.

Key Findings:

- Nursing and medical staffing had improved in some areas since the last inspection. However, there were still a number of nursing and medical staffing vacancies throughout the trust, staff turnover in some areas were particularly high especially in medical care, emergency departments, surgical services, and services for children and young people.

Summary of findings

- The trust had systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care. However, a number of registered nurse shifts remained unfilled despite these escalation processes and we saw examples of wards not meeting planned staffing levels and high patient acuity not identified appropriately.
- There had been a lack of improvement since the inspection in 2015, areas of concern had not been fully addressed in a sustained way and there had been deterioration in a number of services. Safety processes were not always adhered to in some services.
- In 2015, we said that the trust must ensure there is an effective process for providing consistent feedback and learning from incidents. During this inspection learning from incidents remained inconsistent and variable between directorates. Staff we spoke to reported a varying standard of feedback and learning from incidents.
- Assessing and responding to patient was risk was inconsistent and did not support early identification of deterioration in maternity, surgery and urgent and emergency services. This was particularly evident in the Emergency Department (ED) at Diana Princess of Wales Hospital, where the national early warning scores (NEWS) were not recorded in the majority of records we reviewed.
- A Paediatric Early Warning Score (PEWS) was used in ED however there was inconsistent documentation of PEWS scores so we were unable to be sure that the identification and escalation of deterioration in a child's condition would be recognised.
- The trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) checklist. However, from a review of records and observations of procedures, it was apparent that this was not an embedded consistent process.
- Mandatory training rates in infection control were variable across the hospital.
- We found inconsistent practice with regard to resuscitation trolley checks, fridge temperature checks and medication checks across the hospital.
- We were not assured patients had adequate nutrition and hydration whilst they were in the emergency department for a long period of time.
- Patient flow through the hospital however remained an issue with a significant number of patients cared for on non-medical or non-speciality wards. A buddy ward system was in place, however there was still confusion regarding which consultant should review which patient. Patients who were moved more than once could be under the care of different consultants during their stay in hospital.
- Between December 2015 and September 2016 Diana, Princess of Wales (DPoW) hospital had 452 black breaches. However, since the introduction of the ambulance handover team there had been an improvement.
- Patients requiring pre-assessment prior to surgery were not always assessed according to an effective patient pathway. There remained a large number of 'on the day' cancellations for clinical reasons.
- Referral to treatment times across a number of services showed a deteriorating position and were significantly below the national indicator and slightly below the England average. Patients were not always able to access services for assessment, diagnosis or treatment when they needed them. There were long wait times within surgical services and overall the service was not meeting the national referral to treatment times (RTT) or all cancer performance standards.
- Emergency department performance was variable and between August 2015 and July 2016 the department did not achieve the target for 95% of patients to be treated, discharged or admitted within four hours.
- The neonatal intensive care unit (NICU) and Rainforest ward had been closed to admissions on a number of occasions due to capacity or staffing concerns. The paediatric assessment and observation unit (PAOU) was not always available to staff due to adult overflow patients from the emergency department.
- In 2015 we raised concerns regarding the numbers and reporting processes of mixed sex breaches. The trust had updated the policy for eliminating mixed sex accommodation, which was in line with Department of Health guidance (November 2010). However the trust has continued to report mixed sex breaches in a number of core services. Mixed sex breaches occurred twice in both November 2015 and December 2015 in AMU due to capacity issues and problems with patient flow.

Summary of findings

- The trust participated in national and local audit programmes however trust performance against national performance was mixed across most of the core services with many showing performance that was worse than England averages. There was also variation in patient outcomes between the two hospital sites. Patient outcomes were overall slightly better at DPoW when compared to SGH. Mandatory training and appraisal targets had not been met by some staff groups. This included safeguarding training targets and not all staff had the required level of safeguarding training in place.
- The endoscopy unit had lost their Joint Accreditation Group (JAG) accreditation in August 2016 due to an audit that was not submitted within the necessary timescales and communication issues.
- In maternity services we had concerns regarding the completion of the K2 training package (an interactive computer based training system that covered CTG interpretation and fetal monitoring) for midwives and medical staff in maternity.
- We found poor leadership and oversight in a number of services, notably maternity services, outpatients, surgery and urgent and emergency care. In these services leaders had not led and managed required service improvements effectively or in a timely manner. In addition service leads had tolerated high levels of risks to quality and safety without taking appropriate and timely action to address them.
- There was variability in the quality of risk registers, not all risk registers accurately reflected the risks in the service and were not always updated and reviewed effectively.
- Concerns remained regarding the organisational culture. There were a number of themes that emerged from discussions with staff relating to a disconnection still between the executive team and staff, there was a sense of fear amongst some staff groups regarding repercussions of raising concerns and bullying and harassment. Feedback from management teams had a more positive focus.

However:

- The trust had taken action in some areas since the 2015 inspection, for example the trust had stopped using band 4 nurses awaiting professional registration numbers within the registered nurse establishment.
- There were improvements in critical care services. The management team were able to articulate a clear vision and governance processes were effective.
- Infection control processes and cleanliness was satisfactory in the ED.
- There was a new management team in surgery that were able to demonstrate an understanding of the challenges and the areas that required further improvement. They had only recently come into post and had not had sufficient time to implement the changes required to address the ongoing concerns.
- An acute physician model had been established on the acute admissions ward, short stay ward and ambulatory care. One of the benefits of this was to improve the four-hour standard in ED by improving patient flow.
- There was evidence of good multidisciplinary working in most of the services.
- In critical care patient outcomes, for example, mortality, early re-admissions, delayed and out of hours discharges had improved and were in line with similar units.
- There were improvements in the ophthalmology service specifically with regard to the cancellation of clinics and clinical oversight of this process.
- Overall we observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.

We saw several areas of good practice including:

- An ambulance handover team, to see ambulance patients and provide an initial assessment, had been introduced and was providing a positive impact on the ambulance turnaround times.
- An acute physician model had been established on the acute admissions ward, short stay ward and ambulatory care. One of the benefits of this was to improve the four-hour standard in ED by improving patient flow.

Summary of findings

- An online call service run by the infant feeding co-ordinator was being offered to support breast feeding mothers within the community setting.
- The trust had held 'Dying Matters' roadshows at a number of local venues in May 2016, including supermarkets and community centres. These had been advertised as events to provide advice and sign-posting to members of the public on all aspects of planning end of life care, bereavement, dying, organ donation, and will-writing. The introduction of the domiciliary non-invasive ventilation service by the respiratory nurse team. This allowed patients to be monitored at home and reduces the need for hospital admissions. Home assessments could be completed and information could be downloaded onto computer software.
- The development of advanced midwifery practitioners and advanced nurse practitioners in gynaecology.
- The paediatric service used a 'pants and tops' system to allow children to feed back on the care they received. Children filled out 'pants' templates and said what they did not like, or filled in 'tops' templates to say what they did like. However, there were also areas of poor practice where the trust needs to make improvements.

Importantly:

- The trust must ensure that the service risk registers are regularly reviewed, updated and include all relevant risks to the service.
- The trust must monitor and address mixed sex accommodation breaches.
- The trust must continue to improve its paediatric early warning score (PEWS) system to ensure timely assessment and response for children and young people using services.
- The trust must ensure that, following serious incidents or never events, root causes and lessons learned are identified and shared with staff, especially within maternity and surgery.
- The trust must ensure that effective processes are in place to enable access to theatres out of hours, including obstetric theatres, and that all cases are clinically prioritised appropriately.
- The trust must ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist is implemented consistently within surgical services.
- The trust must ensure there are effective planning, management oversight and governance processes in place, especially within maternity, ED and outpatients. This includes ensuring effective systems to implement, record and monitor the flow of patients through ED, outpatients and diagnostic services.
- The trust must ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medication are checked on a daily basis in line with the trust's policy.
- The trust must ensure that there are effective processes in place to support staff and that staff are trained in the recognition of safeguarding concerns including all staff caring for children and young people receiving the appropriate level of safeguarding training and in outpatient services.
- The trust must ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions.
- The trust must ensure that a patient's capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the Mental Capacity Act (2005).
- The trust must ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies.

Emergency and Urgent Care

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

Summary of findings

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

Critical Care

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

Maternity

- The trust must ensure that effective timely assessment and/or escalation processes are in place, including the use of the Modified Early Obstetric Warning Score (MEOWS).
- The trust must continue to improve obstetric skills and drills training among medical staff working in obstetrics.
- The trust must continue to improve midwifery and medical staff competencies in the recognition and timely response to abnormalities in cardiotocography (CTGs) including the use of 'Fresh eyes'.

Children and Young People's Service

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

Outpatients and diagnostic imaging

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

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

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

In the previous CQC inspection in October 2015, we rated the service as requires improvement overall. At this inspection we rated the urgent and emergency care service as requires improvement because:

- The department was not meeting the Department of Health standard, which states that 95% of patients should be treated and discharged or admitted within four hours of arrival. They showed mixed performance against the England average.
- There was disparity in the recording times for the time of arrival to initial assessment. The trust reported one minute. However, different figures were supplied on inspection. The trust was not meeting the 15 minute standard.
- When the department was busy, ambulance staff waited at least 15 minutes prior to booking the patient in at reception. This therefore, affected the figures for the length of time patients were in ED, as patients were up to 15 minutes longer in the department before they were registered as arriving.
- Between August 2015 and July 2016 there was a fluctuating trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes.
- A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between December 2015 and September 2016 Diana, Princess of Wales (DPoW) hospital had 452 breaches. However, since the introduction of the ambulance handover team there had been an improvement.
- Between November 2015 and October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust, was worse than the England average for six out of the 12 months (January 2016 to June 2016).

Summary of findings

- Between September 2015 and August 2016, the Diana Princess of Wales hospital median percentage of patients that left the hospital before being seen for treatment was worse than the England average for 10 months out of this 12 month period.
- Between September 2015 and August 2016, the trust's monthly median total time in ED for admitted patients was consistently worse than the England
- Record keeping was variable. Although observation and triage was documented there were no other nursing documentation regarding nursing care and assessments completed in any of the records we reviewed
- There was lack of the recording of the National Early Warning Scores (NEWS) therefore, we could not be assured that the patients were having the appropriate level of monitoring whilst in the ED.
- We observed an unsupervised bag containing medications used by the streaming nurse. Despite being advised to store this bag in a locked cabinet, it was found unsupervised on a later unannounced inspection.
- We saw evidence that the department did not always meet the planned nurse staffing numbers and medical staffing did not meet national guidance. However, medical and nursing staffing levels and skill mix were planned in line with busy periods. The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department.
- Clinical pathways had not been regularly reviewed or did not have a review date.
- Pain scores were not always recorded consistently.
- We were not assured patients had adequate nutrition and hydration whilst they were in the emergency department for a long period of time.
- The vision and strategy created since our last inspection was still in its infancy. The introduction of the streaming nurse had been in place for three weeks. The vision did not encompass key elements such as compassion, nursing care, patient safety and quality

Summary of findings

- The risk register did not include all risks identified during the inspection and it was not clear who had responsibility for each risk and if any action plans were in place and being monitored

However,

- Openness about safety was encouraged and staff understood their responsibilities to raise concerns and report incidents. We saw that systems and processes worked to keep people safe from harm and abuse and where areas for improvement were identified, this was acted upon.
- There were governance, risk management, quality measurements and processes in place to enhance patient outcomes and openness and transparency about safety was encouraged.
- Staff provided care to patients based on national guidance, such as the National Institute for Health and Care Excellence (NICE) guidance and the Royal College of Emergency Medicine (RCEM).
- The department had an ongoing audit programme that encompassed both local and national audits. Where performance was noted below national standards, the department had implemented action plans to improve the care and treatment of patients.
- Feedback from patients, relatives and carers was consistently positive. Patients' complaints were managed in line with trust policy and feedback was given to staff.
- Despite pressures on capacity and flow, services were safe and we saw that staff were caring and compassionate in their dealings with patients. Patients felt well informed and engaged in their care.
- The department was visibly clean, well-organised and the equipment was maintained in line with trust policies.
- The completion rate for mandatory training for nursing staff in the department was 76% in October 2016; this was below the trust target of

Summary of findings

95%. However, these included new members of staff and by the end of December 2016, the department had a plan in place to ensure the completion rate will be 96%.

- Staff were supported through a process of meaningful appraisal.
- Patient group directives (PGDs) were in use and there was a robust system in place to ensure they were managed appropriately.
- There was evidence of good multidisciplinary working. A rapid response 'core care links' team attended ED 24 hours a day seven days per week when needed. This team reviewed patients and supported safe discharge, liaising with the community team.
- The department offered a 24-hour seven-day service, however some services were available out of hours as an on call service.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity, to provide informed consent to care and treatment.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The department met the standard for 10 months over the 12 month period
- Patients' complaints were managed in line with trust policy and feedback was given to staff.

Medical care (including older people's care)

Requires improvement



We rated this service as requires improvement because:

- There were high numbers of patients cared for on non-medical or non-speciality wards with no reduction in numbers since the last inspection. High numbers of patients were moved between wards late at night due to the demand for beds. The medical review of these patients was variable and when patients were moved between wards, their care would change to a different consultant.
- Waiting lists for procedures were increasing and some patients we spoke with identified that they had long waits for their appointments.

Summary of findings

- Some patients' procedures were cancelled on the day because of a lack of time and this had an impact on the patient's emotional state.
- There were inconsistencies in the effectiveness and the quality of leadership and as a result the endoscopy unit had lost Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.
- The buddying system for medical patients on non-medical wards was not embedded and some staff were confused as to who to contact.
- Staff did not have regular team meetings where they could formally discuss issues or concerns.
- The risk register had not been kept up to date consistently through the year.

However:

- We saw improvements with the recruitment of nurses. As most vacancies had only recently been filled we were not able to see the full benefit of this to the services at the time of our inspection. Staff fill rates for the majority of the wards were within acceptable ranges.
- Patient outcomes in national audits showed that the site had better outcomes than the England average. Patients had a reduced level of readmission at the site in most admission categories.
- Most of the patients and relatives felt involved in their care and thought staff were compassionate about the care they provided. This was reflected in the response rate for the Friends and Family Test and the high percentage of respondents that would recommend the medical wards on the site.
- The number of mixed sex breaches had reduced since the reconfiguration of the service.
- Staff enjoyed working for the trust and identified that the ward managers and matrons were supportive.

Surgery

Requires improvement



In the previous CQC inspection in October 2015, we rated the service as requires improvement overall. At this inspection we rated surgery as requires improvement.

- The directorate did not consistently learn from incidents, or when things could be improved and

Summary of findings

take appropriate action to improve safety standards as a result. Repeat incidents had been reported and lessons learned had not consistently been implemented to prevent the incident from re-occurrence.

- The service did not follow national guidelines when assessing patients. Staff did not always book patients needing emergency surgery into theatres in accordance with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines. No formal emergency theatre booking policy or protocol was available to enable staff to comply with the guidelines.
- Services did not always meet patients' needs. Patients could not always access services for assessment, diagnosis or treatment when they need them. The service had long wait times and overall it did not meet the national referral to treatment times (RTT) or all cancer performance standards. Performance had been worse than the England overall performance since June 2016 and showed a deteriorating trend.
- The service had a high number of clinical and non-clinical cancellations. From April to June 2016, 102 operations were cancelled for non-clinical reasons. The high number of outlying patients often caused non-clinical cancellations; patients nursed in a different speciality areas. In the same reporting period, 184 operations were cancelled on the day for clinical reasons. Staff did not assess elective surgery patients, who needed pre assessment before surgery, using an effective patient pathway.
- The service did not consistently have enough qualified, experienced and skilled staff. Ward managers and co-ordinators had to care for one cohort of patients and supervise another as well as their managerial role. Staff shortages affected staff morale. Staff spoke about a lack of support from the site co-ordination team, in relation to movement of staff, staff shortages and moving patients.
- Performance in national audits was variable. The majority of indicators in the national emergency

Summary of findings

laparotomy, bowel cancer and national hip fracture audits continued to be below national performance. National audit action plans we reviewed did not always reflect the actions required by the audit performance.

- Surgical services did not use patient safety tools consistently. The five steps to safer surgery procedures, including the World Health Organisation (WHO) checklist, was not an embedded consistent process. Staff did not complete formal risk assessments for each day case patient for blood clots (Venous thrombosis). Staff did not always complete nutritional assessments.
- The directorate did not hold specific surgical mortality and morbidity meetings. We reviewed the critical care morbidity and mortality meeting minutes where shared critical care/surgical patients were discussed. However, we did not see evidence that discussion was held specifically for surgical only patients. Although the senior management team said that individual specialities discussed mortality as part of audit meetings, this information was not collated centrally within the directorate.
- Policies and guidelines in use within clinical areas were not all compliant with National Institute of Health and Clinical Excellence (NICE) or other clinical bodies. Data we reviewed from June 2016 showed that policies within the directorate were 69% compliant with NICE guidance.
- The majority of fluid balance charts we reviewed were not completed accurately; this had been previously highlighted on the matron dashboards.
- The clinical strategy for surgical services did not make detailed reference to national reports and recommendations, the trust values and strategy, or have clear deadlines for actions.
- The service had a high number of out of hours transfers, after 8pm. On three occasions we saw records, which showed patients being

Summary of findings

transferred into surgical beds at 1am. This disrupted surgical patient sleep and decreased the number of beds available for elective surgical inpatients.

- We saw no evidence of the service engaging with patient representatives or staff to improve services.
- Surgery did not meet the trust target for mandatory training or appraisals. Overall training rates were 82% but individual training modules, such as resuscitation, rates were much lower at 67%. Although the number of staff receiving regular appraisals had increased, this was still below the trust target.

However:

- The trust had taken action since the 2015 inspection, and had stopped using band 4 nurses awaiting professional registration numbers within the registered nurse establishment.
- We observed positive interactions between patients and staff. The majority of patients we spoke with were happy with the care they received.
- Appraisal rates had improved since the 2015 inspection, however they still remained below internal compliance targets.
- The directorate now had a surgical vision however, due to changes within the senior management team, detailed timescales and plans for action were not available. The senior management team were aware of the challenges within the directorate and spoke with us about their commitment to improving these.

Critical care

Good



In the previous CQC inspection in October 2015, we rated the service as requires improvement overall. At this inspection we rated critical care as good because:

- The service had taken action on most of the issues raised in the 2015 inspection. There was an effective governance process in place with a clear structure for escalation in the directorate and there was evidence of regular review of the risk register and controls in place for the risks.

Summary of findings

- Staff were positive about the recent changes to the senior management team, morale had improved, staff were happy in their work and felt supported and valued.
- There was a clear critical care strategy and staff understood the vision for the service. Staff had begun to rotate between the intensive therapy unit (ITU) and the high dependency unit (HDU) as part of working towards the strategy.
- Patient outcomes in ITU, for example, mortality, early readmissions and delayed discharges were in line with similar units. HDU had begun to collect Intensive Care National Audit and Research Centre (ICNARC) data to monitor patient outcomes.
- There was a good track record in safety. There had been no never events, or serious incidents and staff understood their responsibilities to raise concerns and report incidents. The incidents staff reported mainly resulted in low or no harm.
- Staffing levels and skill mix were planned and reviewed to keep people safe. Staff were supported to maintain and develop their professional skills and mandatory training and safeguarding training rates were near the trust target. A clinical educator had been appointed and was due to commence in post.
- There had been no complaints about the service in the last 12 months and feedback from patients and relatives was positive about the way staff treated them.

However,

- Some of the issues raised at the 2015 inspection remained a concern. For example, medical and nurse staffing was still not yet in line with the Guidelines for the Provision of Intensive Care Services 2015 (GPICS). The critical care strategy had plans in place to address this.
- The rehabilitation after critical illness service was very limited and not in line with GPICS.
- The number of non-clinical transfers and out of hour's discharges from ITU were not in line with

Summary of findings

national guidance and were worse than similar units and the service did not formally monitor the number of patients ventilated outside of critical care.

Maternity and gynaecology

Requires improvement



In the previous CQC inspection in October 2015, we rated the service as good overall. At this inspection, we rated the services as requires improvement because:

- The service had not provided assurance that lessons had been learned and embedded following a never event or from serious incidents.
- The trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) checklist. From a review of clinical records it was apparent that this was not consistently embedded.
- The trust used the Modified Early Obstetric Warning Score (MEOWS) tool to identify deteriorating patients. Results of an audit by the trust found, if a woman required escalation, only 58% of records had evidence of an appropriate referral and management plan.
- Checking of emergency resuscitation equipment for adults and babies was not robust. We found gaps in daily checking within maternity services. This had been raised with the trust following the previous CQC inspection in October 2015.
- The service had not addressed staff training on cardiotocography (CTG). Following a serious incident, one of the actions identified was additional CTG training (K2 training) for all midwifery and medical staff. This action was due for completion on the 30 October 2016. At the time of our inspection, 86% of medical staff and 15% of midwives had completed the training. The percentage of women experiencing third and fourth degree tears following assisted deliveries was above the regional average.
- Governance arrangements did not always allow for identification of risk.

However:

- Clinical areas were visibly clean and tidy.

Summary of findings

- The implementation of care bundles had reduced the number of stillbirths.
- Staff were aware of the procedures for safeguarding vulnerable adults and children.
- Women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- Staff felt supported by their ward managers and felt they could raise concerns.

Services for children and young people

Requires improvement



In the previous CQC inspection in October 2015 we rated the service as good overall. At this inspection we rated services for children and young people as requires improvement because:

- There was a shortage of qualified nursing and medical staff available within the service. Staffing levels did not meet professional guidance and had resulted in services being closed at times of peak demand. There was a lack of senior nursing or medical cover available out of hours and at weekends.
- Mandatory training and appraisal targets had not been met by all staff groups. This included safeguarding training targets and not all staff had the required level of safeguarding training in place.
- We were not assured that staff had received the necessary paediatric life support training. This was because data provided by the trust suggested low rates of compliance. However, staff we spoke with told us that they had training in place.
- The Neonatal Intensive Care Unit (NICU) and Rainforest ward had been closed to admissions on a number of occasions due to capacity or staffing concerns. The Paediatric Assessment and Observation Unit (PAOU) was not always available to staff due to adult overflow patients from the emergency department.
- Identified risks to the service were not always appropriately recorded or monitored via the risk register.

However:

Summary of findings

- The ward environments were clean and we observed good infection prevention and control techniques. Medicines were stored securely and managed appropriately.
- Children and their families told us that they received compassionate and dignified care. Parents told us that they understood the care provided to their child and had been involved in decision making. Parents told us that they would be confident in seeking emotional support from staff.

End of life care

Good



In the previous CQC inspection in October 2015 we did not inspect end of life care. At this inspection we rated this service as good because:

- There were low numbers of incidents involving end of life care patients. Staff we spoke with were aware of the duty of candour. All areas that we visited appeared clean and well maintained. The trust had policies and procedures in place for the safe handling and administration of medicines. There were also specific policies available to support staff caring for patients at the end of their life. Patient records were stored securely and record keeping was of a good standard.
- We saw that trust policies referenced national best practice guidance such as the National Institute for Health and Care Excellence (NICE). This included policies relating to care at the end of life, such as anticipatory drug prescribing for end of life care and the pain and symptom management guidance in the last days of life. We saw evidence of local and national audit participation.
- We saw that patient's pain levels, nutrition and hydration needs were assessed and managed effectively. Staff had effective clinical supervision. The trust had been involved in the development of a Northern Lincolnshire multi-agency end of life care strategy; from this, they had identified seven work streams, each of which had developed key performance indicators to measure the trust performance and patient outcomes.

Summary of findings

- We observed staff being compassionate to patients and their families without exception. Patients and relatives we spoke with said that the staff were 'brilliant' and that the nurses are 'angels'. We found that staff were sensitive to the needs of the patients and their families. We saw staff caring for patients and their families and speaking to them in a respectful and compassionate manner. We saw that staff provided emotional support to patients and their families.
- Patients and staff had seven-day access to specialist palliative nurse support. Staff on the wards told us that the SPCT were visible, available and that they regularly reviewed end of life patients and had discussions with patients and their families. Information received from the trust indicated that 86.5% of patients referred to the SPCT were seen within 48 hours. The bereavement team had developed robust processes to help and support bereaved relatives. 82% of patients audited were asked about and achieved their preferred place of care.
- The trust had been involved in the development of a multi-agency end of life strategy that encompassed the whole of the local health economy. The trust was collating and monitoring quality measures such as patient outcomes through seven strategy sub-working groups. There was a non-executive director with responsibility for end of life care, at board level. Staff reported a positive culture and good working relationships between teams.
- The trust were supporting the development of staff that were caring for patients at the end of life and we saw good examples of innovation and staff whose purpose was to maintain and improve the services provided to patients and their loved ones.

However:

- There was limited use of the trust's last days of life documentation, however the senior team had identified this and were progressing the roll out of the document across the trust.

Summary of findings

- The trust employed less than the National Council for Palliative Care guidance of two whole time equivalent (wte) consultants per 250,000 population, however, there had been no specialist palliative care medical staff in place during our previous inspection therefore this was an improvement. Chaplaincy support was minimal.
- Low numbers of staff had received a yearly appraisal. The trust did not use an electronic palliative care co-ordination system; however, the development of this was part of the strategy action plan. We were concerned that consent to care and treatment was not always obtained in line with legislation and guidance, including the Mental Capacity Act 2005, for patients who lacked capacity.
- Not all risks for the service were identified on the risk register for the end of life care service. For example, the delayed roll out of the last days of life document and completion of the deceased patient audit tool were not on the risk register.

Outpatients and diagnostic imaging

Inadequate



In the previous CQC inspection in October 2015, we rated this service as inadequate. At this inspection we rated this service as inadequate because:

- In January 2016 the trust told us that the concerns raised at the October 2015 inspection had been addressed. However, prior to the inspection and following the inspection further cohorts of patients were identified which were not being effectively managed. The trust had failed to address a number of actions, from the October 2015 inspection, in a timely manner.
- The trust had been slow to implement clinical validation and assessment of risk within waiting lists, across all specialities.
- The trust had been slow to get to the bottom of waiting list issues and was still discovering patients in unmonitored systems in August 2016.
- Referral to treatment times were worsening and the trust told us they were unlikely to recover a good position until March 2018.

Summary of findings

- There continued to be large numbers of patients' overdue follow up appointments or with no due date on the patient administration system.
- The trust had a continuing high number of cancelled clinics.
- Effective oversight, monitoring and management of booking patient appointments and waiting list was not evident in all specialities.
- There was evidence of actual harm and ongoing significant risk of potential harm to patients waiting long periods of time for first and follow up appointments.
- Safeguarding training compliance for the outpatient staff was below the trust target.
- There was mixed feedback from staff in a number of roles regarding leadership and an expressed reluctance to raise concerns regarding management or services, for fear of negative repercussions.

However,

- The trust had taken action to stop cancellation of clinics by non-clinical staff, to improve sharing of lessons from incidents, to ensure safe storage of refrigerated drugs and had improved the facilities and premises in outpatient areas.
- All radiology staff had received training regarding the ionising radiation (medical exposure) regulations (IR(ME)R 2000).
- The staff working in outpatients and diagnostic imaging departments were competent and there was evidence of multidisciplinary working across teams and local networks.
- Nursing, imaging and medical staff understood their roles and responsibilities regarding consent and the application of the Mental Capacity Act.
- We observed staff in all areas treating patients with kindness and respect and patients were very happy with their care.
- Concerns and complaints were taken seriously and staff and managers responded positively to patient feedback. There were low levels of complaints for imaging services.
- The trust performed well against cancer waiting time operational standards.

Summary of findings

- The diagnostic imaging department had a five-year strategy in place to ensure that the department was future proof and had governance processes in place to ensure that risks were mitigated.
-

Diana Princess of Wales Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Surgery (gynaecology); Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging;

Detailed findings

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Background to Diana Princess of Wales Hospital

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 the East Riding of Yorkshire. Its annual budget is around £330 million, and it has 843 beds across three hospitals: Diana Princess of Wales (DPoW) Hospital in Grimsby, Scunthorpe General Hospital (SGH) and Goole & District Hospital (based in the East Riding of Yorkshire). The trust employs around 5,364 members of staff.

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

We inspected the trust from 13 – 16 October 2015 and performed an unannounced inspection on 6 November 2015 and 5 January 2016. This inspection was to review and rate the trust's community services for the first time using the Care Quality Commission's (CQC) new

methodology for comprehensive inspections. The acute hospitals had been inspected under the new methodology in April 2014. We therefore carried out a focussed inspection of the core services that had previously been rated as inadequate or requires improvement. Due to additional information the inspection team also inspected maternity services and caring across the core services included this inspection. We did not inspect children and young people's services or end of life services within the hospitals. Additionally not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

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

CQC carried out its first comprehensive inspection of the trust between 23 – 25 April and on 8 May 2014. 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

Detailed findings

mortality figures across trusts in England. Overall, Scunthorpe hospital was found to require improvement, although CQC rated it as good in terms of having caring staff.

At the comprehensive inspection in April 2014 DPoW and SGH 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 SGH was also found in breach of Regulation 15 (premises). CQC set compliance actions (now known as Requirement Notices) for all these breaches and the trust then developed action plans to become compliant. The majority of the trust's actions were to be completed by September 2014 and all actions by March 2015.

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Consultant, Chair of Inspection

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, End of life care Matron, Critical Care Doctor, Critical Care Nurse, ED Nurse, Medicine Doctor, Medicine Nurse, Surgery Doctor – Surgeon, Surgery Doctor – Anaesthetist, Surgery Nurse, Theatre Nurse, Ophthalmic Nurse – Outpatients, Midwife Matron, Midwife, Consultant Obstetrician, Child Safeguarding, 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).

How we carried out this inspection

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

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

The inspection team inspected the following acute and community core services at the trust.

Acute services:

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

Community services:

- Community health services for adults
- Community services for children, young people and families
- Community end of life care

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

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 also held two similar focus groups, especially for people living with dementia, their families and carers. We used this information to help us decide what aspects of care and

Detailed findings

treatment to look at as part of the inspection. The team would like to thank all those who attended the focus groups, Mencap Scunthorpe Gateway, Care4All Ltd and Alzheimer's Society in Scunthorpe and Grimsby.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, 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 22 – 25 November 2016 and unannounced inspections on 17 October and 8 December 2016.

Facts and data about Diana Princess of Wales Hospital

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

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

This trust has three hospital locations:

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

The trust has a total of 886 beds including:

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

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

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

- 2,016 Other non-clinical staff.

The trust has:

- 132,165 A&E attendances (August 2015 to August 2016).
- 96,576 Inpatient admissions (April 2015 to March 2016).
- 393,617 Outpatient appointments (August 2015 to July 2016).
- 4,520 Births (April 2015 to March 2016).
- 454 Referrals to the specialist palliative care team (March 2015 to April 2016, SGH data only).
- 41,075 Surgical spells (April 2015 to March 2016).
- 2,133 Critical care bed days (February 2016 to July 2016).

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

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

- The health of people in North Lincolnshire is varied compared with the England average. Deprivation is lower than average, however about 19.8% (6,000) of children live in poverty. Life expectancy for both men and women is lower than the England average.
- The health of people in North East Lincolnshire is generally worse than the England average. Deprivation is higher than average and about 28.5% (8,500) of children live in poverty. Life expectancy for both men and women is lower than the England average.

Detailed findings

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

Our ratings for this hospital







Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

Urgent and Emergency Care services are delivered by the Emergency Departments (ED) at the Diana Princess of Wales Hospital and Scunthorpe General Hospital which provide a 24-hour, seven-day a week service to the local populations. Between April 2015 and March 2016, the Diana Princess of Wales Hospital had 64,316 attendances at its urgent and emergency care services. This equates to an average of 176 patients per day. Children aged zero to 16 years accounted for 20% of emergency department attendances between April 2015 and March 2016. This percentage has been consistent for the last three years. There is also a minor injuries at Goole and District hospital but this was inspected in 2016.

The emergency department was a designated trauma unit. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their condition allowed them to travel directly. If not, they were stabilised within the emergency department and either treated or transferred as their condition dictated. There was a protocol to inform the medical team which patient injuries required treatment at a major trauma centre. The department had a nearby open grassed area where the helicopter could land and a protocol was in place for the transfer of the patient into and out of the emergency department.

In order to make our judgements we spoke with 25 patients, four carers and 32 staff from different disciplines including nurses, doctors, managers, support staff and

ambulance staff. We observed daily practice and viewed 34 sets of records. Prior to and following our inspection, we reviewed performance information about the trust and reviewed information provided to us from the trust.

Urgent and emergency services

Summary of findings

We rated the emergency and urgent care service as requires improvement because:

- The department was not meeting the Department of Health standard, which states that 95% of patients should be treated and discharged or admitted within four hours of arrival. They showed mixed performance against the England average
- There was disparity in the recording times for the time of arrival to initial assessment. The trust reported one minute, however, different figures were supplied on inspection. The trust was not meeting the 15 minute standard.
- When the department was busy, ambulance staff waited at least 15 minutes prior to booking the patient in at reception. This therefore, affected the figures for the length of time patients were in A&E, as patients were up to 15 minutes longer in the department before they were registered as arriving.
- Between August 2015 and July 2016 there was a fluctuating trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes.
- A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between December 2015 and September 2016 Diana, Princess of Wales (DPoW) hospital had 452 breaches. However, since the introduction of the ambulance handover team there had been an improvement.
- Between November 2015 and October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust, was worse than the England average for six out of the 12 months (January 2016 to June 2016).
- Between September 2015 and August 2016, the Diana Princess of Wales hospital median percentage of patients that left the hospital before being seen for treatment was worse than the England average for 10 months out of this 12 month period.
- Between September 2015 and August 2016, the trust’s monthly median total time in A&E for admitted patients was consistently worse than the England

- Record keeping was variable. Although observation and triage was documented there were no other nursing documentation regarding nursing care and assessments was completed in any of the records we reviewed.
- There was lack of the recording of the National Early Warning Scores (NEWS) therefore we could not be assured that the patients were having the appropriate level of monitoring whilst in the ED.
- We observed an unsupervised bag containing medications used by the streaming nurse. Despite being advised to store this bag in a locked cabinet, it was found unsupervised on a later unannounced inspection.
- We saw evidence that the department did not always meet the planned nurse staffing numbers and medical staffing did not meet national guidance. However, medical and nursing staffing levels and skill mix were planned in line with busy periods. The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department.
- Clinical pathways had not been regularly reviewed or did not have a review date.
- Pain scores were not always recorded consistently.
- We were not assured patients had adequate nutrition and hydration whilst they were in the emergency department for a long period of time.
- The vision and strategy created since our last inspection was still in its infancy. The introduction of the streaming nurse had been in place for three weeks. The vision did not encompass key elements such as compassion, nursing care, patient safety and quality
- There were governance, risk management, quality measurements and processes in place however we were not assured they were effective due to the concerns raised during inspection.
- The risk register did not include all risks identified during the inspection and it was not clear who had responsibility for each risk and if any action plans were in place and being monitored

However:

- Openness about safety was encouraged and staff understood their responsibilities to raise concerns

Urgent and emergency services

and report incidents. We saw that systems and processes worked to keep people safe from harm and abuse and where areas for improvement were identified, this was acted upon.

- Staff provided care to patients based on national guidance, such as the National Institute for Health and Care Excellence (NICE) guidance and the Royal College of Emergency Medicine (RCEM).
- The department had an ongoing audit programme that encompassed both local and national audits. Where performance was noted below national standards, the department had implemented action plans to improve the care and treatment of patients.
- Feedback from patients, relatives and carers was consistently positive. Patients' complaints were managed in line with trust policy and feedback was given to staff.
- Despite pressures on capacity and flow, services were safe and we saw that staff were caring and compassionate in their dealings with patients. Patients felt well informed and engaged in their care.
- The department was visibly clean, well-organised and the equipment was maintained in line with trust policies.
- The completion rate for mandatory training for nursing staff in the department was 76% in October 2016; this was below the trust target of 95%. However, these included new members of staff and by the end of December 2016, the department had a plan in place to ensure the completion rate will be 96%.
- Staff were supported through a process of meaningful appraisal.
- Patient Group Directions (PGDs) were in use and there was a robust system in place to ensure they were managed appropriately.
- There was evidence of good multidisciplinary working. A rapid response 'core care links' team attended ED 24 hours a day seven days per week when needed. This team reviewed patients and supported safe discharge, liaising with the community team.
- The department offered a 24-hour seven-day service, however some services were available out of hours as an on call service.

- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity, to provide informed consent to care and treatment.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The department met the standard for 10 months over the 12 month period
- Patients' complaints were managed in line with trust policy and feedback was given to staff.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



In the previous inspection we rated the safe domain as requires improvement. During this inspection we rated the emergency department as requires improvement because:

- A National Early Warning Score (NEWS) system for acutely ill patients was in place, which supported the process for early recognition of those patients who were becoming unwell. However, we looked at 19 care records for adult patients' and found that NEWS scores were not recorded in 12 records. We could not be assured that the patients were having the appropriate level of monitoring whilst in ED.
- A similar paediatric early warning score (PEWS) score is used in the process for early recognition of those children who were becoming unwell. Out of the seven paediatric records we checked none had a PEWS score recorded.
- There was disparity on the recording times for the time of arrival to initial assessment. Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The trust reported one minute, however, different figures were supplied on inspection. The trust was not meeting the 15 minute standard.
- Ambulance staff had to wait at least 15 minutes prior to booking the patient in at reception onto the hospital system. This therefore, affected the figures for the hospital, as patients were up to 15 minutes longer in the department before they were registered as arriving.
- Between August 2015 and July 2016 there was a fluctuating trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In September 2015, 58% of ambulance journeys had turnaround times over 30 minutes; in July 2016 the figure was 56%.
- A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between December 2015 and September 2016 Diana, Princess of Wales (DPoW) hospital had 452 breaches. There was a downward trend

in the monthly number of 'black breaches' reported over the period. An ambulance handover team was introduced in May 2016, which saw the trust improve their handover times significantly. Between December 2015 and April 2016 DPoW was averaging 69 breaches a month. However, since the introduction of the ambulance handover team DPoW averaged 21 breaches a month.

- We saw evidence that the department did not always meet the planned nurse staffing numbers and medical staffing and children's nurse staffing did not meet national guidance.
- We reviewed seven paediatric and 27 adult patient records and found that records showed five medicines had been prescribed but had not been administered. No rationale for omission had been recorded.
- We observed a medicine bag used by the streaming nurse on the reception desk left unsupervised. We advised staff to ensure it was stored in a locked cupboard to avoid the general public and children accessing it. When we returned on the unannounced inspection, this medicine bag was left unsupervised.
- Record keeping was variable. Although observation and triage was documented there were no other nursing documentation regarding nursing care and assessments was completed in any of the records we reviewed.

However:

- Openness about safety was encouraged and staff understood their responsibilities to raise concerns and report incidents. We saw that systems and processes worked together to keep people safe from harm and abuse and where areas for improvement were identified, this was acted upon.
- There was a strong culture of reporting incidents which were reported using an electronic system. Incidents were investigated swiftly. Feedback and lessons learned from incidents was shared amongst the staff.
- The department was visibly clean, well-organised and the equipment was maintained in line with trust policies
- There were systems in place to monitor and improve infection control practices.
- The completion rate for mandatory training for nursing staff in the department was 76% in October 2016. This was below the trust target of 95%. However, this included new members of staff and by the end of December 2016, the department had a plan in place to ensure the completion rate will be 96%.

Urgent and emergency services

- Controlled drugs were managed appropriately. Record keeping and balance checks were completed as per trust policy.
- Patient Group Directions (PGDs) were in use and there was a robust system in place to ensure they were managed appropriately.
- Medical and nursing staffing levels and skill mix was planned in line with busy periods. The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department.
- The department had taken part in a major incident exercise and staff were aware of their role in a major incident.

Incidents

- There was a strong culture of reporting, investigating and learning from incidents.
- Staff used an electronic system to report incidents. Staff were confident about using the system and were encouraged to report incidents. Incidents were appropriately graded in severity from low or no harm to moderate or major harm.
- Between September 2015 and October 2016 the trust reported no incidents which were classified as Never Events for urgent and emergency care
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between September 2015 and October 2016, in accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England. Two incidents were a maternity/obstetric incident meeting SI criteria; one a mother and baby, and one a baby only, one was a treatment delay meeting SI criteria and the last was a medication incident meeting SI criteria.
- Following investigations of incidents of harm or risk of harm, staff told us they always received feedback. The department manager would feedback to them personally and learning from incidents was discussed and cascaded through several forums. These included the ward manager meetings for medicine and the

cross-site monthly governance meetings, the twice weekly training sessions, the staff huddle and a file kept in the staff room. We saw evidence from the minutes of these meetings that incidents were discussed.

- Not all junior nursing staff were aware of the statutory Duty of Candour principles. Senior staff told us the department had a system in place to ensure patients were informed and given an apology when something went wrong and were told of any actions taken as a result. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Examples of duty of candour were given and we saw staff were open and honest with the patient and their family.
- We saw evidence in the mortality performance and assurance committee minutes that any unexpected deaths or potentially avoidable deaths that occurred in ED were reviewed within this meeting and a reflection of a case review was shared.

Mandatory training

- The completion rate for mandatory training for nursing staff in the department was 76% in October 2016. This was below the trust target of 95%. However, this included new members of staff and we were told that by the end of December 2016, the completion rate will be 96%.
- There were 13 mandatory training modules, these included bullying and harassment, conflict resolution, medicines management, moving and handling, slips, trips and falls, equality and diversity, mental capacity act, declaration of liberty, information governance, infection control, fire and resuscitation.
- The ward manager provided us with information of who had completed each session.
- The majority of mandatory training sessions were face to face, and time was allocated in the rotas for staff to attend.
- All staff completed competency based assessments, which included 27 basic assessment skills of presenting complaints. Staff were required to attend teaching sessions and have three competencies signed by a senior member of staff.

Urgent and emergency services

- Newly qualified staff attended 'care camp' a week prior to starting in the department. They were given training which included cannulation, catheterisation, dementia training plus all mandatory training.
- Each new member of staff was given a preceptor who supported them and signed off competencies. The preceptor met with them monthly to give support and complete competencies sign off.
- New staff we spoke with said they had a supernumerary period, depending on experience, and a training booklet to work through that contained competency assessments.
- Medical device training was done on a 'train the trainer' basis. The sister was able to show us a file that had competencies signed off for each piece of equipment. .
- Within a staff area there was a list displayed of all mandatory training and who needed yet to complete each session.
- Paediatric advanced life support training was completed by 80% of band 6 senior nurses and advanced life support training was completed by 100% of band 6 senior nurses. Intermediate life support training was completed by 100% of band 5 nurses and 98% of band 3 healthcare assistants.
- The trust was unable to give us a breakdown of the percentage of medical staff who were trained in adult and paediatric life support.
- Any safeguarding concerns were escalated to the senior nurse and doctor.
- Any previous safeguarding alerts were highlighted on the IT system and as these patients were booked in, an additional laminated sheet was placed in their notes to alert staff. This had specific listed actions to complete.
- There was a safeguarding team for adults and children and a robust referral system in place.
- We were informed staff received level four safeguarding children training and were given regular supervision on child protection from the lead for safeguarding. Training figures showed 93% of medical staff had received adult safeguarding training, and 83% of medical staff received safeguarding children training. 56% of nursing staff received safeguarding adults training and 96% of nursing staff received safeguarding children training.
- There was a safeguarding book to highlight any concerns that was collected daily by the safeguarding team. Examples in the book included a teenager who had self-harmed and a child with a fractured wrist whilst staying at his father's house.
- In the nurses' station office, there was documentation clearly displayed for safeguarding adults and children, including guidance for staff, contact numbers, safeguarding prompts and child mental health services.
- Staff were aware of the assessment for child exploitation and female genital mutilation (FGM). There was information readily available in the department and training for FGM was included within the safeguarding training.
- Staff were aware of 'Claire's law' a scheme which aims to protect people from violent partners by allowing police to disclose their history of abuse to present partners and how to recognise victims of domestic violence.

Safeguarding

- The department had a clear system and process in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- We reviewed 12 children's' records specifically to see if they had been assessed regarding safeguarding; 11 had documented the assessment, one had no assessment documented.
- Nursing, medical and administration staff we spoke with were able to explain the process of safeguarding a patient and provided us with specific examples of when they would do this.
- Staff said they knew how to recognise and report both adult and children safeguarding concerns.
- We observed staff accessing the trust safeguarding guidelines, which were readily available on the trust IT system. This provided information of how to make referrals when staff had concerns about a child or adult's safety.

Cleanliness, infection control and hygiene

- The emergency department was visibly clean and tidy. We saw cleaning in progress during the visit. Most of the equipment had 'I am clean' labels attached documenting the time and date when it was last cleaned. We reviewed areas including the sluice, administration stations and relatives waiting areas and found them clean and tidy.
- Needle sharp bins were not over full (more than ¾ full) and the bins were dated and signed by a member of staff, (as required by the trust's policy).

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- We saw that staff adhered to the infection control policy and used personal protective equipment (PPE) when delivering personal care.
 - We observed medical and nursing staff following the trust policy for hand washing and 'bare below the elbows' guidance in clinical areas. There were adequate hand washing facilities throughout the department and hand gel dispensers were available in each cubicle.
 - Staff did not routinely carry out mattress audits. We were told they were checked and cleaned between patients and a healthcare assistant was nominated weekly to ensure all trolley mattresses were checked. Trolleys were deep cleaned daily in the early hours of the morning. On inspection, we checked four mattresses and found they were clean and they had no tears in them and trolleys were clean.
 - The major's areas had appropriate facilities for isolating patients with an infectious condition. One cubicle had a room with a sink and personal protective clothing that staff could access and put on first before going through into the cubicle. This room also had a connected bathroom with toilet and washbasin.
 - There was a separate children's waiting room in the paediatric assessment area, which was through one set of doors from the main waiting room. In the children's waiting areas, toys were visibly clean.
 - The bays had a cleaning checklist in place and we saw these had been completed daily.
 - We spoke with domestic staff whose main role was to assist with the hygiene and cleanliness of the department and they spoke of the importance of infection control and how they contributed to patient safety by ensuring that they followed trust infection control policy. We looked at the cleaning stock room and saw that equipment such as coloured mops and buckets were available and stored correctly. The cleaning chemicals had the appropriate instructions for storage and usage in line with Control of Substances Hazardous to Health national guidelines.
 - Waste was managed in line with effective infection control practices.
 - Infection prevention and control training was completed by 58% of all staff.
 - Hand hygiene was audited on a monthly basis. The audit results for December 2015 to August 2016 showed 100% compliance. In April 2016 there was no audit performed.
 - We viewed monthly cleaning audits from December 2015 to August 2016 and the overall scores were from 88% to 100%.
- ## Environment and equipment
- The hospital department pre-dated current national guidance for compliance in facilities for accident and emergency departments (HBN 15-01: Accident and Emergency Departments)
 - Emergency department patients received care and treatment in three main areas: 'minors', 'majors' and resuscitation bays. Self-presenting patients with minor illnesses or injuries were assessed and treated in the 'minors' bays.
 - Patients who walked in, checked in at reception and patients who arrived by ambulance came in through a separate entrance to an ambulance assessment area. The ambulance assessment area had three trolleys and two chairs.
 - There was a main waiting room, which was used for adults. This had padded chairs which were linked together, vending machines providing hot and cold drinks and snacks. There were information boards with results of the friends and family survey, a 'You said we did' board and patient safety information.
 - There was an electronic screen displaying information regarding how many patients were in the department, how many were waiting for assessment and how many were receiving or waiting for treatment. However, when we did an unannounced inspection on the 8th December, this board had not been updated since 21st November 2016.
 - A separate children's waiting area was through some double doors in the paediatric assessment waiting unit. This had clean bright painted walls, toys and books, a television and a cold water machine.
 - There was access to male and female toilets, disabled toilet and a baby changing room.
 - In the minors area there were eight treatment rooms. One of which was set up to see patients who had an ear, nose or throat problem.
 - The major's area had 13 cubicles, which included an isolation cubicle and a cubicle used for the assessment and treatment of patients with mental health problems. This cubicle could have equipment removed so it was ligature free.

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- Within the majors area, was a chaired area known as the 'red zone'. This was where patients who did not need a trolley could be easily observed.
- There were four resuscitation bays. One of which was equipped for children and one was equipped for dealing with patients who had sustained major trauma. The resuscitation bays were similarly set up which helped staff care and treat patients in a timely and efficient manner. All four resuscitation bays could be used flexibly as needed. The resuscitation area was visibly clean and well organised.
- The department was located adjacent to the x-ray department and CT scanner.
- Access to some areas in the department was controlled by electronic card entry systems. Staff ID badges acted as their access control. This enabled the hospital to restrict access to sensitive areas to particular groups of staff. The card access system could be audited if required to show which staff had used their card to enter a specific area.
- Resuscitation trolleys were labelled and matched with an equipment checklist. We saw evidence that these had regular daily checks throughout November 2016. There was one day missed in October and seven days missed in September 2016.
- There were adequate stocks of equipment and we saw evidence of good stock rotation to ensure that equipment was used before its expiry date.
- Safety testing of electrical equipment had been carried out in the department. All equipment was serviced by the medical engineering department on a rolling programme basis. Stickers on the equipment confirmed servicing and maintenance had been completed.
- Security arrangements were in place 24 hours a day within the hospital. Closed circuit television (CCTV) was also in operation.

Medicines

- Controlled drugs were managed appropriately. Record keeping and balance checks were completed as per trust policy.
- Patient Group Directions (PGDs) were in use and there was a robust system in place to ensure they were managed appropriately. PGDs are written instructions that allow specified healthcare professionals to supply or administer a particular medicine in the absence of a

written prescription. We checked PGDs used by the nursing team and found they were being used effectively to support patient access to medicines in a timely way.

- Prescription pads were stored securely and appropriate records maintained in accordance with national guidance.
- All intravenous infusions were stored in their original boxes or in appropriately labelled containers.
- Medicine prescribing was done on paper records.
- We observed a member of staff administer intravenous drugs. Infection control guidelines were not followed. For example, there was no washing of hands before or after giving the intravenous drug and no gloves or apron was worn.
- During the inspection we observed the streaming nurse at the reception desk with a bag of medicines which included codeine, paracetamol and ibuprofen. This was not secure and was left on reception if the nurse left the desk. We advised staff to lock this safely in a cupboard. When we returned on the unannounced inspection, the medicine bag was open at the reception desk. The nurse left the area for some time and one of the receptionists also left, this meant that the bag was open on the desk for at least five minutes. This could have been easily accessed by a member of the public. When we returned later in the day, this had been locked away in the triage room.
- We reviewed seven paediatric and 27 adult patient records and found that records showed five medicines had been prescribed not given. We were unsure why they were not given.

Records

- Paper records (ED cards) were used within the department and these were scanned onto the IT system following discharge or transfer to a ward. The paper copy was sent to the ward, or if the patient was sent home from ED their records were kept on site, until they were archived.
- A discharge letter was automatically generated and emailed to the GP within 24 hours. If the patient was from out of area a paper copy was posted to their GP.
- Access to patients' previous notes was timely and could be accessed via the medical records department 24 hours, seven days a week.
- We initially reviewed 26 sets of patients' records (19 adults and seven children's) fully and found completion

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of documentation was variable. For example, we could not tell if nursing care was actually given because no record of nursing care was documented in any of the 26 records. This included no record of pressure ulcer assessment or pressure care given and no documentation if the patient had been offered or given food or drinks whilst in ED. Four patients had a falls assessment completed.

- On the following unannounced inspection, we checked a further seven sets of notes and found nursing care rounds documentation was completed in two patients' notes. The care rounds document had a list of checks the nurse makes on a patient including checking pressure areas, changing their position, offering the toilet, offering drinks and food, assessing if they have pain.
- There were a high number of incidents reported of patients attending ED with community acquired pressure ulcers however, assessment of pressure ulcers were not recorded in patients' notes.
- We noted pain scores were not completed in eight out of the 26 records; therefore, it was not possible, from the records, to determine if the eight patients required pain relief.
- Writing was legible in all of the patients' records.
- Records were dated and/or timed in 12 out of the 26 records.
- The frequency and documentation of the recording of patients' observations was appropriate in 18 out of the 26 sets of records. There was a lack of appropriate blood sugar monitoring and often just one set of observations in patients who required more frequent observations recorded. For example, only one set of observations recorded on a patient who had a fit, and had a CT scan performed.
- The recording of the patients' allergy status was in all the records we checked.
- The electronic system alerted staff to any patient specific concerns or risks. For example, if a patient had a previous infection or a safeguarding concern.
- Reception staff collated and filed the patient notes at the end of the visit and arranged for safe storage of notes.

Assessing and responding to patient risk

- A new streaming process had been introduced. This involved a staff nurse at the reception desk who took a very brief history and streamed the patient into the

appropriate place. This could be to see a GP, to go directly into the majors department to be triaged by the nurse working in majors or to see the triage nurse working in the minors department. The streaming nurse offered immediate pain relief to patients if needed.

- A National Early Warning Score (NEWS) system for acutely ill patients was in place, which supported the process for early recognition of those patients who were becoming unwell. However, we looked at 19 care records for adult patients' and found that NEWS scores were not recorded in 12 records. We could not be assured that the patients were having the appropriate level of monitoring whilst in ED.
- A similar paediatric early warning score (PEWS) system was used in the process for early recognition of those children who were becoming unwell. Out of the seven paediatric records we checked none had a PEWS score recorded. An action as a result of the RCEM audit for vital signs in children (July 2016) was for all children to have vital signs recorded unless seen for an injury and recording the paediatric early warning scores (PEWS) score.
- During our inspection, we saw an example of a patient's deteriorating NEWS score being acted upon and the patient moved into the resuscitation bay as a result of the deterioration of their condition.
- We witnessed a patient who was intoxicated being moved to a high visibility cubicle near the nurses' station.
- Patients arriving by ambulance entered through a dedicated entrance specifically for ambulances. There were three bays and two chairs available where patients had an initial assessment by a nurse. The initial assessment included commencing investigations that would assist with diagnosis and treatment. For example, bloods were taken, electrocardiograms (ECG) carried out, analgesia prescribed and x-rays ordered. A nurse then triaged the patient into the appropriate area (unless the patient required immediate access to the resuscitation bay).
- The trust used a recognised triage system in the 'minors' area which categorised the severity of the patient's condition and level of risk. This reflected the order in which patients were seen.
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration.

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- The published data for the median time from arrival to initial assessment for patients arriving by ambulance was better than the overall England median for the whole of the 12 month period. In May 2016, the median time to initial assessment was one minute compared to the England average of seven minutes. The trust has consistently had a median time of one minute each month.
- However, during the inspection, the records we examined showed that the target was met for 16 out of 33 patients' notes we checked. These times were between zero and 86 minutes. Averaging 17 minutes. 11 records had no time of initial assessment recorded.
- We tracked five patients during the inspection who walked into the department. The average time to initial assessment was 13 minutes. We tracked five patients who arrived by ambulance, the average time to initial assessment was 15 minutes.
- The trust provided us with median waiting times from arrival to initial assessment, between January 2016 and October 2016, which averaged 23 minutes. The trust had met the 15-minute standard in none of the 10 months at Diana Princess of Wales hospital. Therefore, there was disparity between the initial assessment time published, the times the trust submitted to us and our findings during the inspection.
- We spoke with ambulance staff during the inspections. They described the process of the handover as arriving at ED and notifying the time of arrival on their ambulance screen. They waited to handover the patient to the nurse. Once the handover was completed they booked the patient into the hospital at reception. If their wait was longer than 15 minutes to handover to the nurse, they would book the patient in after 15 minutes. This therefore, affected the figures for the hospital, as patients could be up to 15 minutes longer in the department before they were registered as arriving on the hospital system.
- We spoke with six ambulance staff on the unannounced inspection and they said they did not generally wait a long time at Diana Princess of Wales Hospital to handover patients. We observed four ambulance handovers and all were booked in within 15 minutes.
- Between August 2015 and July 2016 there was a fluctuating trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In September 2015, 58% of ambulance journeys had turnaround times over 30 minutes; in July 2016 the figure was 56%.
- A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between December 2015 and September 2016 Diana Princess of Wales (DPoW) hospital had 452 breaches. There was an improving trend in the monthly number of "black breaches" reported over the period. An ambulance handover team was introduced in May 2016, which saw the trust improve their handover times significantly. Between December 2015 and April 2016 DPoW was averaging 69 breaches a month. However, since the introduction of the ambulance handover team DPoW averaged 21 breaches a month.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for 10 months over the 12 month period. In September 2015, the median time to treatment was 47 minutes compared to the England average of 55 minutes. There has been a steady increase which has seen the median time rise to 56 minutes compared to the England average of 55 minutes.
- The emergency department was a designated trauma unit and provided care for all trauma patients. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their condition allowed them to travel directly. If not, they were stabilised at the Diana Princess of Wales Hospital and either treated or transferred as their condition dictated. There was a protocol to inform the medical team which patient injuries would require treatment at a major trauma centre. The department was served with a nearby grassed area where the helicopter could land and a protocol was in place for the transfer of the patient into and out of the emergency department.
- A handover process known as SBAR was used when patients were transferred to the wards. (This is used to describe the patient's medical Situation, Background, Assessment and Recommendations). This allowed staff

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to communicate effectively, ensuring key information was passed to relevant staff and reducing the need for repetition. We observed a nurse handing a patient over to the ward staff using SBAR.

Nursing staffing

- There were 48.02 whole time equivalent (wte) nursing staff budgeted within the ED. However, in September 2016 there was 42.8 wte staff in post.
- Shift patterns were an early shift 7am to 7.30pm. A later start early shift 8am to 8.30pm. A night shift 7pm to 7.30am and a twilight shift 6.30pm to 5am. The shift patterns enabled more staff to be on duty at busier times of the day.
- As at September 2016, the trust reported an average turnover rate of 15.04% in ED.
- We reviewed four weeks of nursing rotas between 24th October 2016 and 20th November 2016. Out of 112 shifts, 14 (12.5%) were below the planned staffing number shifts. 13 of these were qualified staff.
- As at September 2016, the department reported an average sickness rate of 5%.
- Between August 2015 and July 2016, the trust reported a bank and agency usage rate of 4.1% in urgent and emergency care. In October 2015 bank usage was at 5.2% and reached its lowest usage in March 2016 with 2.5%. Since March it has increased to 4.1% in July 2016
- In accordance with the safer staffing initiative put in place as part of the NHS response to the Francis enquiry, we saw displayed for each shift the actual versus planned numbers of nursing staff on duty.
- The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department however, the staffing numbers did not always allow this.
- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) identifies that there should always be a registered children's nurse in the emergency department, or trusts should be working towards this. Staff told us that there were eight paediatric trained nurses in post. At the time of the inspection they covered 8am to 8.30pm four or five days per week. However, they planned to have a paediatric nurse on duty seven days a week following recruitment.
- A paediatric assessment unit next to the ED department was open from 9.30am to 10pm and staff from the unit assisted in ED if required.

- A play therapist/ Health Care Assistant worked with the paediatric nurse from 9am to 7.30pm.
- There was an overall consultant lead for children's care in the department.
- The department was overseen by a modern matron who provided managerial support, and clinical support when necessary. However, the matron was new to the department. There were trust wide operational and quality matrons. The medical division had an associate chief nurse.
- Nursing and medical handover occurred separately at the beginning of each shift and there was a huddle in the morning where staff discussed incidents, complaints and other recent relevant issues.
- Board rounds took place. A board round is a discussion with the multidisciplinary team regarding patients.
- The department used bank and agency nurses. Often the same bank and agency nurses were used, providing familiarity to the department and many of the bank nurses were substantive staff. We were told the agency nurses were experienced emergency department nurses.

Medical staffing

- We looked at four weeks medical staffing rotas between 3rd October 2016 and 30th November 2016. Consultant rotas demonstrated that a consultant presence in the department was between 8am and 9pm Monday to Friday.
- On Saturday and Sunday there were consultants provided for three to six hours in the department. This was flexible and consultants attended as needed. Outside these hours, a consultant was available on call and attended the department if there was a clinical need to do so. In the absence of a consultant, middle grade cover was available in the department. This does comply with RCEM guidance that states a minimum of a middle grade doctor should be present in an ED.
- According to the College of Emergency Medicine (RCEM) (2015), the service must ensure there is 16 hours of consultant presence a day, except in Major Trauma Centres which should have 24 hour cover. Therefore, the department did not meet these recommendations.
- According to the Royal College of Emergency Medicine (RCEM) (2015), an emergency department should have at least 10 whole time equivalent consultants to provide a sustainable service during extended weekdays and over the weekend. The department had six consultants.

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- The majority of middle grade doctors were locums.
- Any shortfalls in the rota went out to agency to cover.
- The staffing aim was to have eight middle grades over 24 hours, Monday to Friday. Five middle grades over 24 hours at weekends (working longer hours). Five junior doctors over 24 hours Monday to Friday and three junior doctors over 24 hours at weekends (working longer hours)
- As at September 2016, the trust reported an average vacancy rate of 30.83% in ED at DPoW.
- As at September 2016, the trust reported an average turnover rate of 70.51% in ED at DPoW
- As at September 2016, the trust reported an average sickness rate of 1% in urgent and emergency care. Diana, Princess of Wales Hospital had the highest sickness rate of 1.57%.
- Between August 2015 and July 2016, the trust reported a bank and locum usage rate of 6.3% in urgent and emergency care at Diana, Princess of Wales Hospital.
- The proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust were about the same as the England average.
- A paediatric consultant provided paediatric cover if needed and was on site 24 hours a day, 7 days per week.
- Medical staffing was not on the risk register.

Major incident awareness and training

- The trust had a major incident policy; this was accessible to staff on the trust intranet.
- Staff we spoke with had an understanding of their roles and responsibilities with regard to any major incidents. Staff could tell us where the major incident equipment was kept.
- There was a designated store for major incident equipment that contained specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- In August 2016, there had been a table top exercise.
- Major incident training was mandatory, 100% of band 6 nurses, 94% of band 3 nurses, 85% of band 5 nurses and 90% of receptionist had received up to date emergency planning training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



In the previous inspection, we rated the effective domain as good. During this inspection we rated effective as requires improvement because:

- Outcomes of RCEM audits are below expectations compared with similar services
- In September 2016, two months prior to our inspection, the trust was recognised as being an outlier for deaths from septicaemia (except in labour). The trust had provided a detailed action plan to investigate and address this.
- During our inspection we did not see many patients being offered food and drinks. Out of 33 sets of notes, only one had documented that a patient had a drink of water; therefore we were not assured patients had adequate nutrition and hydration whilst they were in the emergency department for a long period of time.
- Some of these pathways had not been regularly reviewed or had no review date.
- Documentation of pain scores was not always completed. It was not possible from the records, to determine if patients required pain relief.

However;

- Policies and procedures had been developed in conjunction with national guidance and best practice evidence.
- We saw evidence of learning as a result of audits.
- Staff were supported through a process of meaningful appraisal. A preceptor supported new staff, and a supernumerary period of time was given that varied depending on their previous experience and learning needs.
- There was evidence of good multidisciplinary working. A rapid response 'core care links' team attended ED 24 hours a day seven days per week. This team reviewed patients and supported safe discharge, liaising with the community team.

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- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment.

Evidence-based care and treatment

- We saw pathways in place that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) clinical standards for emergency departments. These included a stroke pathway, sepsis pathway, paracetamol overdose pathway, community acquired pneumonia pathway, TIA pathway, blood transfusion pathway and paediatric sepsis pathway. Some of these pathways had not been regularly reviewed or had no review date.
- Clinical pathways were available in paper copy and could be accessed on the intranet.
- From the notes we reviewed we saw evidence of the sepsis, transient ischaemic attack (TIA) and stroke pathway being used. These aimed to promote early treatment and improve patient outcomes.
- We spoke with nursing and medical staff who had a good understanding of the Mental Health Act (MHA) and code of practice. Staff were able to explain how patients detained under the MHA were being treated for their mental disorder and if they required treatment for a physical illness, consent would still have to be sought in line with current legislation.
- The trust participated in the national RCEM audits so it could benchmark its practice against other emergency departments.
- As a result of audit findings, we were told how the department improved pathways and guidance. For example, we saw an audit of foot and ankle x-rays. This was discussed at the clinical governance meeting and identified that a high percentage of locum doctors were ordering x-rays inappropriately. As a result these now have to be discussed with a senior medical doctor to alleviate inappropriate x-rays being requested.
- Junior doctors were able to demonstrate ease of access to guidelines and found them clear and easy to use.
- The ED did not provide an acute service for patients who had a stroke. Patients who attended ED following a stroke were transferred to Scunthorpe General Hospital.

The ambulance service had a protocol in place to take patients directly to Scunthorpe ED. Patients returned to the Diana Princess of Wales hospital stroke unit for rehabilitation.

Nutrition and hydration

- During our inspection patients were not routinely offered food and drinks. An HCA told us that patients did get offered food and drinks regularly and that was part of the HCA role. Out of 33 sets of notes, only one had documented that a patient had a drink of water; therefore we were not assured patients had adequate nutrition and hydration whilst they were in the emergency department for a long period of time.
- Sandwiches were available for patients and there were facilities for making toast and drinks.
- Baby food could be accessed from the children's ward if needed.

Pain relief

- Staff used a pain score tool to assess if a patient had pain. Pain was scored as zero for no pain, up to 10 for severe pain.
- We reviewed 26 sets of adult patients' notes for the completion of pain scores. 19 records did not have a documented pain score. We did find evidence that pain relief was given on 13 of the patient's prescription charts; one had stated pain relief was declined. It was not possible from the records, to determine if patients required pain relief.
- The patients we asked were happy with the pain relief they had received.
- From the seven paediatric notes we checked two children were offered pain relief within 20 minutes of arrival and those in severe pain reassessed every hour (RCEM management of pain in children 2013) (an annual audit is recommended). We were unable to ascertain if the other children had pain.

Patient outcomes

- The RCEM has a range of evidence based clinical standards to which all emergency departments should aspire to achieve to ensure optimal clinical outcomes. The emergency department had participated in a number of audits to benchmark their performance against the RCEM standards.
- In the 2015 RCEM audit for assessing cognitive impairment in older people, the site was in the lower

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quartile compared to other hospitals for three of the six measures and was between the upper and lower quartiles for one of the six measures. The site was not rated for two indicators. The site did not meet the fundamental standard of having an early warning score documented. The measures for which the site performed in the lower quartile were, early warning score documented (49%), cognitive assessment tool place (1%), structured cognitive assessment tool used (0%)

- In the 2015 RCEM audit for initial management of the fitting child, the site was in the lower quartile compared to other hospitals for three of the five measures and was in between the upper and lower quartiles for two of the five measures. The site did not meet the fundamental standard of checking and documenting blood glucose for the fitting child. The measures for which the site performed in the lower quartile were child managed according to APLS or EPLS algorithm (proportion of children actively fitting on arrival) (80%), presumed aetiology recorded (all audited patients) (90%), proportion of discharged patients whose parents/carers were provided with written safety information (all audited patients) (0%)
- In the 2015 RCEM audit for mental health in the ED, the site was in the upper quartile compared to other hospitals for one of the eight measures, in the lower quartile for five of the eight measures and between the upper and lower quartiles for the other two. Of the two fundamental standards included in the audit, the site did not meet the fundamental standard of having a documented risk assessment taken. The site met the fundamental standard of having a dedicated assessment room for mental health patients. The measure for which the site performed in the upper quartile was details of any referral or follow-up arrangements documented (84%).
- The measures for which the site performed in the lower quartile were: Risk assessment taken and recorded in the patient's clinical record (22%). History of patient's previous mental health issues taken and recorded (68%). Mental state examination taken and recorded (10%). Patient assessed by a mental health practitioner (MHP) from organisation's specified acute psychiatric service (42%), Assessed by MHP within 1 hour (0%).
- In the 2015/16 RCEM audit for Procedural Sedation in Adults, the hospital was in the top 20% compared to

other hospitals for one of the seven standards, in the bottom 20% for three standards and in the middle 50% for the remaining three standards. The hospital did not meet any of the fundamental standards set by RCEM.

- In the 2015/16 RCEM audit for VTE Risk in Lower Limb Immobilisation in Plaster Cast, Diana, Princess of Wales Hospital was in the middle 50% compared to other hospitals in the one of the two standards. The trust did not submit data for the remaining fundamental standard.
- In the 2015/16 RCEM audit for Vital Signs in Children, the Hospital was in the upper 20% compared to other hospitals for one of the six standards and in the middle 50% for four standards and did not submit data for the remaining standard. The hospital did not meet either of the two fundamental standards set by RCEM.
- In September 2016, two months prior to our inspection, the trust was recognised as being an outlier for deaths from septicaemia (except in labour). The trust has provided a detailed action plan to investigate and address this. We saw evidence that learning from audits was discussed at the teaching sessions and 'topic of the month' was sepsis.
- The Commissioning and Quality Innovation (CQUIN) framework supports improvements in quality and patterns of care in specific identified areas of care and treatment. In order to achieve CQUINS, the service provider must submit evidence that they are meeting the requirements on a quarterly basis. Screening for sepsis CQUIN from April 2015 to March 2016 showed an average of 83% of patients were adequately screened. The percentage of patients given timely antibiotic treatment was average 59%.
- The department had joined the North Yorkshire and Humber Trauma Network. Trauma networks are set up to deliver specialist treatment to patients with major trauma such as severe heads injuries within a specified geographical area. A requirement of being part of the network to improve and share best practice. The department submits data to the Trauma Audit and Research Network (TARN) on an annual basis. We saw evidence of improvements made. For example as a result of the audit it was noted there was no documentation to suggest if tranexamic acid was considered. (This is a drug used in major trauma to help stop bleeding). A sticker was placed on each set of ED trauma documentation where the doctor can document if this was considered.

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- Between September 2015 and August 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally worse than the England average. In the latest reporting period, trust performance was 9.7% compared to an England average of 8.1%.
- A current RCEM audit for consultant review prior to discharge for adults with non-traumatic chest pain, febrile children under 12 months, unplanned readmissions within 72 hours, unplanned re-attendances within 7 days was ongoing. The trust was unable to supply us audit results as this was an ongoing audit.

Competent staff

- We were told 83% of nursing staff had received an appraisal. However, this figure included nine new staff. The department had a plan in place to ensure that at the end of December 2016, 100% of all new staff will have had their appraisal completed.
- All medical staff should receive an annual appraisal. 86% of medical staff had received an appraisal
- We were told all new staff received a trust induction.
- New nursing staff worked through an emergency department competencies booklet. This contained 27 basic assessment skills of presenting complaints staff must attend the training sessions and have three competencies signed by a senior member of staff.
- A preceptor supported their learning, and they had a supernumerary period of time that varied depending on their previous experience and learning needs.
- Consultants provided teaching sessions for all staff Wednesday and Friday mornings. These took place at the nurses' station and covered a variety of topics including recent incidents, learning from audits and new changes in practice.
- Revalidation is the new process that all nurses and midwives in the UK will need to follow from April 2016 to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practicing. Nursing staff were aware of the revalidation process.
- We were told any new doctor who worked at the trust completed an induction checklist. This contained orientation, equipment, procedures, infection control and fire procedure

- Medical staff have been required to undergo a revalidation process with the General Medical Council (GMC). The trust had a process in place to support medical staff in revalidation procedures.

Multidisciplinary working

- We observed good working relationships between medical and nursing staff in the department. Staff appeared to communicate and work cooperatively between all areas of the emergency department.
- We observed effective communication between nursing and medical teams at their daily huddle and the teachings that took place. We saw staff at all levels within both nursing and medical teams were encouraged to contribute.
- Clinical nurse specialists came to the department to provide clinical expertise and review patients if needed, for example the diabetic specialist nurses
- The critical care outreach team attended the department to help care for patients who were critically ill and offer advice and support to nursing staff.
- The mental health team came to the hospital site to provide assessment to patients with mental health needs.
- A rapid response 'core care links' team attended ED 24 hours a day seven days per week. This team reviewed patients and supported safe discharge, liaising with the community team and could arrange intermediate care placements and 'night rovers' who was part of the district nursing team who would check on patients during the night.

Seven-day services

- The adults and children's ED was operational 24 hours a day, seven days a week.
- The emergency department had x-ray facilities within the department, which could be accessed 24 hours, seven days a week.
- CT scans were available from 7.30am to 8.30pm seven days a week. There were on site radiographers providing 24 hour a day seven days a week cover for CT and Physiotherapy services were available seven days a week and an on call service was provided 'out of hours'.
- Pharmacy services were provided seven days a week and an on call service was available out of hours.
- There was seven-day access to pathology services.

Urgent and emergency services

- MRI scans were available from 7.30am to 10.30pm Monday to Friday, and 7.30am to 8.30pm Saturday and Sundays.

Access to information

- Patients' hospital notes were kept on site and were easily and quickly available from the medical records department.
- A discharge letter was generated and emailed to the GP within 24 hours.
- In the department, at the coordinators station, there were electronic screens that displayed the status and waiting times of all patients in the department.
- By using the trust's intranet, staff had access to relevant guidance, pathways and policies.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where possible, doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.
- Doctors gained written consent from patients who required sedation.
- Training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included within the mandatory safeguarding training.
- We spoke with nursing and medical staff. They were able to describe the relevant consent and decision making requirements relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Standards (DoLS) in place to protect patients. Patients' consent was obtained as per trust procedures.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment. Staff used Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children. The 'Gillick Test' helps clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and

alternative courses of actions. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Are urgent and emergency services caring?

Good



In the last inspection in 2015, caring was not assessed. During this inspection we rated caring as good because:

- The emergency department provided a caring and compassionate service. We observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful.
- Feedback from patients, relatives and carers was consistently positive. Patients told us staff in the emergency department kept them well informed and involved them in the decisions about their care and treatment.
- Care was person-centred and staff were observed to provide care which maintained dignity and privacy.

Compassionate care

- We observed patients being treated with privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed.
- We observed a number of interactions between staff, patients and relatives. Staff were always polite, respectful and professional in their approach.
- We observed staff responding compassionately to patients pain, discomfort, and emotional distress in a timely and appropriate way.
- We observed patients who were waiting in ED a long time placed on beds to make them more comfortable.
- Confidentiality was respected in staff discussions with people and those close to them.
- The trust's urgent and emergency care Friends and Family Test performance (% recommended) was generally worse than the England average between August 2015 and July 2016. In the latest period, July 2016 the trust performance was 81.8% compared to an England average of 85.4%. The trust has seen fluctuating trends over the last year, with a steady decline in performance over the last four months.

Urgent and emergency services

Understanding and involvement of patients and those close to them

- Patients told us staff ensured they understood medical terminology and patients were given literature about their condition when required.
- Each cubicle had a 'hello my name is' board which informed the patient the name of the consultant, staff nurse and healthcare assistant who was caring for them.
- Most patients who used the service felt involved in planning their care, making choices and informed decisions about their care and treatment.
- Staff generally communicated in a way that people could understand and was appropriate and respectful.
- We found medical staff generally took time to explain to patients and relatives the effects or progress of their medical condition and treatment options.
- We observed staff modifying their language, tone and pace of speech to communicate with patients and their relatives to help them understand their care and treatment.
- Patients and relatives told us they were kept informed of what was happening and understood what tests they were waiting for.
- We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred.

Emotional support

- We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.
- There was support available for the bereaved from the multi-faith chaplaincy service.
- The spiritual needs of patients were provided by a 24-hour chaplaincy support that provided sacramental care in the trust chapel and at the bedside and through supporting patients at the end of life.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement



In the previous inspection we rated the responsive domain as requires improvement. At this inspection we rated it as requires improvement because:

- The department was not meeting the Department of Health standard which states that 95% of patients should be treated and discharged or admitted within four hours of arrival.
- Between November 2015 and October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust, was worse than the England average for six out of the 12 months (January 2016 to June 2016).
- Between September 2015 and August 2016, the Diana Princess of Wales hospital median percentage of patients that left the hospital before being seen for treatment was worse than the England average for 10 months out of this 12 month period.

However:

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for 10 months over the 12 month period
- Between September 2015 and August 2016, the trust's monthly median total time in A&E for admitted patients was consistently worse than the England average.
- Patients' complaints were managed in line with trust policy and feedback was given to staff.
- Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people.
- A play specialist/HCA role was in place to support children. There were toys and a distraction box that was used to distract children requiring procedures.

Service planning and delivery to meet the needs of local people

Urgent and emergency services

- Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people. For example, the trust worked with external partners to provide access to primary care services via the urgent GP clinic that was adjacent to the ED. This was in line with RCEM guidance on how to achieve safe, sustainable care in emergency departments.
- The department had developed networks with external providers to deliver increased mental health provisions for the local population.
- The ambulance handover area and the implementation of the streaming nurse delivered an effective initial assessment and triage of patients creating improved flow through the department.
- The separate children's waiting room in the paediatric assessment unit provided good segregation for children away from the adults' waiting area.

Meeting people's individual needs

- Separate male, female and disabled toilets and baby change facilities were available in the waiting room.
- The department was accessible for people with limited mobility and people who used a wheelchair.
- The reception area had a designated hearing loop.
- A play specialist/HCA role was in place to support children. There were toys and a distraction box that was used to distract children requiring procedures.
- A separate waiting area for children in the paediatric assessment unit provided toys and segregation for children from adults.
- Within the waiting room, there were vending machines that contained cold and hot drinks, chocolate and crisps.
- The IT system had a flagging system. This included identifying patients with dementia or a learning disability, to allow staff to put in place support and ensure they are nursed in a suitable place.
- Staff told us if they had a patient with a learning disability or dementia, they would encourage their carer to stay with the patient to help alleviate any anxieties and try and expedite the patient's journey through ED. During the time of inspection, we did not see a patient with a learning disability or dementia.
- There was a link nurse in the department for learning disability and dementia.
- We were told special equipment was available as a distraction for patients with dementia.
- The department had information on dementia and leaflets from the local dementia group.
- Learning disability passports were used. A quality matron was a learning disability lead.
- Some trolleys were able to be used for patients with a weight up to 250kgs. A hoist, bed and bariatric wheelchair were available if needed from the hospital.
- A range of information leaflets were available for patients to help them manage their condition after discharge however, leaflets were available in English only.
- Interpreting and translation services were available. These could be either face to face or by telephone.
- Training was arranged to take place in December 2016 and January 2017 to teach staff basic sign language.
- There was a relative's room and on request, relatives could access a telephone. Hot and cold drinks were offered and available on request. The relatives' room was next to a viewing room for deceased patients providing direct access to people who wished to see their loved one.
- A mental health assessment room had an alarm around the wall for staff to sound if they were concerned. It had a link door to the next cubicle which could be locked from the other side, to provide two access routes. The room could have equipment removed if necessary so no ligature points were available. The mental health team could be accessed 24 hours per day seven days per week. During the inspection we did not see a patient with a mental health problem.

Access and flow

- The bed management team observed flow within the emergency department and at least four meetings took place a day (more frequently if needed) to understand the bed situation to enable planning for expected admissions and discharges, ensuring patient flow throughout the hospital was timely.
- An escalation process was in place that gave staff actions for how to manage the department during periods of extreme pressure. This involved the wider hospital teams, including bed managers and senior managers improving the patient flow throughout the hospital and specialist teams reviewing patients in the ED.

Urgent and emergency services

- Patient flow coordinators were introduced. This was an administration role to help coordinate patients transferring to the wards.
 - There was a standard operating procedure in place for specialist waits. For example, if a patient was waiting for a surgical doctor to review them prior to possible admission to a surgical ward, if the wait for the doctor was over 30 minutes, the patient could go to the ward if a bed was available. This helped improve flow through the ED.
 - The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. Between August 2015 and July 2016 the department breached the standard in all months.
 - Between November 2015 and October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust, was worse than the England average for six out of the 12 months (January 2016 to June 2016). February 2016 was when DPoW had the highest percentage of patients waiting between four and 12 hours from the decision to admit until being admitted with 22.3% and in July 2016 it was 7.6%.
 - Between September 2015 and August 2016, the Diana Princess of Wales hospital median percentage of patients that left the hospital before being seen for treatment was worse than the England average for 10 months out of this 12 month period.
 - The percentage of A&E attendances at this trust that resulted in an admission was lower than the England average 2015/ 2016. The England average has slightly decreased from 2014/2015 to 2015/16 however, the trust's attendances resulting in admission had remained consistent.
 - Between September 2015 and August 2016, the trust's monthly median total time in A&E for admitted patients was consistently worse than the England average. Performance against this metric showed a trend of decline from 125 minutes in September 2015 to 134 minutes in August 2016.
 - Patients who were referred by their GP with a medical problem, went straight to the acute medical unit for assessment, this reduced the number of patients attending the emergency department. However, during the inspection, because the acute medical unit was full patients admitted via their GP came to ED until a bed was available.
 - The department had admissions pathways to ambulatory care. Patients who presented to the emergency department were assessed by a clinician and if their symptoms suggested that they had specific conditions including cellulitis, deep vein thrombosis (DVT) and pulmonary embolisms (PE), they were directed to the ambulatory care centre.
- ## Learning from complaints and concerns
- The department had a complaints response process that addressed both formal and informal complaints, which were raised via the Patient Advice and Liaison Service (PALS). All complaints were answered fully with an assessment of root causes made.
 - Between September 2015 and August 2016 there were 81 complaints about urgent and emergency care services, 43 were for Diana Princess of Wales Hospital. The trust took an average of 56.2 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be responded to within an agreed timescale with the complainant but no longer than six months. Clinical treatment was the theme of 84% of complaints.
 - Response letters to complainants included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectation that services operate under a duty of candour.
 - Staff told us they were aware of how to deal with complaints and feedback was given in the huddle, within the team teachings, the staff meeting, the communication book and we saw evidence of discussion of complaints in minutes of governance meetings.
 - Patients and relatives we spoke with were confident about how to make a complaint to the trust.

Are urgent and emergency services well-led?

Requires improvement



At the 2015 inspection the well-led domain was not inspected as it was rated good in 2014. In 2016 we rated well-led in the emergency department as requires improvement because:

Urgent and emergency services

- The vision and strategy created since our last inspection was still in its infancy. The introduction of the streaming nurse had been in place for three weeks. The vision did not encompass key elements such as compassion, nursing care, patient safety and quality/
- There was disparity in the published time to initial assessment and what the trust sent us and what we found on inspection. The published data for the median time from arrival to initial assessment for patients arriving by ambulance was one minute compared to the England average of seven minutes. The trust has consistently had a median time of one minute each month. This did not correspond to the data the trust provided us about median waiting times from arrival to initial assessment, which averaged 13 minutes. When we raised this with senior managers on the inspection they could not tell us why the published data was one minute and how that figure had been derived.
- The risk register did not include all risks identified during the inspection and it was not clear who had responsibility for each risk and if any action plans were in place and being monitored.
- There was no matron dashboard to monitor patient safety and quality.
- NEWS and PEWS scores were not recorded regularly therefore, we could not be assured that the patients were having the appropriate level of monitoring whilst in the ED.
- Outcomes of RCEM audits are below expectations compared with similar services.

However:

- The emergency department had a clear management structure at both directorate and departmental level.
- Staff described the culture within the service as open and transparent. Staff told us it was a good place to work
- The department demonstrated areas of innovative practice.
- There was strong nursing and medical leadership at local level within the ED.

Leadership of service

- The emergency department was part of the medical directorate. The leadership of the directorate consisted of a triumvirate, composed of an assistant medical director, an assistant chief operating officer and an assistant chief nurse.

- A department manager had been in post for 15 months and provided strong nursing leadership. The staff spoke highly of the department manager and that she had an open door policy and they felt confident that they could voice concerns openly and they would be listened to.
- The trust had an operational matron and a quality matron who had overseen aspects of the department. The assistant chief nurse was visible in the department during our inspections.
- There was a high use of locum doctors and consultant cover was below the RCEM recommendations.
- The medical team had responsibility for audits in the department. Staff told us there was a strong educational resource provided by the senior doctors.
- From our discussions with staff, the local leadership was strong, supportive and staff felt they were listened to and felt valued. However, they did not always feel listened to by senior trust managers.
- Staff were motivated and described a supportive team-working environment.

Vision and strategy for this service

- The emergency department was part of the medical services directorate.
- The senior management team had a clear vision of an urgent care floor model although this was in its infancy. They described an acute physician model on the acute assessment ward. The vision did not encompass key elements such as compassion, nursing care, patient safety and quality. Not all staff were aware of the vision.
- The introduction of streaming for walk in patients which had been in place for a few weeks was successful and staff spoke of the benefits to patient care but were keen to keep the model which included the triage nurse.
- Staff were aware of the trust's values. They kept up to date reading the monthly magazine and could get information on the 'hub' computer system.

Governance, risk management and quality measurement

- A governance system was in place and the agenda items of the monthly emergency care business and governance meeting included discussions of incidents, complaints and lessons to be learned.
- A monthly medicine group governance meeting took place that had representatives from across site.

Urgent and emergency services

Discussions included ratifying operational group policies and procedures, NICE recommendations, audit programmes, risk register and incidents, lessons learned and complaints.

- A three monthly emergency department business meeting took place that incidents, lessons learned, complaints and any new initiatives.
- The Emergency Care Centre risk register was sent to us prior to the inspection. This had a total of six risks recorded at the time of our inspection. Each risk was graded, dependent on severity. There was one graded as high, which was relating to performance against the 95% standard. One was graded as moderate risk, which the recruitment of acute care practitioners who were all locums and they incurred a higher cost. Four were recorded as low risk.
- The risks on the risk register did not match the risks identified in the inspection, for example overcrowding of the department or medical and nurse staffing was not on the risk register.
- It was not clear who had responsibility for each risk and if any action plans were in place and being monitored.
- The department took part in locally agreed audits and they took part in Royal College of Emergency Medicine (RCEM) audits in 2016. Patient outcomes were below expectations compared with similar services.
- We saw evidence that learning from audits was discussed at the teaching sessions and 'topic of the month' was sepsis.
- NEWS and PEWS scores were not recorded regularly therefore, we could not be assured that the patients were having the appropriate level of monitoring whilst in the ED
- There was disparity in the published time to initial assessment and what the trust sent us and what we found on inspection. The published data for the median time from arrival to initial assessment for patients arriving by ambulance consistently had a median time of one minute each month. However, during the inspection, the records we examined informed us that the target was met for 16 out of 33 patient's notes we checked. These times were between zero and 86 minutes. Averaging 16 minutes. We tracked five patients during the inspection who walked into the department during the inspection. The average time to initial assessment was 13 minutes and eight patients who arrived by ambulance, the average time to initial assessment was 23 minutes.

- A trust wide monthly accident and emergency activity dashboard measured the number of attendances and the four-hour performance against the 95% standard.
- There was no matron dashboard used to monitor quality and safety performance.

Culture within the service

- Staff described the culture within the service as open and transparent.
- Staff told us it was a good place to work. The majority felt supported in their work and there were opportunities to develop their skills and competencies which were encouraged by senior staff.
- There was a desire from all staff we spoke with to provide effective care and treatment to patient.
- We observed staff working well together and there were positive working relationships with the multidisciplinary teams.
- We observed staff being flexible and helping in the different parts of the department which were busy to provide a better and more responsive service for patients.
- We asked staff at all levels about the morale of the department and they all said that morale was generally good and they worked as a team. There was a consensus that morale tended to be lower during periods of increased activity within the department.
- We saw evidence of how the service was working towards meeting the requirements related to the Duty of Candour and examples of where this had been carried out. Staff we spoke with felt that identifying when something went wrong could help them to improve patient safety and that when this did occur individuals involved were well supported through reflection, supervision and training and learning was shared.

Public engagement

- The trust took part in the 2014 CQC accident and emergency survey for patients. A questionnaire was sent to 850 people who had attended between January 2014 and the end of March 2014. Responses were received from 275 patients from the trust. There were no results specific to the DPoW site.
- The trust took part in the friends and family test.
- We were told the quality team had brought patients to the department to look at what could be improved.

Staff engagement

Urgent and emergency services

- We saw evidence trust wide of staff receiving recognition for their contribution to the service through internal annual awards ceremonies.
- Staff were encouraged to share experiences and comment on changes and ideas for improvement through the departmental meetings and huddles. However, staff told us it was difficult to have full team meetings as it meant staff attending on their days off.







Innovation, improvement and sustainability

- The department manager had a closed social media site which the staff had signed up to. This enabled the sharing of information to staff such as lessons learned, training programmes and any changes in working practices. If shifts needed covering, they would be posted on the site. An example was given of a video of a

teaching session by a crisis team worker. The manager could see who had viewed the site and received the information. Staff told us this was a great way to keep well informed and updated.

- An ambulance handover team, to see ambulance patients and provided an initial assessment had been established, and was providing a positive impact on the ambulance turnaround times.
- The streaming model had been introduced a few weeks prior to our inspection with a plan to continue with the model of streaming at the ED reception and working with the external providers GP out of hours to create an impact on reducing avoidable admissions and give timely assessment and pain relief.
- An acute physician model had been established on the acute admissions ward, short stay ward and ambulatory care. One of the benefits of this was to improve the four-hour standard in ED by improving patient flow.

Medical care (including older people's care)

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

Information about the service

Diana, Princess of Wales Hospital was part of Northern Lincolnshire and Goole NHS Foundation Trust providing medical care to people in Grimsby and the surrounding area. Three sites across the trust provided medical care services, these were Diana, Princess of Wales, Scunthorpe General Hospital and Goole and District Hospital. Medical care services at the hospital site of Diana, Princess of Wales, provided care and treatment for haematology/ oncology, general medicine, cardiology, respiratory medicine and gastroenterology. There were 195 beds located within eight wards.

Between April 2015 and March 2016, there were approximately 46,741 medical admissions across the whole trust. A total of 18,189 admissions were in relation to general medicine, 7,716 gastroenterology and 6,418 for medical oncology. Emergency admissions accounted for 48%, day cases 49% and elective admissions 3%. Around 50% of medical admissions were at Diana, Princess of Wales Hospital.

A new cardiology unit was opened in August 2015 which provided both outpatient and day case cardiology services at the hospital. The unit contained a cardiac catheter laboratory with a 12 bedded day case area, which provided angiography work for coronary disease and operations for new pacemakers and other cardiac devices. There was also a coronary care unit within the hospital and an endoscopy unit.

The medical wards specialised in certain conditions, these included:

- C1 Kendall - general medicine and cardiology
- C1 Holles - diabetes, endocrinology and Parkinson's Disease
- C5 - respiratory
- C6 - elderly medicine and gastroenterology
- Stroke unit – acute stroke and rehabilitation
- On site was the Amethyst Unit which included Amethyst Ward, which specialised in haematology and oncology and day cases for patients receiving chemotherapy treatments.

During our inspection an overflow ward, ward C8 was in operation. This had four bedded areas and was opened to provide extra beds due to patient demand. This area had also been open from January 2016 to August 2016. One registered nurse and one healthcare assistant provided nursing care to these patients.

There was an acute medical unit (AMU) which had 39 beds split into two parts; assessment and short stay. The unit provided an area for intensive work to stabilise patients and be transferred to another medical ward or to be discharged home within 24 hours of admission. There was also an ambulatory care unit (ACU) open Monday to Friday 8am to 6pm and discharge lounge on site.

During the inspection we looked at 19 patient records, 23 prescription charts, spoke with 19 patients and relatives, and 43 staff including doctors, nurses, therapists, care support workers, ward managers, matrons, administrative assistants and student nurses. We also attended nurse handovers and team meetings. We visited all of the medical wards including AMU, coronary care unit (CCU), cardiology day unit, endoscopy unit and discharge lounge.

Medical care (including older people's care)

We attended a number of staff focus groups and observed care being delivered on the wards we visited. We observed care using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care, which helps us understand the experiences of people who may find it difficult to communicate. Before the inspection, we reviewed performance information from, and about the trust. We also carried out an unannounced inspection on 17 October 2016 and 8 December 2016.

A comprehensive inspection of Diana, Princess of Wales was previously carried out in October 2015; all five domains were inspected for medical care services. Effective, caring and well led were rated as good and safe and responsive as requires improvement, The overall rating for the service was rated as requires improvement.

Summary of findings

We rated this service as requires improvement because:

- There were high numbers of patients cared for on non-medical or non-speciality wards with no reduction in numbers since the last inspection. High numbers of patients were moved between wards late at night due to the demand for beds. The medical review of these patients was variable and when patients were moved between wards, their care would change to a different consultant.
- Waiting lists for procedures were increasing and some patients we spoke with identified that they had long waits for their appointments.
- Some patients' procedures were cancelled on the day because of a lack of time and this had an impact on the patient's emotional state.
- There were inconsistencies in the effectiveness and the quality of leadership and as a result the endoscopy unit had lost Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.
- The buddying system for medical patients on non-medical wards was not embedded and some staff were confused as to who to contact.
- Staff did not have regular team meetings where they could formally discuss issues or concerns.
- The risk register had not been kept up to date consistently through the year.

However:

- We saw improvements with the recruitment of nurses. As most vacancies had only recently been filled we were not able to see the full benefit of this to the services at the time of our inspection. Staff fill rates for the majority of the wards were within acceptable ranges.
- Patient outcomes in national audits showed that the site had better outcomes than the England average. Patients had a reduced level of readmission at the site in most admission categories.
- Most of the patients and relatives felt involved in their care and thought staff were compassionate about the care they provided. This was reflected in the response rate for the Friends and Family Test and the high percentage of respondents that would recommend the medical wards on the site.

Medical care (including older people's care)

- The number of mixed sex breaches had reduced since the reconfiguration of the service.
- Staff enjoyed working for the trust and identified that the ward managers and matrons were supportive.

Are medical care services safe?

Good



At the previous inspection in 2015, we rated the medical care services at Diana, Princess of Wales for safe as 'requires improvement'. At this inspection we rated safe as 'good' because:

- We saw improvements from the last inspection in regards to staff vacancies. We saw vacancy rates had improved and staff had been recruited, however some the nurses were new in post and completing a preceptor period. As a result at the point of inspection there were still some gaps to the planned level of nursing staff.
- Staff informed us that they would complete incident forms and received feedback. We saw examples of where practice had changed as a result of incident reporting. Staff were aware of duty and candour and we saw examples of where duty of candour was applied within incidents.
- Safeguarding processes were in place and staff were aware of how to keep patients safe and report any safeguarding issues.
- We saw improvements from the last inspection in regards to the checking of resuscitation and monitoring of fridge temperatures. Only a few small gaps of inconsistencies were identified.

However:

- Patients were not isolated and the policy was not followed when patients presented with symptoms of unexplained diarrhoea and vomiting. Risk assessments were not always completed such as bowels charts and specimens were not obtained in a timely manner.
- Audits identified that individual patient equipment was not used and that ward areas had been identified as dirty and dusty. There was inconsistency in the use of decontamination tape which is used to identify when equipment has been cleaned appropriately.

Incidents

- Between August 2015 and August 2016, there were 4,215 reported incidents in the medical care service across the trust. The majority of these (99.4%) resulted in no harm or low harm however, 19 caused moderate harm, two caused severe harm and four resulted in patient death.

Medical care (including older people's care)

- The most frequently reported incident category was recorded as implementation of care and ongoing monitoring or review. This accounted for 1,478 of the reported incidents. Patient accident was the second most reported category with 1,102 incidents.
- Most of the incidents (96%) were reported within the expected timescale of 60 days. There were 55 incidents which took longer than 90 days to report which was 1.3%.
- There were 11 serious incidents reported in the medical care services between August 2015 and August 2016, however only one related to Diana, Princess of Wales Hospital. Serious incidents are incidents that require further investigation and reporting.
- There were no never events reported in medical care services between August 2015 and August 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.
- Staff informed us that they would report incidents and the majority of staff would receive feedback. The feedback was given in different ways, some staff said they had individual feedback and other identified that they received information at handovers.
- We saw changes from incidents, for example appropriate staff could now access the cardiology day unit via a swipe card in the event of an emergency.
- We were told about a medication error that occurred on one of the wards, lessons were learned and all the appropriate steps were taken. Staff were trialling wearing tabards when completing the medication round to ensure that nursing staff were not disturbed. We also saw learning from another medication error and laminated posters were on show to identify the correct method of administration. The majority of staff could tell us about the incident that had occurred within the trust.
- There was a lessons learned folder created in the endoscopy unit area which contained details of the clinical support services learning lessons newsletter. Within the newsletter it contained three incidents regarding the endoscopy service. During our inspection it was identified that the ward manager had not discussed the incidents with the staff.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Most staff we spoke with understood the principles of duty of candour and the importance of being open and honest with patients. The trust had an 'Openness and Duty of Candour Policy' which set out the process for duty of candour.
- We reviewed one serious incident investigation and saw that duty of candour was part of the content of the report. The investigation identified that the family had been contacted by telephone and letter and kept informed of the progress through the designated family liaison staff member. On completion of the report, the family were invited to a meeting with the trust to provide an opportunity to talk through the content with the lead investigator. Part of the action plan identified that the trust had communicated with the family in regards to a meeting.
- Mortality and Morbidity meetings were held on a regular basis. We reviewed minutes from the stroke, cardiology and gastroenterology department's mortality and morbidity meetings, which showed discussion and learning points from the review of mortality cases. Within the stroke mortality meeting it identified how many deaths had occurred within the time period and the care every patient received was reviewed and summarised. The meetings also showed wider learning from other forms of feedback such as complaints, PALS and serious incidents.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots), catheter and urinary tract infections (CUTIs). Between October 2015 and October 2016, staff reported 116 pressure ulcers, 24 falls with harm and 34 catheter urinary tract infections in the medical care services across both hospital sites.
- All wards displayed their safety thermometer information for patients and visitors to see. On the stroke unit the amount of falls each month were documented; this ranged from 15 falls in March 2016 to

Medical care (including older people's care)

four falls in October 2016. Information for pressure ulcers identified that there were two pressure ulcers identified in August 2016 and none for September and October 2016.

Cleanliness, infection control and hygiene

- All the wards we visited displayed information regarding ward cleanliness and identified designated staff roles for the completion of cleaning items.
- We observed staff using appropriate personal protective equipment when completing clinical tasks. We saw that staffs' arms were bare below the elbow and correct handwashing techniques and sanitising hand gels were used.
- Hand washing facilities were available at the front of all ward areas and signage to remind people of the importance of handwashing. Handwashing basins and hand wash gel were available at various locations throughout the wards. We found that the dispenser outside the cubicle on Ward C8 was empty; staff rectified this when we told them.
- The trust provided methicillin resistant staphylococcus aureus infection (MRSA) and clostridium difficile audits for when patients had these infections. There had been no incidences of MRSA reported. We observed from the clostridium difficile audits that specific questions were asked to identify if the patient was isolated and risk assessments were in place such as bowel charts. Key themes were identified and other comments provided to be able to give feedback. We observed the audit had been completed three times on Ward C1 Kendall in March, May and June 2016 and received a compliance score of 83% for each of the months. Issues highlighted were that the patient was not isolated within four hours of the onset of symptoms, no access to mop and bucket or stool chart commenced. An audit was completed for a patient on Ward C5 with 100% compliance rate and feedback was given that it was an excellent audit.
- During our inspection, wards were closed due to an outbreak of Norovirus and Rotavirus. We saw that infection control nurses obtained samples from the appropriate patients and completed a report following the outbreak. This highlighted that the first patient on ward C1 Kendall showed symptoms three days before the ward was closed due to further patients acquiring the symptoms. The patient was unable to be isolated

due to lack of facilities and discussion took place with site management. This did not follow trust policy which identified that patients with unexplained diarrhoea and vomiting must be isolated.

- The report identified that equipment on ward C1 Kendall had been noted to be dirty during the previous three months and individual patient equipment was not used and there was no evidence of cleaning between patients. This meant that the ward was not following the correct procedures and that infection control measures were at risk. The report also highlighted that specimens were not all obtained in a timely manner.
- We reviewed the monthly matron audits from June to August 2016 that were carried out on the wards. There was inconsistent use on applying decontamination tape on CCU, C1 Kendall, Amethyst and C5. Bed frames, fans and shelves were found to contain dust in the same ward areas.
- A domestic cleaner was not available for a period of time to clean the room following a procedure performed on a patient who was known to have clostridium difficile. The patient was last on the morning list and the room was left out of use from lunchtime to 5pm, however it was identified that the area would have been used if a patient with an urgent gastrointestinal (GI) bleed presented. The incident was escalated to the appropriate managers and meetings.
- All staff were required to complete infection control training, and the trust target was set at 95%. Within the medical care services, 73% of staff had completed the training.
- Clinical areas participated in monthly audits which focused on ten key elements; these included hand hygiene facilities, environment, waste disposal and sharps safety. We reviewed the audits for AMU and cardiology day case unit between January 2016 to August 2016 and found overall compliance between 86% and 100%.
- We found that the cleaning schedule for the water fountain in the cardiology day unit was completed correctly.
- In the cardiology day unit, we observed that a patient, who had previously had a clostridium difficile infection, was to have their procedure carried out last. The theatre and bay area were to be deep cleaned following this.

Environment and equipment

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- The trust had an electronic medical devices register which identified where equipment was stored and the frequency of the service required. The register logged when the equipment was serviced along with the asset and serial number identification labels. The trust had a policy for maintaining equipment which outlined the process to follow when repairs to equipment were needed. We checked equipment such as hoists, infusion pumps and machinery during our inspection and found them to be serviced correctly and the dates recorded appropriately.
- Staff said that equipment to meet patient's needs were available, this included the appropriate pressure relieving equipment. Equipment to prevent falls such as sensor pads and low level beds was available on all of the wards, although on Amethyst Ward we were told that three of the sensor pads were broken.
- The layout of some of the wards, for example Amethyst Ward, meant that the cubicles were closest to the nurse's station and more visible rather than the bay areas. This meant that it was more difficult to observe patients in the bays. Wards C1 Kendall and C1 Holles shared the same store rooms due to lack of space and the storeroom was found to be cluttered with IV bags on the floor.
- Resuscitation equipment was available on all of the wards; we reviewed the monthly matron audits from June 2016 to August 2016 and found that most of the days had been recorded. We identified that there were small gaps in the daily recordings. For example in August 2016 there were two days on AMU where the daily checks were missing from the checklist. On C1 Holles three daily checks were missing in July 2016 and two in August 2016.
- We checked the sluice area in CCU and cardiology day unit and found it to be clean and clutter free. Ward areas appeared to be clean and well organised.
- We checked the controlled drug medication storage on wards, in the discharge lounge and the cardiology unit and found the record books to be completed correctly. Regular balance checks of controlled drugs were performed in accordance with the trust policy.
- At our inspection in October 2015, we found that there were issues regarding the monitoring and controlling of drug fridge temperatures. As a result the fridge temperatures were checked as part of the monthly audit by the matrons and documented. We reviewed the audits and found there were some gaps in the monitoring. Within the audits for July 2016 on Amethyst ward and cardiology it highlighted that there were multiple dates missing from the fridge. In AMU the fridge temperatures were recorded regularly but no actions were identified if the temperature was out of the approved range.
- On inspection we checked the arrangements for medicines requiring refrigeration. On ward C1 Kendall and the stroke unit, fridge temperatures had been recorded which were above the recommended range. No action had been recorded by ward staff. In addition, there were gaps in temperature records on the stroke unit on three days in October and nine days in September 2016. This meant staff were not following the trust policy for monitoring medicines requiring refrigeration.
- On ward C8 we saw that patients' medication was locked away to be administered, there was no storage on ward C8 for controlled drugs. If patients required controlled medication this would be accessed through CCU which was situated next to ward C8.
- All patients had a drug administration record. Within the record it allowed for the prescriber to identify the patient's allergies and also record when any medication was omitted.
- We reviewed 23 prescription charts, VTE assessments had been completed in eighteen of the charts. All the charts were legibly written, signed and dated.
- We identified gaps in five administration records where nursing staff had not signed medicines cards. This meant it was not possible to tell whether people had received their medicines as prescribed.

Medicines

- At our inspection in October 2015, we found there was a lack of safe storage facilities for medicines in the discharge lounge. During this inspection, we visited the discharge lounge where we found that medication was now kept in a locked cupboard until the patient was ready for discharge.

Records

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- Records were stored securely in lockable units; part of the nursing record was by the patient's bedside and easily accessible to complete care records. Other assessments were completed on the trust electronic system and could be seen within the ward area.
- We reviewed 19 sets of patients' records which included care bundles and risk assessments. Each patient had a medicine care plan bundle which included nine care plans such as pain, vital signs, anxiety, nutrition and hygiene. These were completed in all 19 sets of notes and in line with trust and professional standards.
- In some nursing records we found that the fluid balance was not always completed to identify the amount of fluid the patient had consumed.
- We reviewed two stroke care pathway patient records, these were a multi-disciplinary record. We saw evidence in both records that the patients received speech and language tests to identify if there were any issues with swallowing. Both records contained information about the patient's condition and assessments from physiotherapist, occupational therapists, nurses and doctors.
- Information was stored on the patient's electronic system and allowed for referrals to be triggered to specialist services such as dieticians.
- The trust had an adult pressure area management pathway which included a risk assessment and documented management plan for any pressure ulcers identified. We saw evidence that the risk assessment was completed for patients and reassessments. However, there was some confusion over measuring patient's wounds as one staff member commented that they thought it was the responsibility of the tissue viability team. We saw evidence that wounds were measured and documented in the patients' records.
- The trust completed a report in August 2016 that reviewed 41 patient records on medical wards. The audit reviewed that risk assessments were completed appropriately. The results showed that the majority of patients were commenced on pressure area pathways and followed. Moving and handling assessments were completed on most wards with CCU receiving 75% and C1 Holles 86%.
- Staff completed information governance training, with an overall compliance of 81%; the trust target was 95%.
- The trust had policies and procedures in place for safeguarding children and adults. Both policies were in date and provided staff with flowcharts to aid decision making and to ensure the correct processes were followed.
- Staff were aware of how to access the safeguarding policies and were clear about their safeguarding responsibilities. Staff knew how to contact the safeguarding team and felt they could access these for support and advice. Information regarding how to contact the team was available to patients, visitors and staff on the entrance to each ward area.
- Overall compliance with safeguarding training for staff providing medical care services at this hospital was 84%. Safeguarding adults training was 82%, safeguarding children level one, two and three was 84%, 87% and 67% respectively.

Mandatory training

- Newly trained and overseas nurses completed most of their mandatory training at an induction programme called Care Camp. Care Camp was a one week hands-on clinical education programme to ensure that all staff received the same training. We spoke with one staff member who identified that they had to complete moving and handling training prior to being able to provide patient care.
- We observed that some staff were booked in for the mandatory training required and they showed us evidence of their record.
- The trust's mandatory training and statutory programme included information governance, moving and handling, safeguarding adults and children, infection control, fire and resuscitation. The trust target for mandatory training was 95%. Training could be completed either face to face or online. Staff were also required to complete statutory training such as fire safety training. Overall compliance for mandatory training within the medical care service was 77%; the trust target was set at 95%. Mandatory training included resuscitation which was at 67%, harassment and bullying within the service was 90%. Moving and handling training was completed by 78% of staff within the service.
- We saw mandatory training figures displayed on some ward areas. On CCU it identified that training figures were reviewed in October 2016. Compliance with

Safeguarding

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conflict resolution training was 85%, blood transfusion 100% and moving and handling 55%. Staff on the unit would complete two different requirements for life support and these averaged at 72%.

- Mandatory training figures on the cardiology day unit were 97%, 85% on the endoscopy unit and 79% on AMU.

Assessing and responding to patient risk

- The trust used the National early warning score (NEWS) tool, which indicated when a patient's condition may be deteriorating and when they may require a higher level of care. We saw evidence that patients' scores were recorded and reviewed by doctors.
 - The trust completed a report in August 2016 that reviewed 41 patient records on medical wards. Part of the report looked at the NEWS scoring and identified that in all wards apart from stroke unit vital signs were recorded in accordance with the NEWS score. When the observations were outside of the NEWS score, 100% of patients' records on AMU documented the reason why. Four sets of patients' records on the stroke unit did not document why. The action taken in response to the NEWS score was fully documented on Amethyst, Ward C1 Holles and Ward C1 Kendall. In six records on AMU the actions taken were not fully documented. On Ward C5 only 67% of records identified the actions taken and 60% on Ward C6. On the stroke unit no actions were fully documented. The report does not identify any action plan in relation to the findings.
 - We saw that when patients had fallen, a post-falls assessment was completed and the patient was given red non-slip socks to wear. There had been an increase in the number of falls on Ward C6, which was due to a specific patient who had repeated falls and all the appropriate measures were in place including one to one care. However on other wards we were told that one to one care was not always available when required for patients.
 - Since the introduction of intentional rounding and the checking of patient's pressure area, avoidable pressure ulcers had reduced. Staff had access to small pocket mirrors which allowed them to observe hard to see pressure areas and assess the area more accurately.
- The trust used the safer nursing care tool as recommended by the National Institute for Health and Care Excellence (NICE) to calculate safe nurse staffing levels based on patients' level of sickness and dependency.
 - Twice daily safety brief meetings took place at the operational centre every day. The aim of this meeting was to ensure that minimum safe staffing levels were achieved in all areas. Senior staff attended safety briefings and each ward was given a rag rating of red, amber or green depending on their staffing levels. There was an escalation process in the event of vulnerable staffing levels. For any areas rated as red, bank or agency staff would be requested. Permission to do this would be escalated to director level for approval. Another option was to move staff from their substantive area to other areas to make this safe.
 - The trust reported they had 9.5% nursing vacancies on all the medical wards in July 2016 resulting in 40 whole time equivalent (wte) less staff than their allocated level and this had an impact on their staff fill rates. Overall the staff fill rates were 77.9% at Diana, Princess of Wales. We spoke with several ward managers about vacancies on the wards and were told that several had now been filled and staff were becoming competent within the role. Some staff were awaiting their PIN number as a registered nurse and were currently working as a band 4 healthcare assistant.
 - We looked at information provided by the trust for the period January 2016 to September 2016 for nurse and healthcare assistant fill rates. No data for June or August 2016 was provided. They identified that the registered nurse staff fill rates remained lower for the day shifts. A rating system was attached to the percentage of fill rates with red indicated as below 79%, amber 80 - 84% and green for above 85%. On the stroke unit, the registered nurse day staff fill rate was rated red each month and ranged between 70.9% and 80.5%. Most wards between January 2016 and May 2016 had registered nurse fill rates that were green and between 85.3% and 97.8%. However in July 2016 and September the staff fill rate had reduced to red and were between 73.7% and 81.7% for ward C1 Kendall, C1 Holles, C5 and C6. The night fill rates for registered staff were within the acceptable threshold above 85%. Healthcare assistant fill rates for both day and night time was also above 85% for most of the months.

Nursing staffing

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- On the stroke unit during the day, planned staffing levels were four registered nurses and four healthcare assistants to care for 25 patients. We were informed that staffing on the stroke unit was one nurse to eight patients plus the co-ordinator. When we visited the ward there were only three nurses and four healthcare assistants. Two supernumerary staff were also providing care on the ward; these were nurses waiting to receive their PIN number from the NMC. We reviewed eight weeks of rotas for the ward and found that on 25 days out of 56 the planned establishment was met with four registered nurses during the day. We observed staff completing extra shifts to meet the planned requirements. Bank and agency staff were requested to meet the shortfall.
- From information provided by the trust we could identify that new staff had commenced post on the stroke unit and the vacancy rate was 1.2 wte registered nurses however the vacancies for healthcare assistants had increased for November 2016.
- The staffing establishment for the stroke unit at night time was two registered nurses and three healthcare assistants. During our unannounced visit on 17 October 2016, actual staffing met planned staffing levels. This included one registered nurse and healthcare assistant employed through an agency. We were told that when staffing was at the correct level, staff were often moved to other wards where the need was considered greater. We looked at the nurse rota specifically at night shifts from 1 October 2016 to 31 October 2016 and found that on 14 occasions bank or agency staff had been requested to meet the required registered nurse staffing levels for the ward. In addition, only two days out of 31 had the correct amount of permanent healthcare assistants from the ward. We reviewed September 2016 rota and identified that only five days have the planned amount of healthcare assistants. Bank and agency staff were requested to meet the required level of staff; the staff fill rate for September identified that only 83.5% of shifts were filled.
- We reviewed staffing levels on Ward C6 from 1 October 2016 to 17 October 2016. The appropriate staffing levels were met on six days; the remaining days were reduced by one registered nurse. The staffing vacancy rate on Ward C6 had been previously 9.8% and had reduced to one registered nurse vacancy. Information provided by the trust identified that in October 2016 agency staff were used every day apart from five days. One registered nurse on the day of the inspection had been moved from the ward to cover Ward C8 leaving the ward with less than their planned allocation.
- Bank and agency staff were used daily on Ward C1 Kendall. There had been seven vacant nursing positions on the ward and the final vacancy had been recruited to recently. Four newly qualified staff had commenced in their role in September 2016, however they had to wait to receive their pin number to be able to practice as a registered nurse. The ward manager identified that the ward would be fully staffed by January 2017. On the day of the unannounced inspection we inspected ward C1 Kendall and the amount of actual registered nurses was three instead of the planned four nurses. One of the registered nurses on duty was an agency nurse who worked regular for the ward. We reviewed the nurse rota from 3 October 2016 for seven days and identified that on three days the planned requirement did not meet the actual amount of registered nurses on duty. Due to sickness on 9 October 2016 between 3.30pm and 7.30 pm only one registered nurse was on duty.
- On the day of the unannounced inspection we also inspected ward C1 Holles and the amount of actual registered nurses was three instead of the planned four nurses. We reviewed the nurse rota for a two week period from 26 September 2016 and identified that on eight days the planned registered nurse requirements were not met. On one day the planned nursing requirements were not met for the early and afternoon shifts. For six days the healthcare assistant planned requirements were also not met.
- Nurse staffing on AMU had improved since our last inspection in October 2016 where there were 10 nurse vacancies. During the unannounced inspection there were no vacancies on AMU however the ward had recently commenced seven newly qualified nurses in post and some were still awaiting their pin numbers from the NMC. Planned staffing on AMU was seven registered nurses during the day and six at night. We reviewed the nurse rota from October and found that on most days the actual amount of nurses was six. Staff commented during the inspection that the ward would often work with one less registered nurse.
- We reviewed the nurse rota for a two week period on CCU where actual staffing levels met the planned numbers. There was only one staff vacancy of a healthcare assistant on CCU; however some staff were

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not available to work due to maternity leave and sickness. We were told on the inspection that four newly qualified registered nurses had started on the unit in recent months. Agency staff regularly worked shifts on CCU and staff who currently worked on the ward would provide extra shifts to cover the staff shortage.

- Nurse staffing levels on the night shift had changed recently on CCU. The number of registered nurses had reduced from three to two overnight with the addition of a healthcare assistant to care for up to 10 patients. Staff commented that when the unit had three registered nurses, one would often be moved to cover on other wards.
- Nurse staffing within the endoscopy unit had improved following the inspection in October 2015. The unit were currently advertising 1.8 whole time equivalent vacancies. Bank staff were used to cover any gaps that were identified.
- Information provided by the trust identified that nursing bank and agency use in medical care was 1.8% at Diana, Princess of Wales.
- Within the cardiology day unit the same experienced bank staff were used on a regular basis, no agency staff were utilised.
- We observed that newly qualified nurses prior to receiving their PIN number were not counted within the registered nurse allocation for that day. We spoke with two newly qualified nurses who told us they started the role as a band 2 healthcare assistant and once confirmation had been received they had passed their student nurse course they increased to a band 4 level. Within this role they would provide care to a cohort of patients and perform the same duties as a registered nurse apart from administration of medication. New staff would be supernumerary for a period of two weeks.
- We observed a nursing handover which included all nursing staff, and covered a routine overview of each patient, ongoing condition and planned investigations. The staff received information verbally and on a typed handover sheet.

Medical staffing

- The percentage of consultants working at the trust in July 2016 was about the same as the England average and the proportion of middle career doctors was slightly higher. There was a lower proportion of registrars and higher proportion of junior doctors than the England average.

- We reviewed the medical staff rota and talked to registrars and junior doctors. The trust reported a vacancy rate of 26.1% in July 2016 at Diana, Princess of Wales Hospital. As a result the trust used locums to provide continuity of care to patients. Locum doctors were used on a regular basis in cardiology. We were told that the locums mainly completed the clinics and would see patient referrals. We spoke with some of the locums at the hospital who confirmed that they completed a proportion of shifts. Information provided by the trust identified that bank and locum staff had been used between August 2015 and July 2016 and accounted for 1.4%.
- Medical cover at night at this hospital was one registrar and two junior doctors (one FY1 and one senior house officer), supported by an on call consultant.
- There were three permanent gastroenterology consultants within the hospital. On one day during the inspection, no gastroenterologists were available due to sickness and planned annual leave.
- Acute Care Physicians (ACPs) were present in AMU from 8am to 5pm. During the inspection we also saw the ACPs working on Ward C8. Junior doctors were present and available 24 hours a day on AMU. On call ACPs were available from 5pm to 8pm and also 8pm to 8am. Middle grade registrars were also on call 24 hours a day.
- At the weekend there were two on call consultants who covered both days and nights. The on call day consultant was available from 8am to 8pm and the night consultant was available on call from 8pm to 8am.
- A discharge team was available at the weekend, which consisted of junior doctors and consultant working from 8am to 5pm to review patients who may have been fit for discharge.
- Some nursing staff reported that it was difficult for doctors to respond to routine tasks at night-time on the wards due to the demands of their workload and because they were busy admitting patients onto AMU. In one example staff called a doctor three times during the night but no one arrived until the morning.
- We observed a morning medical handover on AMU which was led by the day consultant and night medical staff. Each medical team attended the handover and discussed a proportion of the patients admitted to the ward identified on patient need. Staffing concerns were discussed and doctors were re-allocated by rota co-ordinators that were also in attendance at the handover.

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- Patients were reviewed every day in CCU by either a consultant or registrar. Staff were aware that they could contact the medical team with any concerns.
- We reviewed the on-call consultant rota for gastrointestinal bleeds from April 2016 to November 2016. This showed consultant cover for emergency or urgent endoscopy procedures Monday to Friday between 8am and 6pm. There were no gaps in cover provided during the week. The weekend was covered by an on-call consultant who would perform any urgent oesophago-gastroduodenoscopies within the allocated two hour time slot. We saw there was one Sunday and one bank holiday in May 2016 where there was no consultant cover. Agreement had been reached to remove consultants from the medical on-call rota in order to provide cover for a 24 hour GI bleed rota. This rota was not yet in place because managers were still in the process of negotiating 24 hour nursing cover.

Major incident awareness and training

- The trust delivered major incident training during induction for all staff. As of July 2016, 100% of staff on site had completed the training.
- The trust had a major incident policy and this was accessible to staff on the trust intranet. Staff confirmed they were aware of the policy and their role within it.

Are medical care services effective?

Good



At the previous inspection in 2015, we rated the medical care services at Diana, Princess of Wales for effective as 'good'. At this inspection we rated effective as 'good' because:

- Patients' pain and hydration needs were maintained and patients commented that they were responded to promptly for these.
 - We saw evidence of effective multidisciplinary team (MDT) working in all areas. We saw wards completed daily and weekly reviews of patients to review their individual needs.
 - Performance in national audits such as Myocardial Ischaemia National Audit Project (MINAP) and Lung Cancer Audit 2015 showed that the site had better outcomes than the England average.
- Readmissions rates at Diana, Princess of Wales were lower in most elective and all non-elective admission categories.

However:

- The endoscopy unit had lost JAG accreditation in August 2016 and was working on an action plan to meet the necessary requirements.
- The trust did not have 24 hour GI cover in place and ongoing work was in place to look at this.

Evidence-based care and treatment

- Policies and care pathways were based on Royal College of Physicians guidelines, cancer network and National Institute for Health and Care Excellence (NICE) guidance.
- The trust policy for non-invasive ventilation was in line with national / British Thoracic Society (BTS) guidance and during our inspection we saw care was delivered and staff worked in line with the policy.
- Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. They knew how to access the information and were provided with details when new policies were released. Of the three that we reviewed, all had identified author/owner and all had review dates.

Pain relief

- We observed staff respond to patient's pain requests promptly and effectively and patients commented their pain was managed well. We heard that patients arriving in the cardiology day care unit were asked about their pain levels.
- Nursing staff used and documented an evidence based pain score to assess patient's needs. We saw from patients care plans that pain was assessed on a regular basis. Pain was recorded as part of the intentional rounding.
- On reviewing 23 prescription charts, 21 patients were prescribed pain relief on the 'as needed' part of the prescription chart. This allowed the patient to receive medication for pain relief quickly to alleviate their symptoms.

Nutrition and hydration

- A Malnutrition Universal Screening Tool (MUST) was used on the wards and uploaded onto the patient

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electronic system identifying the risk. The computer system would identify when a reassessment was required. We observed that patients' MUST scores were completed.

- The trust completed a report in August 2016 that reviewed 41 patient records on medical wards. The report identified that only 50% of hydration assessment screens were completed within six hours on Amethyst ward, other wards achieved 100% compliance. MUST scores were recorded on the patients' records at 100% apart from C1 Holles that achieved 83%.
- Patients said they were offered different choices of food. We observed that soft diets were available and that the patient's nutrition status was recorded on a board above their bed. Patients had access to additional supplements as well as their meals, these consisted of drinks or dessert based products.
- Protected meal times were in place and we observed that patients were provided with their meals promptly and with assistance where needed. Drinks were provided at meal times and between meals; we saw that drinks were placed within patients' reach.
- On several wards we observed information displayed regarding healthy eating and leaflets were available.

Patient outcomes

- The hospital-level mortality indicator (SHMI) statistics from July 2015 to June 2016 showed that the SHMI remains in the 'as expected' banding with a figure of 110.
- In 2015, the trust was identified as a CQC outlier for patients dying from acute bronchitis and cardiac dysrhythmias. The trust provided a comprehensive report about the work they had undertaken to act upon the findings of the data. No further concerns relating to these conditions have arisen.
- In September 2016, two months prior to our inspection, the trust was recognised as being an outlier for deaths from septicaemia (except in labour). The trust provided a detailed action plan to investigate and address this.
- The endoscopy unit had lost their Joint Advisory Group (JAG) accreditation in August 2016 due to an audit that was not submitted within the necessary timescales and communication issues. The unit had an action plan in place to meet the actions required for reaccreditation.
- The trust participated in the 2015 Lung Cancer Audit and 90.5% of patients were seen by a cancer nurse specialist; the audit's minimum standard was 90%. The

proportion of fit patients with advanced non-small cell lung cancer (NSCLC) receiving chemotherapy was 61% and small cell lung cancer was 72.1%. Both of these figures were not significantly different to the national level.

- Diana, Princess of Wales Hospital took part in the 2013/14 Myocardial Ischaemia National Audit Project (MINAP). This site was the only site within the trust to have any metric score better than the England average; this was for NSTEMI patients seen by a cardiologist or a member of team and the site scored 100% compared to an England average of 94.3%.
- In the National Diabetes Inpatient Audit 2015, the site scored better than the England average in 14 metrics and worse than the England average in three metrics. The indicator regarding "Seen by the MDFT within 24" had the largest difference versus the England average.
- Diana, Princess of Wales Hospital completed the Heart Failure Audit 2015. The hospital scored better than the England average for three of the four standards relating to in-hospital care. It also performed better than the England average for four of the seven standards relating to discharge. Performance in the discharge indicator Referral to cardiology for follow-up was notably better than the England and Wales average with this site scoring 76% compared to the national average of 52.2%. Performance in the discharge indicator referral to cardiology for follow-up was notably better than the England and Wales average with this site scoring 76% compared to the national average of 52.2%.
- Between March 2015 and February 2016, patients at this site had a lower than expected risk of readmission for both non-elective and elective admissions. The only specialty that had a higher than expected risk of readmission was gastroenterology in the elective admission category. Elective admissions in medical oncology and non-elective admissions in geriatric medicine both had a notably lower than expected relative risk of readmission.
- The average length of stay for medical elective patients at Diana, Princess of Wales Hospital was three days between April 2015 and March 2016, which was lower than the England average of 3.9 days. For medical non-elective patients, the average length of stay was 7.5 days for the same time scale, which was worse than the England average of 6.7 days. Elective medical oncology had a longer average length of stay at the trust at 3.1 days compared to the England average of 1.6 days.

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Competent staff

- New staff had competency booklets where they would record and complete certain competencies. We spoke with two staff that had been in post since September 2016 but had not yet received their booklets.
- We saw that competent bank staff were used in areas where specialist skills were required such as cardiology.
- Training was available for staff to be competent in areas of oncology. Several staff had completed further training and had progressed into clinical nurse specialist roles.
- We were told by staff in the cardiology day unit that medical companies would provide training on new equipment so staff could learn and become competent in how to use the devices.
- Training packages for endoscopy nurses and healthcare assistants were being relaunched to ensure competency. Information provided by the trust identified staff within the endoscopy unit had recognised they needed support and extra training for discharging patients who had received upsetting results.
- Medical staff received training from the Deanery on a monthly basis. We were told that the trust did not provide any formal training but medical staff did talk about informal training from doctors that was good. Staff on Ward C5 told us that weekly training sessions were completed for medical staff by the consultants. Nursing staff on Ward C5 were competent in specialist skills such as blood gases and cannulas.
- Between April 2016 and August 2016, 64% of staff within medical care services at the trust had received an appraisal in the rolling programme compared to a trust target of 95%. The appraisal rate for the majority of staff groups showed an improvement compared to 2015/16. For example appraisal rates for nurses and administrative and clerical staff increased by 26% and 39% respectively. Appraisal rates for medical staff during this period had decreased by 11%.
- Appraisal completion rates reported by the trust for Allied Health Professionals (AHPs) were 0% for April 2016 to August 2016 and were not reported for the previous financial year.
- During the inspection, we saw that the appraisal rate within the cardiology day unit and Ward C1 Kendall was 100% and 94% on AMU. Data provided by the trust showed that 90% of staff within the endoscopy department had completed their appraisals.

- We spoke with two staff that had recently commenced work, they did not have a PDR booked in yet however, they had spoken with their ward manager and a future date would be set.

Multidisciplinary working

- We observed good multidisciplinary working (MDT) on all the wards. On the stroke unit a weekly meeting was held with various members of the MDT to discuss all the stroke patients on the ward and their rehabilitation needs. We also saw home visits completed by the occupational therapist and a thorough record of the details and requirements needed to help for discharge.
- Staff had access to specialist services in order to provide care to patients. The dietician visited wards daily to review patient's nutritional needs. The pharmacy team visited the wards daily during the week to check patient's medication charts and complete drug reconciliation.
- Each ward had a link nurse for tissue viability. These staff attended meetings and shared the information with staff in their ward area.
- Strong links were in place with community services with the introduction of specific respiratory pathways. Respiratory nurse specialists worked with the respiratory medical team and also with nurses on the main respiratory ward. They worked closely with their colleagues in the community to provide support for patients after they are discharged from hospital.
- Pulmonary rehabilitation and home oxygen services had been set up and put into place. The six week programme of exercise and education for pulmonary rehabilitation was provided by the multidisciplinary team. This offered patients the opportunity to gain better control of their breathing, increase their exercise tolerance and improve the quality of their lives and also that of their carers.
- One patient commented that when they moved wards from HDU to the stroke unit, the physiotherapist changed. The patient felt they had built up confidence and a rapport with the specialist and were aware of their capabilities.

Seven-day services

- The endoscopy service was working towards a 24 hour GI bleed service, in house cover was available Monday to Friday 8am – 6pm. Cover for out of hours upper GI

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bleeds was currently an on-call consultant available on the rota for a two hour slot both Saturdays and Sundays normally between 11am and 1pm, however this could vary for individual consultants. Any urgent GI bleeds out of these times were to be sent as agreed to another local hospital.

- The endoscopy unit was open six days a week, Monday to Saturday and an on call service for Sundays. A business case to move endoscopy services to seven days had been completed.
- Ward rounds were in place every day and a discharge team was available on a weekend to identify any patients fit for discharge.
- Physiotherapists provided treatment seven days a week plus an on-call service was available overnight. Although it was highlighted that on the stroke ward the service was only available five days a week.
- Imaging and pathology services were accessible 24 hours a day, seven days a week.
- Pharmacy services were available seven days a week including bank holidays. The service did not visit all the wards at weekends; they targeted wards with new patient admissions.

Access to information

- The trust had an information management and technology strategy which included the trust's patient electronic system. The system collated information on each ward such as staffing, patient dependency and individual patient risk assessments.
- We saw that the patient's electronic system was accessible to all staff and they felt confident in using the system. The system allowed staff to easily view both scans and X-rays.
- Some staff identified that they could access their work emails at home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Within the patient's admission document it highlighted whether the patient had capacity to consent to treatment. We saw that in the notes we reviewed that this section was completed appropriately.
- We observed staff obtaining verbal consent and giving an explanation prior to completing a procedure. Patients we spoke with also said that staff asked for consent prior to delivering care.

- Patients who required a Deprivation of Liberty Safeguards (DoLS) in place were correctly completed with the appropriate urgent and standard DoLS applications. Staff said they linked with the mental health teams in the completion of the forms and we spoke with staff that had completed them. Staff completed an incident form for patients that required a DoLS.
- Mental Capacity Act assessments were completed and in place identifying why the patient did not have mental capacity. We saw that capacity assessments and possible DoLS applications were discussed at nursing handovers.
- We saw the correct forms completed for patients who lacked capacity and required procedures completing. These forms were signed by two consultants.
- A CCTV monitor was in place for the single cubicle on CCU that could not be visually seen from the nurse's station. The trust's policy and information was displayed outside the room to inform patients and relatives that the monitor was in use but no recordings were made. We were told that verbal consent was taken and documented in the patient's notes. We reviewed the patient's record that was in the room at the time of inspection but no consent was documented regarding the CCTV monitor. It was identified on the unit's improvement board that staff needed to document within the patient's record regarding consent for the CCTV.
- Staff completed DoLS training with an overall compliance of 80% and Mental Capacity Act training was 83% across the trust within the medical care services. Training by the mental health provider was provided to staff regarding mental health awareness following an incident that had occurred.

Are medical care services caring?

Good



At the previous inspection in 2015, we rated the medical care services at Diana, Princess of Wales for caring as 'good'. At this inspection we rated caring as 'good' because:

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- Patients and families told us that they received compassionate care and that staff supported their emotional needs.
- Staff provided care and compassion to patients and relatives and patients provided us with positive examples of care they had received.
- We observed staff maintaining the privacy and dignity of patients when providing care.
- We saw evidence that patients and families were involved in care planning.
- Results from the Friends and Family Test identified that between 90% and 100% of respondents would recommend the ward.

Compassionate care

- We spoke with 19 patients and relatives who spoke positively about the care they received on the ward. Patients described staff as being very helpful and supportive of their needs. Relatives said they felt informed and believed that the care patients received was good.
- We observed staff interacting with patients in a caring and compassionate manner. Staff engaged with patients to introduce themselves and listened compassionately to patient concerns.
- We observed that staff respected the privacy and dignity of patients. Curtains were drawn around patient's bed when care was being delivered and staff provided the suitable clothing to change into for procedures.
- One relative identified that the patient was hard of hearing and staff accommodated their speech in order for the patient to hear at the correct level and understand.
- One patient said, "The care I received was very good, anything you ask for is given even though the staff are rushed off their feet".
- Some of the comments from patients included, "staff are always changing water jugs", "nursing staff have been really good" and "care has been excellent".
- We observed patient call bells were within reach and staff responded in a timely and respectful manner to patients' requests.
- The Friends and Family Test response rate between November 2015 and September 2016 for medical care services at the trust was 52% which was better than the

England average of 25%. All trust sites had a higher response rate than the England average and the majority of wards had recommendation rates of 90% to 100%.

- In response to feedback from patients, ear plugs and eye masks are provided on various wards. One patient told us that they had spoken to the ward matron due to concerns over noise and disturbance. The matron listened and acknowledged the issues and worked with the patient to be moved to a more appropriate setting.
- We observed various amounts of thank you cards and feedback from patients and relatives on the wards.

Understanding and involvement of patients and those close to them

- Patients told us that the medical staff were clear in their explanation of the care and involved the patients during the consultations. One patient told us that they were extremely happy with the way the medical staff was open and honest.
- We saw evidence in patient's records that decisions had been discussed with both patients and relatives. Patients confirmed that they felt doctors and nurses communicated well together.
- One patient commented that they found information regarding their condition was a lot to take in, however they felt staff had been patient and explained things thoroughly.
- Two patients told us about their discharge plans and they understood how to manage their condition at home.
- On CCU a patient quality survey was completed every month and the results displayed. The results for October 2016 revealed that 85% of patients felt included in the decisions and 90% found the amount of information sufficient. Ninety six per cent of patients identified the information was given in a way that was easy to understand.

Emotional support

- A chaplaincy service was available to provide pastoral, religious and spiritual support for patients and relatives. We were told that chaplains and volunteers would visit the wards on request or as part of their routine visits.
- Nurse specialists provided psychological support to patients with new and ongoing diagnoses.

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- We heard good examples of staff providing additional emotional support to patients. For example a discussion took place regarding a patient's DNACPR status and the patient said they felt involved in the conversation and were provided with support with the decisions agreed.

Are medical care services responsive?

Requires improvement



At the previous inspection in 2015, we rated the medical care services at Diana, Princess of Wales for responsive as 'requires improvement'. At this inspection we rated responsive as 'requires improvement' because:

- Patient flow through the hospital remained an issue with a significant number of patients cared for on non-medical or non-speciality wards with no reduction in numbers since the last CQC inspection.
- High numbers of patients were moved wards late at night and into the early hours of the morning.
- The trust's referral to treatment time (RTT) indicator for admitted pathways for medical services was worse than the national indicator and the England average performance. Figures for October 2016 showed 74.9% of this group of patients were treated within 18 weeks.
- Waiting lists for cardiology and endoscopy procedures were lengthy and patients commented that they had waited long times for their appointments.

However:

- AMU had been reconfigured and no mixed sex breaches had occurred since the change.
- Staff members provided us with examples of specific complaints and explained how practice and staff had changed as a result.

Service planning and delivery to meet the needs of local people

- Wards had designated visiting times in order to ensure that meal times were protected.
- Some ward areas had overnight facilities for patient's relatives to stay the night. We saw that two patients with learning disabilities had been admitted to Ward C1 Holles, no dedicated relatives' bedroom was available and if carers were required to stay over they would have to sleep in the recliner chair.

Access and flow

- A temporary Ward C8 had been opened since 21 November 2016 and used as an overflow area to aid patient flow. The area was also opened for six months from January 2016 and 125 patients were looked after on the ward. The area was used previously as a high dependency unit and had space for four beds. At the time of inspection all four patients in the bay area were admitted for cardiology conditions and the expectation was that the area was used for patients with the same specific specialities.
- Mixed sex breaches occurred twice in both November 2015 and December 2015 in AMU due to capacity issues and problems with patient flow. AMU was reconfigured and amalgamated with the short stay ward which enabled the unit to improve mixed sex breaches. AMU now had 39 beds and patients would stay up to 72 hours. There have been no mixed sex breaches since the unit was reconfigured.
- Between November 2015 and October 2016 the trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England overall performance. Figures for October 2016 showed 74.9% of this group of patients were treated within 18 weeks. Over the time period, RTT performance had deteriorated ranging between 80-89% to between 70-79% while the England average has remained fairly consistent at 91-93%.
- Three speciality areas were above the England average for admitted referral to treat times; these were general medicine was 100%, rheumatology 100% and thoracic medicine at 96.2%. Two speciality areas were below the England average for admitted referral to treatment times; these were cardiology 69.7% and gastroenterology 86.7%.
- Information regarding bed moves between August 2015 and July 2016, indicated that across medical services for Diana, Princess of Wales Hospital, 32% of patients had no moves, 43% were moved once during their stay, 17% were moved twice, 5% three times and 3% of patients were moved 4 or more times.
- The amount of patients that had no moves had improved by 2% from the previous year however the amount of patient that had moved once had increased by 3%.
- There were 626 patients who were moved wards after 10pm from February 2016 to July 2016, with over 130

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patients in the month of February 2016, the amount had begun to reduce but increased to 115 patient moves in July 2016. We observed in stroke meeting minutes that a patient was sent to the ward at 12 midnight.

- Information provided by the trust showed that between August 2016 and November 2016 there were 366 patients moved between 10pm and 6am. In August 2016 and November over 100 patients were moved. Fifty of these were for capacity reasons, 200 for clinical reasons and 116 did not identify the reason for the move.
- Bed occupancy was recorded twice a day at midday and midnight. This identified that bed occupancy within most of the medical wards ranged between 91% and 100%. This meant that there were less available beds to admit new patients in to.
- Issues with bed capacity led to medical patients being cared for on non-speciality or non-medical wards. Information provided by the trust identified that 905 patients between April 2016 and September 2016 were cared for on non-medical wards. The trust had adopted a buddy ward system where medical patients outlying on other wards would be cohorted and reviewed. Staff on the surgical wards were clear that they used a medical ward buddying system.
- There were 22 medical outliers at the time of inspection on Ward B4 which was a surgical ward. Twelve of these patients were admitted with gastroenterology conditions and 10 with cardiology conditions. This meant that there could be up to seven consultants coming onto the ward to see various patients. The amount of medical outliers was affecting services and we found in the divisional report that pressure on the surgical wards from outlying medical patients was resulting in the cancellation of surgical procedures.
- During the unannounced inspection on 17 October 2016, there were 11 patients on ward B4 as medical outliers. One of the patients required end of life care and had been admitted directly from the emergency department.
- The majority of surgical wards had medical patients located on them, staff we spoke with and records we reviewed showed that medical outliers were not assessed regularly and were at risk of delays in their care due to being transferred to different wards and consultants. Medical outliers were not always allocated to the most appropriate medical consultant for their care for example: patients with diabetes or respiratory conditions did not always receive care from a medical

consultant from these specialities. If patients remained, unstable they were referred to the appropriate medical consultant however; this could lead to delays in treatment and discharge plans. On ward B4 staff we spoke with said that it was difficult to get in touch with medical doctors to review patients when patients deteriorated.

- Four patients were on Amethyst ward, a specialist haematology and oncology ward as medical outliers and were under the care of the diabetes and endocrinologist consultant. We reviewed the medical records and found these patients had received a daily review from the appropriate specialist team.
- We visited the stroke unit as part of our inspection; the ward had 25 beds to provide care for patients who required rehabilitation following a stroke. On the day of our inspection 10 patients were receiving care for stroke rehabilitation. The rest of the patients were admitted as medical outliers for other medical conditions. The consultant on the ward would see all 25 patients and refer to specialist consultants regarding their conditions. We were assured that patients who had a stroke were not cared for on other medical wards on the site. This meant that the ward would not be able to admit patients who had a stroke from other hospitals for rehabilitation.
- Ward C6 was the specialist ward for gastroenterology although many patients on the ward would have other primary medical reasons for admission. The gastroenterology team would see all patients on the ward.
- The endoscopy unit had identified there had been an increase in the number of referrals by 4.5% and the unit was looking at how to manage this through capacity and demand. We looked at the live waiting list at the time of inspection which showed that 164 patients would be breaching the six week wait standard by the end of November 2016. Two patients had been waiting for as long as 21 weeks. In minutes provided by the trust, it was noted that there were over 700 patients waiting for procedures in August 2016. The unit was in the process of extending the opening hours to reduce the waiting list.
- Information provided by the trust identified that the two week wait and urgent breaches were increasing. From April 2016 to November 2016, there were 804 patients

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waiting for procedures. This had increased from April 2016 with 51 patients waiting to 131 patients in August 2016. At present in November there were 121 patients waiting under the two week wait.

- Elective procedures were previously all completed on CCU and staff said they were struggling to complete these due to availability of beds. Procedures that were completed in CCU alone such as cardioversions were mostly now completed in the cardiology day unit, this allowed for fewer cancellations due to a lack of beds.
- We were told at inspection that there were 67 patients waiting for a cardioversion procedure. We spoke with two patients who told us about their long wait for their appointment within the cardiology day unit.
- The waiting list for cardiology procedures was printed off each month to look and review the amount of patients on the list. Information provided by the trust identified that it did not identify fully the waiting time that patients had waited for their procedure, in most cases it identified that there were no wait in days for patients. In other information provided it identified that in November 2016 the current position for patients waiting for angiograms was 189. This was made up from 56 patients had been waiting up to one week and 53 patients up to three weeks. The report identified that 12 patients had been waiting up to 11 weeks and eight patients 13 weeks.
- Information provided by the trust from June 2016 to November 2016 identified that 12 patients had their procedure cancelled by the catheter laboratory on the day across the trust. During inspection we were told that patients were cancelled as they would often run out of time to complete the procedure. We spoke with two patients who had their procedure rearranged as a result who felt this had affected their emotional well-being.
- On certain days in the cardiology day unit an anaesthetist was assigned to provide care to the patients in the unit. On any other day an anaesthetist had to be requested for certain procedures to be completed, one procedure was cancelled due to no available anaesthetist.
- We visited the discharge lounge where eight patients were awaiting discharge home. Patients were delayed in the discharge lounge waiting for the medical discharge summary; some patients had been waiting up to four hours for this information.
- We saw that when patients required bariatric equipment this was easily accessible. One patient identified that the appropriate equipment was available within two days.
- Face to face interpreters were available and there was also access to a telephone translation service. Staff were aware of how to access the translation services if needed.
- The trust had a quality matron who was the trust lead for learning disability patients; staff could contact the staff member through the hospital switch board. The trust was in the process of recruiting to two full time posts to support people with learning disabilities.
- We saw that staff were encouraged to be involved with dementia care such as the 'My Life' booklet. Once the booklet had been completed patients would have a magnetic board placed above their bedside to alert staff that this had been completed.
- Staff could tell us which patients on the wards were living with dementia and this was identified within their record. Dementia screening was also completed for patients over 75 years old.
- Some staff took on a dementia friendly role and felt passionate about this responsibility. This included encouraging others to learn more about dementia. Wards had access to activities and special distraction equipment for patients living with dementia. We also observed on the ward information regarding dementia and contact numbers for support.
- The hospital had access to a quality matron who was the trust lead for dementia. The trust was in the process of recruiting to two full time posts to support people with dementia.
- Trust wide, 75% of staff in medical care services had completed dementia training.

Learning from complaints and concerns

- Between September 2015 and August 2016 there were 124 complaints about medical care services across the trust. Specifically at Diana, Princess of Wales Hospital there were 58 complaints for medical care services. The most common theme of complaints were clinical treatment followed by communication. The trust took an average of 47.5 days to investigate and close complaints.

Meeting people's individual needs

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- Staff members provided us with examples of specific complaints and explained how practice and staff had changed as a result. In one specific example the ward sister spoke with the family to provide an apology and kept them informed of the outcome with the findings.
- Staff we spoke with were aware of how to deal with complaints. They gave examples of how to resolve situations and when to refer on to more senior staff members.
- Information for patients was evident within ward areas of how to make a complaint.

Are medical care services well-led?

Requires improvement



At the previous inspection in 2015, we rated the medical care services at Diana, Princess of Wales for well-led as 'good'. At this inspection we rated well-led as 'requires improvement' because:

- The leadership team had not been in effective in ensuring the JAG accreditation was retained: it was lost due to communication issues and the audit was not submitted correctly.
- The medicine risk register was not regularly updated and some risks were not graded.
- There was no action plan to demonstrate how the medicine group were going to meet their business objectives.
- Staff did not have team meetings regularly to be able to discuss any issues or raise any concerns in a formal way.
- Ward managers had limited time to carry out their management duties as they were counted in the nursing numbers four days out of five.

However:

- Staff enjoyed working at the hospital and felt supported by their immediate line managers. Some staff had identified that they been given a preference in which site they wanted to work at the trust and they had requested Diana, Princess of Wales.

Leadership of service

- The medicine group was led by an associate medical director, associate chief operating officer and an associate chief nurse.

- Poor leadership issues had contributed to the loss of JAG accreditation in endoscopy at both the Scunthorpe General and Diana, Princess of Wales Hospitals. However, there had been learning from this, which resulted in the appointment of new clinical leads for endoscopy, the introduction of business support managers (since August 2016) and a clinical lead nurse post for endoscopy.
- Ward managers had limited time to carry out their management duties as they were counted in the nursing numbers four days out of five. We observed from nurse off duties that at times the ward manager was counted in the planned nurse requirements due to staff vacancies or sickness. We found on some wards junior sisters were in charge as part of their development; however, their knowledge was limited. For example when we asked about enquiries raised on a specific ward the ward sister identified that the ward manager would be aware of that information however they were on holiday at the time.
- Staff on the surgical wards had highlighted issues with the medical ward buddy system due to the amount of consultants that would visit the ward and also the amount of different consultants a patient may be under if they moved wards. This had been escalated to the medical director. We also observed on one of the unannounced visits that two consultants voiced their concerns about medical outliers. One of the consultants refused to see a patient as it was not their buddy ward and the patient had to be reallocated on the patient system. The buddy system had only been introduced in July 2016 and was not embedded by all staff.
- The senior team had worked on the recommendations provided at the last inspection in October 2015 in relation to recruitment and changes were seen in the staffing levels.
- It had been highlighted that staff were using ward C1 Kendall as a thoroughfare to and from AMU, staff had challenged this, but the practice had continued. This was highlighted as an issue in the potential spreading of Norovirus and Rotavirus in November 2016.
- The overflow area of Ward C8 was open for eight months from January 2016 to August 2016. We were told at inspection that when staffing on the ward was unacceptable, staff from CCU had to cover. The ward had reopened two days ago and was constantly covered by staff from other ward areas or bank and agency staff; as a result there was no off duty available for staff to

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identify who would be working on the ward. During our inspection we spoke with the staff member who had been moved wards that morning on their arrival to work. The nurse did not know who would cover them for their breaks or who would be on for the next shift. We asked staff what they would do if no-one turned up on the ward to cover the next shift and staff would call the matron to escalate the issue.

- Many ward areas felt they were not having team meetings often due to time and staffing constraints. Steps such as providing newsletters and asking staff to sign to ensure they had read up to date information were put in place.
- Staff spoke highly of the matrons, who would visit the ward areas daily to provide support, assess staffing needs and any other general issues. They found them to be supportive and helpful.

Vision and strategy for this service

- We saw the medicine group business objectives for 2016/17, which had five main headings; however, there were no details of how these objectives were going to be achieved.
- The medicine group management team had a vision and plan renovate the medical floor at the hospital, this included moving the stroke unit, increasing the beds on CCU and creating a new cardiology unit. This was in being implemented at the time of the inspection and the senior management team had discussed the changes with the consultants.
- Good practice from the Scunthorpe General Hospital site was being mirrored at the Diana, Princess of Wales. These included further development of the acute care model with the expansion of ambulatory care and increasing the number of Acute Care Physicians (ACPs).

Governance, risk management and quality measurement

- Operational meetings would take place twice a day to look at staffing; during our inspection further meetings took place to look at staffing risks due to the closure of some wards because of an outbreak of Norovirus. Within the meeting strategies that had been put in place were discussed such as texting staff to work, providing extra payments and requesting authorisation to pay the increased agency rate. High risk areas where the risk had been judged as a red shift needed to be staffed first; these included emergency department, high

dependency unit and Ward C1 Holles. The demand for beds was great and managers had considered in opening Ward C2 to allow patients to be admitted to the hospital. Discussion took place and it was decided not to open this ward area as it was unlikely to be able to staff the ward area. Within the meeting it was noted that Ward C8 was only covered for staff until the next day.

- We reviewed the medicine risk register, which contained 55 risks. All risks had been reviewed in September 2016 however prior to this several risks had not been reviewed for over a year. We found some risks were not rated therefore it was impossible to know whether these risks should be escalated onto the corporate risk register. This did not appear to be a live working document.
- The medicine group held monthly governance meetings, which were attended by staff from all hospital sites within the trust. Actions were clearly documented and included items to be escalated to trust governance level.
- Speciality groups held monthly or bi-monthly business and governance meetings, which fed into the overarching medicine group meeting. The governance section of the meeting had standard agenda items, which included complaints and compliments, safety alerts, claims, never events and incidents and mortality updates. We saw in a sample of minutes that there was little discussion of governance agenda items at these meetings.
- Risk and governance facilitators were in place to provide support with governance requirements. There were two facilitators in the medicine group.
- We reviewed medicine operational performance meeting minutes where finance, nursing position and governance items were discussed. We saw that the team highlighted in September 2016 that they were challenged by vacancies and new staff were due to start that month. It was emphasised that the skill mix may not be right however more staff will be present.

Culture within the service

- Staff on the most wards felt their teams were approachable and supportive.
- We spoke with several staff members who had completed student nurse placements at the hospital

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and returned as registered nurses as they enjoyed their placements. One staff member commented that they had received other job opportunities from different hospitals and chose to return to the hospital.

- We spoke with two medical locums who told us that they felt part of the team and were not treated as locums.
- Staff within the cardiology day unit felt supported and would have small team meetings to review the week. They would attend meetings on how to use new equipment and reflect afterwards how the session was performed.
- More junior medical grades felt they could not receive the full support due to the shortage of more senior doctors. We spoke with staff who said they had completed surveys and informed senior managers of their workload but they felt they were not listened too.
- Staff felt that onsite managers and deputy managers did not visit the wards often and felt they did not listen.

Public engagement

- As part of the JAG action plan, patient focus groups were set up. Issues identified within the focus group were waiting times and communication, these were included within the action plan. One of the patient groups set up was a support group run on a weekly basis, away from the hospital environment. The staff were available for anyone requiring additional emotional, practical or social support and advice. Guest speakers attended the groups to talk about topics such as diet and exercise. A video of patients providing positive feedback on the group was presented at the trust board meeting.
- Both the public and staff members were able to attend the quarterly governor and members' forum. Performance against the key targets, mortality information and a brief overview of the trust's finances were discussed at these forums.

- Wards displayed improvements they had made based on feedback from patients and relatives. This was in a 'you said', 'we did' format. For example on CCU ear plugs were provided in response to patients saying that it was noisy with all the machines.







Staff engagement

- The trust was due to reconfigure the medical floor, which involved the movement of certain wards. Staff in these areas felt they were not involved in the process. Staff were aware that consultants had been invited to meetings. The associate chief operating officer informed us that the next phase was to invite ward staff to meetings to discuss the changes.
- We saw evidence trust wide of staff receiving recognition for their contribution to the service through internal annual awards ceremonies. In the trust's 2016 awards, C1 Holles won the 'Patients' Choice Award nominated by a panel of patients.

Innovation, improvement and sustainability

- The service was reviewing ways to improve the effectiveness of medical and nursing staffing. For example, the policy was to be altered to allow nursing staff to flush chest drains, a procedure currently performed by medical staff. A training package was to be devised to identify staff's learning and competency to perform this.
- An annual ward training day would take place for both nursing and medical staff on Ward C5.
- The introduction of the domiciliary non-invasive ventilation service by the respiratory nurse team. This allowed patients to be monitored at home and reduces the need for hospital admissions. Home assessments can be completed and information can be downloaded onto computer software. The plan is to expand the service to out of area patients who have attended the site for more than one admission.

Surgery

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

Information about the service

Diana Princess of Wales Hospital (DPoW) is part of the Northern Lincolnshire and Goole NHS Trust. The surgical directorate provides a range of surgical services for the population of Grimsby and surrounding areas. Surgical services were managed divisionally across all three locations rather than by single location.

The trust has 19 main operating theatres and 13 surgical wards covering Gynaecology, General Surgery, Head and Neck, and Trauma and Orthopaedics across the three sites of Grimsby, Scunthorpe and Goole. Overall, the trust has 38 day-case beds and 250 inpatient beds.

On this site, the surgical directorate provides elective (planned) and non-elective (acute) treatments for different specialities such as ear, nose and throat, gastroenterology, general surgery, ophthalmology, orthopaedic and urology. The surgical service had five wards surgical wards at with 76 inpatient beds. The hospital has seven operating theatres, and a day surgical ward.

The trust had 41,075 surgical admissions between April 2015 and March 2016. Emergency admissions accounted for 9,810 (23.9%), 26,661 (64.9%) were day case spells and the remaining 4,604 (11.2%) were elective.

Within the trust urology accounted for the largest number of surgical admissions 7,333 (17.9%), with 6,919 (16.8%) colorectal surgery and 6,909 (16.8%) ophthalmology.

During our inspection, we spoke with 36 members of staff including nursing, medical, and allied health professionals as well as 23 patients We visited all surgical wards, theatres

and day surgical units. We reviewed 24 sets of patient records. We observed care and treatment of patients and reviewed a range of performance information about the surgical directorate.

We attended a number of staff focus groups and observed care being delivered on the wards we visited. We observed care using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care, which helps us understand the experiences of people who may find it difficult to communicate. Before the inspection, we reviewed performance information from, and about the trust. We also carried out an unannounced inspection on 17 October and 8 December 2016.

A comprehensive inspection of DPoW was previously carried out in October 2015; all five domains were inspected for surgical services. We rated safe, effective, responsive and well led as requires improvement. Caring was rated as good and overall the service was rated as requires improvement.

During this inspection, the service was rated overall as requires improvement.

Surgery

Summary of findings

The overall rating for surgery from the 2015 inspection was requires improvement. At the 2016 inspection, we rated surgical services at DPoW hospital as 'requires improvement' overall because:

- The directorate did not consistently learn from incidents, when things go wrong, or when things could be improved and take appropriate action to improve safety standards as a result. Repeat incidents had been reported and lessons learned had not consistently been implemented to prevent the incident from re-occurrence.
- The service did not follow national guidelines when assessing patients. Staff did not always book patients needing emergency surgery into theatres in accordance with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines. No formal emergency theatre booking policy or protocol was available to enable staff to comply with the guidelines.
- Services did not always meet patients' needs. The directorate did not have effective processes to avoid unplanned reductions in activity and were not fully aware of all the services they needed to provide to meet the demands of the population. Patients could not always access services for assessment, diagnosis or treatment when they need them. The service had long wait times and overall it did not meeting the national referral to treatment times (RTT) or all cancer performance standards. Performance had been worse than the England overall performance since June 2016 and showed a deteriorating trend.
- The service had a high number of clinical and non-clinical cancellations. From April to June 2016, 134 operations were cancelled for non-clinical reasons. The high number of outlying patients often caused non-clinical cancellations; patients nursed in a different speciality areas. In the same reporting period, 98 operations were cancelled on the day for clinical reasons. Staff did not assess elective surgery patients, who needed pre assessment before surgery, using an effective patient pathway.
- The service did not consistently have enough qualified, experienced and skilled staff. Ward managers and co-ordinators had to care for one

cohort of patients and supervise another as well as their managerial role. Staff shortages affected staff morale. Staff spoke about a lack of support from the site co-ordination team, in relation to movement of staff, staff shortages and moving patients. Patient information was not shared with GP's in an effective way. Data we reviewed showed that there were 1964 letters requiring review, approval, distribution and completion (September 2016), 266 of these letters being urgent cancer patients letters. Delays in the system have the potential to lead to treatment delays in the patient pathway.

- Performance in national audits was variable. The majority of indicators in the national emergency laparotomy, bowel cancer and national hip fracture audits continued to be below national performance. National audit action plans we reviewed did not always reflect the actions required by the audit performance.
- Surgical services did not use patient safety tools consistently. The five steps to safer surgery procedures, including the World Health Organisation (WHO) checklist, was not an embedded consistent process. Staff did not complete formal risk assessments for each day case patient for blood clots (venous thrombosis). Staff did not always complete nutritional assessments.
- The directorate did not hold specific surgical mortality and morbidity meetings. We reviewed the critical care morbidity and mortality meeting minutes where shared critical care/surgical patients were discussed. However we did not see evidence that discussion was held specifically for surgical only patients. Although the senior management team said that individual specialities discussed mortality as part of audit meetings, this information was not collated centrally within the directorate.
- Policies and guidelines in use within clinical areas were not all compliant with NICE or other clinical bodies. Data we reviewed from June 2016 showed that policies within the directorate were 69% compliant with National Institute for Health and Care Excellence (NICE) guidance.
- The majority of fluid balance charts we reviewed were not completed accurately; this had been previously highlighted on the matron dashboards.

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- The clinical strategy for surgical services did not make detailed reference to national reports and recommendations, the trust values and strategy, or have clear deadlines for actions. The service had a high number of out of hour's transfers, after 8pm. On three occasions we saw records, which showed patients being transferred into surgical beds at 1am. This disrupted surgical patient sleep and decreased the number of beds available for elective surgical inpatients.
- We saw no evidence of the service engaging with patient representatives or staff to improve services.
- Surgery did not meet the trust target for individual mandatory training modules, such as resuscitation, at 67% compliance.

However:

- The trust had taken action since the 2015 inspection, and had stopped using band 4 nurses awaiting professional registration numbers within the registered nurse establishment.
- We observed positive interactions between patients and staff. The majority of patients we spoke with were happy with the care they received.
- Appraisal rates had improved since the 2015 inspection, however they still remained below internal compliance targets.
- The directorate now had a surgical vision however, due to changes within the senior management team, detailed timescales and plans for action were not available. The senior management team were aware of the challenges within the directorate spoke with us about their commitment to improving these.

Are surgery services safe?

Requires improvement



At the previous inspection in 2015, we rated the surgical services at DPoW hospital for safe as 'requires improvement'. At this inspection we rated safe as 'requires improvement' because:

- The directorate did not consistently learn from incidents, when things go wrong, or when things could be improved and take appropriate action to improve safety standards as a result. Repeat incidents had been reported and lessons learned had not consistently been implemented to prevent the incident from re-occurrence.
- The service did not consistently have enough qualified, experienced and skilled staff. Ward managers and co-ordinators had to care for one cohort of patients and supervise another as well as their managerial role.
- Surgical services did not use patient safety tools consistently. The five steps to safer surgery procedures, including the World Health Organisation (WHO) checklist, was not an embedded consistent process. Swab counts in theatre were not always performed as per the trust policy and best practice guidance. We saw two procedures where no instruments were counted.
- Surgery did not meet the trust target for individual mandatory training modules but, such as resuscitation, at 67% compliance.
- Staff did not complete formal risk assessments for each day case patient for blood clots (Venous thrombosis). Day case admissions had no formal risk assessments for VTE completed during the admission. Staff did not always complete nutritional assessments.
- The directorate did not hold specific surgical mortality and morbidity meetings. We reviewed the critical care morbidity and mortality meeting minutes where shared critical care/surgical patients were discussed. However we did not see evidence that discussion was held specifically for surgical only patients. Although the senior management team said that individual specialities discussed mortality as part of audit meetings, this information was not collated centrally within the directorate.

However:

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- The trust had taken action since the 2015 inspection, and had stopped using band 4 nurses awaiting professional registration numbers within the registered nurse establishment.
- The wards and departments had systems in place for the identification and management of adults and children at risk of abuse.

Incidents

- Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. Although each never event has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event. One never event had been declared within the DPOW in the reporting period September 2015 to October 2016; this involved a retained drain. The incident was in the process of being investigated, and a root cause identifying. Staff we spoke with were aware of the never event and immediate recommendations and changes in practice had been made.
- The directorate did not consistently learn from incidents and take actions to improve safety standards as a result. Within minutes of the September quality and safety meeting we reviewed, the senior management team had highlighted concerns over recent incidents that had occurred in the directorate and that were similar to previous incidents. They concluded that lessons had not been learned from the previous incidents. This was a view echoed by some clinicians.
- In the 2015 inspection report, we were concerned with the learning and action taken post a never event within ophthalmology which occurred in early 2015. During this inspection staff we spoke with said that consultant ophthalmic surgeons had still not agreed a standard operating procedure (SOP) across all theatres to check ophthalmic lenses prior to implantation. We requested the SOP from the directorate and were provided with a lens checking SOP; however, this did not have a version control, date of issue or author detailed. We were not assured that this process was embedded. There remains a potential for similar incidents to happen again.
- Serious incidents (SI) are incidents that require further investigation and reporting. The surgical directorate reported ten serious incidents within the surgery during the reporting period September 2015 to August 2015 with four incidents occurring within DPOW. Of these, the most common type of incident reported was treatment delay with 60% of the incidents reported. We reviewed three serious incident reports two were for treatment delay, and noted the recording of duty of candour discussions, recommendations and further learning identified as appropriate.
- There was an average of 160 incidents reported per month with the directorate. We reviewed incident data supplied to us by the trust that showed surgical wards and departments reported 1914 incidents from August 2015 to August 2016, Ninety nine percent of all incidents resulted in no or low harm. Reported incidents we reviewed showed two graded as death, none graded as severe harm, 21 as moderate harm, 593 graded as low harm and 1298 graded as no harm/ near miss. The number of reported incidents had remained similar to the level reported in the 2015 report of 1,907 incidents in the reporting period July 2014 to August 2015.
- Surgery and critical care was the second largest reporter of incidents in the trust with 17.8 % of all incidents reported. The most frequently reported incident reported incident category was implementation of care and ongoing monitoring and review 672 reports. Patient accident was the second largest reported type of incident with 467 incidents and access, admission, transfer incidents reporting 187 incidents. Staff we spoke with were aware of the top three incidents.
- The directorate had a performance indicator to code and grade all incidents within five working days; performance was 73.2%, below the trust threshold of 95%. Data we reviewed showed that 96% of incidents were reported within the expected timescale of 60 days. There were 23 incidents, which took longer than 90 days to report.
- Nursing and medical staff we spoke with were aware of the reporting system and staff, could describe their roles in relation to the need to report, provide evidence, take action or investigate as required. Staff also spoke with us about not reporting all incidents for example they did not report patient transfers at night.
- In 2015, we said that the trust must ensure there is an effective process for providing consistent feedback and learning from incidents. The majority of staff we spoke with said that they did not receive feedback following completion of incident forms, staff investigating incidents were aware of what action needed to be taken to provide staff with feedback.

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- Staff we spoke with said that the directorate shared learning from incidents internally through safety briefs during shift handovers, ward meetings, communication books, quality and safety bulletins and lessons learned newsletters. From a handover, we observed on B3 no safety brief, safety messages or lessons learned were shared
- Bi-monthly quality and safety days were held within the directorate to improve communication and sharing learning across both sites.
- There was evidence of changes in practice from incidents: for example, staff had been asked to improve written communication about intravenous devices in patients following the never event, and staff had received further training and skills assessments in relation to medication competencies and knowledge following a series of medication issues.
- In 2015, we said that the trust must ensure that action is taken to address the mortality outliers and improve patient outcomes. No specific surgical mortality and morbidity meetings were held within the directorate. We reviewed the critical care morbidity and mortality meeting minutes where shared critical care/surgical patients were discussed. However we did not see evidence that discussion was held specifically for surgical only patients. The senior management team said that individual specialities, discussed mortality as part of audit meetings, however this information was not collated centrally within the directorate.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of duty of candour requirements and described it as being open and honest with patients they were able to provide examples of its use.
- Response letters to complaints included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectations of the service under duty of candour requirements.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and

analysing patient harm and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombosis (blood clots) and catheter and urinary tract infections (CAUTI's).

- Information from the safety thermometer data was displayed in areas we visited.
- During the reporting period, October 2015 to October 2016 the trust reported 62 pressure ulcers, 14 falls with harm and 14 catheter urinary tract infections CAUTI's. There was an increase in the reports of pressure ulcer and CAUTIs acquisition from the 2015 inspection report when 77 incidents of harm were reported, 54 pressure ulcers and 7 CAUTIs. The number of falls was slightly lower than the 2015 rate of 16 falls in the reporting period July 2014 to July 2015.
- During the reporting period October 2015 to October 2016, the rate of new pressure ulcers reported and falls showed a decreasing trend. The rate of urinary tract infections reported in patients with a catheter showed a variable trend.
- Venous thrombosis (blood clot) assessments were carried out for overnight admissions in the trust and trust data we reviewed August 2016 showed 94.2% of patients received the appropriate assessment of risk. Staff we spoke with said that they received a list of patients every week highlighting outstanding VTE assessments.

Cleanliness, infection control and hygiene

- The infection, prevention and control team delivered training face to face and via e learning. IPC training compliance rates for the hospital were 83% lower than the trust own compliance rate of 95%. However, this rate had improved from the 2015 rate of 79%.
- Infection prevention and control information was visible on all wards we visited; this information included information on preventing infections.
- The trust reported no cases of hospital acquired methicillin resistant staphylococcus aureus (MRSA) April to August 2016 The trust reported seven cases of hospital acquired clostridium difficile (C.Difficile) in the same reporting period this was lower than the agreed threshold.
- The trust had a policy for screening surgical patients for methicillin resistant staphylococcus aureus (MRSA). Emergency and elective patients undergoing surgical procedures and fitting the national criteria were tested for MRSA. We reviewed compliance rates with screening

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and noted 97% compliance against a target rate of 95% during the reporting period April to October 2016. During the inspection, we observed on the majority of occasions staff complied with IPC policies; for example, hand hygiene and standard precautions. Isolation rooms were available for the isolation of patients, and patients requiring isolation were isolated however on ward B6 the sign indicating a patient was being nursed in isolation was not noticeable and the door was left open. The room was also cluttered making cleaning difficult.

- We saw staff washing their hands, using hand gel between patients and staff and complying with 'bare below the elbows' policies.
- Hand hygiene audit data we reviewed showed 96.6% compliance for in the reporting period January 2016 to October 2016. The infection prevention and control team validated the data on a monthly basis at reported a rate of 86.1% in the same reporting period. Data we reviewed showed compliance ranged from 17% to 100%.
- During the inspection, we saw hand hygiene compliance data displayed on the wards and departments we visited.
- Wards and departments were visually clean and we saw ward cleanliness scores displayed in public corridors.
- The hospital carried out surgical site infection surveillance. They participated in national surgical site infection surveillance through Public Health England. The hospitals participated in the knee replacement module.
- We reviewed five pieces of clinical equipment and noted these to be clean and labelled. Staff also used labels to provide assurance to patients that they were clean.

Environment and equipment

- Equipment we reviewed had been electrically safety tested.
- In the majority of occasions, for the resuscitation equipment we checked staff had recorded that checks were completed. On B6 there were gaps in the checks and from the documentation we reviewed it was not clear when checks had been completed. When we opened the trolley, the equipment was not in an organised manner and lots of miscellaneous items were present.
- Staff we spoke with said there were adequate stocks of equipment and we saw evidence of good stock rotation.

- The main theatre doors were not able to be consistently locked; these doors were on the risk register and had been since 2012. Work had been carried out but it had not solved the issue. Leaving these doors unsecured was a security risk to staff, patients and equipment in theatres. Staff in theatres were aware of control measures to make sure doors were closed, however; during the inspection we were able to access the theatre through unsecured doors.
- The day surgical unit had moved locations due to a leak in the Intensive care unit roof; the current area was temporary whilst work was completed.
- Staff we spoke with said they did not have equipment available for bariatric patients but they were aware of how to order this equipment.

Medicines

- In 2015, we said that the trust must ensure the safe storage of medicines within fridges, specifically with regard to temperature and stock control. During the inspection, we saw that, medicines fridges were secured. Temperature records were not always completed in accordance with national guidance and trust policy. We saw examples of when fridge temperatures had fallen outside of the recommended range and ward staff had taken no action. In theatres we saw fridges were not able to be locked, staff we spoke with said there were no keys to lock them. Staff did take prompt action when a fridge temperature was outside the range.
- On surgical wards we visited, medicines were appropriately stored and prescribed, and access to medicines was restricted to authorised staff. However, we found evidence of a number of gaps in patient records where staff had not signed to say they had administered medicines. In theatres we found medications left on worktops.
- Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained. Regular balance checks were performed in line with the trust policy.
- From prescription charts we reviewed and medicine administration records for patients on the ward. We saw on the majority of occasions arrangements were in place for recording the administration of medicines. On the majority of occasions these records were clear and

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fully completed. The records showed patients were receiving their medicines when they needed them and as prescribed. Records of patients' allergies were recorded on the prescription chart.

- We observed nurses following the hospital policy when administering medicines to ensure the safety of patients. This included checking the patient's identity.
- Newly qualified registered nurse's had to undertake competency assessments prior to them administering medications.
- Emergency medicines were readily available and there was a robust procedure in place to ensure that they were fit for use.
- We saw a lack of information to guide staff on how to safely administer when required (PRN) medicines, in some cases the maximum dose or minimum dose interval was not stated.

Records

- Paper records were available for each patient that attended the wards or department; the trust used a computerised patient administration system, and an integrated computerised patient assessment system and bed management system.
- Electronic boards were available on all wards visited, which provided easy access for staff to key information, for example, flags for dementia, post-operative confusion, patient acuity and discharge plans. This system had expanded since our last inspection and now included the theatre management system.
- We reviewed 24 sets of medical and nursing care records whilst on site and on the majority of occasions, staff used black ink, legible handwriting and documentation occurred at the time of the review or administration of medication as per compliance with trust policy and professional standards.
- Patient records were stored in notes trollies that could be locked, or were stored in secure areas. Paper records we reviewed had loose sheets within them, this had the potential for patient details could be mislaid or inappropriately filed in another patient's records.
- The wards and departments used risk assessments records that we reviewed. They showed that; staff accurately documented falls and pressure care assessments. These were audited as part of the quality assurance audit and reported monthly by the matrons.

Safeguarding

- The wards and departments had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- Safe we spoke with were able to describe their roles in relation to the need to report and take action as required when safeguarding issues were identified. Staff were aware of the safeguarding lead for the trust.
- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by refresher training. We reviewed safeguarding training compliance rates for July 2016 for medical and dental staff these showed 83% compliance with level 1 adults and level 1 children, 82% compliance with level 2 and 50% compliance with level 3. Lower than the trust target of 95%. Nursing staff had rates of 90% level 1 adults, 94% level 1 children and 93% level 2 children. The trust did not supply us with any level 3 training data for nursing in the surgical directorate.

Mandatory training

- Mandatory training was delivered as face-to-face training sessions or via e-learning programme.
- The trust target for mandatory training completion was 95% compliance; training data we reviewed showed an overall training compliance rate for the surgical health group of 82%. This was the same as the 2015 data, when 82% of staff received mandatory training. All training modules were below the target for medical and dental staff, while nursing and midwifery staff met or exceeded the target in three out of the 13 modules. Resuscitation, moving and handling and fire training had the lowest completion rates across both staff groups. Resus training had only been completed by 67% of the staff. Within the theatre department resus training rates were 38%.
- New or junior medical and nursing staff received a corporate induction, which included some aspects of their mandatory training, and departmental induction-training programme.

Assessing and responding to patient risk

- In 2015, we said that the trust must ensure the five steps for safer surgery including the World Health Organisation (WHO) safety checklist is consistently applied and practice audited in theatres.
- The hospital used the five steps for safer surgery procedures including the WHO safety checklist. The hospital reviewed compliance with the safety checklist

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via audit; the internal audit department had audited the emergency team brief. Results we reviewed showed moderate levels of assurance 70-89%. The directorate had a plan to re-audit the WHO checklist in September 2016, however we were not provided with the results of this audit.

- During the inspection, we reviewed four sets of surgical notes containing WHO checklists and we observed these were complete. We observed four patient operations when the WHO checklists were used. On the majority of occasions the checklist were completed; however from our observations it was apparent this was not a consistent process as we saw one time out check performed after the patient had been prepped for operation. Swab counts in theatre were not always performed as per the trust policy and best practice guidance. We saw two procedures where no instruments were counted, staff we spoke with said this was because it was a “small case”. However, this was against trust policy which states that all instruments and swabs must be counted and documented.
- The trust used the national early warning score (NEWS) tool to identify deteriorating patients; surgical areas used an electronic based system to record the early warning score. Nursing staff identified deteriorating patients to medical staff by an internal bleep system. Nursing staff we spoke with able to identify the clinical condition of a deteriorating patient.
- The hospital reviewed compliance with completion of NEWS via audit; the internal audit department retrospectively reviewed 57 records in October 2016. The results we reviewed showed good levels of performance 96% compliance with the outcome measure for vital signs recorded; however improvements (63% compliance) was required with completion of a management plan including, treatment, parameters and escalation of care.
- From six out of seven sets of notes we reviewed we saw effective escalation of deteriorating patients.
- In 2015, we said that 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. Patients were assessed in pre assessment clinics prior to surgery. Staff we spoke with were aware of surgical elective patients being cancelled due to clinical reasons and this not been highlighted at the time of the assessment. The senior

management team were aware of the issues and had been working with the pre-assessment team to develop a business case for improvements in the pre-assessment pathway; this work was still to be approved.

- Ward B3 had a high observation bay (HOB); patients were nursed in the bay if they required higher levels of nursing care. Ward staff we spoke with said that they were able to move patients into the HOB if they deteriorated on the ward, following discussions and agreement with clinicians.
- Day case admissions had no formal risk assessments for VTE completed during the admission.
- Venous thrombolysis (blood clot) assessments were carried out in the trust and trust data we reviewed August 2016 showed 94.2% of patients received the appropriate assessment of risk. Staff we spoke with said that they received a list of patients every week highlighting outstanding VTE assessments.

Nursing staffing

- In 2015, we said the trust must ensure that there are sufficient numbers of suitably skilled and experienced staff in line with best practice and national guidance taking into account patients’ dependency levels. We also said that the trust must stop including newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses, during the inspection; we did not see any band 4 nurses counted within the registered nurse numbers.
- At the time of the inspection, surgical wards and departments had 28.4 whole time equivalent (wte) registered nursing vacancies. We reviewed vacancy rates and this showed a 17.1% vacancy rate. This was a similar figure to the vacancy rate seen in 2015. All surgical wards we visited had vacancies; wards B4 had 6.9 wte vacancies (41.8% of the total staffing establishment).
- Within theatres at this hospital, 46 wte staff with 29 wte staff in post July 2016. Theatres had 33.2% (14.6 wte) vacancy rate.
- The trust used the safer nursing care tool (SNCT) to assess nursing staff requirements per ward and department, per shift. Nursing staff reviewed the acuity and inputted into the computerised system three times a day to ensure the acuity, occupancy and

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dependencies were correct within the areas. The on-site co-ordination team used this information to aid decision making regarding movement of staff to other areas.

- The surgical wards displayed planned and actual nurse staffing levels for each shift. The trust-planned nurse to patient ratios was based on one registered nurse per eight patients. This ratio was based on the national standard that then the trust review against the SNCT ratio.
- Prior to the inspection, we reviewed the safer staffing report October 2016 for surgical wards. On the majority of occasions the average fill rate for registered nursing (RN) staff per day and night shift was above the trust threshold of 85%. However, on ward B4 the rates had fallen below the trust threshold of 85% for the April-September 2016. For care staff the average fill rates were above 100% for the majority of day and night shifts. Data we reviewed ranged between 75.7% to 100.9% average fill rate for registered nurse RN day shifts and 93.7% to 101.6% average fill rate for night duties.
- We reviewed duty rosters for the previous three months and out of 252 registered nurse shifts reviewed, we saw that 69 shifts were staffed at below the established levels and 88 shifts had bank staff on duty.
- Staff we spoke with and records we reviewed showed that ward managers had difficulty ensuring the ward skill mix was correct, wards we visited had a high number of newly qualified nurse on the duty rota and many of the nurses had not been assessed as competent to undertake medication rounds. This meant that senior staff nurses had to provide medication rounds for a large cohort of patients and oversee another cohort of patients being looked after by a junior or bank member of staff. All staff we spoke with expressed concerns over the number of newly qualified staff on the wards. Senior staff were supportive of the newly qualified staff as they wanted to retain them and improve their skills.
- The surgical wards and departments used bank and agency staff to improve staffing levels; we reviewed use of bank and agency staff and noted 1.2% agency usage. Wards B4 and B3 had the highest bank and agency usage. Overall usage increased in February and March 2016 on both these wards. On ward B4 out of 54

registered nurse shifts we reviewed we saw than bank staff were on duty on 32 occasions. On the majority of occasions on a night duty, a regular member of bank staff covered the shift.

- The surgical directorate was actively recruiting to vacant posts, both local and international recruitment events had been undertaken, an intake of new staff from the local university commence employment in 2016.
- Daily safety brief reviews took place each day across the hospital, the purpose of this meeting was to ensure at least minimum safe staffing levels in all areas. Senior staff attended the safety briefings. Staff were often moved from their substantive area to ensure minimum staffing levels in all areas. Staff we spoke with said they did not always receive an induction or handover when they moved wards this had been highlighted to senior nurses.
- We saw that the senior management team had taken decisions to close beds on ward B4 to improve nurse to patient ratios. During the inspection, we saw no reductions in the amount of beds available; staff we spoke with did have a clear understanding of bed reductions required to meet available staffing levels. During the inspection ward, B2 had four more beds open than their normal bed base. Staffing levels had not been increased due to reflect the increase in available beds.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover and saw that patients' clinical conditions were discussed and levels of support or risks were identified.

Surgical staffing

- For all surgical specialities a consultant was present on site 8 am until 5 pm Monday to Friday.
- On-call cover was provided 24-hours a day by foundation level one and two doctors; middle grade staff and consultants were available on an on-call basis from 5pm until 8am. Whilst on-call doctors covered general surgery and urology, Trauma and orthopaedics had a separate on-call rota. The senior management team spoke with us about improvements in middle grade doctor cover had been made since the last inspection. Middle grade doctors were now resident on-call, the senior management team hoped this would improve patient flow and senior decision making in the trust.

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- At the time of the inspection, surgical wards and department had 35 wte surgical medical staff vacancies. We reviewed vacancy rates and this showed 25.2% wte vacancies. The urology units had the highest vacancy rate at 69.2%.
- Junior doctors we spoke with said that consultants were accessible on an on-call basis.
- Between April 2015 and March 2016, the proportion of consultant staff reported to be working at the trust was lower than and the proportion of junior (foundation years 1 and 2) staff was higher than the England average.
- The surgical wards and departments used locum staff to improve staffing levels; we reviewed use of locum staff during the reporting period of August 2015 to July 2016 and noted 1.5% agency usage. Orthopaedics reported the highest bank and locum usage at 3% followed by general surgery 2.9%. Overall bank and locum usage had increased over the time period from 1.3% to 2%.
- Formal medical handovers took place twice a day with informal handovers occurring during the shift when required.

Major incident awareness and training

- The trust delivered major incident training during induction for all staff. As of July 2016, 100% of staff had completed their training.
- The trust had a business continuity plan. This was available to staff on the trust intranet.
- We saw the major incident plan; this outlined the process for managing and coordinating the hospital's emergency response in the event of such an incident. Staff we spoke with were familiar with these plans.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures were available; staff we spoke with were able to articulate these.

Are surgery services effective?

Requires improvement



At the previous inspection in 2015, we rated the surgical services at DPoW hospital for effective as 'requires improvement'. At this inspection we rated effective as 'requires improvement' because:

- Staff did not always book patients needing emergency surgery into theatres in accordance with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines. No formal emergency theatre booking policy or protocol was available to enable staff to comply with the guidelines.
- Performance in national audits was variable. The majority of indicators in the national emergency laparotomy, bowel cancer and national hip fracture audits continued to be below national performance. National audit action plans we reviewed did not always reflect the actions required by the audit performance.
- Patient information was not shared with GP's in an effective way. Data we reviewed showed that there were 1964 letters requiring review, approval, distribution and completion (September 2016), 266 of these letters being urgent cancer patients letters. Delays in the system have the potential to lead to treatment delays in the patient pathway.
- Policies and guidelines in use within clinical areas were not all compliant with National Institute for Health and Care Excellence (NICE) or other clinical bodies. Data we reviewed from June 2016 showed that policies within the directorate were 69% compliant with NICE guidance.
- The trust had an internal appraisal target to achieve 95%. Appraisal records we reviewed showed that within surgery and critical care in the reporting period April 2016 to August 2016, showed 75% of staff had an up to date appraisal, this did not meet the trust compliance target but was an improvement on the 2015 compliance of 69%.

However:

- Whilst on the wards we observed good communication and support between members of the medical, nursing, allied health professionals and specialist teams.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Two nurses were currently in training to allow them to insert specialist intravenous lines into patients requiring additional support.

Evidence-based care and treatment

- We saw patient's treatment was mainly based on national guidance, such as the National Institute for Health and Care Excellence (NICE), the Association of Anaesthetists, and from the Royal College of Surgeons.

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- Policies were stored on the trust intranet and staff we spoke with said they were able to access them.
- In 2015, we said that the trust must ensure policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies and that staff must be aware of the policies within surgery. Data we reviewed from June 2016 showed that the directorate was 69% compliant with NICE guidance. This was a slight increase in the number of compliant policies seen in the 2015 inspection. However, within minutes of the October governance meeting we noted concerns over a “deteriorating position” the associate medical director was leading on this work.
- Access to emergency theatres was not consistent or in conjunction with national guidelines. Staff we spoke with said that clinicians held discussions in accordance with the National confidential enquiry into patient outcome and death (NCEPOD) guidelines. However, data we reviewed showed that patients were not consistently booked as per NCEPOD classifications. Staff we spoke with and records we reviewed showed that no physiological risk assessments were completed on cases, no formal planning meeting for cases to be discussed was held and no approved protocol or policy was available indicating how cases should be booked for theatres was available.
- At the unannounced inspection, we reviewed 32 booking forms, five forms were completed, five were incorrectly completed and eight forms had no emergency theatre classification available and a further 14 forms did not have time taken to theatre so we were unable to say whether these patients met emergency theatre booking guidance. We were supplied with a draft protocol for emergency theatre booking, however this had not been approved and was not a cross-site document. We discussed this with the senior management team, who agreed to take action.
- We saw evidence of a range of standardised, documented pathways and agreed care plans across surgery, examples of these included hip fracture pathways.
- The directorate had a local audit programme and local audit meetings; the audit programme was also discussed during governance meetings.
- Wards and departments we visited took part in nursing audits for example; infection prevention and control

practices, medication and pressure area care. The matrons used the results in a matron dashboard report highlighting action required and actions requiring escalation.

- Staff we spoke with were knowledgeable about sepsis pathways and application of the protocol.

Pain relief

- The hospital used a number of different medicines for relieving pain post-operatively dependent upon the surgery.
- We saw that patients offered pain relief, patients we spoke with said they were offered pain relief regularly and staff checked that pain relief administered had been effective.
- Staff used a pain-scoring tool to assess patient's pain levels; staff recorded the assessment on paper records. We observed staff reviewing pain in the recovery area post-surgery. If a patient had pain, they administered pain relief and checked this had the desired effect.
- Patients had access to a pain control specialist nurse.

Nutrition and hydration

- We saw staff offered patients regular drinks and food. Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Nutritional screening tools (MUST) tool was used, nutritional risk assessment documentation we reviewed showed on two out of two occasions this was not complete. This was not audited as part of the quality assurance audits.
- Staff referred patients to dietician if this was required.
- We observed two meal services during the inspection, staff working on the ward did not ensure that patients requiring support with eating receive this within five minutes of being provided with warm food.
- Patients had access to fresh water where appropriate. The majority of the fluid balance charts we reviewed were not completed accurately. Staff had not calculated the patients overall fluid intake or output.
- The trust staggered theatre fasting times, however, because of list overruns some patients we spoke with had fasted for longer times than planned. The trust did not undertake internal fasting audits.
- A snack menu was available on all surgical wards. This provided patients with additional food between meals such as crisps, yogurts and ice creams.

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Patient outcomes

- In the reporting period March 2015 to April 2016, patients at this site had a lower expected risk of readmission following elective and non-elective surgery than the England average. Elective trauma and orthopaedics had the largest relative risk of readmission, although this was the same as the national average.
- The trust participated in the national bowel cancer audit 2015; the majority of measures fell within the expected range, however, the trust performed worse than the national aggregate for England and Wales on all measures. In the 2015 audit report, 83% of patients, undergoing a major resection had a post-operative length of stay greater than five days, this was worse than the national aggregate; this was similar to the 2014 figure of 81%. The risk-adjusted 90 days post-operative mortality rate was 6.1%, which was within expected, range, this was worse than the 2014 rate of 5%. The risk-adjusted two-year post-operative mortality rate was 28.4%, which falls within the expected range. This was worse than the 2014 data of 24.8%. The risk-adjusted 90-day unplanned readmission rate was 22.8%, which falls within the expected range. This was worse than the 2014 data of 18.3%. The risk-adjusted temporary stoma rate in rectal cancer patients undergoing major resection was 54%, which falls within expected range. This was better than the 2014 rate of 58%.
- In the national emergency laparotomy organisational audit (NELA) 2015, this site achieved a green rating (>70%) for one measure, an amber rating (50-79%) for four measures and a red rating (>49%) for five measures. The final case ascertainment rate was rated as green. The rating represents a score of between 70-100%. We reviewed the trust action plan, this was populated with deadlines and contained two actions, however; this did not contain actions required to consistently improve patient outcomes.
- In 2015, we said that the trust must ensure it continues to improve on the number fractured neck of femur patients who receive surgery within 48 hours Internal trust data we reviewed indicated that surgery was still not occurring consistently within 48 hours. Current compliance showed the proportion of patients having surgery on the day or day after admission was 74.1%, which does not meet the national standard of 85%, this had improved however on the 2015 result of 69.9%. Best

practice guidance recommends than surgery is carried out on patients with a fractured neck of femur within 36 hours following attendance the trust monitored this and performance was 58% August 2016.

- The trust participated in the national hip fracture audit. Performance in the 2016 Hip fracture audit was mixed, with three measures improving, two deteriorating and one remaining the same. The risk adjusted 30- day mortality rate was 7.1%, which is within expected levels; this had improved from the 2015 audit when it was 8.7%. This was a decrease on the 2015 rate of 90.3%. The proportion of patients not developing a pressure ulcer was 96%, which falls in the middle 50% of all trusts. This was an improvement on the 2015 score of 91.1%. The length of stay was 16.1 days, which falls in the best 25% of trusts; however, the length of stay had increased from the 2015 audit by 1 day (15.1 days 2015). The fractured neck of femur best practice action plan was all complete apart from one action. We discussed fractured neck of femur performance with clinicians, senior management team and theatre staff and there did not appear to be an understanding of the reasons why performance had not improved remarkably in the previous two years. The senior management team took this as an action point.
- Trust patient reported outcome measures (PROMs) from April 2015 to March 2016, showed that for the majority of indicators the trust performed in line with the England average. Groin hernia indicators and knee replacement indicators showed more patients' health improved than the England averages. The hip replacement indicator showed fewer patients' health improved and more patients' health worsened than England averages.
- The trust did not take part in the national vascular registry.
- In the 2016, the trust participated in the Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 20.6%. This placed the trust within the highest 25% of all trusts for this measure. The 90-day post-operative mortality rate was not reported for this trust. Case ascertainment was better than the national aggregate at >90% in both the 2015 and 2016 audits. The proportion of patients treated with curative intent in the Yorkshire and Humber strategic clinical network was 34.3% significantly lower than the national aggregate.

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- The trust's quality assurance report reviewed and reported data on various nursing indicators to the chief nurse on a monthly basis.
- The hospital had local quality improvement projects identified these were discussed at the quality and safety days.
- The trust monitored performance against a range of clinical indicators via a performance dashboard. This data included compliance with NICE guidance and performance in national audits.

Competent staff

- In 2015, we said that the trust must continue to improve against the target of all staff receiving an annual appraisal and supervision and that actions identified in the appraisals are acted upon.
- The trust had an internal appraisal target to achieve 95%. Appraisal records we reviewed showed that within surgery and critical care in the reporting period April 2016 to August 2016, 75% of staff had an up to date appraisal, this was an improvement on the 2015 compliance of 69%. Performance had improved from the previous financial year across all staff groups, particularly across administrative and clerical, which had improved to 53% from 17% in 2015/2016. Data for medical staff appraisal showed that within the directorate in the same reporting period, 74% of medical staff had an up to date appraisal an improvement on the 2015/2016 data of 71%. On ward B6, appraisal rates were 46%; senior staff were in the process of receiving training to improve this. All staff we spoke with said they had received an appraisal in the last year and thought these had been beneficial.
- Newly qualified staff had a period of preceptorship following employment; during this period, staff were to complete specific competencies for example administration of medication. Staff we spoke with said that due to staffing levels and current skill mix on wards and departments, newly qualified staff found it difficult to have competencies signed off by senior staff.
- Specific ward based induction was undertaken on the surgical wards and departments this involved training on specific issues and equipment used on the area. Agency and bank nurses told us they received an orientation and induction to the ward area. This included use of resuscitation equipment and medicines management.
- The majority of medical staff we spoke with said they had received time for specialist training, education and portfolio development.
- Nursing staff we spoke with were aware of and felt supported through the registered nurse revalidation requirements.
- Two nurses were currently in training to allow them to insert specialist intravenous lines into patients requiring additional support.
- Ward B4 had recently developed scenario based training programmes their first sessions were due to be delivered on sepsis management and management of a patient with a rectal bleed.

Multidisciplinary working

- There were established multi-disciplinary team (MDT) meetings for discussions of patients on cancer pathways. MDT meetings included attendance from specialist nurses, surgeons, anaesthetists and radiologists. Consultants from the trust also attended specialist MDT at the local tertiary hospital when they had made referrals.
- Clinical nurse specialists attended wards to provide clinical expertise and review patients if needed. Whilst on the wards, we observed good communication between the tissue viability team and ward staff, and ward staff and the acute pain nurse.
- Whilst on the wards we observed good communication and support between members of the medical team.
- Nursing and medical staff referred patients to dieticians from the surgical wards. Dieticians attended wards daily Monday-Friday.
- Nurses, occupational therapist and physiotherapists held daily meetings on wards B6 and B7 (orthopaedic wards). Staff we spoke with said this improved discharge planning and flow within the orthopaedic department. Staff also said that they meet regularly with SGH occupational therapist and physiotherapists which shares information and improves development of new ideas/
- Theatre managers from each site met regularly, however implementation of common policies, procedures and ways of working for theatres for example theatre-booking procedures required improvement.

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- Pre –assessment staff on the DPoW site we spoke with said that they did not benchmark or have communication with the pre-assessment team on the SGH site; this has the potential to hamper improvements in the pre-assessment service.

Seven-day services

- On-site junior medical cover was available seven days a week; consultants out of hours (OOH) supported this.
- Middle grades or junior medical staff reviewed patients on admission.
- National audit performance showed that the trust did not consistently provide consultant review prior and post-surgery within the agreed timescales.
- Surgical inpatients had access to diagnostic and radiology services 24 hours, seven days a week to support clinical decision-making. The trust was compliant with this standard.
- Surgical inpatients had timely 24- hour access, seven days a week, to consultant-directed interventions for Emergency general surgery these were available on-site and via formally agreed networked arrangements.
- Access to occupational therapy and physiotherapy services were available Monday to Friday, with emergency cover on a Saturdays and Sundays.
- Pharmacy staff were available six days a week and an on-call service was available out of hours.
- The surgical admissions unit was open Monday to Friday 07.30am to 12.30pm the directorate had plans to increase this to 3.30pm.

Access to information

- Staff recorded information about patients in paper format and on a computer based administration systems.
- Patient information was not shared with GP's in an effective way. Data we reviewed showed that there were 1964 letters requiring review, approval, distribution and completion (September 2016), 266 of these letters being urgent cancer patients letters. Delays in the system have the potential to lead to treatment delays in the patient pathway.
- Data supplied by the trust showed that the directorate had a performance indicator to send immediate discharge letters to the GP within 24 hours. Currently directorate performance was 76.2% against a threshold of 98%. We spoke with the senior management team about this who said this was due to consultant capacity

for e- approvals. The senior management team spoke with us about a backlog of clinician's letter requiring approval; they had spoken to clinicians and reminded them of the importance of completing these letters.

- Discharge summaries were prepared for the GP, records we reviewed showed these contained relevant information.
- Handover reports were electronic and contained relevant information.
- Medical staff we spoke with said GP's had direct access to middle grade and consultants for advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing and medical staff obtained consent via both verbal and written routes. The staff we spoke with were aware of how to gain both written and verbal consent from patients and their representatives. We observed staff obtaining consent before undertaking clinical procedures.
- Where patients lacked capacity to make their own decisions, staff we spoke with said they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient. Staff said that where this was not possible and due to the nature of the surgery-required staff had to make best interest decisions to enable lifesaving treatment to precede staff said that these decisions were documented within care records. In records, we reviewed not all patients that required a capacity assessment had received one. When staff had carried out a capacity assessment, there was an absence of evidence as to how the conclusions about the capacity status of a patient had been reached.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). During the inspection, the trust had patients subject to a DoLS authorisation. However, the electronic patient system and internal database did not routinely flag up applications waiting for assessment or those authorisations about to expire.
- Training records for the surgery and critical care July 2016 showed 81.7% of staff had undertaken mental capacity training against a trust target of 95%. Deprivation of liberty safeguards training was completed by 80% of staff.

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Are surgery services caring?

Good



At the previous inspection in 2015, we rated the surgical services at DPoW hospital for caring as 'good'. At this inspection we rated effective as 'good' because:

- We observed positive interactions between patients and staff. The majority of patients we spoke with were happy with the care they received.
- During the announced inspection, we carried out on one ward a short observational framework for inspection (SOFI). Through our observations, we saw that on the majority of occasions, patient mood states were mainly positive or neutral and interactions with patients were positive. During the observation, all patients in the bay were treated with dignity and respect.
- Patients we spoke with said they felt supported by staff and involved in their care.

Compassionate care

- We spoke with 23 patients during the inspection. We observed positive interactions between patients and staff. The majority of patients we spoke with were happy with the care they received. Patients on B6 did say that staff did not always introduce themselves.
- The NHS Friends and Family test (FFT) is a national survey that measures satisfaction with the healthcare the patient has received. The response rate was 38% better than the England average of 29% in the reporting period August 2015 to July 2016. Ward level recommendation rates have been generally high, scoring between 90-100% across the majority of the reporting period. Wards and departments we visited displayed their friends and family results.
- During the announced inspection, we carried out on ward B4 a short observational framework for inspection (SOFI). Through our observations, we saw that on the majority of occasions, patient mood states were mainly positive or neutral and interactions with patients were positive. During the observation, all patients in the bay were treated with dignity and respect.

- The majority of patients we spoke with were happy with the standard of care they received, they had drinks and call buzzers located within easy reach.
- In the majority of occasions we observed that patients were dressed, encouraged to eat out of bed and be independently mobile where possible.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risks and benefits of treatment.
- Patients said they would know who to approach if they had issues regarding their care, and they felt able to ask questions.
- The majority of patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.
- We saw that ward managers were visible on the wards and relatives and patients were able to speak with them.

Emotional support

- Clinical nurse specialists (CNS) were available within surgery and attended the wards to provide support and advice to patients and staff.
- Patients diagnosed with cancer were supported by clinical nurse specialists and provided with written and verbal information; patients were offered contact details of the CNS team.
- Counselling was provided prior to surgery for cancer or potential stoma colorectal patients.
- All patients with a stoma received two home visits post discharge for further support.
- A multi-faith chaplaincy service was available for patients to access during their stay.

Are surgery services responsive?

Requires improvement



At the previous inspection in 2015, we rated the surgical services at DPoW hospital for responsive as 'requires improvement'. At this inspection we rated responsive as 'requires improvement' because:

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- The directorate did not have effective processes to avoid unplanned reductions in activity and were not fully aware of all the services they needed to provide to meet the demands of the population.
- Patients could not always access services for assessment, diagnosis or treatment when they need them. The service had long wait times and overall it did not meeting the national referral to treatment times (RTT) or all cancer performance indicators. Performance had been worse than the England overall performance since June 2016 and showed a deteriorating trend. Data for October 2016 showed 73.7% of patients were treated within 18 weeks (national standard of 92%) versus an England performance of 75.5%. In November 2016, the trust reported that two surgical patients had waited over 52 weeks for treatment, one in general surgery and one in urology.
- The service had a high number of clinical and non-clinical cancellations. From April to June 2016, 98 operations were cancelled for non-clinical reasons. Non-clinical cancellations were often caused by the high number of outlying patients; patients nursed in a different speciality areas. In the same reporting period, 184 operations were cancelled on the day for clinical reasons. Staff did not assess elective surgery patients, who needed pre assessment before surgery, using an effective patient pathway.
- Staff we spoke with also expressed concerns over the inappropriate times patients were transferred to surgical wards. Records we reviewed showed that a number of surgical and medical transfers happened passed 8pm at night on and on three occasions we saw records and patients we spoke with co-corroborated that patients were being transferred into surgical beds past 1am. This disrupted surgical patient sleep and decreased the amount of beds available for elective surgical inpatients.

However:

- The wards and departments were accessible for people with limited mobility and people who used a wheelchair. Translation services were available for people whose first language was not English.
- Patient we spoke with said that staff did not take long to answer call bells; during the inspection, we did not hear call bells ringing for long periods.
- Complaints were shared with staff via team meetings and individual conversations.

Service planning and delivery to meet the needs of local people

- The surgical directorate provided non-elective (acute) treatments for different specialities such as ear, nose and throat, gastroenterology, general surgery, ophthalmology, orthopaedic and urology. The surgical service had four wards surgical wards with 87 inpatient beds. The hospital has eight operating theatres.
- Services did not always meet patients' needs. The directorate did not have effective processes to avoid unplanned reductions in activity and were not fully aware of all the services they needed to provide to meet the demands of the population. They were working closely with NHS improvement to identify current capacity and demand. They were aware of this in some services like ophthalmology however; in services like orthopaedics, it was not clear if this work had been completed.
- The senior management team highlighted to us that current data collection issues were hampering progress, as they currently could not obtain all the relevant theatre utilisation data. Data we reviewed showed that 361 theatre sessions were cancelled during August to November 2016, these were cancelled for a variety of reasons including surgeons leave and no cases booked for the list. We reviewed the theatre sustainability plans some actions had been completed, some actions were overdue and for theatre timings it was not clear from the plan whether these had been completed and agreed with the surgical teams.
- The directorate worked with the commissioning team when creating their strategy. They were also taking into account of local transformation plans.
- Local agreements were available to provide services in the local tertiary hospital when the trust was unable to provide those services.

Access and flow

- NHS England published operational standards for the expected level of referral to treatment targets (RTT) for patients, incomplete pathways were set at (92%).
- The trust performance of meeting referral to treatment times (RTT) for patients admitted for treatment within 18 weeks of referral has been worse than the England overall performance since June 2016. Data for October 2016 showed 73.7% of patients were treated within 18 weeks versus an England performance of 75.5%. Trust

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performance over the period shows a deteriorating trend, having moved from being consistently above the England average to below from June 2016. Whilst the England average has also deteriorated over the time, it has stabilised somewhat from June while the trust has continued the downward trend.

- Trauma and orthopaedics and ophthalmology were performing below the national average with data 63.2% (67.2% national) and 72.6% (78.7% national) respectively. Urology, ear nose and throat, general and oral surgery were all performing above the national average, with data ranging from 79% to 82.9% (national data ranged from 70.3% to 80.2%).
- We reviewed performance against the cancer standards and noted that one cancer standard was not achieved by the trust in August 2016, this was the 62 day standard. The senior management team were aware that they were short of approximately four clinics per week to allow them to meet cancer standards; they were discussing this issue with commissioners.
- The trust was working closely with NHS Improvement (NHSi) to improve RTT and cancer standards performance.
- The trust had commenced working with outside partnerships organisations to improve performance in key areas like ophthalmology and maxillofacial surgery.
- We requested to review recovery plans for individual specialities however, we were only supplied with one of these documents for ophthalmology we were not supplied with any other specialities to review.
- Theatre usage within the trust ranged from 0% to 95.4% during the period of May 2016 to July 2016. Data for this site was lowest at 63% overall usage. Theatres 5 and 6 reported 0% in May and June 2016, after which they had utilisation rates of 80%). The trust had a target for theatre utilisation of 93%.
- Elective theatre lists were available five days a week and emergency theatre lists were available seven days a week. Services shared access to theatres for emergencies overnight and at weekends.
- In 2015, we said that 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.
- A last minute cancellation is a cancellation for non-clinical reasons on the day the patient is due to arrive, after they have arrived or on the day of their

appointment. Patients' who are cancelled at the last minute must be relisted and treated within the next 28 days; otherwise, this is recorded as a breach in the standards. For the reporting period quarter two 2014/2015 to quarter one 2016/2017 the trust cancelled 1,186 surgeries, of these 0.6% were not treated within 28 days

- All cancelled operations (not just last minute cancellations) as a percentage of elective admissions for the period quarter 2 2014/15 to quarter 1 2016/17 at the trust were generally greater than the England average although they have dropped below the England average during the last quarter.
- We reviewed on the day cancellation rates April 2016 to June 2016, at DPoW for clinical and non-clinical reasons 98 patients had their operation cancelled on the day for clinical reasons and 134 for non-clinical reasons. However, when both sites are added together and compared against last year's data this shows that the trust cancelled more patients in April 2016 to June 2016 282 patients for clinical reasons against 240 patients in March 2015 to May 2015. This was reflected in cancellations for non-clinical reasons 236 April 2016 to June 2016 against 180 March 2015 to May 2015. We discussed this with the senior management team who were aware of the number of cancellations, and said that a number of them were due to the industrial action by junior medical staff in April 2016.
- The trust shared information with us that two surgical patients waited over 52 weeks for treatment one in general surgery and one in urology November 2016.
- The average length of stay for surgical elective patients was 2.9 days in the reporting period April 2015 to March 2016, this was similar to the England average (3.3 days). For surgical non-elective patients the average length of stay was 5.3 days, similar to the England average of 5 days.
- During the inspection, wards all wards apart from B6 had medical patients (medical outliers) located on them. We discussed this with the staff working on the ward. Having medical patients in surgical wards had an impact on the availability of surgical beds.
- Staff we spoke with also expressed concerns over the inappropriate times patients were transferred to surgical wards they provided examples of disrupting patients sleep. Records we reviewed showed that a large number of patient transfers happened passed 8pm at night on two occasions we saw records, which showed patients being transferred into surgical beds after 1am. This

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disrupted surgical patient sleep and decreased the amount of beds available for elective surgical inpatients. Staff we spoke with said that on occasions they have received five or six transfers to their area at the same time.

- We reviewed data which amount of time the recovery area was used to nurse critical care patient's data we saw showed that this area was used less during 2016 than it was in 2015.
- Staff provided telephone access to patients for advice and guidance post discharge following surgery.

Meeting people's individual needs

- The wards and department used a butterfly symbol to support people living with dementia, we saw some areas that were decorated in a dementia friendly way, for example, coloured signs on toilet door or clocks in rooms.
- Directorate performance data for dementia and delirium screening for over 75's was 81.4% July 2016 against a threshold of 90%.
- We saw 'this is my life' booklets used for patients as part of the disabilities passport.
- Healthcare assistants provided one to one observation and support for vulnerable patients.
- The High observation area on ward B3 admitted both female and male patients. The protocol for admission into this area indicated that these patients were level one-dependency patients. National guidance indicates that it is acceptable to have level two patients in mixed sex accommodation, however level 1 patients must not be mixed.
- The wards and departments were accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available.
- The pre-assessment team or the admitting ward reviewed patient's needs on admission, in regards to hearing difficulties and specialist needs.
- Translation services were available for people whose first language was not English. Staff we spoke with said that this service was responsive. A welcome sign was in place on the entrance to ward 22 welcoming people in 22 different languages.
- There were links between specialist nurses and ward staff to ensure continuity of care and support for patients.

- Specialised equipment required for bariatric patients were available, staff we spoke with were aware of how to access this.
- Relevant information to patients was displayed on the walls of corridors of wards we visited, such as ward performance in safety audits.
- Ranges of leaflets were available for patients within surgical wards and departments for example prevention of pressure ulcers, carers information and condition related information.
- The majority of patients on surgical wards that we spoke with said that staff did not take long to answer call bells; during the inspection, we did not hear call bells ringing for long periods. However, patients on B6 said they could wait up to 15 minutes for staff to answer call bells, we did hear a number of call bells in this area ringing for up to 10 minutes.

Learning from complaints and concerns

- The trust had a process that addressed both formal and informal complaints that were raised via the Patient Advocacy and Liaison Service (PALS).
- In the reporting period, September 2015 and August 2016 there were 46 (54.1% of total) complaints about surgical care. The trust took on average 52.6 days to investigate and close complaints, one complaint had been open since October 2015. The most common theme of complaints was clinical treatment followed by communication.
- We reviewed five complaints received by the surgical directorate and their responses and noted evidence of duty of candour requirements, an apology and acknowledgement when things did not go according to plan.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required. Senior staff we spoke with were aware of the number of complaints and the themes received for their area.
- Complaints were shared with staff via team meetings and individual conversations.

Are surgery services well-led?

Inadequate



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At the previous inspection in 2015, we rated the surgical services at DPoW hospital for well led as 'inadequate'. At this inspection we rated well led as 'inadequate' because:

- We did not receive assurance that the surgical directorate had clear, up to date recovery plans to recover referral to treatment times (RTT) performance, and this was leading to increased waiting times for patients.
- The directorate had not fully implemented its pre-assessment and theatre sustainability programmes which we had raised as a concern in 2015; this was leading to high levels of cancellations within the directorate.
- The service action plans in response to national audits did not always reflect the actions required by the trust to improve performance.
- The clinical strategy for surgical services did not make detailed reference to national reports and recommendations, the trust values and strategy, or have clear deadlines for actions. The senior management team said that this document had been shared with clinical team however; staff we spoke with working in the clinical areas were not aware of the directorate vision and strategy, or their role within it.
- The service did not consistently have enough qualified, experienced and skilled staff. Staff shortages affected staff morale. Staff spoke about a lack of support from the site co-ordination team, in relation to movement of staff, staff shortages and moving patients. The high level of senior nurse turnover provided uncertainty in the directorate.
- The culture and leadership within the directorate did not always reflect the vision and values of the organisation, encourage openness, transparency, and promote quality care.
- National audit action plans we reviewed did not always reflect the actions required by the audit performance. Compliance on the number fractured neck of femur patients who receive surgery within 48 hours had not improved significantly over the last two years and no clear reason for performance was identified.
- We did not see evidence of surgical wards and departments engaging with patient representatives to improve services.

However:

- The surgical directorate had a clear management structure; the senior management team were new into post (July 2016). All management posts were filled with substantive staff. This new structure required further time to be established and embedded. However; we could see improvements in the new management team and they appeared to have an understanding of the issues facing the directorate.
- There was a risk register in place. Risks for the directorate were discussed at governance meetings; medical and nursing staff attendance at these meetings. Items requiring escalation to the trust governance and assurance committee were clearly identified. The risk register reflected most of the current risks relevant to the operational effectiveness of the health group.
- From our discussions with staff, the majority of nursing staff said that ward level senior leadership was supportive and staff felt listened too. Junior medical staff we spoke with felt supportive in their roles and said there was an improvement in culture.

Leadership of service

- In the 2014 and 2015 inspection reports, it was noted that the senior management team was new and that it had not had time to identify and prioritise the issues and take action and implement change. During the 2016 inspection, there had been another recent change in management team, the new management were aware of the issues that required action however had not had time to implement or plan the changes effectively. The senior management team recognised that they needed more time to develop and become fully effective in their roles.
- A number of the senior nursing team had changed roles or were about to change roles in the days following the inspection. The majority of the band 7/6 staff were new in post or about to change roles and required further time to be fully effective in the role. Ward B4 had recently had a new nursing manager and from our discussions with staff it was clear that the culture on the ward was beginning to improve, mandatory training rates and staff engagement had improved.
- In 2015, we said the trust must ensure it carries out a review of dedicated management time allocated to ward co-ordinators and managers. Whilst ward managers were allocated dedicated time, due to staffing and skill mix issues it was difficult for them to protect this time. We saw that ward co-ordinators had to care

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for a cohort of patients whilst undertaken the co-ordinators role. This meant that the co-ordinator/ward manager had to prioritise work to ensure patient care was not compromised.

- In 2015, we said that the trust must ensure it continues to improve on the number fractured neck of femur patients who receive surgery within 48 hours. Compliance had not improved significantly over the last two years and no clear reason for performance was identified.
- We did not receive assurance that the surgical directorate had clear, up to date recovery plans to recover referral to treatment times (RTT) performance, and this was leading to increased waiting times for patients.
- The directorate had not fully implemented its pre-assessment and theatre sustainability programmes which we had raised as a concern in 2015; this was leading to high levels of cancellations within the directorate.
- The service action plans in response to national audits did not always reflect the actions required by the trust to improve performance.
- Nursing staff turnover rates in July 2016 the trust reported a turnover of 16.2% within surgery this rate was worse at 22%, with one ward with greater than 30%, ward B4 which reported 54.1% (5 wte staff). Medical staff turnover was worse 37.8% than the trust rate of 26.9%. Both urology and general surgery had the highest turnover for medical staff rates.
- Nursing staff sickness in the trust was 4% within surgery the reported rate was worse at 5.7% in July 2016. The wards with the highest sickness rates were day surgical unit 11.2% and theatres 9.3%. The trust report medical sickness staff rates 0.6%, surgical wards and departments reported lower than the trust rate at 0.1%. The senior management team were aware of the rise in sickness rates especially on the DPoW site, additional support had been offered to B6/B7 and theatres.
- From our discussions with staff, the majority of nursing staff said that senior nurse leadership was supportive. The majority of staff we spoke with said that the chief nurse was visible on the wards and departments.
- All wards we inspected had staff meetings. These were held at different frequencies due to staffing levels and vacancies.
- During the inspection wards, B6 and B7 have an action plan in place to improve knowledge, competence and

staff morale on the ward. We reviewed the action plan and saw deadlines had been identified for actions required and that the senior management team was monitoring this action plan.

- Staff on B4 used a closed social media group to share key messages.

Vision and strategy for this service

- In 2015, we said that the trust must take action to ensure development of a surgical clinical strategy and vision. Since the last inspection, the senior management team had developed a vision and strategy, this strategy had objectives identified, however it did not make any detail referenced national reports and recommendations and it did not reference the trust values and strategy documents. It also did not have any deadlines identified. We discussed this with the senior management team who were aware of the issues and said that this document was a list of immediate priorities to focus on, and as they were new in post, they required further time to populate and embed all of the actions required.
- In 2015, we said that 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 senior management team said that this document had been shared with clinical team. During the inspection, staff we spoke with working in the clinical areas were not aware of the directorate vision and strategy, or their role within it; however this document was a recent development, and as such it required further time to be implemented.

Governance, risk management and quality measurement

- The surgical directorate had a clear management structure; the senior management team were new into post (July 2016). All management posts were filled with substantive staff. This new structure required further time to be established and embedded. However; we could see improvements in the new management team and they appeared to have an understanding of the issues facing the directorate.
- The directorate held governance meetings; we reviewed three sets of meeting minutes and noted multidisciplinary attendance, discussion of risks and incidents. There was no discussion recorded about complaints, mortality or performance data in the

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minutes we reviewed. We reviewed business minutes from breast, urology and ophthalmology from April to July 2016. Evidence of discussion in relation to incidents, performance and complaints and issues were identified for action and escalation.

- We reviewed two sets of the Matrons Quality assurance reports for surgery and critical care, headlines and support required was identified. Data was reported on if the ward scored less than 80% on the nursing audits carried out. However; on reviewing June and July 2016 report it was clear that actions required were not always documented if scores were below the expected level.
- There was a risk register in place. Risks for the directorate were discussed at the governance meeting; medical and nursing staff attendance at these meetings. Items requiring escalation to the trust governance and assurance committee were clearly identified. The risk register reflected most of the current risks relevant to the operational effectiveness of the health group. Data we reviewed from 2016 showed 28 risks with 14 rated as high risks, seven medium risks and seven low risks identified.
- The senior management team said the main risks for the directorate were workforce, performance and finance. These were all issues identified on the current risk register and controls measures had been identified. A number of risks had remained on the risk register for a number of years; however, these had been regularly reviewed.
- The senior management team spoke with us about the computerised system used within theatres did not provide the senior management team with data required for example, theatre start and finish times.

Culture within the service

- The culture and leadership within the directorate did not always reflect the vision and values of the organisation, encourage openness, transparency, and promote quality care. At ward and department level, staff we spoke with described the culture as mixed, some staff highlighted periods of low morale due to staffing levels, number of outlying patients on the ward and not feeling valued in their role, However, some staff we spoke with said they did feel valued but were aware of low morale within the team.
- During the inspection, we observed two posters threatening staff with disciplinary action for not completing tasks, the posters were removed following

our immediate feedback. We also heard about a number of ongoing staff disciplinary procedures within the directorate. We discussed this with the senior management team who confirmed these were area specific posters and the senior management nor executive team had approved these posters, however the poster had been in use since September 2016. The senior management team also outlined issues where disciplinary processes were used.

- Staff spoke with us about feeling able to raise concerns and feeling listened to by their immediate senior team. However, during the inspection we did receive two whistleblowing enquiries.
- The majority of nursing staff we spoke with spoke about issues of support offered from the site co-ordination team, when staff raised concerns in relation to movement of staff, staff shortages, and transferring patients, they did not always feel listened too. Staff provided examples of when plans had been agreed with ward managers this was changed by site co-ordinators once the ward manager was not on duty.
- The senior management team said they were proud of the staff working within the directorate and staff working in the directorate spoke with us about feeling able to raise concerns and feeling listened to by their immediate senior team.
- A member of staff on B4 had recently received a letter complimenting them on their nursing documentation following a root cause analysis investigation.

Public engagement

- Surgical wards and departments participated in the NHS Friends and family test (FFT).
- Within the surgical directorate, no patient representative was available on key groups or committees.
- Wards we visited had clinical leadership boards in place these had “You said, we did boards” which highlighted actions taken because of patient feedback, for example, patients had said they were worried staff did not chart all their drinks. The ward now allocated nursing staff to complete charts and ensure patients were drinking.

Staff engagement

- In 2015, we said that 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. During the

Surgery

inspection, staff we spoke with working in the clinical areas was not aware of the directorate vision and strategy, or their role within it; however, this document was a recent development, and as such, it required further time to be implemented.







- In the 2015 staff survey, the surgical health group had scored joint second highest directorate for experiencing harassment, bullying or abuse from staff in the last 12 months with 32% of surgical staff completing the survey, 14% of surgical staff completing the survey said they had reported the harassment, bullying or abuse. The surgical directorate also scored the second lowest score when asking staff what percentage reported good communication between senior management and staff. The directorate also scored lowest overall for the recommendation of staff that the organisation is a good place to work, or receive treatment. We discussed this with the senior management team who discussed with us their actions to improve staff morale.

- During the inspection, the executive team reported that the theatre department at DPoW was “outstanding” during the inspection the team working in this area were unaware of this and were unable to identify the areas that made them an outstanding department.

Innovation, improvement and sustainability

- The trust has recently started to use social media to recruit new members of staff; the theatre department had recently shortlisted employees, which have come through this new method of recruitment.
- The trust held a yearly award ceremony to recognise great work from staff.
- During the inspection we saw evidence of innovation within the directorate, especially in regards to breast care provision, ophthalmic surgery and information technology.

Critical care

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

Information about the service

Northern Lincolnshire and Goole Hospitals NHS Foundation trust provides critical care services at Diana Princess of Wales Hospital (DPoW) and Scunthorpe General Hospital (SGH). The surgery and critical care directorate manage the services.

There is one intensive therapy unit (ITU) at DPoW. The unit had to be temporarily relocated to the day surgery unit in August 2016 due to structural issues in the ITU. At the time of the inspection the temporary relocation was expected to last for 18 to 24 months. The ITU is a six bed combined level three (patients who require advanced respiratory support or a minimum of two organ support) and level two (patients who require pre-operative optimisation, extended post-operative care or single organ support) facility. There are four beds in one open bay and two beds in another open bay. It is staffed to care for a maximum of six level three patients.

There is one high dependency unit (HDU) at DPoW. The HDU is a seven bed level two facility. The unit is working towards a combined level two and three facility in a staged approach as part of the critical care strategy. There are two three-bedded bays and one side room. It is staffed to care for a maximum of seven level two patients.

Intensive Care National Audit and Research Centre (ICNARC) data for ITU showed that between 1 April 2015 and 31 March 2016 there were 452 admissions with an

average age of 63 years. Sixty-seven percent of patients were non-surgical, 28% emergency or unplanned surgical and 5% planned surgical. The average (mean) length of stay on ICU was three days.

A critical care outreach team provided a supportive role to medical and nursing staff on the wards when they were caring for deteriorating patients or supporting patients discharged from critical care. The team was available 12 hours a day, seven days a week.

The critical care service was part of the North Yorkshire and Humberside Critical Care Network.

In October 2015, CQC carried out an announced comprehensive inspection. We rated safe, effective, responsive and well led as requires improvement and caring as good. The service was rated requires improvement overall.

During this inspection we visited ITU and HDU. We spoke with one patient and 19 members of staff. We observed staff delivering care, looked at seven patient records and seven medication charts. We reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Critical care

Summary of findings

We rated this service as good because:

- The service had taken action on most of the issues raised in the 2015 inspection. There was an effective governance process in place with a clear structure for escalation in the directorate and there was evidence of regular review of the risk register and controls in place for the risks.
- Staff were positive about the recent changes to the senior management team, morale had improved, staff were happy in their work and felt supported and valued.
- There was a clear critical care strategy and staff understood the vision for the service. Staff had begun to rotate between ITU and HDU as part of working towards the strategy.
- Patient outcomes in ITU, for example, mortality, early readmissions and delayed discharges were in line with similar units. HDU had begun to collect Intensive Care National Audit and Research Centre (ICNARC) data to monitor patient outcomes.
- There was a good track record in safety. There had been no never events, or serious incidents and staff understood their responsibilities to raise concerns and report incidents. The incidents staff reported mainly resulted in low or no harm.
- Staffing levels and skill mix were planned and reviewed to keep people safe. Staff were supported to maintain and develop their professional skills and mandatory training and safeguarding training rates were near the trust target. A clinical educator had been appointed and was due to commence in post.
- There had been no complaints about the service in the last 12 months and feedback from patients and relatives was positive about the way staff treated them.

However,

- Some of the issues raised at the 2015 inspection remained a concern. For example, medical and nurse staffing was still not yet in line with the Guidelines for the Provision of Intensive Care Services 2015 (GPICS). The critical care strategy had plans in place to address this.

- The rehabilitation after critical illness service was very limited and not in line with GPICS.
- The number of non-clinical transfers and out of hours discharges from ITU was not in line with national guidance and was worse than similar units and the service did not formally monitor the number of patients ventilated outside of critical care.

Critical care

Are critical care services safe?

Good



In 2015 the service was rated requires improvement for safety. At the 2016 inspection we rated safe as good because:

- The service had taken action on some of the issues raised in the 2015 inspection. For example, ITU had replaced the ageing beds, staff reported restraint as an incident in line with the policy and multidisciplinary critical care morbidity and mortality meetings were held.
- The service showed a good track record in safety. There had been no never events, or serious incidents and incidents reported mainly resulted in low or no harm. Staff understood their responsibilities to raise concerns and report incidents.
- Systems and processes in infection control, medicines management, patient records and the monitoring, assessing and responding to risk were reliable and appropriate.
- Staffing levels and skill mix were planned and reviewed to keep people safe.
- Mandatory training and safeguarding training rates were near the trust target.

However,

- Medical and nurse staffing was still not yet in line with the Guidelines for the Provision of Intensive Care Services 2015 (GPICS). For example, care was not always led by a consultant in intensive care medicine, medical rotas did not support continuity of patient care and there was no supernumerary nurse coordinator available at all times.

Incidents

- Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers. There were no never events reported in the service between October 2015 and October 2016.

- Senior staff on ITU were involved in an investigation of a never event that occurred in surgery after the patient had been discharged from critical care. The investigation was still underway at the time of our inspection; however, staff we spoke with were able to tell us about the initial learning that had been shared from the incident and the changes they had made to their practice.
- The service reported no serious incidents between September 2015 and August 2016.
- ITU reported 147 incidents between September 2015 and August 2016. Of the incidents reported 62% were classed as no harm and 28% as low harm. Frequently reported incidents were pressure ulcers, equipment, medication errors and delayed or out of hours discharges.
- HDU reported 107 incidents between September 2015 and August 2016. Of the incidents reported 51% were classed as no harm, 42% as low harm and 4% as moderate harm. Frequently reported incidents were pressure ulcers, falls and medication issues.
- All staff we spoke with understood what to report as an incident and how to report it using the electronic system. They gave us examples of incidents that staff reported on the unit; these matched the themes we saw on the incident report.
- Senior staff had completed training to investigate incidents and accessed support from managers and other clinicians as needed. They shared information from incidents at handover, team meetings, on noticeboards in the staffroom, in the diary on ITU and electronically via email.
- Learning from incidents was also shared at the bimonthly cross site directorate quality and safety day. Staff we spoke with were aware of learning from trust wide incidents, for example, a medication incident.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty of candour and the importance of open and honest care.
- The trust included the process for duty of candour in the being open and duty of candour policy.
- The service had introduced monthly critical care specific mortality and morbidity meetings. The trust provided

Critical care

examples of two sets of minutes from the meeting. The minutes showed evidence of multidisciplinary attendance, review of two cases a month where the Intensive Care National Audit and Research Centre (ICNARC) expected mortality was less than 20% and the learning from these cases.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- Neither of the units displayed safety thermometer information visible to staff and visitors.
- Data for ITU from October 2015 to October 2016 showed between 50% to 100% harm free care on the day the data was recorded. The service did not report any falls with harm or VTEs during this period, new pressure ulcers were reported in one out of the 13 months and new CUTIs were reported in one out of the 13 months.
- Data for HDU from October 2015 to October 2016 showed between 25% to 100% harm free care on the day the data was recorded. Twenty-five percent was reported in September 2016 when the sample size was four patients. The service reported falls with harm in four of the 13 months, new CUTIs in one of the 13 months, new pressure ulcers in one of the 13 months and new VTEs in five of the 13 months.

Cleanliness, infection control and hygiene

- Infection prevention and control information was displayed to staff and visitors on both the units.
- All areas on both units were clean and tidy.
- All the equipment we observed was visibly clean and all the disposable curtains around bed spaces were within date for replacement.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Both units' records for flushing taps to prevent *Legionella* were up to date and complete.
- At the time of the inspection ITU did not have facilities for isolation. This was recorded on the risk register and senior staff were working with the infection control team. When patients were repatriated from other critical

care units, staff requested the repatriating trust completed a methicillin resistant staphylococcus aureus infection (MRSA) screen prior to transfer and this was discussed with the microbiologist. Pods to provide isolation facilities were due to be fitted in January 2017.

- The estates department had fitted additional sinks in ITU; however, the unit did not comply with Department of Health building regulations (HBN02). This was recorded on the risk register.
- Ninety one percent of staff in the service had completed infection control training. The trust target was 95%.
- The trust provided methicillin resistant staphylococcus aureus infection (MRSA) and clostridium difficile audits. There had been no incidences of clostridium difficile in ITU and HDU between January and August 2016.
- There had been once incidence of MRSA in ITU and one in HDU between January and August 2016.
- ITU achieved 100% compliance in the MRSA audit and HDU achieved 67% compliance. Two components were incomplete in HDU; the patient was not given a leaflet and the pathway was not up to date.
- ICNARC data showed ITU had 0.7 unit acquired infections in blood per 1000 patient bed days between 1 April 2015 and 31 March 2016. This was better than similar units.
- Staff we spoke with told us they could access a microbiologist for telephone advice, however, due to capacity, the microbiologists did not visit the unit on a regular basis.

Environment and equipment

- Access to both units was by an intercom. There was an adjoining corridor from the ITU to the operating theatres.
- ITU had been temporarily relocated to the day surgery unit in August 2016 due to structural issues in the original unit. At the time of the inspection, the temporary relocation was expected to last for 18 to 24 months. On arrival to the unit we were able to enter an unsecured visitor's area where medical consumables and equipment were stored including the critical care transfer trolley. We raised our concerns about this equipment being unsecured to senior staff who took immediate action to mitigate the risk of unsecured access to the equipment.

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- The unit provided mixed sex accommodation for critically ill patients within the Department of Health guidance. To maintain patients' privacy the bed spaces were separated by curtains.
- Staff checked the defibrillator and other emergency equipment daily. The records for this were up to date and complete.
- The paediatric equipment trolley on ITU did not have an expiry date on one of the boxes of consumable equipment. We raised this with staff at the time of the inspection who addressed this immediately.
- Disposable items of equipment were in date and stored appropriately.
- All electrical equipment we observed was clean and had been safety tested.
- The unit kept up to date equipment maintenance records.
- Cleaning equipment was stored appropriately and we observed staff following cleaning schedules and completing the appropriate documentation.
- The trust completed a monthly environmental audit. Information provided for ITU showed 95% and above compliance between January and June 2016. The results deteriorated in July and August 2016 to 88% and 93% compliance with areas of concern being the general environment and isolation of infected patients. This was at the time the unit relocated and environmental concerns had been recorded on the risk register with controls put in place.
- The trust completed a monthly environmental audit. Information provided for HDU showed 97% and above compliance between January and August 2016.
- ITU had replaced the beds since our inspection in 2015. Staff we spoke with told us they no longer had incidents of beds breaking down. They also told us access to air mattresses for patients on the unit had improved from 2015.
- ITU had ordered new ventilators and staff told us delivery was expected within six to eight weeks at the time of our inspection. Support and training for the new equipment had been arranged with the company.
- Nursing and medical staff were responsible for ensuring that equipment was fit for purpose and contacted medical engineering with any concerns. Staff we spoke with told us they did not experience delays in obtaining equipment or with equipment maintenance.

- The service did not have a critical care specific capital replacement programme. Equipment was considered as part of the trust wide capital replacement programme.

Medicines

- HDU had appropriate systems to ensure that medicines were handled safely and stored securely. On ITU, intravenous fluids were not stored in a locked cupboard which was not in line with national guidance.
- A transfer bag which contained emergency medications was stored in the unsecured visitor's area on ITU. We raised our concerns about these medications being in an unsecured area to senior staff who took immediate action to store the medications securely on the unit.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- Staff monitored medication fridge temperatures in line with trust policy and national guidance. This meant that medications were stored at the appropriate temperature.
- Ninety-nine percent of staff in the service had completed medicines management training. The trust target was 95%.
- We reviewed seven medication charts. They had all been completed in line with national and trust guidance.
- We saw evidence in the records that staff had reviewed the use of medication such as sedation and antibiotics regularly.

Records

- Records were stored securely and all components of the record were in one place.
- Medical staff in ITU completed a daily critical care assessment form that met the National Institute for Health and Care Excellence (NICE) CG50 guidance (a tool for recognising and responding to deterioration in acute ill adults in hospitals).
- In the seven records we reviewed, the nursing documentation included care bundles and risk assessments. Nursing records were accurate, complete and in line with trust and professional standards.
- In the seven records we reviewed, the medical documentation did not record that care was delivered in line with GPICS. For example, staff did not print their name and grade when they signed the record; this was

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not in line with trust and professional standards and also meant there was no documented evidence of when a consultant review had taken place following admission to critical care.

- Ninety-three percent of staff in the service had completed information governance training. The trust target was 95%.

Safeguarding

- Staff we spoke with were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff knew how to access the trust's safeguarding policy and the safeguarding team.
- Eighty-four percent of staff in the service had completed safeguarding adults level one training. The trust target was 95%.
- Eighty-five percent of staff in the service had completed safeguarding children level one training and 92% of staff had completed safeguarding children level two training. The trust target was 95%.

Mandatory training

- Mandatory training included moving and handling, resuscitation training and dementia training.
- Senior staff supported staff to attend mandatory training, however, told us some sessions such as resuscitation and conflict resolution could be difficult to access due to lack of availability or cancellation.
- Information provided by the trust showed that overall compliance with mandatory training was 88% in the service. The trust target was 95%.
- Resuscitation training had the lowest compliance in the service of 77%.

Assessing and responding to patient risk

- ITU did not undertake care for children. Senior staff told us in the last 12 months four children had been admitted to the unit whilst waiting for the regional critical care retrieval team.
- Medical and nursing staff on HDU told us the admitting medical teams, respiratory consultants and anaesthetists provided support and reviewed patients regularly and promptly at their request.
- A consultant nurse managed the deteriorating patient team which included the critical care outreach nurses, vascular access nurse specialist and sepsis nurse specialist.

- A member of the critical care outreach team was available 12 hours a day, seven days a week. The hospital at night team managed patients outside of these hours.
- The critical care outreach team supported patients stepped down from critical care and reviewed patients alerted to them by emergency department (ED) and ward staff. The team also delivered non-invasive ventilation outside of critical care in line with the trust policy.
- Information provided by the trust showed that, between November 2015 and November 2016, the critical care outreach team responded to 697 referrals from the wards and ED and followed up all patients discharged from ITU.
- The trust used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care.
- The trust used a sepsis screening tool and pathway.
- The patient records we reviewed all included completed risk assessments for VTE, pressure areas and nutrition.
- Information provided by the trust showed 64% compliance on HDU with the completion of pressure area pathways in July 2016. This was worse than the trust target of 80%. The action from this was for matrons to reiterate to ward teams and highlight the issues with the ward manager.

Nursing staffing

- Nurse staffing met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients' ratio for level two patients.
- Both units displayed the planned and actual staffing figures.
- A new ward manager for ITU had been appointed and was due to commence in post in December 2016. HDU had appointed a substantive deputy ward manager.
- The planned staffing figures included a supernumerary clinical co-ordinator for ITU for twelve hours during the day. At the time of the inspection there was not a supernumerary clinical co-ordinator during the night shift. GPICS standards state the supernumerary clinical co-ordinator should be on duty 24 hours a day.
- The ITU establishment for registered nurses was 37.2 whole time equivalent (wte). Information provided by

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the trust showed that in July 2016 there were 33.8 wte registered nurses in post. At the time of our inspection, senior staff told us there was currently a 0.7 wte vacancy and recruitment was underway.

- The HDU establishment for registered nurses was 21.6 wte. Information provided by the trust showed that in July 2016 there were 20.9 wte registered nurses in post. At the time of our inspection senior staff told us there were currently two wte vacancies and interviews for these posts were planned for December 2016.
- Information available on the trust's website showed the fill rates for registered nurses on ITU, but not on HDU. The fill rates were 92% for day shifts and 90% for night shifts in July 2016, 94% for day shifts and 89% for night shifts in September 2016 and 97% for day shifts and 79% for night shifts in October 2016.
- Information provided by the trust showed the average bank usage for registered nurses between August 2015 and July 2016 was 0.9%. The units did not use agency staff; bank staff that worked on the unit were the unit's own staff. This also met GPICS standards.
- The average sickness rate in the service between March 2015 and April 2016 was 3%. Senior staff managed sickness with support from the human resources and occupational health teams in line with trust policy.
- The critical care outreach team was staffed for one band 6 nurse on site between 8am and 8pm seven days a week. Staff told us this was not always achieved with annual leave and sickness.

Medical staffing

- Critical care had a designated clinical lead consultant.
- The consultant establishment was 13 wte. Six of these consultants were intensivists and seven were anaesthetists. The unit met GPICS requirements for medical staffing between Monday and Thursday 8am to 9pm as care was led by a consultant in intensive care medicine. However, the work pattern did not deliver continuity of care as the consultant changed on a daily basis. The service was actively recruiting additional intensivists to meet GPICS standards 24 hours a day, seven days a week as part of the critical care strategy.
- There was no evidence that consultants completed twice daily ward rounds which was not in line with GPICS.

- HDU had a resident junior doctor between 8:30am and 5:30pm Monday to Friday. The respiratory consultant and ITU consultant carried out a daily ward round on HDU Monday to Friday.
- Out of hours the on call medical team covered HDU.
- Two anaesthetic trainee doctors were on site overnight; one was based on the ITU and was supported by the on-call consultant. Between 6pm and 8:30am, the doctor had responsibility for ITU and maternity. This was not in line with GPICS or obstetric anaesthetic standards.
- Information provided by the trust showed the average sickness rate for March 2015 to April 2016 was 1% in critical care.
- Information provided by the trust showed the average vacancy rate for March 2015 to April 2016 was 10% in critical care.
- Information provided by the trust showed the average locum usage from August 2015 to July 2016 was 1.6% in critical care.

Major incident awareness and training

- Senior staff were able to clearly explain their continuity and major incident plans. The recent relocation of ITU had been declared a major incident and the management team were proud of how the staff dealt with the incident.
- Staff knew how to access the major incident and continuity plans on the intranet.

Are critical care services effective?

Good



In 2015 the service was rated requires improvement for effective. At the 2016 inspection we rated effective as good because:

- The service had taken action on the issues raised in the 2015 inspection. For example, patient outcomes, specifically mortality and early readmissions in ITU were in line with similar units. HDU had begun to collect intensive care national audit and research centre (ICNARC) data to monitor patient outcomes. The baby monitor was not routinely used in ITU and staff demonstrated an improved understanding of restraint and consent and worked in line with trust policy.

Critical care

- Care and treatment was mostly planned and delivered in line with current evidence based guidance.
- The service participated in national and local audit.
- Staff were supported to maintain and develop their professional skills. Staff had begun to rotate between ITU and HDU and complete competencies. A clinical educator was due to commence in post in January 2017.
- We observed patient centred multidisciplinary team working.
- Staff assessed patients' nutritional and hydration needs and met these in a timely way.

However,

- Staff did not consistently complete delirium screening.
- There was limited evidence of compliance with NICE CG83 rehabilitation after critical illness.

Evidence-based care and treatment

- The service's policies, protocols and care bundles were based on guidance from the national institute for health and care excellence (NICE), the intensive care society (ICS) and the faculty of intensive care medicine (FICM). Staff we spoke with on both units demonstrated awareness of the policies and how to access them on the electronic critical care hub.
- The ITU admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.
- During the ward round on ITU, staff used a checklist to ensure the daily management plan was based on current evidence.
- The HDU operational policy was based on and referenced relevant, up to date national guidance.
- The physiotherapy team completed a national rehabilitation outcome measure 'Chelsea Critical Care Physical Assessment Tool' which is a scoring system to measure physical morbidity in critical care patients.
- The critical care outreach team identified patients to invite to the follow up clinic in line with recommendations from NICE CG83 rehabilitation after critical illness.
- The sepsis screening tool had been updated in line with NICE guidance, however, at the time of our inspection the trust did not have a planned launch date for the new tool.

- The service had an up to date delirium policy, however, nursing staff we spoke with on ITU did not routinely assessing patients for delirium and told us medical staff completed this. However, there was no evidence of delirium screening in the patient record.

Pain relief

- We observed staff assessing pain using the trust scoring system and giving support to patients who required pain relief.
- The trust's guideline and observation chart for the management of pain, agitation, delirium and sedation had been approved in June 2016.

Nutrition and hydration

- Nursing staff assessed patients' nutritional and hydration needs using the malnutrition universal screening tool (MUST). This triggered an electronic referral to the dietitian if it was required.
- ITU had a dedicated dietitian who visited daily.
- Staff we spoke with told us they could access and commence total parenteral nutrition (TPN), nasogastric (NG) and enteral feeding for unconscious patients out of hours. This meant there was no delay in the feeding of patients if a dietitian was not available. Guidelines for emergency feeding were being developed; the enteral feeding algorithm was being reviewed by the nutrition group at the time of our inspection.
- We observed on both units that water was available and within reach for patients who were able to drink.
- A patient on HDU told us they always had enough to eat, had access to water and could have a hot drink whenever they wanted one.

Patient outcomes

- HDU had started to collect ICNARC data; however, as they were in the first six months of data collection no validated data was available at the time of our inspection. The ICNARC data for all units was reviewed monthly at the critical care provision group meeting.
- We reviewed the ICNARC data for ITU from 1 April 2015 to 31 March 2016; the risk adjusted acute hospital mortality ratio was 1.12. This was in line with similar units.
- The units had a 1.2% unplanned readmission in 48 hours rate. This had improved from our 2015 inspection and was better than similar units.

Critical care

- The ICNARC data coordinators worked with clinical staff to collect additional information the service used for research and audit.
- The critical care outreach team collected patient outcomes in an electronic database.
- The clinical lead planned to audit the service's compliance with NICE CG83 rehabilitation after critical illness. However, this had not been completed at the time of our inspection.
- The trust provided titles of audits that had been undertaken in 2016. There were no critical care specific audits underway at DPoW on the list provided.
- Nurses on HDU completed annual training and local competencies. The service planned to introduce the national competency framework for adult critical care nurses to all HDU staff once the clinical educator was in post.
- Nurses in the critical care outreach team completed local competencies for additional clinical skills, for example, arterial blood gas sampling and nasogastric tube insertion.
- The rotation of nursing staff between HDU and ITU had begun; HDU staff spent 12 weeks working on ITU. Six of the weeks were supernumerary and staff worked towards completion of the competency framework for adult critical care nurses. ITU staff spent four weeks working on HDU. Three of the weeks were supernumerary and they completed competencies for the different equipment that was used on HDU.
- Staff on both units had link nurse roles, for example, tissue viability and infection control and learning disabilities. They attended trust meetings and shared information with staff.
- The service kept records of staff training for specialist equipment. This training had been delivered by company representatives or senior staff in the absence of a clinical nurse educator.
- Staff in the deteriorating patient team delivered a large amount of education in the trust, for example, high dependency skills for ward based nurses, ALERT and BEACH courses (multi-professional courses that train staff in recognition of patient deterioration and actions to treat the acutely unwell) and tracheostomy training.
- Trainee medical staff told us they received a good level of support and teaching on the both the units.
- Senior staff were confident to manage performance issues in line with the trust policy and with support from occupational health and human resources.

Competent staff

- Information provided by the trust showed that 95% of registered nurses and 100% of health care assistants on HDU had an up to date appraisal. This was in line with the trust target of 95%.
- Information provided by the trust showed that 61% of registered nurses on ITU had an up to date appraisal. This was worse than the trust target of 95%.
- Information provided by the trust showed that 100% of registered nurses in the critical care outreach team had an up to date appraisal. This was better than the trust target of 95%.
- Staff we spoke with found their appraisal a useful process and gave examples of senior staff supporting their development through the appraisal process.
- Information provided by the trust showed that 78% of anaesthetists had an up to date appraisal. This was worse than the trust target of 95%.
- Information provided by the trust showed that 49% of nurses in ITU had a post registration qualification in critical care. This was just below the GPICS minimum recommendation of 50%.
- Information provided by the trust showed that 38% of nurses in HDU had a post registration qualification in critical care.
- The service had successfully recruited a clinical educator to work across both units who was due to commence their post in January 2017.
- New members of nursing staff received an induction onto the units, were allocated mentors and had a six week supernumerary period.
- Nurses on ITU completed a local competency package; this was based on the national competency framework for adult critical care nurses.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit and at the bedside during our inspection. During the ward round on ITU that we observed, all members of the team gave their opinions and were included in the discussions.
- There was a lead physiotherapist, dietitian and pharmacist for ITU. Nursing staff told us they had access to occupational therapy and speech and language therapy when required.

Critical care

- A physiotherapist visited HDU daily and treated people at the nurses' request. A pharmacist visited HDU daily. Nurses had access to an occupational therapist, dietitian and other members of the multidisciplinary team by referral.
- Both units had a full time ICNARC audit clerk.

Seven-day services

- A consultant was available and completed a ward round seven days a week. However, this was not in line with GPICS recommendations as not all the consultants who worked in the service were intensivists. The critical care strategy included a plan to address this and active recruitment was underway.
- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.
- Physiotherapists provided treatment seven days a week and an on-call service was available overnight.
- A specialist critical care pharmacist visited ITU Monday to Friday to check prescriptions and reconcile patients' medicines. The pharmacy was open seven days a week with a 24 hour on call service.

Access to information

- Staff could access guidelines, policies and protocols on the electronic critical care hub.
- Staff were able to access blood results and x-rays via electronic results services.
- Staff completed a discharge document for patients who were transferred from ITU to a ward in the trust. This was in line with NICE CG50 acutely ill patients in hospital and was due to be reviewed in 2018.
- A standard critical care network out of hospital transfer form was completed for patients who were transferred from ITU to another trust.
- Staff on ITU had access to a folder of current guidelines and protocols at each bed space.
- The ward round 'checklist of information to consider when formulating daily management strategy in critical care unit' was available at every bed space in ITU.

Consent and Mental Capacity Act

- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.

- There was evidence in the patient record and on the ward round that staff reviewed sedation regularly. All patients had a sedation score completed where appropriate.
- Staff we spoke with demonstrated an understanding of consent, the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). They told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity.
- Ninety-three percent of staff in the service had completed mental capacity act training. The trust target was 95%.
- Staff we spoke with demonstrated an understanding of restraint. We did not see any evidence of restraint in use during our inspection, for example, chemical restraint or mittens. In information provided by the trust prior to the inspection, we saw evidence that staff reported the use of mittens as an incident. This was in line with the trust policy.

Are critical care services caring?

Good



In 2015 the service was rated good for caring. At the 2016 inspection, we rated caring as good because:

- All staff communicated in a caring and compassionate manner with both conscious and unconscious patients.
- Feedback from patients and relatives was positive about the way staff treated them.
- We observed all staff responded to patients' requests in a timely and respectful manner.
- Patients were supported, treated with dignity and respect, and were involved in their care.

However,

- The service did not have access to psychological support or counselling services.

Compassionate care

- The units did not carry out patient surveys. Both units displayed thank you cards and recent feedback from patients and relatives.
- On ITU we observed a ward round where all staff spoke about, and with patients in a very caring and compassionate manner.

Critical care

- We observed curtains being drawn around patient's beds when care and treatment was being delivered to maintain patient privacy and dignity.
- We observed all members of staff responding to patients' requests in a timely and respectful manner.
- On ITU we observed that all staff communicated with both conscious and unconscious patients in a kind and compassionate way.
- We observed all patients on HDU had their call buzzers within reach. Patients told us staff answered their call buzzers promptly.

Understanding and involvement of patients and those close to them

- A patient we spoke with on HDU, told us they were pleased with the care from the nurses and doctors. Staff explained everything they did in a way they could understand and involved them in any decisions about their care.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- During our inspection we observed staff explaining to patients what they were doing and why. Staff we spoke with felt they were able to support patients and relatives and explain their care to them.
- Staff we spoke with on ITU knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff we spoke with on HDU were less familiar with this process and the role of the specialist nurse for organ donation; they would ask for support from ITU staff if needed.
- During the ward round on ITU staff included those patients who were able to participate in all the discussions about their care. Staff explained the treatment plan sensitively and in a way the patient could understand.

Emotional support

- Nurses on ITU 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.
- Staff we spoke with on HDU told us about the care and support they felt they were able to provide for families of and patients who were at the end of their life. This included ensuring the patient was in their preferred place and staff worked with families to ensure all their needs were met.

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

Are critical care services responsive?

Requires improvement



In 2015 the service was rated requires improvement for responsive. At the 2016 inspection, we rated responsive as requires improvement because:

- Some of the issues raised at the 2015 inspection remained a concern. For example, the number of non-clinical transfers and out of hours discharges from ITU was not in line with national guidance and was worse than similar units. We were unsure from the information staff recorded whether ITU still had mixed sex accommodation occurrences and breaches.
- The rehabilitation after critical illness service was very limited and not in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS).
- The service did not formally monitor the number of patients ventilated outside of critical care.

However,

- Some of the issues raised in the 2015 inspection had improved. For example, the service's bed occupancy was lower than the England average, there were no cancelled operations and the delayed discharges were about the same rate as similar units.
- There had been no formal complaints about the service in the last 12 months.

Service planning and delivery to meet the needs of local people

- The service was actively involved in the regional critical care network.
- Critical care provision was flexed to meet the differing needs of level two and three patients on ITU.
- The rehabilitation after critical illness service was limited. Critical care outreach staff held a monthly follow up clinic. There was no medical or multidisciplinary input to the follow up clinic which was not in line with GPICS. If patients needed onward referrals from the follow up clinic staff made these through the patients GP.

Critical care

- The service did not have a critical care patient and relative support group.
- A visitors' waiting room was available on both units, however, there was no overnight accommodation available for relatives.

Meeting people's individual needs

- Staff we spoke with knew how to access translation services for patients whose first language was not English.
- The units had access to speech and language therapists and communication aids.
- Staff we spoke with on HDU told us they used the 'my life' booklet for patients living with dementia and the unit had resources to use with patients living with dementia, for example, a rummage box. Staff had received training on dementia as part of the mandatory training programme.
- The units had link nurses for patients with a learning disability. Staff we spoke with felt confident to care for patients with a learning disability and told us that they tried to adopt patients likes and dislikes and gave of examples when carers and relatives had stayed with patients to assist staff to meet their needs.
- Staff could access equipment to care for bariatric patients through a hire company; they told us this arrived promptly and had not experienced delays to patient care.

Access and flow

- The decision to admit to ITU was made by the critical care consultant together with the consultant or doctors already caring for the patient.
- The decision to admit to HDU was made by either the critical care consultant or respiratory together with the consultant or doctors already caring for the patient. This was in line with the HDU admission policy.
- Records for seven patients showed staff recorded the time of the decision to admit the patient to critical care; all seven patients arrived in critical care within four hours. This was in line with GPICS.
- Information provided by the trust showed that between November 2015 and May 2016 the bed occupancy for the critical care service ranged from 86% to 95%. This was higher than the England average. However, bed occupancy between June and October 2016 ranged from 68% to 82%. This was lower than the England average.

- Information provided by the trust showed that:
 - there had been no elective cancelled operations between April and October 2016 due to a lack of critical care bed.
 - the service did not keep a record of the number of adult patients ventilated outside of ITU, however, information provided by the trust showed that between April 2015 and March 2016 there were 42 delayed admissions to ITU and of this number 25 were ventilated prior to admission to the unit.
 - The ICNARC data from 1 April 2015 to 31 March 2016 showed ITU had transferred 2.4% of patients due to non-clinical reasons. This was not in line with guidelines for the provision of intensive care services (2015), and was worse than 0.9% in similar units. ICNARC data from 1 April to 30 June 2016 showed non-clinical transfers had increased to 4.4%; this was also worse than 1.7% in similar units.
- The ICNARC data from 1 April 2015 to 31 March 2016 showed the ITU delayed discharge of over eight hours rate was 4.7%. This was about the same as similar units' rate of 4.8%.
- The ICNARC data from 1 April to 30 June 2016 showed the ITU bed days of care post eight hour delay rate was 2% and the bed days of care post 24 hour delay rate was 1.3%. These were both better than similar units' rate of 4.1% and 2.5%.
- The ICNARC data from 1 April 2015 to 31 March 2016 showed the ITU out of hours discharge to the ward rate was 7.1%. This was worse than similar units' rate of 3.5%.
- The ICNARC data from 1 April to 30 June 2016 showed the ITU out of hours discharge to the ward rate was 5.9%. This was worse than similar units' rate of 3.9%.
- The trust had updated the policy for eliminating mixed sex accommodation. This was now in line with Department of Health guidance (November 2010) and stated that patients must be moved from specialist areas within four hours of the decision being made. Staff worked in line with the policy and completed the critical care mixed sex immediate occurrence reporting tool when appropriate.
- On ITU we reviewed five mixed sex occurrence forms completed in the two months prior to our inspection. None of the forms recorded the time the patient was ready for discharge or the time the patient was

Critical care

discharged, so we were unsure whether there had been any mixed sex accommodation breaches. On every form staff documented the measures taken to promote patients' dignity and the explanations given to patients.

- On HDU we reviewed one mixed sex occurrence form completed in the two months prior to our inspection. This patient had been discharged in line with the policy. Staff had documented the measures taken to promote the patient's dignity and the explanation given to them.

Learning from complaints and concerns

- The service had received no complaints in the 12 months prior to our inspection.
- Staff we spoke with understood the process for managing concerns and how patients or relatives could make a formal complaint.
- The ward manager on HDU gave an example of how they managed a relative who raised concerns about communication through the patient advice and liaison service at ward level. The concerns were documented in the patient record and shared with staff at handover.
- The units displayed information on how to make a complaint.

Are critical care services well-led?

Good



In 2015 the service was rated requires improvement for well-led. At the 2016 inspection, we rated well led as good because:

- The service had taken action on most of the issues raised in the 2015 inspection. For example, there was evidence of regular review and actions against their risk register. Staff morale had improved; staff were happy in their work and felt supported and valued.
- There was a clear critical care strategy and staff understood the vision for the service. Staff had begun to rotate between ITU and HDU as part of working towards the strategy.
- The service had an effective governance process in place with a clear structure for escalation in the directorate.
- Recent changes had been made to the directorate senior management team. Staff were positive about the changes and found the team approachable and visible.

- Staff felt that the culture on the units was open and honest.

However,

- The service had limited formal processes to collect patient or relative feedback.

Leadership of service

- Leadership of the service was in line with GPICS standards. There was a Lead Consultant for Intensive Care and both units had a Lead Nurse.
- Recent changes had been made to the directorate senior management team. All staff we spoke with were positive about the team and found them approachable and visible.
- The management team were very proud of all the staff and the quality of patient care they provided.
- It was clear that staff had confidence in the units' leadership. All staff we spoke with reported feeling supported by their team and managers.
- Senior nursing staff attended directorate and trust wide ward manager meetings.
- Trainee medical staff told us they felt supported by consultants at all times.
- Senior staff had completed leadership and management courses, appraisal, mentoring, coaching and root cause analysis training. They felt their development needs were met and supported by the senior management team.
- Staff we spoke with were unaware of the trust executive team's "adopt a ward" scheme. Staff could not remember seeing a member of the executive team on either of the units.

Vision and strategy for this service

- The directorate strategy and objectives were in line with the trust's strategy and objectives.
- There was a clear critical care strategy with focus on compliance with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) and additional obstetric anaesthetic guidance. The strategy recognised risks and focussed on staffing and the access and flow issues the service faced. By 2018/19 the service forecast to be compliant with 69 of the 80 standards, this was an improvement from compliance with 56 of the 80 standards in 2015/16.

Critical care

- Staff we spoke with understood the vision for the service was for ITU and HDU to be managed by critical care with staff working across both units with the flexibility to care for both level two and three patients on both units.
- The senior management team were proud of the ICNARC data such as the patient outcomes and the delayed discharge rates and the improvements this had made to patient care since the 2015 inspection.
- We observed staff delivering care and demonstrating behaviours in line with the trust's values.

Governance, risk management and quality measurement

- The service held monthly critical care provision group meetings that included multidisciplinary attendance. We reviewed minutes from these meetings; the CQC action plan, governance, ICNARC data, and review of the risk register were some of the items discussed.
- The directorate held monthly clinical governance meetings and bi monthly quality and safety days. We reviewed the minutes of these meetings and saw evidence of multidisciplinary attendance, review of and sharing of directorate specific and trust wide information.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the risk register were assigned an initial and current risk rating. The directorate's risk register identified key risks in critical care at DPoW as ageing ventilators, the gap analysis in the service against the national standards, staffing and environmental and capacity issues as a result of the temporary relocation of ITU. The risk register showed that controls were identified to mitigate the level of risk and progress notes were recorded.
- The management team and senior staff were aware of the issues on the risk register and agreed they were representative of the risks in the service.
- A critical care clinical administrator had responsibility to ensure guidelines and policies were up to date and monitored.
- Staff in the critical care outreach team had not evaluated the follow up clinic due to lack of capacity.

Culture within the service

- Staff we spoke with told us they were happy in their work, felt supported and valued by their immediate and directorate managers. They felt able to raise concerns and that the culture on both units was open and honest.
- Staff were proud of the teams they worked in and of the care they were able give to patients and their families. They were aware of the importance of being open and honest and the need to apologise to patients and relatives if there had been a mistake in their care.
- Staff we spoke with told us they thought the rotation of nurses between ITU and HDU had improved relationships and teamwork between the two units.
- Staff morale had been affected by the movement of nurses from ITU to the wards to cover shortfalls in staffing. Staff had raised their concerns and spoke positively of the changes the new leadership had made, for example, ensuring the moves were fairly distributed and the change to expectations of nurses when moved to the wards to ensure they were not working outside of their competency.

Public engagement

- The service did not complete a formal patient or relative survey.
- Both units displayed patient and relatives comments and thank you cards.
- HDU collected patient and relative feedback in a suggestion box on the unit.

Staff engagement

- Both units held regular staff meetings; however, senior staff told us attendance was variable. Senior staff recorded minutes of the meetings and shared them with all staff. Topics discussed at the meetings included incidents, equipment updates and issues staff raised.
- Information was shared on the units through a communication book and noticeboard in the staff room. Urgent issues were communicated verbally by the ward managers and nurses in charge at handover.







Innovation, improvement and sustainability

- The service was actively involved in the regional critical care network.
- Staff rotation between HDU and ITU had begun as part of bringing the two units together in line with the critical care strategy.
- HDU had an audit clerk in post and were collecting ICNARC data.

Critical care

- The consultant nurse in the deteriorating patient team had developed a business proposal to bring the critical care outreach service in line with national outreach forum operational standards.
- A consultant nurse led the deteriorating patient team which included the sepsis specialist nurse, vascular access specialist nurse and critical care outreach team.

Maternity and gynaecology

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

Information about the service

Northern Lincolnshire and Goole NHS Foundation Trust provided maternity and gynaecology services for women and families within the hospital and community setting across three sites. Services ranged from specialist care for women with increased risks to a home-birth service and midwifery led care for low risk pregnancies.

There were consultant-led units at Diana, Princess of Wales Hospital (DPoW) in Grimsby and Scunthorpe General Hospital (SGH) and a midwife-led unit at Goole District Hospital. Community midwifery services were provided at all three sites. We did not inspect Goole District Hospital as part of this inspection.

The maternity service at DPoW had 33 beds. The service offered a labour, delivery, recovery and postnatal (LDRP) model of care. This meant that women's care through labour, delivery, recovery and the postnatal period was delivered in the same room for their whole stay in hospital unless they needed to go to the obstetric theatre.

Women with low-risk pregnancies were cared for by the community midwives. There were two teams of community midwives who delivered antenatal and postnatal care in women's homes, clinics, general practitioner (GP) practices and children's centres.

Women received care in the pregnancy assessment centre, where they had their first scan and any other tests required during pregnancy. The centre also dealt with complicated, high-risk pregnancies, such as women with hypertension or

diabetes. Clinics offered included, smoking cessation, teenage pregnancy, fetal medicine, vaginal birth after caesarean section and pre-operative caesarean section clinics.

The maternity service at DPoW delivered 2663 babies from November 2015 to October 2016.

The gynaecological and female breast ward (Laurel ward) had 17 beds. Gynaecological services offered medical and surgical terminations of pregnancies. Between November 2015 and October 2016 the service carried out 592 medical terminations and 110 surgical terminations.

During our inspection, we spoke with four women, and 24 staff including senior managers, and service leads, ward managers, midwives, consultants, doctors, nurses, anaesthetists, health care support workers, administrators and domestics. We reviewed 12 sets of maternity records.

In October 2015 the CQC carried out an announced comprehensive inspection. The overall rating of the service was good. However, the safe domain at DPoW was rated as requires improvement. Outstanding incidents had not been investigated for several months, checks of emergency equipment were not being done consistently, intravenous fluids were not stored in line securely and the midwife to birth ratio was 1:30 against a recommended ratio of 1:28.

Maternity and gynaecology

Summary of findings

At the last inspection in October 2015, we rated maternity and gynaecology services as good overall. At this inspection, we rated maternity and gynaecology services at Diana Princess of Wales Hospital as requires improvement because:

- The services had not provided assurance that lessons had been learned and embedded following a never event or from serious incidents.
- The trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) checklist. From a review of clinical records it was apparent that this was not consistently embedded.
- The trust used the modified early obstetric warning score (MEOWS) tool to identify deteriorating patients. Results of an audit by the trust found, if a woman required escalation, only 58% of records had evidence of an appropriate referral and management plan.
- Checking of emergency resuscitation equipment for adults and babies was not robust. We found gaps in daily checking within maternity services. This had been raised with the trust following the previous CQC inspection in October 2015.
- The service had not addressed staff training on cardiotocography. Following a serious incident, one of the actions identified was additional CTG training (K2 training) for all midwifery and medical staff. This action was due for completion on the 30 October 2016. At the time of our inspection, 86% of medical staff and 15% of midwives had completed the training.
- The percentage of women experiencing third and fourth degree tears following assisted deliveries was above the regional average.
- Governance arrangements did not always allow for identification of risk.

However:

- Clinical areas were visibly clean and tidy.
- The implementation of care bundles had reduced the number of stillbirths.
- Staff were aware of the procedures for safeguarding vulnerable adults and children.

- Women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- Staff felt supported by their ward managers and felt they could raise concerns.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Inadequate



At the previous inspection in October 2015, we rated safe as requires improvement. During this inspection we identified some concerns that would now make safe inadequate because:

- The trust had not provided assurances of lessons learned following serious incidents that raised concerns around cardiotocography (used to record fetal heartbeat and uterine contraction during pregnancy).
- The service had not provided assurance that lessons had been embedded following a never event which related to a retained swab.
- The trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) checklist. From a review of records we found that this was not embedded consistent.
- Actual midwifery staffing levels were often below the planned staffing level which increased risks to patients.
- During the previous inspection in October 2015 we found the checks of emergency equipment were not being done consistently. During the inspection we found gaps in daily checking of emergency resuscitation equipment for adults and babies.
- Arrangement for assessing and responding to risk were not sufficient, there was a risk that patient safety needs may be overlooked because appropriate prompts were not included in the services escalation of clinical concern document.
- The trust used the modified early obstetric warning score (MEOWS) tool to identify deteriorating patients. Results of an audit by the trust found, if a woman required escalation, only 58% of records had evidence of an appropriate referral and management plan.
- Out of hours anaesthetist cover was shared with the critical care unit. We saw evidence of two incidents that resulted in delays to patient treatment.
- The service documentation audit showed that patient care records were not always completed in accordance with trust policy.

However:

- There were clear safeguarding processes in place and staff knew their responsibilities in reporting and monitoring safeguarding concerns.
- Clinical areas were clean and tidy and we observed good practice in relation to infection prevention.

Incidents

- The trust had a policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trusts electronic reporting system.
- The service had a maternity trigger list for incidents and near miss reporting. The list provided guidance to staff about incidents which required escalation to serious incidents.
- Staff were able to describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses. This was reflected in the results of the 2015 National NHS staff survey. The trust scored higher (better) than the national average for staff reporting potentially harmful errors, near misses and incidents.
- A system was in place for staff to receive feedback. Once they had submitted an incident form, staff could tick a box if they wanted feedback.
- Staff said feedback from incidents was shared in a number of ways including team meetings, face to face feedback from managers, emails and a learning lessons newsletter.
- We saw posters displayed in the staff room summarising lessons learned following a never event and serious incidents. Staff said a lessons learned folder had been introduced in the past two weeks that included summary sheets of lessons learned from incidents.
- Incident data provided by the trust showed from September 2015 to November 2016, 1078 incidents were reported within maternity and gynaecology services at DPOW. 66.6% resulted in no harm, 29.3% resulted in low harm, 1.7% resulted in moderate harm and 0.2% resulted in severe harm/death. Analysis of the data showed commonly reported incidents related to treatment and procedures, access, admission, transfer and discharge and implementation of care and ongoing monitoring and review.
- Serious incidents are incidents that require reporting and further investigation. There were two serious incidents reported to the Strategic Executive

Maternity and gynaecology

Information System (STEIS) between November 2015 and November 2016. One incident related to an unexpected neonatal deaths and the other to a baby born in poor condition.

- For each serious incident the service completed a root cause analysis (RCA). An RCA is a structured method used to analyse serious incidents. We reviewed the two investigation reports which identified notable practice, key learning points, recommendations and action plans.
- We had concerns that lessons learned from serious incidents were not embedded within the service or across hospital sites. These concerns were shared with other external stakeholders. Three serious incidents had resulted in an unexpected neonatal death (two were at DPoW and one was at SGH). The investigation reports identified delays in commencing cardiotocography (CTG), delays in recognising CTG abnormality and delays in escalating and responding to CTG abnormalities. (CTG is used to record fetal heartbeat and uterine contraction during pregnancy).
- The trust had arranged an assurance meeting with the local supervising authority (LSA) and head of midwifery to discuss concerns from the serious incidents investigations. The service had agreed to work with the LSA midwife to test out lessons learned. A meeting had been scheduled for December 16 2016.
- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures are in place. Although each never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event. There were no never events reported at DPoW from October 2015 to September 2016.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There were no never events reported at DPoW from October 2015 to September 2016.
- The service had run a simulation exercise on 29 November 2016 and found it provided assurance that the two person checks and signatures were completed and plastic trays were been used.
- However, from reviewing clinical records, we were not assured that learning from the never event had been fully embedded. We reviewed six sets of records of patients undergoing caesarean sections and instrumental deliveries and found that swab counts were not correctly documented in four sets.
- A re-audit of swab counts presented at the obstetrics and gynaecology clinical audit meeting in May 2016 provided limited assurance. At DPoW 66% of records had both swab checks fully completed. This was below the trust standard of 100%.
- The multidisciplinary maternity documentation audit presented at the service clinical audit meeting, in September 2016, reviewed swab counts. The audit found that swab counts were correctly recorded and countersigned in 85% of records for women who underwent suturing and in 79% of records for women who had an operative delivery. This was below the trust target of 100%.
- Staff held weekly case review meetings to discuss incidents such as emergency caesarean sections, instrumental deliveries and shoulder dystocia (difficulty in delivering the baby's shoulders). Paediatricians also attended the meetings.
- The service held monthly perinatal mortality meetings (attended by gynaecology, obstetric and neonatal staff). Minutes from August 2016 showed outcomes from serious case reviews were discussed and recommendations were made to improve care and treatment. Minutes from June 2016 showed that recommendations to improve practice included reviewing policies.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff spoke about duty of candour and understood the importance of being open and honest with patients.
- It was also evident in the serious incident investigations we reviewed that the duty of candour had been applied and families were invited to attend a meeting with the trust to allow opportunities to discuss all aspects of care and interventions.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and

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analysing patient harms and the percentage of harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.

- We reviewed safety thermometer data for Laurel ward. Harm free care was reported at 100% for eight out of 12 months from October 2015 to October 2016. The percentage ranged from approximately 78% to 94% for the other four months.
- The maternity safety thermometer allowed maternity teams to monitor and record the proportion of mothers who experienced harm free care. The maternity safety thermometer measured harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar (a check used by midwives and doctors to assess the health of a newborn) of less than seven at five minutes and those who are admitted to a neonatal unit. The service did not submit data to the maternity safety thermometer.

Cleanliness, infection control and hygiene

- From November 2015 up until the time of the inspection there were no cases of methicillin-resistant staphylococcus aureus (MRSA), no cases of clostridium difficile (C. difficile) and no case of methicillin sensitive staphylococcus aureus (MSSA) within maternity and gynaecology.
- At the previous inspection, in the antenatal clinic we found that cardiotocography (CTG) monitoring belts were not cleaned between patient uses. During our inspection we found that the antenatal clinic now used single use CTG belts. Therefore, there was no longer a risk of cross infection.
- Hand washing facilities and antibacterial gel dispensers were available at the entrances of wards and there was signage encouraging visitors and staff to wash their hands.
- All areas we visited appeared visibly clean, staff cleaned equipment after use and used green cleaning assurance stickers to indicate it was clean and ready for use.
- Laminated cleaning rotas were displayed in all rooms on the obstetric inpatient wards. We looked in three rooms and saw that cleaning rotas were up to date.
- We observed staff complying with bare below the elbows policy, correct handwashing technique and use of hand gels in the clinical areas we visited.

- Results from hand hygiene audits showed that from February 2016 to October 2016 compliance with hand hygiene across all the wards within maternity and gynaecology ranged from 70% to 100%. No action plan was provided with the audit results.
- Within the obstetric inpatient wards, one room was identified to be used in the event of a patient needing isolation and staff were aware of the procedure.
- There were small-varnished wooden tables in patient rooms on the inpatient obstetric unit. Some of these showed signs of wear for example, those tables in rooms 18 and 21. There could be a potential risk of infection control as the surface of the tables could not be effectively cleaned.
- All clinical areas participated in monthly audits. The audit looked at ten elements including; hand hygiene facilities, the general environment, isolation of infected patients, dirty utility, sharps storage, treatment rooms and patient environment. We reviewed the audit results. In August 2016, jasmine, holly and honeysuckle ward were 100% compliant overall and blueberry ward was 96% compliant overall. Laurel ward was 98% compliant overall.
- Clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate bins for clinical and domestic waste were evident throughout all wards visited.
- In the 2015 CQC Maternity Survey, the service scored 9.1 out of 10 for the cleanliness of rooms and wards and 9.1 out of 10 for the cleanliness of toilets and bathroom facilities. Both results were similar scores to the England average.
- Pregnant women were offered the flu vaccination during their routine appointment at antenatal clinics.

Environment and equipment

- During the previous inspection we identified gaps in the daily checking of adult and neonatal resuscitation equipment. We reviewed the trusts action plan and found the recommendation for checking emergency equipment were RAG rated as green. However, during our inspection we found gaps in the daily checking of resuscitation equipment.
- We inspected two advanced resuscitation trolleys on the inpatient area. On one of the advanced resuscitation

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trolley check records, we saw checks were not recorded on the 07 October and from the 10 to the 14 October 2016. On the second trolley the equipment checks had not been recorded from the 09 to 13 November 2016.

- We inspected the infant resuscitaire equipment cabinets in seven patient rooms. The equipment cupboards had been checked, restocked following use and the cupboard sealed with a tag to indicate they were ready for use.
- In three of the seven cabinets inspected, the index list to show what equipment was inside the cupboard was not in place. In four of the rooms, items listed on the stock index were not available. These included infant hats, disposable gloves and aprons. We saw the record book in each cabinet, had been signed by the staff member to denote the equipment was present. We brought the discrepancies to the attention of staff and they replaced the equipment at the time.
- The resuscitation policy was dated April 2006 and had a review date of May 2007. We brought this to the attention of staff at the time of the inspection.
- On the 07 November the service had introduced a checklist to remind staff to carry out the resuscitation, trolley equipment check against an index list.
- There was no dedicated labour ward; women remained in the same room from admission to discharge, unless they needed to go to obstetric theatre. The obstetric unit was divided into four ward areas, blueberry, honeysuckle, jasmine and holly. In total there were 33 beds.
- Access to the inpatient obstetric wards was via an intercom system. Closed-circuit television (CCTV) cameras were installed at the entrance in line with Health Building Note 09-02 – Maternity care facilities (2013).
- The unit had a birthing pool; safety nets were stored in the room. Staff ran yearly emergency pool evacuation simulation.
- The unit had a bereavement room for women and their families experiencing the loss of an infant.
- We saw equipment was available to meet people's needs. For example, CTG machines, specialised chairs and exercise balls.
- A system was in place for the security of babies in the hospital. Although there were some instances reported where the system alarmed for no apparent reason, staff reported it had worked well. This meant no one could leave the unit with a baby, without sounding an alarm.

- There was a dedicated obstetric theatre located just off the inpatient obstetric ward area. When a second theatre was required the service used the anaesthetic room and a standard operating procedure was in place to support this.
- Bariatric theatre tables and beds were available when needed.
- Laurel ward had 17 inpatient beds and a treatment room.
- Safety testing of portable electrical equipment took place and had dated stickers on the equipment to show when it was last tested. We checked 14 pieces of electrical equipment and all were in date.

Medicines

- We checked the storage of medications on the wards we visited. We found that medications were stored securely in appropriately locked rooms and fridges.
- On our previous inspection we found intravenous fluids were not safely stored in line with guidance or legislation on the obstetric wards. During our inspection we found intravenous fluids were stored securely with access restricted to authorised staff.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Accurate records were maintained and we found balance checks were carried out regularly in accordance with trust policy.
- Medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures in accordance with national guidance. We saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range.
- From September 2015 to August 2016, maternity and gynaecology services did not report any serious incidents relating to medication errors that resulted in serious harm.
- We reviewed two prescription charts and found they were completed appropriately. No unexplained gaps were found and allergies were recorded.

Records

- Women had a complete record of antenatal test results in their hand-held maternity records in accordance with NICE quality standard 22.

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- Maternity records included appropriate antenatal risk assessment to identify any medical, obstetric, or psychological risk factors including venous thromboembolism (VTE) risk assessment.
- The 'fresh eyes' approach was used to review CTG's. Fresh eyes involved a second person reviewing the trace and aimed to improve the accuracy of CTG interpretation. The service had introduced antenatal and intrapartum stickers to allow midwives to record the minimum data set.
- Trust guidelines on CTG for continuous electric fetal monitoring states an hourly systematic assessment of the CTG trace must be recorded and that every two hours the practitioner providing care must seek the assistance of a colleague to systematically review the CTG trace.
- We reviewed CTG's in nine sets of records and found five (55%) sets had no evidence of hourly CTG reviews or fresh eyes had been completed.
- A review of fetal monitoring was included in the services multidisciplinary maternity documentation audit presented at the service clinical audit meeting in September 2016. In relation to fresh eyes the audit found that in only 58% of cases fresh eyes were provided and recorded at least two hourly.
- We reviewed the multidisciplinary maternity documentation audit presented at the service clinical audit meeting in September 2016. The audit reviewed 247 sets of records of women who had delivered from March 2015 to July 2016. The aim of the audit was to assess compliance against basic record keeping standards and assess care provided during the antenatal, intrapartum and postnatal periods.
- In relation to general record keeping the audit found eight out of the 13 standards scored below 90%. For example, 64% of records had the clinicians/midwives designation documented.
- In relation to antenatal care, 14 out of the 29 standards scored below 90%. For example, 88% of records had a birth plan completed and only 71% of records had a completed antenatal risk assessment tool with a review at each appointment.
- In relation to intrapartum records, including electronic fetal monitoring, 32 out of 68 standards were highlighted as non-compliant. For example, recording observations during the second stage of labour.
- The audit also reviewed swab counts. For women who underwent suturing, swab counts were correctly recorded and countersigned in 85% of records. For women who had an operative delivery swab counts were correctly recorded and countersigned in 79% of records.
- In relation to postnatal care records, 16 out of the 20 standards scored below 90%. For example, in 50% of records the breast feeding assessment page was fully completed and in 58% of records there was evidence that care plans were reviewed at each appointment. The action plan and recommendation from the audit were still to be agreed. Further information provided by the trust included a copy of the services action plan.
- Records were stored securely in all of the clinical areas we visited.
- On the door to the anaesthetic room we saw a list of patients with confidential information attached to the door. This was in the same area where patient's partners changed; therefore, there was a risk that confidential patient information could be viewed. We raised this with the coordinator who addressed this immediately.

Safeguarding

- There were processes in place to safeguard women and babies. The service had a named safeguarding midwife who supported staff with the safeguarding process.
- The trust's safeguarding policy provided a framework for all staff when identifying, responding to and reporting any aspects of safeguarding.
- Staff we spoke to knew how to escalate safeguarding concerns. Staff were clear about what was seen as a safeguarding concern and were able to give us examples of safeguarding referrals made, including domestic abuse.
- Information was displayed in ward areas with a contact number for people if they had a safeguarding concern.
- We saw a screening tool used in the antenatal period, for identifying domestic abuse.
- We saw evidence in patient's records of good safeguarding documentation with clear plans and liaisons with the appropriate professionals.
- Safeguarding level 3 training included FGM training and training on child sexual exploitation (CSE).
- Training data provided by the trust showed 80.1% of staff had completed safeguarding adult's level 1 training, 91.4% had completed safeguarding children level 1 and level 2 training and 86.9% had completed safeguarding children level 3 training. The trust target was 95%.

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- Staff were aware of the trust's abduction policy, which detailed actions to be taken in the event of a baby being taken. However, the obstetric inpatients wards did not run any live drills of the abduction policy.
- Teenagers who presented to the pregnancy advisory service were referred to the safeguarding team.
- Safeguarding supervision compliance for community midwives was 38%.

Mandatory training

- The trusts mandatory training consisted of 13 topics and included fire safety, infection and prevention control, moving and handling, information governance, conflict resolution and resuscitation. Overall compliance within the Women's and Children's group was 87%; this was below the trust target of 95%.
- We reviewed training data for staff groups and found compliance rates ranged from 71% to 100%. Training percentages for medical staff within obstetrics and gynaecology were 71% and 90% respectively. This was below the trust target of 95%.
- Midwives working on the four obstetric inpatient wards achieved between 86% (jasmine team) and 98% (holly team) compliance, community midwifery teams achieved 81% and labour coordinators were 95% compliant with training. Specialist gynaecology nurses were 89% compliant.
- Staff said they could access trust mandatory training either via an electronic learning system or could attend face to face training. Staff said it was challenging completing mandatory training due to staffing levels. Information provided from the trust following the inspection stated that staff had been 'pulled away' from mandatory training to work on the unit to mitigate short staffing issues.
- All staff could access their mandatory training record and received alerts to indicate when training was due. Ward managers could monitor mandatory training compliance.
- Midwives, medical staff and healthcare assistants attended an annual obstetric skills and drills training session. This covered topics such as sepsis, pre-eclampsia, breech presentation, post-partum haemorrhage and shoulder dystocia.

Assessing and responding to patient risk

- Within maternity and gynaecology services staff used the modified early obstetric warning score (MEOWS) and

the national early warning score (NEWS) respectively to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient's clinical condition was changing and prompted staff to get medical support if a patient's condition deteriorated.

- We reviewed the services process for escalation of clinical concern and found this was not robust. There was insufficient guidance on the documentation as to what constituted a clinical concern.
- The trust audited MEOWS as part of their maternity documentation audit which was presented at the service clinical audit meeting in September 2016. The audit reviewed 247 sets of records and found 79% of women had a MEOWS completed immediately after delivery, 73% had a MEOWS completed between six and 12 hours post-delivery. The audit found if a woman required escalation, only 58% of records had evidence of appropriate referral and a management plan. The audit did not include an action plan.
- The hospital used the five steps for safer surgery procedures including the World Health Organisation (WHO) safety checklist. The surgical safety checklist is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications.
- The service completed an audit to assess compliance with the safety checklist for women undergoing surgical procedures and presented it to the clinical audit group in August 2016. 16 maternity cases and 10 gynaecology cases were reviewed at DPoW. Within gynaecology the audit found 38% compliance in all areas of the checklist. Within obstetrics, 38% of records were compliant with all aspects of the checklist. The audit stated that recommendations and an action plan were still to be agreed.
- The service held a meeting on the 9 November 2016 to discuss compliance with the safer surgery checklist. The service was planning a review of the maternity theatre booklet, to ensure it complied with safer surgery guidelines.
- Findings of three serious incidents (two at DPoW and one at SGH) that resulted in unexpected neonatal deaths found delays in commencing CTG's, delays in recognising CTG abnormality and delays in escalating and responding to CTG abnormalities.
- Following the serious incidents, actions taken by the trust included a review of the guidelines for continuous electrical fetal monitoring in labour, the development of an antenatal and intrapartum classification sticker to

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assist staff with the interpretation and classification of monitoring in labour. Labour ward coordinators and consultants were to attend CTG masterclass training, introduction of K2 training (an interactive computer based training system that covered CTG interpretation and fetal monitoring) and developing CTG champions. Despite the actions taken, we were not assured that these changes had been embedded across the service.

- Trust guidelines on CTG for continuous electrical fetal monitoring, stated an hourly systematic assessment of the CTG trace must be recorded and that every two hours the practitioner providing care must seek the assistance of a colleague to systematically review the CTG trace.
- We reviewed CTG's in nine sets of records and found five (55%) sets had no evidence of hourly CTG reviews or 'fresh eyes' process had been completed.
- A review of fetal monitoring was included in the services multidisciplinary maternity documentation audit presented at the service clinical audit meeting in September 2016. In relation to fresh eyes the audit found that in only 58% of cases fresh eyes were provided and recorded at least two hourly. 53% of records had evidence of hourly reviews and annotation of events and if a CTG trace was suspicious, action taken was recorded on the trace in 82% of records.
- A further audit provided by the trust reviewed 66 cases and found 55 (83%) cases had fresh eyes reviews recorded every 2 hours.
- We reviewed information relating to post-delivery suturing. We reviewed the trusts guideline and definition of perineal trauma and repair and it stated: 'repair perineal trauma as soon as possible after birth to minimise blood loss and the risk of infection.' Data provided by the trust showed one patient had experienced a delay however when we reviewed the services incident data, from September 2015 and October 2016 there had been four incidents reported at DPoW. For example, in April 2016 a woman waited one hour and thirty minutes.
- The trust had a policy for the emergency transfer of women from a community setting to the hospital.

Midwifery staffing

- The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour recommend a ratio of one midwife to 28 births

(1:28). Information on the Women's and Children's reporting dashboard showed the midwife to birth ratio was 1:32. Subsequent information following our inspection showed this had improved to 1:30 following recruitment.

- Staffing of the maternity service was reviewed using the Birthrate Plus® midwifery workforce planning tool in accordance with the recommendations and procedures outlined in the National Institute for Health and Care Excellence (NICE) safe staffing guidelines. Maternity service undertook A Birth Rate establishment review in 2014 based on 2013 data.
- We found staffing levels were displayed on the entrance to all wards and there was a correlation between planned and actual staffing numbers.
- We reviewed planned and actual midwifery staffing levels from 01 August 2016 to 31 October 2016. On honeysuckle and jasmine ward out of 92 days, ten days had above the planned staffing level and 82 days were below the planned staffing level. On blueberry and holly ward, out of 92 days, 31 days had above the planned staffing levels and 61 days were below the planned staffing levels.
- We reviewed incident data from August 2016 to November 2016 and found 27 incidents relating to staffing had been reported.
- As part of the escalation policy inductions of labour and elective caesarean sections were delayed at times of short staffing. We reviewed incident data from the trust and found from August 2016 and November 2016 there had been one delay in an elective caesarean section and 20 delayed inductions of labour.
- As part of the maternity staffing escalation policy, community midwives covered the acute hospital at times of short staffing. We reviewed incident data and found there had been six occasions where community midwives had been called in. This had impacted on the service and information provided by the trust showed three women were unable to have a home birth due to suspension of the service from December 2015 to November 2016.
- Following the inspection the service provided further information to outline some of the actions taken to mitigate short term staffing issues. These included, pulling staff away from mandatory training, daily staffing reviews, covering long term sickness with temporary posts and the recruitment of three new midwives.

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- Despite the challenges around staffing data provided by the trust showed that from November 2015 to October 2016, 99.9% of women received 1:1 care in labour.
- The 2015 maternity survey asked women if they felt a member of staff helped them in a reasonable amount of time during labour and birth. The trust scored 9.1/10 which was about the same as other trusts.
- From August 2015 to July 2016, the trust reported bank and agency usage rate at DPoW ranged from 0.2% to 0.9%.
- The total number of staffing working in gynaecology services had increased from 18.3 whole time equivalent (wte) nurses in May 2015 to 20 wte nurses in April 2016.

Medical staffing

- The average number of hours per week consultant cover on labour ward was 60 hours. This was in line with recommendations by the Royal College of Obstetricians and Gynaecologists for the number of deliveries.
- There was dedicated consultant presence on the labour ward Monday to Friday 9:00am to 7pm and from 9am to 2pm on a weekend. There was a resident on call consultant outside of these hours. The on call arrangements were 1:6, meaning they were on call one out of six weekends.
- The service had advanced midwifery practitioners (AMP) who were able to support the medical staff and carrying out some of the duties traditionally performed by a senior house officer.
- From April 2015 to April 2016, the proportion of consultant staff working at the trust was lower than the England average. The proportion of junior (foundation year 1-2) staff reported to be working at the trust was higher than the England average.
- Dedicated anaesthetic cover was available on the labour ward during the day. From 6pm to 8:30am, anaesthetic cover was available with the anaesthetist also providing a service to the critical care unit and theatres. There was an additional on-call anaesthetist if required.
- RCOG guidelines state that there must be a 'duty anaesthetist' immediately available for the obstetric unit 24 hours a day.
- Out of hours staff reported there were rarely any delays in anaesthetist cover. However, we did hear an example of a patient who had an epidural sited and it had not worked. The anaesthetist was unable to come and review the patient as they were in theatre and the on

call anaesthetist was also busy. We also saw two incidents reported at DPoW in September 2016 that resulted in delays to patient care. One patient with a retained placenta was delayed going to theatre and another patient who was booked for an elective caesarean section had a normal delivery as the anaesthetist was called to an emergency.

- Staff reported the consultant obstetricians were available when needed and patients said they received consultant and medical care which met their needs.
- From October 2015 to September 2016, the trust reported a vacancy rate of 2.5% in gynaecology and of -2.5% in maternity at DPoW.
- From August 2015 to July 2016 the trust reported a bank and locum usage rate of 0.4% in both maternity and gynaecology.
- We observed a medical handover; it involved the multidisciplinary team and was well attended. The handover was comprehensive and advised on prioritisation of work.

Major incident awareness and training

- The trust had appropriate policies with regard to major incident planning. These policies detailed actions to be taken and key contact information to assist staff in dealing with a major incident.
- Staff we spoke with knew how to access the major incident policy.
- Medical staff and midwives attended yearly skills and drills training in neonatal and obstetric emergencies. These enabled staff to maintain skills in a range of emergency situations, for example maternal collapse, neonatal resuscitation and haemorrhage.
- Escalation plan for maternity services were in place to manage staff shortages and potential closures of the unit.

Are maternity and gynaecology services effective?

Requires improvement



At the previous inspection in October 2015, we rated effective as good. During this inspection we identified some concerns that would now make effective requires improvement because:

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- Following a serious incident the trust identified that all midwifery and medical staff were to complete training on cardiotocography interpretation by November 2016. Only 15% of midwives and 86% of medical staff had completed the training.
- The percentage of women experiencing third and fourth degree tears following assisted deliveries was above the regional average.
- Only 39% of medical staff were up to date with obstetric skills and drills training.
- The service was unable to implement Royal College of Gynaecology Guidelines – Small for Gestational Age Fetus, Investigation and Management due to a lack of scanning capacity.

However:

- The implementation of the saving baby's lives in Northern England (SABINE) care bundle had reduced the number of stillbirths.
- Women's care and treatment was planned and delivered in line with National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines.
- Different options of pain relief were available and women reported having their pain effectively managed. Support was available for women when feeding their babies.

Evidence-based care and treatment

- Policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Examples of guidelines we reviewed included bladder care guidelines and major obstetric haemorrhage guidelines. All guidelines had a review date with version control and the author was clearly identified.
- All staff could access guidelines, policies and procedures on the trusts intranet website.
- Policies and guidelines for ratification were discussed at the obstetrics and gynaecology clinical governance meeting.
- The service reviewed its compliance against thirteen NICE quality standards. Of the thirteen standards the service declared itself fully compliant with four of the standards and partially compliant with seven of the

standards. The service had not yet assessed itself against two of the standards. Quality standards that the service were partially compliant with included; QS109: Diabetes in pregnancy, QS35: Hypertension in pregnancy, QS22: Antenatal care, QS46: Multiple Pregnancy: Twin and Triplet Pregnancies and QS69: Ectopic pregnancy and miscarriage.

- The trust had implemented changes to practice following the saving babies lives in Northern England (SABINE) study. The midwifery teams had implemented standardised fundal height measurements and plotting on a customised growth chart.
- The service had introduced carbon monoxide (CO) monitoring in line with NICE PH26, smoking: stopping in pregnancy.
- A sepsis care bundle and sepsis management guidelines were available.
- The services risk register identified that they did not have adequate resources to implement RCOG Guidelines – Small for Gestational Age Fetus, Investigation and Management. The service did not have enough capacity to offer women the required number of scans. The trust had completed a business case to recruit additional sonographers and for midwives to be trained in scanning.
- The service audited compliance with The Abortion Act 1967. This included the completion of Certificate HSA1 forms. The trust reviewed the health records of 40 women who were admitted for a medical termination of pregnancy or a surgical termination of pregnancy during a one month period in 2015. The audit found 100% of women received an outpatient appointment within five working days, a data scan was performed in 100% of cases and HSA1 forms were completed and signed by two registered medical professionals prior to treatment commencing in 100% of cases.
- At the previous inspection we found there was not a standard operating procedure in place should the second theatre (anaesthetic room) need to be used. The trust now had this in place and it outlined the process to be followed, should a second theatre be required.

Pain relief

- There were several methods of pain relief available to women in labour. Women said they were provided with information about pain relief during their pregnancy.
- A birthing pool was available on the jasmine ward.

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- Nitrous oxide and oxygen (Entonox®) was piped directly into all delivery rooms and opiates were also available.
- The service provided a 24-hour anaesthetic and epidural service. We saw written information about epidurals and the associated risks were available for women.
- All women said they were able to access pain relief in a timely way, analgesia was offered regularly and their pain was well managed.
- Educational childbirth preparation classes were available for expectant parents. One of the topics covered was stages of labour including pain relief options.
- Women who had undergone gynaecological procedures said they received sufficient pain relief and nursing staff responded to requests for pain relief promptly.
- Clinical records showed staff assessed patient's pain throughout labour. On the gynaecology ward, pain scores were recorded on the NEWS charts.
- The service had an infant feeding coordinator who was responsible for the coordination of infant feeding practices and provided educational sessions to women and their partners.
- Women said that the food was very good and told us that different dietary and religious requirements were catered for. One patient said their partner and child were visiting when food was been served and they were offered something to eat.
- We saw staff taking beverages to patients regularly and patients had jugs of water in their rooms and tea and coffee making facilities.
- Maternity services had a dedicated area on the trust website. There was a wide range of information and videos available on the website about breastfeeding including maximising breast milk and hand expression.

Patient outcomes

Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in the hospital from November 2015 to October 2016 ranged from 61.6% to 69%. This was below the trust target of 74.4% and the England average of 76 %.
- The United Nations Children's Fund (UNICEF) baby friendly initiative is a global accreditation programme developed to support breast feeding and promote parent/infant relationships. The service was level two accredited and was due to be assessed for level three accreditation in January 2017.
- We saw poster outlining the UNICEF baby feeding friendly initiative and the ten steps to successful breast feeding. Breastfeeding advice was available for women.
- Healthcare assistant were trained to support new mums breastfeeding, using expression pumps and bottle feeding.
- Peer support workers saw women daily on the ward and provided breastfeeding support and advice. They continued to provide support via telephone calls once women had been discharged home.
- Women said they felt well supported and educated about feeding. Women said staff had shown them how to make up formulas and felt supported with breastfeeding.
- The trust did not have any active maternity outlier alerts, 'outlier alerts' are a description used to describe when a service lies outside the expected range of performance. However, the trust had reported a number of serious incidents resulting in poor outcomes including unexpected neonatal deaths.
- The maternity service at DPoW delivered 2663 babies from November 2015 to October 2016.
- The trusts Women's and Children's reporting dashboard provided information on a range of clinical indicators. We reviewed the dashboard for DPoW and saw from November 2015 to October 2016 the average rate for normal vaginal deliveries was 70.1%. This was better than the trust target of 60.9%. The average rate of instrumental deliveries was 5.4%; this was better than the trust target of 12.7%.
- For the same reporting period the hospital had an average elective caesarean section rate of 10.4%; this was better than the trust target of 11% and an average emergency caesarean section rate of 11.6%. This was better than the trust target of 15.2%.
- From November 2015 to October 2016 the rate of 3rd and 4th degree tears at DPoW ranged from 1.3% to 4.1% for normal deliveries and 0% to 30% for assisted deliveries. The service had no set targets on their dashboard for this clinical indicator.
- The percentage of postpartum haemorrhages above 1500mls ranged from 0.9% to 4%. There was no target set by the trust for this clinical indicator.

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- The trust participated in the Yorkshire and Humber regional performance dashboard; this allowed comparison with other hospitals in the region and help identify trends and patient safety issues. This was in accordance with recommendations of the Royal College of Obstetricians and Gynaecology 2008.
- The Yorkshire and Humber maternity dashboard RAG rated the service as red for 3rd and 4th degree tears in assisted births, and amber for 3rd and 4th degree tears in normal births. Third and fourth degree tears following an assisted birth was 12.5% compared to a regional average of 5.4% and in normal births was 3.1% compared to a regional average of 2.5%.
- In November 2016 the service audited 3rd and 4th degree tears. Recommendations from the audit included episiotomies with instrumental deliveries, continuing with daytime consultant supervision of trainee doctors during assisted deliveries and to include a demonstration of the instrumental delivery procedure during trainee doctor's inductions. The service planned to repeat the audit in 12 months.
- From January 2016 to October 2016 the number of unexpected admissions to NICU was 100. The data did not state the number of full term babies.
- The National Neonatal Audit Programme (NNAP) included two questions that applied to maternity services. The 2015 report indicated that the hospital was achieving 95% compliance with recording babies' temperature within an hour of birth; this was below the target of 98%. The hospital achieved 95% compliance for the percentage of mothers receiving a dose of antenatal steroids; this was above the target of 85%.
- Data provided by the trust showed the stillbirth rate per 1000 births had reduced from 6.5% in 2013, to 3.5% in 2016 which was below the threshold of 4.7%. This reduction was felt to be as a direct response to the implementation of the SaBiNE care bundles.
- Maternal deaths, readmissions rates or unplanned admissions to ICU were not recorded on the trusts dashboard. We requested this data from the trust; they reported no maternal deaths but did not provide information on the number of unplanned admissions to ICU or readmission rate.
- The trusts target for home delivery rate was 2.2%. From November 2015 to October 2016 the hospital achieved this rate in February 2015 (5.1%), June 2016 (2.2%), August 2016 (2.8%), September 2016 (3.1%) and October 2016 (2.2%).
- From April 2015 to March 2016 across the whole service, 283 births were to mothers under the age of 20. This equated to 6.5% of all births and was higher than the England average of 3.4%. There were 3,517 births to mothers aged 20-24, this equated to 80.6% of all births and was higher than the England average of 75.4%.
- The Yorkshire and Humber maternity dashboard RAG rated smoking at booking and smoking at time of delivery as red. The percentage of women smoking at the time of booking was 22.3% compared to a regional average of 17.3% and the percentage of women smoking at time of delivery was 21.5% compared to a regional average of 14.6%. Carbon monoxide monitoring was offered by community midwives and women were referred to a stop smoking practitioner.
- We reviewed information relating to post-delivery suturing. We reviewed the trusts guideline and definition of perineal trauma and repair and it stated: 'repair perineal trauma as soon as possible after birth to minimise blood loss and the risk of infection.' Data provided by the trust showed one patient had experienced a delay however when we reviewed the services incident data, from September 2015 and October 2016 there had been four incidents reported at DPoW. For example, in April 2016 a woman waited one hour and thirty minutes.
- In November 2015 the service audits compliance with six different screening programmes including; infectious diseases, Down syndrome/fetal anomaly, sickle cell and thalassaemia, new born hearing, new born blood spot and new born physical examination screening. The audit reviewed 26 sets of records and carried out a patient survey. The audit found good compliance, 98% of women were offered each of the screening programmes, 97% of women had the offer for screening within the agreed timescale, 96% of women had the results documented and 100% of women who had a positive screening result were referred for treatment in the appropriate timescale.

Competent staff

- At the time of our inspection, 94% of midwives and healthcare assistants and 50% of medical staff had completed an appraisal. Within gynaecology, 81.5% of nursing staff and healthcare assistants and 71.4% of medical staff had completed an appraisal.

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- The majority of staff we spoke with said they had completed an appraisal or were expecting one in the future. Staff said the appraisal process allowed them to discuss their development and learning needs.
- Midwives, medical staff and healthcare assistants attended an annual obstetric skills and drills training session. This enabled staff to maintain skills in a range of emergency situations and covered topics such as cord prolapse, pre-eclampsia and post-partum haemorrhage. Training data provided by the trust showed 84% of midwives had completed the training, however only 39% of medical staff had completed the update.
- All midwives must have a supervisor of midwives (SOM). Their role is to provide support and guidance for all practicing midwives. National recommendations for the number of SOM to midwives is 1:15. At the time of our inspection the ratio of supervisors to midwives was 1:13.
- All midwives said they had a designated SOM. Staff confirmed they had access to a supervisor of midwives for advice and support 24 hours a day.
- The LSA report complied in January 2016 confirmed that for the practice year five or more midwives had not completed their annual review. The report found that statutory supervision was very effective but the SOM needed to ensure all midwives were up to date with their annual reviews.
- The service had a clinical skills and governance midwife in post.
- The trust offered two types of CTG training, one of which was mandatory and the other was additional training known as a K2 training package (an interactive computer based training system that covered CTG interpretation and fetal monitoring). At the time of the inspection, 72% of midwives and 37.5% of medical staff had completed the mandatory training.
- One of the themes identified following a serious incident was CTG misinterpretation. One of the recommendations was for all medical and midwifery staff to complete the K2 training package, the timescale for completion was 30 October 2016. Training data provided by the trust showed to date 86% of medical staff and 15% of midwifery staff had completed the training.
- Community midwives said they participated in annual skills and drills training and that the training was tailored to fit community scenarios.
- The service had provided training to band 3 healthcare assistants to allow them to scrub in obstetric theatre.
- During our inspection we observed midwives carrying out teaching sessions with student midwives on the unit.
- The trust had a preceptorship programme for newly registered staff. The midwifery preceptorship document outlined specific competencies and training for midwives.
- The service had eight advanced midwife practitioners who contributed and lead in the care of women and their families. They were able to undertake some duties traditionally carried out by a senior house officer.
- Advanced nurse practitioners working in gynaecology had undertaken additional training allowing them to perform scans.
- Nursing staff said they felt supported in the revalidation process.

Multidisciplinary working

- We saw evidence of multidisciplinary working within clinical areas. All necessary staff and teams were involved in assessing, planning and delivering patients care and treatment.
- Staff described good working relationships with the medical staff in the care of patients and said they worked well together as a team.
- Systems were in place to ensure communication between the hospital-based midwives and community-based midwives on discharge. Communications with GPs, community midwives and health visitors included summaries of antenatal, intrapartum and postnatal care.
- At the previous inspection, coordinators were rotating across sites to share practice and promote a trust approach to service provision. During the inspection staff said this was no longer taking place.
- We saw evidence of staff working closely with community staff and GP's when dealing with safeguarding concerns.
- Anaesthetists attended the multidisciplinary team handover on labour ward and were made aware of any high risk women.
- Midwives used the SBAR tool (situation, background, assessment, recommendation) when handing over the care of women. SBAR stickers were used in patient records to document the handover.

Maternity and gynaecology

- We observed good multidisciplinary working within the obstetric theatre environment.
- Staff said they could access support and advice from specialist nurses/midwives and confirmed there were systems in place to request support from other specialities such as pharmacy and the critical care outreach team.
- Staff worked closely with children's services to care for babies admitted to the transitional care unit. (Transitional care is where babies who need a little more nursing care and monitoring can stay).

Seven-day services

- There was a consultant presence on the unit from 9:00am until 7:00pm on weekdays. There was designated consultant on-call cover outside of these hours.
- The maternity unit had access to a dedicated obstetric theatre which was available for use 24 hours per day, seven days a week.
- Out of hours anaesthetists were available and had shared responsibilities with critical care and theatres. A second anaesthetist was available on-call if required.
- There was an on-call rota of Supervisors of Midwives (SOM). They were available 24 hours a day, seven days a week and provided midwives with support. Staff did not report a problem contacting a SOM.
- The antenatal day unit was open from 8:30am to 5pm Monday to Friday, and from 9:00 am to 1pm Saturday and Sunday.
- The early pregnancy assessment unit was open from Monday to Friday.
- An on-call pharmacy service was available.
- Maternity and gynaecology services had access to diagnostics and imaging services out of hours.

Access to information

- Information relating to a women's discharge was sent to their GP's and community midwives.
- A 'hand held book' was used for recording women's care. This was kept by the women during their care and was completed as part of a record of their care between GP's, midwives and obstetricians where appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training was included in the trusts mandatory training programme. Training data requested from the trust did not demonstrate the percentage of staff compliant with the training.
- The trust had a policy for consent to examination or treatment, with a review date of June 2017.
- Women told us they were given sufficient information to enable them to make an informed choice about the delivery of their baby.
- We saw evidence in patient's records of consent forms completed for women undergoing caesarean sections and instrumental deliveries. Consent forms detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- Midwives and nursing staff were able to articulate how they would ensure consent was obtained either verbally or written prior to a procedure.
- There was a system to ensure consent for termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We reviewed five sets of records and found women were correctly consented for the procedure and forms were signed by two doctors.
- The pregnancy advisory service assessment used guidelines for assessing a child's competency to make decisions about their care and treatment.

Are maternity and gynaecology services caring?

Good



In 2015 the service was rated good for caring. At the 2016 inspection We rated caring as good because:

- Maternity and gynaecology services were caring. The NHS Maternity Friends and Family Test for September 2016 showed the number of women who would recommend maternity service was similar or better than the national average.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful way. There were arrangements to ensure privacy and dignity in clinical areas.
- Women spoke positively about their treatment by clinical staff and the standard of care they had received. They felt well supported and cared for by staff, and their care was delivered in a professional way.

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- Women felt involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care. The service scored similar to other trusts in the CQC's survey of women's experiences of maternity service 2015 when asked about involvement in decisions about their care.
- An 'afterthoughts' service was available for postnatal women who had experienced traumatic deliveries. It allowed women and their partners to attend an appointment with a midwife and discuss aspects of their care and treatment.

Compassionate care

- The trust received 103 responses to the CQC Survey of Women's Experiences of Maternity Services 2015. Results were similar to other trusts for 15 out of the 16 indicators relating to care received during labour and birth, staff during labour and birth and care in hospital after birth. The other indicator was better than other trusts (raising concerns and having it taken seriously).
- Friends and Family maternity test results from July 2016 to September 2016 showed the percentage of people recommending the hospital was consistently above the England average with the exception of patients who would recommend antenatal care. Results for September 2016 confirmed that 89%, 100%, and 100% of women would recommend the antenatal care, birth, and postnatal community care respectively. Data was not collected for the postnatal ward as women received all their care on the same ward.
- During our inspection, we spoke with four women. All of the women we spoke with were positive about the care and treatment they had received. One woman told us she had chosen to give birth at the hospital.
- Women told us staff were available if they needed them and promptly responded to call bells.
- We observed positive interactions between staff and patients. Staff introduced themselves and we witnessed staff using 'Hello my name is...'
- We saw letters and cards of appreciation displayed on a notice board on the unit.
- To assist in bonding, we saw posters displayed encouraging skin to skin contact whether the baby was breast or bottle feed.
- Women who were concerned about their pregnancy could contact the antenatal day unit. We heard staff providing encouragement and reassurance to women who were anxious and worried.

Understanding and involvement of patients and those close to them

- CQC's Survey of Women's Experiences of Maternity Service 2015. Showed results similar to other trusts for questions relating to involvement in decisions about care. The trust scored 8.5/10 for being involved in decisions about their care during labour and birth and score 8.1/10 for partner being involved as much as they wanted.
- Women said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby.
- Partners said that they felt involved in their partners care and treatment and were able to stay over with new and expectant mums.
- The Local Supervising Authority (LSA) completed an annual audit in January 2016. Part of the audit looked at care planning and supporting women's choices. The service was assessed as partially compliant as they had presented limited examples of care planning and supporting women's choices.
- However, the LSA report did identify some positive comments in relation to involvement in decision making and found that women felt they were provided with good levels of information and choices regarding feeding, birth plans and pain relief.

Emotional support

- The chaplaincy service was available and could provide support to women if requested.
- Staff said perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period.
- An 'afterthoughts' service was available for postnatal women who had experienced traumatic deliveries. It allowed women and their partners to return for a one to one appointment with a midwife to discuss aspects of their care and treatment.
- There were no specific counselling services for women who had experienced pregnancy loss. However, staff said women were given a contact number and could contact the clinic at any time for support and advice.

Maternity and gynaecology

- Patients undergoing surgical terminations of pregnancies were admitted onto the surgical day unit. Following the procedure staff said they would pull the curtains around patients but the environment did not always offer patients privacy.

Are maternity and gynaecology services responsive?

Good



In 2015 the service was rated good for responsive. At the 2016 inspection, we rated responsive as good because:

- The service involved women in the planning of services. The service worked with the Maternity Services Liaison Committee to design services to meet the needs of women and their families.
- Services were planned, delivered and co-ordinated to take account of women's needs and enable women to have the flexibility, choice and continuity of care to meet their needs.
- Women using the service felt they could raise concerns and complaints and they would be listened to. Learning and improvements were made to the quality of care because of complaints and concerns.

However:

- The service did not have a bereavement midwife. The service had produced a business case to recruit a bereavement midwife.
- Medical outliers on the gynaecology ward were having an impact on elective procedures and on patients accessing beds in a timely manner.

Service planning and delivery to meet the needs of local people

- Women had the option to either deliver at home, in the midwifery led unit at Goole or at SGH or DPoW.
- Community midwives carried out routine antenatal care. Hospital antenatal clinics were available for higher risk women. Midwives could refer expectant mums to the hospital antenatal clinic if they developed any problems.

- Maternity and gynaecology services worked with the local commissioners of services, the local authority, other providers, GP's and patient's to coordinate care pathways.
- The maternity services liaison committee (MSLC) had an active role in maternity services and minutes from July 2016 showed a good representation from service users.
- Clinics were held within the antenatal clinic to support women, such as smoking cessation clinics and diabetic clinics.
- The service offered a labour, delivery, recovery and postnatal (LDRP) model of care. This enabled women to stay in the same room throughout their stay.
- Partners were encouraged to stay overnight from delivery to support their partners and help take care of the baby.
- The service offered educational childbirth preparation classes run by midwives. Topics included, comfort, back pain and exercise in late pregnancy, signs of labour and when to come into hospital, natural coping strategies, stages of labour including pain relief options, assisting your partner in labour, variations of normal delivery including caesarean section, introduction to breastfeeding and life after birth.
- Gynaecology services had Advanced Nurse Practitioners who could perform scans and specialised in colposcopy, oncology and gynaecology scanning.
- The early pregnancy assessment unit (EPAU) provided care and treatment for women less than 20 weeks pregnant.
- From July 2015 to October 2016 the bed occupancy levels for maternity across the trust were generally lower than the England average, with the trust having 84.2% occupancy compared to the England average of 89%.
- From November 2015 to October 2016 the service had achieved 98.1% of antenatal booking appointments at gestation less than 13 weeks; this was above the regional average and the England average for the same reporting period.
- From February 2015 to July 2016 there were no maternity unit closures.
- As part of the staffing escalation plan, maternity service would go on internal divert and transfer women to DPoW. From 01 November 2015 to the 31 October 2016, 8 women were transferred to DPoW.

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- Staff said that the lack of capacity on NICU was increasing the number of maternal transfers. This had affected the service, and 15 women in the past 12 months were transferred to neighbouring trust (12) or internally to SGH (three) to deliver their babies.
- The service did not collect data about the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. However, staff told us all women were seen immediately on transfer to the labour ward by a midwife. Consultants reviewed patients in accordance to need, for example, a low risk woman would not need to be reviewed by an obstetric consultant.
- The services performance of meeting referral to treatment times (RTT) for gynaecology patients admitted for treatment within 18 weeks of referral was 94%.
- The service audited compliance with The Abortion Act 1967. This included the waiting times from decision to proceed. The trust reviewed the health records of 40 women who were admitted for a medical termination of pregnancy or a surgical termination of pregnancy during a one month period in 2015. The audit found 100% of women received an outpatient appointment within five working days.
- It was identified on the services risk register that pressures on the gynaecology ward from outlying medical patients was having an impact on the elective gynaecology procedures. From September 2015 to June 2016, 30 patients had their elective gynaecology procedures cancelled because a bed was not available on Laurel ward due to medical outliers.
- Staff raised concerns about gynaecology patients being unable to access beds on the ward in a timely manner due to medical outliers. For example in October 2016 a patient with a ruptured ectopic pregnancy was sent to theatre from the waiting area. Another patient who was experiencing a spontaneous miscarriage and bleeding heavily had to wait in the waiting area until they were moved to the examination room on the ward.
- We reviewed a complaint letter from a patient who was undergoing a medical TOP and was unable to have a side-room due to medical outliers on the ward.
- When we visited the ward they had eight medical outliers. Staff said the process for accepting medical

outliers were not robust and information about patients was not always handed over. For example, the ward had accepted a patient but had not been informed the patient had dementia.

Meeting people's individual needs

- Women told us they felt their individual needs were met and they felt listened to and able to participate in decisions about their care.
- There were specialist midwives in place including a teenage pregnancy midwife and a safeguarding midwife who specialised in substance misuse. However, the service did not have midwives who specialised in substance misuse, perinatal mental health, or bereavement.
- Women carried their own records and had contact numbers for the wards should they need advice.
- Maternity services had a dedicated area on the trust website. Pregnant women and their families could access the site and view information about the service, the facilities at the trust and advice about breastfeeding.
- Information leaflets were available on the ward and in antenatal clinic areas on a variety of subjects such as, induction of labour, breech deliveries and your baby's movement in pregnancy.
- In all areas we visited staff described how to access interpretation services through a telephone system called 'the big word'.
- Each of the four obstetric inpatient areas had a room that was designed for a specific use. For example, Honeysuckle ward had a room designed for disabled access, Holly ward had a high dependency room, Blueberry ward had a bereavement room and Jasmine ward had a birthing pool.
- A bereavement room was available on blueberry ward and gave privacy to women and their families experiencing pregnancy loss. Staff said families could use the room for as long as they needed.
- The trust did not have a specialist midwife for bereavement in post; however, the service had produced a business case to recruit one wte bereavement midwife. It was not clear from the business case if funded had been approved.
- Maternity staff said they had not completed bereavement training. The service's strategic plan had identified that the trust should provide training and two bereavement study days were scheduled for March 2017.

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- Memory boxes were offered to women who experienced pregnancy loss.
- Antenatal care and postnatal follow up was available for high risk women. This included access to an 'afterthought service; this allowed women and their partners to return for a one to one appointment with a midwife to discuss aspects of their care and treatment.
- Staff said bariatric equipment was available for patients and could be accessed in a timely manner.
- The service offered an eight-week education programme called young expectant parents (YEP). The programme was aimed at expectant teenage mums and offered support with finances, education on caring for a baby and peer support.
- Support was given to families for the sensitive disposal of fetal/placental tissue. Staff supported families and enabled them to make an informed choice with burial and funeral arrangements.
- Staff on the gynaecology ward could describe adjustments they would make in caring for those patients living with dementia, such as ensuring patients were in an area on the ward which could easily be observed.

Learning from complaints and concerns

- The trust had a policy in place for the management of complaints, concerns, comments and compliments. The policy was dated September 2016 and was in line with recognised guidance.
- The service had a system in place for handling complaints and concerns. Staff said they would try and resolve complaints at a local level and were aware of the procedure to follow.
- We saw information displayed advising patients and visitors how to make a complaint.
- From September 2015 to July 2016, maternity and gynaecology services received 34 complaints. Nineteen of these complaints related to DPOW. Themes of complaints included clinical treatment, communication, staff behaviours and patient care.
- The trust took an average of 49 days to investigate and close complaints; this was not in line with their complaints policy, which stated that category one complaints (single issue) should be completed within 30 working days.
- The service held monthly obstetrics and gynaecology operational meetings. Complaints were a standing

agenda item. Meeting minutes from 11 May 2016 noted an increasing trend in the number of complaints to the Patient Advice and Liaison Service (PALS) relating to the behaviour of staff.

- Minutes from the quality risk profile on the 24 August 2016 stated the number of complaints regarding Women's and Children's group had doubled since last year.
- We reviewed two response letters following complaints. The responses included an acknowledgement when care fell below the expected standard, and apology and actions to be taken.

Are maternity and gynaecology services well-led?

Requires improvement



At the previous inspection in October 2015, we rated well-led as good. During this inspection we identified some concerns that would now make well-led requires improvement.

We rated well-led as requires improvement because:

- There was a lack of assurance that lessons had been learned and embedded following serious incidents.
- Significant issues that threatened the delivery of safe and effective care were not always identified promptly and adequate action taken to manage them. For example, accessing obstetric theatre out of hours and midwifery staffing levels.
- A review of an RCA investigation found that it did not identified all of the factors that contributed to the root cause. This had impacted on the key learning points.
- Senior staff told us that there was a lack of support for the directorate at board level.

However:

- Staff said that ward managers were supportive and approachable. Governance and reporting structures were in place.

Leadership of service

- Maternity and gynaecology services formed part of the Women's and Children's group. An associated chief operating officer, a clinical lead for obstetrics and gynaecology and the head of midwifery led the service.

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Each hospital site had an operational matron. There was no nominated clinical director, with consultants instead operating as a forum and providing representation via a nominated representative.

- Senior staff told us that they felt that they lacked a representative at board level to lead and champion issues within the service. Staff felt that this impacted on the priority given to the service within the trust.
- Staff said that ward managers were supportive and approachable.
- Staff said the head of midwifery (HOM) had been more visible over the past few weeks and a 'meet and greet' session with the HOM had been organised by the service. However, due to poor staffing levels midwives had been unable to attend.
- We saw information and contact details for the head of midwifery displayed on a notice board in the staff room.
- Midwifery staff said the coordinator did a daily walk around the unit and were accessible. They said they allowed staff autonomy but offered support and guidance when required.
- The trust offered an in-house leadership training course.

Vision and strategy for this service

- Maternity and gynaecology services were part of the Women's and Children's health group.
- The vision for the group was, 'every woman and child in our locality is healthy and happy' and the 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.'
- The service had strategic objectives and an action plan to implement the services strategy. The actions were timed, assessed against an assurance framework and RAG rated.
- The strategic action plan was based on regional and national recommendations for example, the Kirkup report, saving babies' lives and recommendation for improving stillbirth and bereavement care in Yorkshire.
- Key priorities identified by the service included, improving the patient experience and support following bereavement including a bereavement midwife and implementing RCOG guidelines for small gestational age.

Governance, risk management and quality measurement

- Following our previous inspection the trust had recruited a clinical skills and risk midwife who had commenced in post in April 2016.
- The risk register was a standing item on the monthly governance meetings.
- Local risk registers assisted the service in identifying and understanding the risks. There were 11 risks, of which four 'high risk' were identified for maternity and gynaecology services. All had risk scores attached to them, review dates and existing controls to mitigate the risks. Examples of risks identified by the service included, medical outliers of the gynaecology ward, suturing and swab checks and CTG archiving.
- Midwifery staffing was not contained in the service risk register. Information provided by the trust following the inspection stated that midwifery staffing was now registered as a risk on the group risk register.
- A range of governance meetings took place within the service and the wider women and children division. This included monthly team meetings, operations meetings, clinical review meetings, a clinical audit group and morbidity and perinatal mortality meetings.
- These meetings then fed into a monthly care group wide clinical governance meeting. This worked to a set agenda and included dashboard and trend monitoring.
- We reviewed minutes of these meetings from August 2016 and saw complaints, incidents including lessons learned, audits, RCOG guidelines and policies were discussed. Previous actions were reviewed and monitored.
- We reviewed minutes of these meetings from August 2016 and saw complaints, incidents including lessons learned, audits, RCOG guidelines and policies were discussed.
- There had been a gap analysis undertaken following the publication of the Kirkup report (2015). There was an action plan to address areas of improvement with clear timescales and responsibilities. The action plan fed into the services strategic plan.
- Weekly case review meetings were held to discuss incidents such as emergency caesarean sections, instrumental deliveries and shoulder dystocia (difficulty in delivering the baby's shoulders).
- We reviewed the services women's and children's reporting dashboard and saw not all the maternity clinical indicators had targets. For example the number

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of 3rd and 4th degree tears and postpartum haemorrhage rate above 1500mls. Therefore it was unclear if the service was achieving above or below their target.

- Lessons learned from serious incidents were not embedded within the service or across both hospital sites. These concerns were shared with other external stakeholders. We reviewed three serious incidents that had resulted in unexpected neonatal deaths (one at DPoW and at SGH). All three incidents identified delays in commencing CTG's, delays in recognising CTG abnormality and delays in escalating and responding to CTG abnormalities.
- Following our inspection the trust had arranged an assurance meeting with the local supervising authority (LSA), deputy chief nurse and senior maternity team. The trust had produced an action plan and this was to be monitored through both the group and trust governance structures. The service had agreed to work with the LSA midwife and a meeting had been scheduled for December 2016.

Culture within the service

- Staff said they were encouraged to be open and honest, staff were aware of reporting incident and were aware of the duty of candour.
- The trust had worked hard to enable the different hospital sites to work more collaboratively. Cross-site senior meetings were held to share practice amongst teams. However, ward staff rarely worked across site.
- Staff said they were encouraged to raise concerns. One midwife said she had concerns about staffing levels and emailed the matron and HOM and got a response from both.

Public engagement

- We saw information displayed for patients about how to make a suggestion to improve the service.
- The maternity service had links to the local Maternity Services Liaison Committee (MLSC). The MLSC was run by a group of patient representatives who worked with staff and commissioners to develop maternity services.

We reviewed meeting minutes from the 15 July 2016 and saw good attendance. The agenda for the next meeting included an open meeting to discuss bereavement support.

- Friends and Family maternity test results from July 2016 to September 2016 showed the percentage of people recommending the hospital was consistently above the England average with the exception of patients who would recommend antenatal care. Results for September 2016 confirmed that 89%, 100%, and 100% of women would recommend the antenatal care, birth, and postnatal community care respectively. Data was not collected for the postnatal ward as women received all their care on the same ward.







Staff engagement

- Monthly briefings took place to keep staff up to date with events across the trust.
- There was no service specific data from the 2015 NHS staff survey in relation to staff engagement. However, the overall score for staff engagement was 3.7 this was below the national average (3.8).

Innovation, improvement and sustainability

- An online call service run by the infant feeding co-ordinator was being offered to support breast feeding mothers within the community setting.
- The development of advanced midwifery practitioners and advanced nurse practitioners in gynaecology.
- The trust had secured funding to deliver CTG masterclass training to all labour ward coordinators and obstetric consultants. The training provided staff with advanced skills in CTG interpretation.
- The trust had secured funding to purchase new equipment to deliver effective and realistic simulation training for obstetric emergencies.
- In 2016 the community midwifery team were nominated for the provision of an education programme aimed at expectant teenage mums and fathers.
- A leadership/management programme had been developed to support new aspiring leaders.

Services for children and young people

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

Information about the service

The service consists of both inpatient and outpatient services, alongside a paediatric observation and assessment unit (PAOU) co-located in the emergency department. The service provides a range of paediatric care, including general surgery, medicine and high dependency care.

Rainforest ward consists of 16 beds, plus an additional two high dependency beds. Of the 16 beds, there is one four bedded bay, two rooms with two beds/cots, and the remaining rooms are single occupancy. There are also two en-suite rooms available. The neonatal intensive care unit (NICU) has twelve cot spaces available and the PAOU has a trolley based assessment and observation area for six children and young people. The outpatient department consists of six outpatient clinic rooms in separate outpatient building on the hospital site. This was shared with the trust's child development centre.

During our inspection, we spoke with 16 members of staff, six parents of young children, two children receiving care and reviewed 11 sets of medical records. We also met with the service leadership team.

Summary of findings

At the previous inspection in 2014 we rated the children and young people service as good. At this inspection we rated this service as requires improvement because:

- Mandatory training and appraisal targets had not been met by all staff groups. This included safeguarding training targets and not all staff had the required level of safeguarding training in place. Clinical supervision was also not always formally recorded. Staff told us that the demands of the service meant that they were not always able to find time to access training or support.
- Learning from incidents was not always effectively shared. Learning was shared at team meetings and a service newsletter was in place. However, staff told us that they did not always have time to attend meetings or read minutes.
- We were not assured that staff had received the necessary paediatric life support training. This was because data provided by the trust suggested low rates of compliance. However, staff we spoke with told us that they had training in place.
- The tool used for paediatric early warning scoring did not provide a robust assessment of patient risk. Medical records were not always appropriately signed or completed by medical staff.

Services for children and young people

- National audit data results for diabetes and asthma were worse than national scores. The range of transition services available to older children was also limited. Paediatric surgery did not meet standards set by national guidance.
- There was a shortage of qualified nursing and medical staff available within the service. Staffing levels did not meet professional guidance and had resulted in services being closed at times of peak demand. There was a lack of senior nursing or medical cover available out of hours and at weekends.
- The NICU and Rainforest ward had been closed to admissions on a number of occasions due to capacity or staffing concerns. The PAOU was not always available to staff due to adult overflow patients from the emergency department.
- No specific safe room was used to assess or treat CAMHS patients and no wider ward based risk assessment had taken place.
- Complaints were not always responded to in line with the trust's target timescales and appropriate action plans were not in place.
- Identified risks to the service were not always appropriately recorded or monitored. We saw that staffing, CAMHS, and access issues were not specifically addressed in the service or trust risk register.
- Staffing shortages and workload pressures had impacted on morale and senior staff told us that there was a lack of support for children's services at board level. Ward based leaders had limited time dedicated to management duties.
- There were limited examples of staff and public engagement to drive improvements in the service.

However:

- Governance and reporting structures were in place and incidents were appropriately reported and investigated.
- The ward environments were clean and we observed good infection prevention and control techniques.

Medicines were stored securely and managed appropriately.

- Children and their families told us that they received compassionate and dignified care. Parents told us that they understood the care provided to their child and had been involved in decision making. Parents told us that they would be confident in seeking emotional support from staff.
- Staff spoke positively about their immediate line management and felt that they were working better cross site with Scunthorpe.

Services for children and young people

Are services for children and young people safe?

Requires improvement



At the previous inspection in 2014 we rated the children and young people service as good for safe. At this inspection we rated it as requires improvement, because:

- Learning from incidents was not always effectively shared.
- Not all staff had met requirements for level three safeguarding children's training.
- We were not assured that staff had received the necessary paediatric life support training.
- The tool used for paediatric early warning scoring did not provide a robust assessment of patient risk.
- Not all staff had met mandatory training targets.
- Medical records were not always appropriately signed.
- The environment for paediatric surgery did not comply with national guidance.
- There was a shortage of qualified children's nurses available within the service and staffing establishments did not meet professional guidance.
- There was a shortage of paediatric medical staff.

However:

- Incidents were appropriately reported and investigated.
- Medicines were stored securely and managed appropriately.
- The ward environment was clean.
- We observed good infection prevention and control techniques.
- Pain and nutritional needs were appropriately met.

Incidents

- Between September 2015 and August 2016 the trust reported no incidents which were classified as never events for children's services. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in

children's services which met the reporting criteria set by NHS England between September 2015 and August 2016. All incidents occurred at Scunthorpe General Hospital.

- Data from the Patient Safety Thermometer showed that the trust reported no pressure ulcers, no falls with harm and no catheter urinary tract infections between August 2015 and August 2016 in children's services. The NHS safety thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Rainforest ward and the PAOU reported 99 incidents between September 2015 and August 2016. The majority of these (83) were reported as no harm, with 16 as low harm and one as moderate harm. We saw that incidents we reviewed were appropriately graded and that duty of candour had been noted as being commenced in the moderate harm incident.
- The NICU reported 37 incidents in the same period. Of these, 28 were reported as no harm, seven as low harm, one moderate harm and one death. The death related to a pre-term baby born after a caesarean section. This was passed to midwifery to lead on the investigation. We saw that incidents we reviewed were appropriately graded and that duty of candour had been noted as being commenced in the incident involving the death.
- Management staff told us that they had identified a number of cases of misidentification within the children service. This had not caused harm to patients, but had resulted in confusion and on one occasion breast milk being provided to the wrong child. As a result, a decision had been taken for a concise root cause analysis (RCA) investigation to take place into every misidentification incident. We reviewed a copy of one of these RCAs. This included appropriate detail on the cause of the misidentification and set out appropriate actions to resolve these concerns.
- Staff told us that incidents were shared and discussed at team meetings. However, many staff told us that they were not always able to attend meetings due to work pressures. Meeting minutes were circulated and displayed in staff areas. However, there was no way for staff to sign or confirm that they had read the minutes in order to learn about the incidents that had been shared.

Services for children and young people

- The service participated in bi-monthly perinatal morbidity and mortality meetings with maternity services to discuss the deaths of neonates. The service told us that the deaths of older children were not as frequent and could be discussed individually or in other forums (for example, a child death in the emergency department would be discussed at the emergency department meeting).
- Staff we spoke with were broadly aware of the duty of candour and requirements to be 'open and honest' with patients when things went wrong. However, the majority of staff were unfamiliar with the legal duties and processes under the duty of candour regulation.

Cleanliness, infection control and hygiene

- Ward based nursing and medical staff had attained 84% and 88% compliance with mandatory infection prevention and control training. Outpatient staff had attained 100% compliance, but paediatric play specialists had a lower compliance of 67%.
- The trust conducted monthly infection control audits. The NICU performed consistently well between December 2015 and August 2016 with average scores between 93% and 98%.
- Rainforest ward recorded mixed results across this period with overall scores ranging from 87% to 100%. There was no particular trend or theme identified across the low reported scores.
- Hand washing basins and gel were available in clinical areas. Hand gel was also available outside patient rooms and on entry to the ward. Signs were in place to encourage staff and visitors to wash their hands.
- We observed the majority of staff complying with the arms bare below the elbow policy when entering clinical areas.
- We observed the majority of staff that interacted with patients adopted appropriate hand hygiene techniques.
- At the time of our inspection, a number of children on the ward were suffering from bronchiolitis. These children had been isolated in side rooms and appropriate notices were in place to advise staff of the precautions that needed to be taken in interacting with these patients. We saw staff using appropriate personal protective equipment and hand hygiene techniques when interacting with these children.
- In the latest CQC children's survey in 2014 the trust scored 9.09 for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts. Site level data was not available.

Environment and equipment

- Matron conducted a monthly environmental assessment of the ward areas. This incorporated observations around areas such as general environment, equipment, and waste disposal. In the latest available audit in August 2016, Rainforest ward scored 96% overall. However, ward environment (86%) and equipment (88%) were two of only three areas not to score 100%. The children's outpatient department had last been audited in June 2016 and had achieved a score of 99% overall.
- Staff told us that one former four bedded bay had been divided into two rooms with two bed/cot spaces. We observed that these rooms were cramped and staff told us that they did not have room to safely manoeuvre around the bed areas. Theatre trolleys could not fit into the room and staff told us that, in the event of a resuscitation call, it was likely that one bed/cot would need to be removed to allow staff to safely respond to the call. Staff we spoke with were not aware of any formalised risk assessment that had taken place around these rooms and it was not recorded in the service risk register. This meant that there was a risk that the environment was not suitable.
- We saw that resuscitation equipment was available on Rainforest. In addition, cot side resuscitation equipment was available at each cot area within the NICU. Resuscitation equipment on Rainforest had not been consistently checked in the previous three months; it had not been checked on seven days in September, 14 days in October, and three days in November 2016. However, at the time of our inspection we saw that the trolleys and cot sides had appropriate stocks of medicines and equipment.
- Access to the NICU and Rainforest ward was via swipe card or buzzer system. CCTV was available to staff to monitor access and identify visitors before being allowed in.
- There was a fridge on NICU for expressed breast milk to be stored. Milk was labelled to show which baby it was

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to be used for. The fridge and room it was in were not locked. This meant that there was a risk that milk could be tampered with. However, no such incidents had been reported at the time of our inspection.

- We saw that children and young people were placed on adult theatre lists. They were anaesthetised in the same area as adults, and were recovered in shared recovery bays with adults, with a curtain separating them. However, there was a risk that children in recovery would be able to see adult patients being transported and recovered. This process was not in line with Royal College on Anaesthetist standards (Standards for Children's Surgery, 2013) or Royal College of Nursing guidance.
- In the latest CQC children's survey in 2014 the trust scored 9.46 for the question 'Did you feel safe on the hospital ward?' The trust scored 9.5 for the question 'Did you feel that your child was safe on the hospital ward?' The trust scored 8.8 for the question 'Did the ward where your child stayed have appropriate equipment or adaptations for your child?' These scores were about the same as other trusts.

Medicines

- Medical and outpatient staff were 100% compliant with mandatory medicines management training. Ward based nursing staff were 88% compliant with this training at the time of our inspection.
- Medication charts were appropriately completed and signed in the records we reviewed. This was in line with professional guidance and Trust policies.
- The temperature of medication fridges on the NICU and Rainforest was recorded to ensure that medications were stored at appropriate refrigerated temperatures. We saw no gaps in the checking of medication fridges in NICU and only minor omissions on the ward. These were locked to maintain security.
- Staff told us that the ambient temperature of the room where other medicines were stored was not routinely recorded. There was a thermometer in the room and staff told us that they would report any temperature they thought was excessively high to the pharmacy team in case this impacted on the drugs stored in the room.

- Controlled drugs and medication prescription pads were securely locked away in a separate cabinet to maintain their security. We saw that controlled drugs books were up to date to show medicines received and given out.
- Staff told us that they received a daily visit from pharmacy staff during week days. Weekend discharges were planned in advance so that any medications to take home could be ordered and checked by pharmacy during the week.
- Staff used an electronic key system to activate the controlled drugs cupboard. This meant that there was a log of which key had been used to access the cupboard. The key also deactivated if not used within a certain period. This protected against access from keys which could have been lost/misplaced without the need to replace locks.
- We checked the patient group directives (PGDs) in place. PGDs are documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions. These were in date and had been appropriately signed by staff to acknowledge compliance.

Records

- Medical staff were 95% compliant with mandatory information governance training. Outpatient staff and ward based nursing staff were 100% compliant.
- We reviewed 11 sets of records across Rainforest and NICU. In general, we saw that the documentation was of a good quality in regard to the recording of clinical interactions, with appropriate entries being recorded in the records and few gaps in planned observations.
- However, the majority of records did not contain a legible signature from medical staff or their GMC number. This meant that it was not always possible to identify which member of medical staff had made an entry in the records. This was not in line with General Medical Council guidance on record keeping.
- Staff on NICU told us that standard observations charts had been introduced between DPoW and Scunthorpe in the past six months to ensure there was a consistent approach to the monitoring and recording of observations. The charts we reviewed had been fully completed by staff.
- Multidisciplinary staff, NICU staff and medical staff wrote in black ink. On the ward we saw that nursing staff wrote

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in the medical records in red pen. Staff told us that this was custom and practice within the trust. No concerns had been identified by staff around the legibility of records that required photocopying.

Safeguarding

- The trust set a target of 95% for completion of the relevant level of safeguarding children training by staff. Intercollegiate guidance (Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, March 2014) states that all clinical staff working with children, young people and/or their parents should undergo appropriate safeguarding training. The required levels of safeguarding training had not been achieved throughout the service. This meant that there was a risk that staff looking after children did not have appropriate training to identify and address safeguarding concerns.
- At the time of our inspection, the hospital medical staff had met training targets for level one and level two safeguarding. However, only 63% of staff had completed relevant level three training.
- Ward based nursing staff had also met training targets for level one and level two safeguarding training. However, only 84% of staff had completed relevant level three training. Outpatient department staff were 100% compliant with all necessary training.
- Surgical staff in theatres operated on and cared for children and young people. Data provided by the Trust showed that no staff received level three safeguarding training. The theatre manager told us that training was at 85% compliance. However, this meant that there was a risk that staff in theatres and recovery were not appropriately trained to identify or act on any safeguarding concerns.
- Nursing staff were also required to undergo level one training in safeguarding adults. At the time of our inspection, ward based nursing staff had failed to meet a target of 95% with 71% of staff having received this training.
- Although some safeguarding children training was above target levels, level three training and safeguarding adults training was below the trust target across the service. The risk around level three safeguarding was recorded on the corporate risk register and monthly compliance reporting was taking place.
- An up to date safeguarding policy was in place. This provided guidance to staff when identifying, responding

to and reporting safeguarding concerns. The policy included reference to child sexual exploitation. . A separate policy was in place to provide staff with guidance on female genital mutilation.

- Staff told us that they were confident in identifying safeguarding issues and reporting. Staff provided practical examples of things that would raise concern and how they would report this.
- Designated nurses and medical staff were available at both hospital sites for staff to contact should they wish to discuss any safeguarding concerns.
- The 'failure to be brought' policy for outpatient consultations set out safeguarding concerns that could be raised due to parents or carers not bringing children and young people to planned appointments. It provided guidance on how to escalate and act on these concerns.

Mandatory training

- The trust set a target of 95% for completion of mandatory training. This included 13 modules across a range of subjects.
- At the time of our inspection, medical staff had achieved 72% compliance with mandatory training. Only four of 19 modules had made completed by more than 95% of staff.
- Ward based nursing staff had achieved 87% compliance with mandatory training. Six of the 19 modules had been completed by more than 95% of staff. Outpatient staff had achieved 100% compliance in all but one module.
- Training was available online and via some face to face sessions.
- Staff on NICU told us that they did often have time to complete mandatory training in work time. However, staff on the ward felt that there was not sufficient opportunity to complete mandatory training in work time and that this was often done on their own time after work.

Assessing and responding to patient risk

- Mandatory training data provided by the trust showed that staff needed to undergo a yearly resuscitation training course. For the yearly course, 68% of ward based nursing staff, 89% of outpatient staff, and 26% of medical staff were shown as being compliant with this

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training. In addition, medical staff were expected to undergo additional training every two years. At the time of our inspection, 63% of medical staff were compliant with this additional training.

- Additional data provided by the trust showed that 24% of medical staff and 56% of nursing staff had undergone training in paediatric intermediate life support. This meant that there was a risk that there may be a lack of staff on duty with appropriate resuscitation training.
- However, nursing and medical staff we spoke to told us that their resuscitation training was up to date. This did not correlate with the data provided to us by the trust.
- Cross site data provided by the trust showed that there had been 24 paediatric resuscitation or trauma calls in the emergency department that had been attended by ward staff between September and November 2016. Staff told us that they carried an emergency bleep to attend these calls due to a shortage of paediatric trained staff in the emergency department. Staff said that attending calls could leave ward staffing levels at unsafe levels.
- The trust paediatric early warning scoring (PEWS) system comprised of a traffic light alert system, with observations set out in normal (green) abnormal (amber) and very abnormal (red) on age dependant paper observation charts.
- We saw that the tool did not provide a numerical scoring system to prompt staff as to the risk to the patient. This meant that it could be difficult to identify the risk to a patient where scores were elevated across more than one set of observations.
- Management staff told us that efforts had been made to move to an electronic system, but that this was found to be unable to show the trends involved if a patient's condition was changing. At the time of our inspection, management staff told us that consultation work was ongoing in the local region with other NHS trusts to develop a new regional numerical scoring tool.
- An audit of nursing documentation in July 2016 considered the PEWS scoring in two case files from Rainforest ward. This identified mixed compliance with the use of the PEWS tool. PEWS scoring was found to be used appropriately and accurately documented. However, there were concerns that the associated management plan did not contain all the necessary

elements. We saw no specific action plan in place to address this. However, management staff told us that audit results were shared with ward staff at team meetings.

- The NICU had developed a neonatal early warning scoring system (NEWTT) and observation charts. We saw that these were used effectively to monitor and assess risk.
- The service undertook a gap analysis against the UK Sepsis trust's standards for the emergency management of sepsis in children. This identified that paediatric patients presenting to the service may not be screened for sepsis. In response to this, laminated PEWS charts for all ages, and NICE Guidance re 'Clinical assessment of children with Fever' had been placed in the emergency department and PAOU for guidance and reference. However, the gap analysis also noted that specific training on sepsis was not available to paediatric staff.
- The service was able to access support and guidance on the transfer of critically ill patients via the local EMBRACE network. Staff reported good working relationships with EMBRACE and knew how to contact them for support if required.

Nursing and other staffing

- As at July 2016, the trust reported that it had an establishment level of 20.6 whole time equivalent (wte) nursing staff on Rainforest and 27.4 on the NICU. Staffing was above establishment level on Rainforest (21.7). However, staffing was below establishment on the NICU (24.6).
- Between August 2015 and July 2016 the trust reported no vacancies at the hospital. However, the staff turnover rate was noted to be 10.5%. This was significantly higher than the turnover rate in Scunthorpe (0.8%).
- Sickness levels at the hospital were also higher than those reported in Scunthorpe (6% versus 4.8%).
- The hospital reported low usage of bank or agency staff, with 0.4% of shifts being covered. This was higher than the reported rate at Scunthorpe (0.1%).
- Staff worked a two shift system, from 7am-7pm and 7pm-7am. There had recently been a move to introduce a further additional nurse on a 7/8am-3/4pm shift on Rainforest ward.
- The service told us that it used a recognised staffing acuity tool to measure the acuity and dependency of patients. The acuity and dependency of patients was

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measured three times a day and used to measure the safety of staffing in the clinical area, in line with Royal College of Nursing and British Association of Perinatal Medicine guidance.

- Data provided by the trust showed that for the last reported three month period (June to August 2016) the average fill rate for nursing shifts on Rainforest and the NICU was below establishment levels. Fill rates for nursing staff on Rainforest were 74.9% for day shifts and 82.2% for night shifts. Fill rates for nursing staff on the NICU were 87.1% for day shifts and 84% for night shifts.
- The service told us that efforts had been made to recruit nursing staff to increase establishment. This had included the recruitment of nine adult nurses who had undergone additional in house training and two pre-registration, newly qualified nurses from outside of the UK. The service told us that it had encountered difficulties in recruiting qualified children's nurses. A staff bank was in use; however, this had only limited numbers of staff available to it.
- However, this meant that adult trained staff could not be rostered together without a qualified children's nurse on duty. Also, the two pre-registration nurses employed had been employed as band 5 staff members. However, they could only be rostered as band 4 staff due to the lack of registration. This meant that two band 5 staff posts were not filled by band 5 staff.
- Data provided by the trust showed that for the last reported three month period (June to August 2016) the average fill rate for healthcare assistant shifts on Rainforest was above establishment levels. Fill rates for healthcare assistant staff on Rainforest were 100.5% for day shifts and 144.3% for night shifts. However, fill rates for healthcare assistant staff on the NICU were below establishment levels 48.6% for day shifts and 53.6% for night shifts.
- During the inspection, we observed that ward staffing was not in line with Royal College of Nursing guidance to treat the acuity of patients. There was no supernumerary senior nurse on night or weekend shifts. Only two band 6 staff members were employed within the service (with one near retirement). This meant that some night and weekend shifts were led by a band 5 nurse, with no senior children's nursing cover on site. In addition, we saw that it was not always possible for two qualified children's nurses to be on duty at the same time.
- To mitigate this, senior staff told us that band 7 staff could be called in from the NICU to offer support. In addition, senior nursing staff said that they were available by telephone if staff had any concerns out of hours.
- Staffing of the PAOU was also not in line with RCN guidance that two children's nurses should be available during operating hours, with only one nurse being on duty at any given time. Staff working in the PAOU told us that this could be challenging and meant that they did not always get a break. In addition, staff in the PAOU told us that they were often busiest in the evening; when nursing cover on the ward had reduced.
- At the time of our inspection, the ward had nine patients (one high dependency, six children under two years old, and three children over two years old). Guidance states that there should be a nurse to patient ratio of 0.5:1 for high dependency patients, 1:3 for patients under two years old, and 1:4 for patients over two years old. The majority of these patients were being nursed in side rooms, which require additional nursing resource. Three nursing staff were on shift, with one additional nurse working a 7am-3pm shift. In addition to this, staff also had to treat patients attending via PAOU, ward attenders, and carried the emergency bleep for paediatric resuscitation.
- The night prior to our visit, the ward had three high dependency patients and six other children. Only two nurses (one band 5 registered children's nurse and one of the ward's adult nurses) had been on duty and the ward had been closed to admissions due to a lack of suitably qualified staff to care for the number of patients.
- Data from November 2016 showed that 62.5% of shifts on the NICU had been filled in accordance with British Association of Perinatal Medicine guidance on staffing numbers. This was greater than the national average of 57.9%. The service also identified that 88.5% of shifts had been staffed with appropriate 'qualified in specialty' nurses. This was also above the national average of 72.4%. No shifts had been covered by a designated supernumerary team leader. This was below the national average of 22.9% and was not in line with BAPM guidelines.
- Rainforest ward had an establishment of 4.6 wte play specialists. At the time of our inspection, 3.2 play specialists and a 0.5 nursery nurse were in post. Staff told us that play support was available for most week

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days and at specified outpatient clinics. However, no cover was available at weekends, in accident or emergency, or at most outpatient clinics. This was not in line with The National Service Framework for Children's Services (2004) which identifies that play specialists should be available to all children attending hospital services.

Medical staffing

- The proportion of consultant staff reported to be working at the trust was lower than the England average. The trust had a notably larger proportion of junior staff (foundation year 1-2) than the England average, reporting 17% compared to the England average of 7%.
- Between August 2015 and July 2016 the trust reported a vacancy rate of 9% for medical staff at the hospital. Staff turnover was 35.5%, which was lower than the rate reported at Scunthorpe (43.6%).
- Sickness levels were 2.2%, which was roughly equivalent to Scunthorpe (2.4%).
- The hospital reported use of bank and agency staff to be 4.5%. This was greater than the usage of bank and agency staff at Scunthorpe (1.7%).
- The hospital had seven paediatric consultants. A consultant of the week system was in operation. During the week, one consultant was available for Rainforest ward between 9am-1pm and one consultant was available to NICU between 9am-5pm. The consultant on Rainforest handed over to the NICU consultant at 1pm and they then covered both wards. After 5pm there was a different consultant on call who was non-resident (with consultants covering a one week in six rota).
- The consultant cover did not meet the Facing the Future: Standards for acute general paediatric services (2015) in regard to consultants being present and readily available in the hospital seven days per week or the number of consultants on the rota.
- There were 11 middle grade doctors at the hospital (four specialty doctors and seven trainees from ST4 to ST7). One doctor was available on each of the PAU, Rainforest and NICU wards between 9am-5pm Monday to Friday. Two doctors were available between 5pm-9pm. One doctor was available overnight from 9pm-9am. There was also one doctor available at weekends.
- There were eight junior doctors or trainees and six advanced nurse practitioners (ANPs) rostered with the junior grades. One doctor was available on each of the

PAU, Rainforest and NICU wards between 9am-5pm Monday to Friday. Two doctors were available between 5pm-9pm. One doctor was available overnight from 9pm-9am. There was also one doctor or ANP available at weekends.

Major incident awareness and training

- The trust delivered major incident training during induction for all staff. As of July 2016, all staff had completed this training.
- Staff were broadly aware of the major incident policy in place and said that they would be able to access this online, or seek support from senior staff in the event of a major incident occurring.

Are services for children and young people effective?

Requires improvement



At the previous inspection in 2014 we rated the children and young people service as good for effective. At this inspection we rated it as requires improvement, because:

- There was a lack of senior nursing or medical cover available out of hours and at weekends.
- Staff appraisal rates for ward based nursing and medical staff were below target levels.
- Clinical supervision was not always formally recorded in line with trust policies.
- National audit data results for diabetes and asthma were worse than national scores.
- The range of transition services available was limited.

However:

- Pain and nutritional needs were appropriately met.
- Guidance used was in line with national recommendations.
- Staff were aware of Gillick considerations when considering consent to treatment.

Evidence-based care and treatment

- A rolling audit plan was in place for the service. This included prescribing, outpatient growth charts and transfer of critically ill children. Audit results were not available to us at the time of our inspection.

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- Monthly reports were completed by Matron and submitted to the Chief Nurse. This included audits in relation to ward and NICU record keeping and infection control practices. The latest report from October 2016 had not been completed, with indicators listed as not being completed that month.
- Policies we reviewed were up to date and based on appropriate Royal College and National Institute of Health and Care Excellence guidance.
- The trust acquired UNICEF Baby Friendly level two status in 2015 and was working towards a Level three accreditation. The assessment was scheduled to take place in January 2017.
- The NICU was in the process of developing and submitting action plans to gain BLISS accreditation and was waiting to hear on the outcome of applications.
- The NICU had recently been subject to a visit peer review visit from the local Neonatal Operational Delivery Network. The report was published in April 2016, which highlighted positive aspects of the NICU. It also identified capacity and staff recruitment concerns shared by the unit team.
- We saw that the NICU used guidance issued by the regional neonatal network. We found that some of the guidance in use was out of date, with renewal dates for three policies being in 2010, 2014 and 2015. There was no evidence that the policies had been reviewed or steps had been taken to consider whether revised guidance was necessary.

Pain relief

- The records we reviewed showed that pain was considered and appropriately documented.
- We observed that pain relief medication was appropriately prescribed and dispensed by staff.
- Staff explained the ways in which they would determine if a child or young person was in pain, including verbal and non-verbal cues. Staff were confident in their ability to identify pain and to access appropriate medical advice to act on this.

Nutrition and hydration

- The records we reviewed showed that nutrition and fluid balance sheets had been completed appropriately.
- Protected meal times were in place on the ward to allow children and young people time to eat their meals without clinical interventions taking place.

- Menus were available to children and young people to allow them to select the meals they would like to eat the following day. Staff told us that multi-faith food could be ordered if required.
- Food and drink facilities were available to parents in the parent's room. This included the ability to make hot drinks, store food and heat food.
- Breast milk was stored on the NICU and there were parent rooms available to allow breastfeeding mothers to feed their child in private if they desired.

Patient outcomes

- The trust performed worse than the England average in the 2014/2015 national paediatric diabetes audit. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. There were fewer patients having a HbA1c value of less than 58 mmol/mol compared to the England average (18.8% versus 22.1%) and the mean HbA1c was higher than the England average (71.7% versus 70.5%).
- Between March 2015 and February 2016 there was insufficient data available to compare to the England average for patients readmitted following an elective admission in both the under one and 1-17 age groups.
- Data was available to show that between March 2015 and February 2016 there was a lower percentage of under ones readmitted following an emergency admission compared to the England average (2.3% versus 3.4%) and a lower percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average (1.5% versus 2.8%).
- Between April 2015 and March 2016 the trust had insufficient data to compare performance to the England average for the percentage of patients under the age of one who had multiple readmissions for asthma, epilepsy and diabetes.
- The trust performed marginally worse than the England averages for the percentage of patients aged 1-17 years old who had multiple readmissions for all three conditions. For asthma this was 17.6% versus 16.6%, for epilepsy this was 13.6% versus 13.1%, and for diabetes this was 31.1% versus 29.3%.
- In the 2015 National Neonatal Audit the hospital met or was above the NNAP standard/benchmark for three of the four indicators and was below the NNAP standard/benchmark for the remaining indicator.

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- The hospital was below the NNAP benchmark for “What proportion of babies <33 weeks gestation at birth are receiving any of their mother’s milk when discharged from a neonatal unit?” The hospital proportion meeting the standard was 32% against a benchmark of 60%.
- The trust action plan set out that staff would ‘continue to promote and support women breastfeeding on the unit and where possible encourage them to continue after discharge’. We saw that breastfeeding was promoted on the NICU.
- Staff told us that they had received reminders and guidance in relation to revalidation. Staff were confident that they could seek additional support if this was required.
- Theatre and recovery staff caring for children did not have specific paediatric training and there was no specialist paediatric anaesthetist available. The trust instead relied on its own anaesthetists who had an interest in paediatric anaesthesia. Staff told us that theatre staff and anaesthetists maintained their competency by treating paediatric patients regularly. However, staff also told us that there were not many children operated on at the trust. This meant that there was risk that staff could not evidence competence to treat these children.

Competent staff

- As at November 2016, 70% of ward based nursing staff, 75% of outpatient staff, 83% of paediatric play specialists and 60% of medical staff had undergone an annual appraisal compared to a trust target of 95%. On average, 73% of staff across the service had received an appraisal.
- Staff told us that appraisals were helpful and that they had the opportunity to feed into appraisals to identify any development needs.
- Clinical supervision was expected to take place once or twice per year in accordance with the trust policy. Staff told us that supervision took place more frequently, but that this was often informal via team meetings and one to one conversations. This meant that clinical supervision was not always formally recorded to show how frequently this was occurring or what had been discussed.
- We saw that health care assistants were placed in charge of babies in the transitional area. These staff underwent additional preceptorship training over a 12 month period to provide enhanced skills and knowledge in regard to the care of babies. A competency package was also being developed to monitor progress going forward. However, we saw that staff were relied on to provide care without completing all aspects of the preceptorship training.
- Senior staff told us that this care was usually limited to areas where training had been provided and where support was available from qualified staff. However, some staff told us that this did not always occur, and that due to the demands of the NICU, healthcare staff were sometimes left to care for babies without having completed the correct formal training.

Multidisciplinary working

- The ward was able to access support from therapy services. Staff told us that these staff would not routinely attend ward rounds, but would do so if there was a specific patient that was identified as needing therapy support
- There was a dedicated pharmacist for the children’s service available during week days.
- We saw that the MDT notes were clearly recorded in individual patient records.
- The service told us that paediatric transition services were focused on diabetes, which has a monthly transition clinic shared with a paediatric consultant and an adult consultant who jointly saw young people aged from 15 to 19 years. In addition hospital sites undertook epilepsy transition clinics whereby a paediatrician and adult medical consultant reviewed young people quarterly. Management staff told us that they were currently in the process of establishing an endocrine transition clinic with adult services which would take place at least twice per year.
- For children with physical disabilities, learning disabilities and complex health problems there were currently no transition clinics. Young people were referred to the appropriate adult services between the ages of 16 to 17.5 years old.
- Staff had access to 24 hour, seven day telephone support from the child and adolescent mental health service. In addition, the service told us that CAMHS

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would contact the ward following a cooling off period (usually overnight) for admitted patients. CAMHs would routinely see patients in person on the ward prior to discharge.

- In the last CQC children's survey in 2014 the trust scored 8.4 for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.

Seven-day services

- The medical cover available meant that overnight, or at weekends, there was routinely only one middle grade and one junior grade doctor on site to cover Rainforest ward, NICU, the PAOU, and any emergency resuscitation calls. Staff told us that consultants were available and did always attend when requested. However, this still meant that there was a risk that medical staffing at night and weekends was not sufficient to meet demand. Some staff told us that they did have concerns about the medical cover available at these times.
- There was routinely no band 6 or 7 nursing cover available on Rainforest ward overnight or at the weekend.
- Outpatient clinics had been running on Saturdays in the three months prior to our inspection. Staff understood that this had been a temporary measure and that there were no plans for a Saturday service to operate going forward.
- The PAOU was open at the weekends between 9am and 10pm.
- Staff told us that they were able to access paediatric pharmacy services during week days between 9am-5.30pm. There was a general pharmacy provision at weekends between the hours of 9.00am and 1.30pm. This team could be contacted to provide pharmacy support if required. However, staff told us that this was not a paediatric specialty service. Given this, staff kept a stock of regularly required medication to allow medicines to be provided to patients attending at weekends.

Access to information

- Staff reported no concerns in being able to access patient medical records on site.
- Policies and guidance were available via the trust intranet. Staff told us that it could be hard to locate documents online, but that these were available and could be accessed from any trust computer.

- We saw that discharge summaries were provided to the relevant GP on discharge. Staff told us that GPs could contact the ward to request further information if required.

Consent

- Staff we spoke with were aware of the requirements of Gillick competence when considering consent for treatment from children and young people.
- The medical records we reviewed showed that consent had been considered and recorded where appropriate. We observed staff interacting with parents of younger children to seek their consent to treatment.
- At the time of our inspection, 68% of medical staff, 71% of ward based nursing staff, and 100% of outpatient staff were compliant with Mental Capacity Act (MCA) training. This meant that there was a risk that medical and ward based staff would be unable to accurately assess the capacity of parents or carers in making decisions about their child's care.

Are services for children and young people caring?

Good



At the previous inspection in 2014 we rated the children and young people service as good for caring. At this inspection we rated it as good, because:

- We saw that children and their families told us that they received compassionate and dignified care.
- Parents told us that they understood the care provided to their child and had been involved in decision making.
- Parents told us that they would be confident in seeking emotional support from staff.
- Play specialists were available to help provide support to children using services.

However:

- The trust performed below average in some questions around the understanding of parents and emotional support in the last CQC Children's Survey in 2014.

Compassionate care

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- We spoke with six parents of young children and babies receiving care. All parents told us that staff had been caring and compassionate towards their children and the family.
- We observed staff provided dignified and compassionate care to the children in their care. This included ensuring that privacy was maintained in bay areas and that children were engaged in their care.
- The most recent NHS Friends and Family data from October 2016 showed that the NICU had received 100% satisfaction scores. However, only seven responses had been received. Rainforest also scored 100% satisfaction ratings, from 15 responses.
- NICU had a 'quiet hour' every day to allow parents time to spend with their baby uninterrupted by medical or nursing staff. Parents told us that they found this very helpful in spending quality time with their child.
- NICU used a butterfly sticker in cot areas to identify multiple pregnancies where not all of the children survived. This allowed staff and visitors to be aware and be sensitive of the feelings and needs of these parents.
- The trust performed about the same as the England average for all of 14 questions relating to compassionate care in the CQC children's survey 2014.

Understanding and involvement of patients and those close to them

- The majority of parents we spoke with felt that they had been kept up to date with the care being provided to their child and had been involved in decisions about care. The older children we spoke with were also able to describe why they were in hospital and what they expected to happen.
- The NICU used a 'parent's journal' in which both staff and parents were encouraged to write and share information about a babies development, including stories, comments or concerns. We observed that of the six journals we saw, these were only around 20% complete. Staff acknowledged that they would like the journals to be utilised more to increase information sharing and participation between staff and parents.
- In the CQC children's survey 2014 the trust scored 8.3 for the question 'Did a member of staff agree a plan for your child's care with you?' This was about the same as other trusts.
- However, the trust performed worse than other trusts for three out of 19 questions relating to understanding and involvement of patients and those close to them.

The questions where the trust performed worse than other trusts were all regarding staff communication with parents/carers, particularly around aspects of the child's care.

Emotional support

- Open visiting hours were available on the ward and NICU for parents. NICU then allowed visiting between 2pm-4pm and 6.30pm-8pm. The ward allowed visiting from 8am-8pm.
- Play specialists were available during week days to support children.
- Parents we spoke to told us that they felt supported by staff and would be comfortable speaking to staff to request emotional support.
- Staff told us that there were leaflets and information available for parents to direct them toward local counselling or support services if needed.
- Staff told us that they understood the need to interact and provide wider support to children, young people and families. They were happy to spend time to offer support, but did comment that this could be limited due to the demands on them.
- The trust performed worse than other trusts for one out of three questions relating to emotional support in the CQC children's survey 2014. This question was regarding staff communicating with parents/carers regarding who they should talk to if they were worried about their child post-discharge.

Are services for children and young people responsive?

Requires improvement



At the previous inspection in 2014 we rated the children and young people service as good for responsive. At this inspection we rated it as requires improvement, because:

- The NICU and Rainforest ward had been closed to admissions on a number of occasions due to capacity or staffing concerns.
- The PAOU was not always available to staff due to adult overflow patients from the emergency department.
- No specific safe room was used to assess or treat CAMHs patients and no wider ward based risk assessment had taken place.

Services for children and young people

- Complaints were not always responded to in line with the trust's target timescales and appropriate action plans were not in place.

However:

- Appropriate facilities were available to parents.
- Translation services were available if required.

Service planning and delivery to meet the needs of local people

- Rainforest ward had 16 bed spaces and two high dependency beds. The ward did have additional bed spaces available. However, staff told us that these had been closed to admissions for some time due to being unable to staff to the full ward occupancy level.
- The NICU had 12 cot spaces, with the unit capable of accepting intensive care, high dependency and special care babies. Routinely, space was available for three intensive care baby, two high dependency babies, and seven special care babies.
- The PAOU was open between the hours of 9.30am-10pm, seven days a week. The last admission to PAOU was accepted at 7pm. Outside of these hours, paediatric patients would attend the emergency department. Lower risk patients would then be asked to attend Rainforest for treatment. The PAOU was located to the rear of the emergency department in the main hospital building.
- Outpatient clinics were routinely available between 9am to 5pm, Monday to Friday. These provided consultation to children, young people and families over a range of medical and surgical specialties.
- The NICU and Rainforest were located together in a newer building to the rear of the hospital. This allowed a separate point of entry and exit for children, young people and families.
- Data provided by the trust between July and October 2016 showed that there had been 55 admissions/transfers of patients aged 14-16 to non-children's wards. This broke down as three young people aged 15 and 52 young people aged 16. The most common non-paediatric ward they were admitted/transferred to was the surgical emergency assessment and the diagnostic and investigation unit (9).
- The NICU had been required to close 51 times in the year to July 2016 due to pressure on beds. Staff told us that a business case was being progressing to look at increasing bed numbers at both hospital sites. We saw

that an escalation policy was in place to instruct staff on closure of the unit and the steps that could be taken to obtain additional staff or transfer out well babies to try and maintain the unit being open.

- Data provided by the trust showed that Rainforest ward had been closed to admission 14 times since May 2016 due to a lack of beds.
- Up to date escalation policies were available and staff told us that these were followed so that admissions were diverted to Scunthorpe. When this was not possible, efforts were made to ensure patients could be diverted to other specialist paediatric services within the region.
- Concerns around access to PAOU were recorded on the risk register and raised with us by staff. Out of hours, the PAOU was used by the emergency department as an additional bed space. Staff noted concerns that it was not always possible to open PAOU as planned in the morning as adult patients remained in the bed space. When this occurred, the PAOU operated out of Rainforest ward, but this placed additional demand on ward capacity and could cause some confusion for children, young people and families.
- The NICU had purpose built accommodation for parents to be resident with their babies. The unit had a single room and two double rooms that accommodated parents, along with shared kitchen facilities. There was also an addition room available that was shared between the NICU and the ward. Kitchen, toilet and shower facilities were also available.
- The ward also had a dedicated room for parents to reside. Parent beds and recliners were also available on the ward for parents to stay over. However, staff told us that there were not currently sufficient beds or recliners to accommodate all parents. New recliners had been purchased from charitable funds and a further application for charitable funds was in the process of being made.

Access and flow

- Overall, the trust had 3,699 patient spells between April 2015 and March 2016. Emergency spells accounted for 94.4%, 5.3% were elective spells, and the remaining 0.3% were day cases. A total of 96.5% of spells were paediatrics, 2.9% neonatology and 0.6% were well babies. It was not possible for this data to be provided at hospital site level.

Services for children and young people

- The most common reason for admission for children under one year old was acute bronchitis (17.5%). The most common reason for admission for children and young people aged one to 17 years was viral infection (10%). These figures were in line with England averages.
 - Between April 2015 and March 2016 the median length of stay for children under the age of one and children and young people aged one to 17 was similar to the England average.
 - Between September 2015 and August 2016, data provided to NHS England showed neonatal cot occupancy has been continuously below the England average. Occupancy rates continuously fluctuated during this time period with December 2015, February 2016 and June 2016 data from NHS England showed zero occupancy.
 - However, an internal trust analysis prepared as part of a neonatal staffing review in May 2016 identified cot occupancy to be 109% at the hospital and 99% at Scunthorpe on average. Staff we spoke to on the units confirmed that this was accurate and that they could only recall capacity being close to 100%, as reported in the internal staffing review.
 - At the time of our inspection, outpatient reporting data for children and young people showed that of 2101 children and young people for follow up and not on an active referral to treatment pathway, only 76 (3.6%) were overdue an appointment. An additional 30 (1.4%) children and young people were noted as having no due date for an appointment.
 - For the 35 children and young people for follow up on an active referral to treatment pathway, only one (2.8%) was reported as being overdue for an appointment. However, an additional nine (26%) of children and young people were noted as having no due date for an appointment.
 - For the 263 children and young people awaiting a first appointment, the majority (230 or 84%) were seen within six weeks of referral. Four patients (1.5%) had waited longer than 18 weeks for an appointment.
 - A 'failure to be brought' policy was in place setting out the steps that staff should take to refer children and young people back to GPs or discharge them from the service if appointments were not attended.
- via the emergency department and such patients were rarely seen on Rainforest. In total, data provided by the service showed that one CAMHS patient had been admitted to Rainforest in the 12 months prior to our inspection. This was due to the need for medical intervention.
- However, staff we spoke with on the ward told us that they would see children and young people with mental health problems more regularly; often a number of times per month. In addition, a report prepared on children and young people presenting with self-harming problems, or where this was diagnosed during their hospital stay showed that between November 2015 and October 2016 there had been 41 (34) such admissions. This meant that there was a risk that this information was not being accurately captured within the service.
 - There was no specific safe room used to assess or treat CAMHS patients. Instead, a tool was in use to assess the risk posed to CAMHS patients by the ward environment and prompt staff to remove any risks to their health (for example, oxygen tubing or curtains that could be used as ligatures). Staff told us that support could be provided by local services to provide 'sitters' to remain with patients noted as being at a higher risk of self-harm. Staff told us that no wider ward based risk assessment had taken place.
 - The ward had a dedicated room for breaking bad news or allowing parents to be with children who had died. The room was sensitively decorated, with a sofa, crib and household furniture. There was also a stock of clean clothing to allow any deceased children to be dressed in new clothes.
 - Rainforest had an adolescent room for older children and young people. This included games consoles, age appropriate games and films, and a pool table. Staff told us that this allowed a separate area for older children to spend time away from younger children or their family.
 - A play room was also available for younger children. This included games and activities to allow parents or play workers to engage young children in play.
 - Translation services were available on the telephone or could be booked for face to face consultations if required. Leaflets in languages other than English were not routinely kept on the ward or NICU. However, staff told us that these could be requested if required.
 - There was no specific specialist nurse available to support children and young people with learning

Meeting people's individual needs

- Information provided by the trust prior to our inspection explained that routine contact with CAMHS patients was

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disabilities. The service told us that instead an in reach service was available from the locally commissioned community service who could be contacted to request support for patients with specific needs.

Learning from complaints and concerns

- There were 10 formal complaints made to the hospital, the majority of which were regarding clinical treatment or communication. This was greater than the number of complaints received by Scunthorpe (1).
- We reviewed three complaint responses provided by the service. These provided explanations around care received and were in an appropriate tone. However, one response failed to address all of the issue set out in the complaint. In addition, we saw only one response contained an action plan to monitor learning. The action plan was not robust and was considered complete when issues had been referred to meetings for discussion. This did not identify the outcome of discussions or what actions had been taken to prevent similar failings occurring in the future.
- The trust took an average of 49 days to investigate and close complaints, and the children's core service took an average of 46 days (excluding cases with renegotiated deadlines). This performance was not in line with the complaints policy which anticipated that the majority of complaint (single issue complaints and multiple issue complaints about the service) should be responded to within 30-45 days.

Are services for children and young people well-led?

Requires improvement



At the previous inspection in 2014 we rated the children and young people service as good for well-led. At this inspection we rated it as requires improvement, because:

- Identified risks to the service were not always appropriately recorded or monitored.
- There was a lack of dedicated management time for ward based leaders.
- Staff morale was affected by staffing shortages and demands on the service.
- Staff and public engagement was limited.

- Staff were not aware of the business strategy for the service.

However:

- Governance and reporting structures were in place.
- Staff spoke positively about their immediate line management.
- Staff felt that they were working better cross site.

Leadership of service

- The service formed part of the Women's and Children's group. An associate chief operating officer and a head of children's nursing, formed part of the leadership team. There was no nominated clinical director, with consultants instead operating as a forum and providing representation via a nominated representative. Each hospital site had an operational matron and ward based and outpatient managers.
- Senior staff told us that they felt that they lacked a representative at board level to lead and champion children's issues. Staff felt that this impacted on the priority given to children's services within the trust.
- Staff spoke positively about their immediate management at ward and matron level. Nursing staff told us that they felt supported and valued by their immediate managers.
- Ward managers had nine and a half hours per week dedicated management time. Outside of this they were rostered to work as clinical staff. We saw that it was sometimes necessary for ward managers to cover additional clinical shifts when staffing shortages were recorded. This meant that there was limited time available for ward managers to carry out management tasks and functions.
- A minority of staff spoke less positively about senior leaders. Some staff told us that they did not feel senior staff always listened to feedback from front line staff. Staff also told us of examples where e-mails and messages to senior staff were not responded to or acted on, or where action was taken without consultation or communication with staff.
- Staff told us that senior leaders were visible and that they would know how to speak with senior staff if they had any concerns.
- Staff told us that there was no identified lead for paediatric surgery.

Vision and strategy for this service

Services for children and young people

- The vision for the child and women's health group was, 'every woman and child in our locality is healthy and happy' and the 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'.
- The service had identified five business objectives for the 2016/2017 financial year. This included objectives in relation to staffing, costs, improvement and innovation.
- Staff we spoke with were broadly aware of the wider vision for the service. However, they were not aware of the business objectives provided to us by management staff.
- Staff told us that they had increased cross site working within the past 12 months and expected that this would increase further as part of the wider vision of services. Staff told us that they felt more like a single service than they had in the past.
- These meetings then fed into a monthly care group wide clinical governance meeting. This worked to a set agenda and included dashboard and trend monitoring.
- We reviewed the minutes of the meetings and saw that they were well attended. Issues discussed included incidents, complaints, patient safety alerts, mandatory training, serious incident and RCA action plans and the risk register. Previous actions were reviewed and monitored
- Managers told us that they had developed an attendance monitoring system to ensure that senior staff were attending this meeting. This was now linked to job planning with a view to ensuring that information shared in the meeting was able to be shared with staff.
- Staff told us that there was no standard operating procedure in place for paediatric surgery.
- Following our inspection, the service provided us with a copy of an assurance plan developed for the division. This noted concerns around access and flow issues, as well as staffing and skill mix concerns. A staffing and skill mix review was planned alongside process mapping patient pathways through the service. No specific target date had been noted for completion of this work.

Governance, risk management and quality measurement

- A risk register was in place for the service. This identified ten areas of risk (six moderate and four low risks). We saw that some risks had remained on the register for over six years without a resolution being achieved. We saw that some risks had received regular review and follow up to ensure that mitigating action was in place. However, other risks were simply noted as 'ongoing' or 'to monitor' for a number of months.
- Paediatric medical staffing was not contained in the service risk register. Paediatric nurse staffing was also not contained in the risk register provided by the Trust at the time of our inspection. However, following our inspection the Trust confirmed that paediatric nurse staffing had been added to the service risk register in August 2016. There was also no consideration of the risk posed to CAMHS patients due to the lack of a safe room for treatment.
- General risks around staffing were contained within the corporate risk register. However, this did not specifically refer to concerns in relation to paediatric staffing or action in place to address this concern.
- A range of governance meetings took place within the service and the wider women and children division. This included monthly team meetings, operations meetings, clinical review meetings, a clinical audit group and morbidity and perinatal mortality meetings.

Culture within the service

- Staff told us that they were proud to work within the service and did their best to provide excellent care. However, many staff reflected on staffing shortages as causing fatigue and stress. They felt that this was why some core tasks (for example, mandatory training) was not completed.
- The majority of nursing staff did feel part of the wider trust and said that they had good working relationships with staff in Scunthorpe. A minority of staff felt that there was still a divide between the sites and explained that they did not always feel like a combined service.
- Staff explained that there was a different approach to disciplinary action for nursing and medical staff. Staff told us of examples of incidents where as a result nursing staff had undergone disciplinary action, but medical staff involved had not.
- Staff told us that they would receive written warnings for failures to complete standardised daily clinical checklists. Guidance stated that the trust had a zero tolerance approach to checks being missed. However,

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

- Staff felt that many of the challenges they faces were due to staffing issues, but were uncertain what steps were being taken to improve this.
- Staff said that they were encouraged to be 'open and honest' in their dealings with children, young people and families.

Public engagement

- The service used a 'pants and tops' system to allow children to feed back on the care they received. Children filled out 'pants' templates and said what they did not like, or filled in 'tops' templates to say what they did like. At the time of our inspection, completed templated were displayed on the ward. However, these had not been updated since August 2016.
- The adolescent room on Rainforest had been developed in conjunction with pupils from a local school. The pupils had been involved in designing the room and creating art work for the walls.
- At the time of our inspection, the service told us that no specific public engagement activities had taken place. However, a service user group was being developed to

include parents of babies/children who had accessed services. The service told us that 'parent participants' had been recommended by staff from the NICU and paediatric wards. Terms of reference were in development and the inaugural meeting was scheduled to take place in December 2016.





Staff engagement

- Monthly 'open meetings' were available for staff groups to meet with senior managers in the service.
- Ad hoc open meetings had also been held with newly appointed staff and neonatal staff to discuss specific issues.
- Staff told us that they did not always feel that their views were sought before changes were made. However, the majority of staff told us that they understood the nature of changes being made to services, for example in a change in NICU staffing.

Innovation, improvement and sustainability

- The NICU at both hospital sites had received an award as 'ward of the year' at the trust's internal award presentation evening.
- The local regional network identified the services NEWTT scoring and observation charts as being a positive innovation.

End of life care

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

Information about the service

Northern Lincolnshire and Goole NHS Foundation 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. The hospitals located in Northern Lincolnshire are Diana, Princess of Wales Hospital and Scunthorpe General Hospital. Goole District Hospital is in East Riding of Yorkshire. During this inspection, we did not visit Goole Hospital. The trust has approximately 850 beds.

End of life care encompasses all care given to patients who are approaching the end of their life and following death, and may be delivered on any ward or within any service of a trust. It includes aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services.

The trust employed a specialist palliative care team (SPCT); this included a Macmillan lead cancer nurse, a MacMillan end of life care clinical coordinator, an end of life care practice facilitator and two consultants. There were no specialist palliative care clinical nurses employed by the trust at this hospital, this was provided by an external independent healthcare provider through a service level agreement.

During our inspection of Diana Princess of Wales Hospital, we visited ten wards and departments where end of life care was provided. We met with the senior management team for the service. We spoke with 18 members of nursing staff and medical staff. We also spoke to porters and housekeeping staff.

We also visited the mortuary and bereavement suite and spoke with a member of staff from the mortuary.

We spoke with two patients and two relatives and looked at the care records of seven patients receiving care at the end of life.

The last comprehensive inspection of end of life care services at the hospital was in April 2014; at that time, we found the service to be good overall.

End of life care

Summary of findings

At the inspection in 2014, we rated end of life care services as good. At this inspection we rated this service as good because:

- There were low numbers of incidents involving end of life care patients. Staff we spoke with were aware of the duty of candour. All areas that we visited appeared clean and well maintained. The trust had policies and procedures in place for the safe handling and administration of medicines. There were also specific policies available to support staff caring for patients at the end of their life. Patient records were stored securely and record keeping was of a good standard.
- We saw that trust policies referenced national best practice guidance such as the National Institute for Health & Care Excellence (NICE). This included policies relating to care at the end of life, such as anticipatory drug prescribing for end of life care and the pain and symptom management guidance in the last days of life. We saw evidence of local and national audit participation. We saw that patient's pain levels; nutrition and hydration needs were assessed and managed effectively. Staff had effective clinical supervision. The trust had been involved in the development of a Northern Lincolnshire multi-agency end of life care strategy; from this, they had identified seven work streams, each of which had developed key performance indicators to measure the trust performance and patient outcomes.
- We observed staff being compassionate to patients and their families without exception. Patients and relatives we spoke with said that the staff were 'brilliant' and that the nurses are 'angels'. We found that staff were sensitive to the needs of the patients and their families. We saw staff caring for patients and their families and speaking to them in a respectful and compassionate manner. We saw that staff provided emotional support to patients and their families.
- Patients and staff had seven-day access to specialist palliative nurse support. Staff on the wards told us that the SPCT were visible, available and that they regularly reviewed end of life patients and had

discussions with patients and their families. Information received from the trust indicated that 86.5% of patients referred to the SPCT were seen within 48 hours. The bereavement team had developed robust processes to help and support bereaved relatives. 82% of patients audited were asked about and 71% achieved their preferred place of death.

- The trust had been involved in the development of a multi-agency end of life strategy that encompassed the whole of the local health economy. The trust was collating and monitoring quality measures such as patient outcomes through seven strategy sub-working groups. There was a non-executive director, at board level. Staff reported a positive culture and good working relationships between teams. The trust were supporting the development of staff that were caring for patients at the end of life and we saw good examples of innovation and staff whose purpose was to maintain and improve the services provided to patients and their loved ones.

However:

- There was limited use of the trusts last days of life documentation, however the senior team had identified this were progressing the roll out of the document across the trust.
- The trust employed less than the National Council for Palliative Care guidance of two whole time equivalent (wte) consultants per 250,000 population however, there had been no specialist palliative care medical staff in place during our previous inspection therefore this was an improvement. Chaplaincy support was minimal.
- Low numbers of staff had received a yearly appraisal. The trust did not use an electronic palliative care co-ordination system; however, the development of this was part of the strategy action plan. We were concerned that consent to care and treatment was not always obtained in line with legislation and guidance, including the Mental Capacity Act 2005, for patients who lacked capacity.

End of life care

- Not all risks for the service were identified on the risk register for the end of life care service. For example, the delayed roll out of the last days of life document and completion of the deceased patient audit tool were not on the risk register.

Are end of life care services safe?

Good



At the inspection in 2014, we rated safe as good. At this inspection we rated safe as good because:

- There were low numbers of incidents involving end of life care patients. Staff we spoke with told us that they were encouraged to report incidents; they were confident in the use of the trust's electronic reporting system and were aware of their duty of candour.
- All areas we visited, that were providing care at the end of life, appeared clean and well maintained. We saw staff using appropriate personal protective equipment and washing their hands before providing care to patients.
- The trust had policies and procedures in place for the safe handling and administration of medicines. There were also specific policies available to support staff caring for patients at the end of their life.
- We found that patient records were stored securely and record keeping was of a good standard.
- Staff were aware of their responsibilities in relation to safeguarding and were aware of the process they would follow if they had a concern or needed to raise an alert. Trust safeguarding policies were available to support staff.

However:

- Use of the trusts last days of life documentation was minimal however the SPCT were progressing the roll out of the document across the trust.
- The trust employed less than the National Council for Palliative Care guidance of two wte consultants per 250,000 population however, there had been no specialist palliative care consultants in place during our previous inspection therefore this was an improvement.
- Chaplaincy support was minimal, the trust establishment of 2.5 whole time equivalent chaplains, was less than the levels recommended by the NHS Chaplaincy Guidelines 2015, Promoting Excellence in Pastoral, Spiritual & Religious Care.

Incidents

End of life care

- All staff we spoke with told us that they were encouraged to report incidents and that they were confident in the use of the trusts electronic reporting system.
- Senior staff told us that incidents were coded so that they were identified as involving patients receiving end of life care. Information provided by the trust showed that there were low numbers of incidents.
- This hospital had reported nine incidents, between September 2015 and August 2016, which involved patients receiving care at the end of their life. All of these incidents were low or no harm. Most related to a deterioration in patients skin condition or problems arranging transport to get patients to their preferred place of care in a timely manner.
- Staff from the SPCT told us that they received notifications when incidents involving end of life care patients happened. If necessary, the SPCT would liaise with the relevant ward managers to address any actions needed or to support staff in the care of their patients.
- We looked at minutes of the palliative care business and governance meetings and saw that incidents relating to end of life care patients were discussed at this meeting.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with were aware of their responsibilities in relation to duty of candour. We saw that following incidents the trust apologised to the patients involved and their families. There had been no incidents requiring duty of candour for patients receiving care at the end of life. However, staff told us about being open, honest, and apologising if things went wrong.

Infection Control and cleanliness

- Personal protective equipment (PPE) such as gloves and aprons was available in all areas. Hand sanitiser was also available at the entrances to all wards and outside patient bays and side wards. We saw staff using appropriate PPE and washing their hands before providing care to patients.
- We saw a health and safety policy and laboratory safety handbook to support staff working in the mortuary. This policy contained guidance relating to infection prevention and control.

- We asked the trusts for infection control audits of the mortuary; we were told that the infection prevention control nurses did not formally undertake these at the time of our inspection but that this was to be added to the schedule.
- Staff completed IPC training as part of their mandatory training programme.

Environment and equipment

- Many wards and departments at the hospital provided care at the end of life. Staff we spoke with told us equipment, such as syringe pumps and specialist mattresses, were readily available for patients.
- All areas that we visited, that were providing care at the end of life, appeared clean and well maintained. This included the ward areas, departments such as the intensive care unit, coronary care unit and the accident and emergency unit, as well as the mortuary and the bereavement team offices.
- The mortuary staff completed a daily audit of fridge temperatures. We saw that these were fully completed and accurate. The fridges in the mortuary had an electronic automated alarm system to alert staff if the temperature of any individual fridge became out of the normal range. Staff were available 24 hours per day in case of emergencies.

Medicines

- The trust had policies and procedures in place for the safe handling and administration of medicines. There were also specific policies available to support staff caring for patients at the end of their life, these included the anticipatory drug prescribing for end of life care and pain and symptom management guidance in the last days of life.
- Anticipatory prescribing ensures that staff are able to provide symptom control medications, in a timely way, to patients as and when it is needed. This includes medications for pain, shortness of breath, restlessness, nausea and respiratory tract secretions.
- We found that anticipatory medications were prescribed for five of the seven (72%) patients whose care records we reviewed.
- In an audit of care records completed in May 2016, 43% of the records showed that all anticipatory medications

End of life care

had been prescribed and 43% showed that these had been partially prescribed. This meant that anticipatory prescribing appeared to have improved since the audit was undertaken.

- Staff on accident and emergency told us that the unit stocked anticipatory medications that meant that they were able to provide patients with appropriate symptom control on admission.
- On one ward we were told that sometimes patients were discharged before their medications were ready, when this happened, we were told that staff delivered the medications later.

Records

- We found that medical and nursing records were stored securely in all areas we visited. This meant that patients' confidential records were kept safe.
- The trust used an intentional rounding tool. Intentional rounding involves nursing staff using predetermined questions to ask patients on a regular basis about care needs and checking the patient environment to ensure that it is clean and uncluttered and that everything is in reach of the patient. We saw that these were in place for all patients.
- In the records we reviewed, we found that patients risk assessments were completed. We saw generic trust care plans in place that were appropriate for the patients' needs, however we did not see evidence that care plans were individualised.
- We looked at seven sets of patient care records and found that where the SPCT had been involved a comprehensive review and assessment of the patients needs was completed.
- In May 2016, an audit of end of life care patient's records had shown that individualised additional information had been discussed with the patient's family in 70% of cases. In the records, we looked at patient and family involvement was clearly documented in all of the records, which was an improvement.
- We saw limited evidence of advanced care planning for patients approaching the end of their life.
- The trust was in the process of implementing a last days of life document that would support staff in the care and treatment of patients approaching the end of their life. We did not see this documentation in use on any of the wards we visited; we did see one blank copy of the document in the records of one patient who was receiving end of life care. We discussed this with the

senior management team, who confirmed that the roll out of the document had taken longer than expected but that the recruitment of more staff to the SPCT would assist with this.

Safeguarding

- Staff completed adult and children's safeguarding training as part of their mandatory training.
- Nursing staff, we spoke with told us that they had completed safeguarding training and were able to describe the process they would follow if they had a concern or needed to raise an alert.
- Staff also said that they knew how to access safeguarding policies and procedures via the trust intranet.

Mandatory training

- The trust target for completion of statutory and mandatory training compliance was 95%. Data showed overall compliance of 86% for the mortuary team and 79% for the bereavement and chaplaincy teams. Whilst compliance was below the trust target, there had been absences within the chaplaincy team and there were small numbers within the teams.
- All clinical nursing staff completed syringe driver training as part of their mandatory training requirement. Most staff we spoke to said they had completed this training. Staff who had not yet had the opportunity to complete the training told us that they were not involved in setting up syringe drivers.
- The trust had recently introduced end of life care as part of all clinical staffs' mandatory training.

Assessing and responding to patient risk

- The trust used a recognised national early warning score tool (NEWS). These tools assist staff in the early recognition and response to a deteriorating patient. We saw these in use in the care records we reviewed.
- We saw that risk assessment tools were completed for all patients. This included venous thromboembolism (VTE), falls, pressure area, malnutrition and moving and handling. When a patient was identified as at risk, we saw that a care plan was created.
- An audit completed in May 2016 showed that 86% of patients did not have an ongoing daily review by a doctor or an initial assessment of their symptoms. In the records reviewed at the time of our inspection, we saw that a doctor had seen all patients daily.

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- Advice is issued to the NHS as and when issues arise, via the Central Alerting System. National patient safety alerts (NPSA) are crucial to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. We saw that national safety alerts, which related to the team, were discussed at the palliative care business and governance meeting and actions needed were identified and shared.

Nursing staffing

- The trust did not employ any specialist palliative care nurses at this hospital. An external independent health provider was commissioned to provide this service, seven days a week, through a service level agreement.

Medical staffing

- The trust provided acute hospital services and community services to a population of more than 350,000 and employed two wte palliative care consultants. This was less than the National Council for Palliative Care guidance of two wte consultants per 250,000 population.
- A consultant was available for face to face or telephone advice and support Monday to Friday 9am to 5pm. There was no out of hours telephone advice service available.

Chaplaincy, Mortuary and Bereavement Teams

- The trust had an establishment of 2.5 whole time equivalent (wte) chaplains. The NHS Chaplaincy Guidelines 2015, Promoting Excellence in Pastoral, Spiritual & Religious Care, suggests that the trust should employ 6.6 wte chaplains. At the time of our inspection, two wte chaplains were in post and there had also been high levels of absence within the team.
- This hospital had an establishment of 0.5 wte chaplaincy cover. This post was vacant at the time of our inspection.
- Staff we spoke with raised concerns about the availability of chaplains. We were told that in the four months prior to our inspection there had been 44 days with no chaplaincy cover.
- Three chaplaincy volunteers provided additional support at the hospital. A Roman Catholic chaplain was retained for one session per week and for specific Roman Catholic needs out of hours.

- There were no vacancies in the mortuary or bereavement team. We were told that annual leave and sickness was covered within the team.

Major incident awareness and training

- NHS providers have a statutory obligation to ensure they can effectively respond to emergencies and business continuity incidents whilst maintaining services to patients. We saw that the trust had a business continuity plans and major incident policy.
- The trust had needed to declare a major incident, a few weeks prior to our inspection, due to the trusts computer systems had being hacked. All staff who spoke with us about this told us that the incident had been well managed and that care to patients was not affected.
- Staff completed major incident training as part of their mandatory training.

Are end of life care services effective?

Requires improvement



At the inspection in 2014, we rated effective as good. At this inspection we rated effective as requires improvement because:

- The trust did not meet the NICE guidance for seven-day palliative care provision.
- We saw limited use of the trusts care in the last days of life document however; members of staff from the senior team told us that the roll out of the documentation was being prioritised.
- Low numbers of staff had received an appraisal within the last year.
- The trust did not use an electronic palliative care co-ordination system however; the development of this was part of the strategy action plan.
- We were concerned that consent to care and treatment was not always obtained in line with legislation and guidance, including the Mental Capacity Act 2005, for patients who lacked capacity.

However:

- We saw that trust policies referenced national best practice guidance such as the National Institute for

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Health & Care Excellence (NICE). This included policies relating to care at the end of life, such as anticipatory drug prescribing for end of life care and the pain and symptom management guidance in the last days of life.

- We saw evidence of local and national audit participation. Where necessary the trust had developed action plans to improve the care of end of life patients.
- We saw from patients' records that pain levels were assessed regularly and patients said that their pain relief was managed effectively and that staff responded quickly when they needed painkillers.
- Staff had effective clinical supervision. Staff on the wards were receiving additional end of life care educational sessions from the MacMillan end of life care clinical coordinator and the practice facilitator. End of life care had also become part of all staffs mandatory training.
- The trust had been involved in the development of a Northern Lincolnshire multi-agency end of life care strategy; from this, the trust had identified seven work streams, each of which had developed key performance indicators to measure the trust performance and patient outcomes.

Evidence-based care and treatment

- We saw that trust policies referenced national best practice guidance such as the National Institute for Health & Care Excellence (NICE). This included policies relating to care at the end of life such as anticipatory drug prescribing for end of life care and the pain and symptom management guidance in the last days of life.
- The trust was part of a multi-agency end of life strategy group. NICE guidance was discussed at this meeting and any actions required by the trust were then developed through the trusts strategy working groups.
- The Liverpool Care Pathway (LCP) was developed during the late 1990s at the Royal Liverpool University Hospital, in conjunction with Marie Curie Palliative Care Institute. It was intended to provide the best possible quality of care for dying patients.
- In June 2014, The Leadership Alliance for the Care of Dying People (LACDP) was formed in response to a report that had criticised the use of the LCP. The report recommended that the LCP should be phased out, and a new approach to improving end of life care be developed using five key priorities of care. The trust had developed a Care in the Last Days of Life document to replace the LCP.

- We saw posters displayed on some wards that contained details about the five priorities of care. We saw copies of the LCP on one of the wards we visited. We raised this with a senior member of staff.
- We saw two care records audits that had been completed for end of life care patients in October 2015 and May 2016. An action plan created following an end of life care records audit in October 2015 indicated that the planned completion date for the roll out of the new documentation was April 2016.
- During a meeting with senior members of the team, we were told that this had been completed on only three wards at this hospital. Some staff we spoke with were aware of the new documentation and had used the symptom control guidelines, which had also been developed by the trust; however, we found that most staff were not aware of the documentation and we only saw one blank copy in one set of notes on the ten areas we visited.
- The records audit completed in May 2016 showed that the new documentation had only been used in 28% of the records audited. Data provided by the trust indicated that between August 2015 and July 2016, of the 779 patients who had died in this hospital 274, 35%, had been cared for using the last days of life document.
- The senior team also told us that a MacMillan end of life care coordinator and practice facilitator for end of life care had been appointed and educational sessions on the new end of life care plan were in progress.
- The bereavement team completed an informal audit of the completion all death certificates. This enabled them to address any concerns about the completion of the certificates with the relevant clinician.

Pain relief

- We did not see reference to the guidance outlined in the 2015 core standards for pain management services within any of the trust documents that related to pain relief, however in the records we reviewed, where appropriate, we saw that patients at the end of life were prescribed pain medication in line with NICE guidance.
- We saw from patients' records that pain levels were assessed regularly and patients we were able to speak with said that their pain relief was managed effectively and that staff responded quickly when they needed painkillers.
- The 2015/2016 national care of the dying in hospital audit showed that 71%, 55 of the 77 patients audited

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had a pain assessment completed in the last 24 hours of their life. 87% of the patient records audited had documented evidence that the patients' pain was controlled.

- Two local records audits completed in October 2015 and May 2016 showed that prescribing of anticipatory medications had improved.

Nutrition and hydration

- Two audits of end of life care records were completed in October 2015 and May 2016; these showed that not all patients were being assessed for their nutrition and hydration needs however, during our inspection we saw nutrition and hydration assessments in the care records we looked at. If patients were assessed as high risk of malnutrition or dehydration food and fluid charts had been implemented.
- We saw that some patients were also prescribed nutritional supplements and that these had been administered as prescribed.

Patient outcomes

- The trust participated in the End of Life Care Audit – Dying in Hospital: National report for England 2016. The trust scored the same as the England average for one clinical quality indicator, better for two and worse for three of the indicators. The trust met seven of the eight organisational indicators.
- The trust were also submitting end of life patient data for the collation of minimum data set information for the National Council for Palliative Care (NCPC). The minimum data set (MDS) for specialist palliative care services is collected by NCPC on a yearly basis, with the aim of providing an accurate picture of hospice and specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services in the voluntary sector and the NHS in England, Wales and Northern Ireland.
- The Gold Standards Framework (GSF) is a systematic, evidence-based approach to optimising care for all patients approaching the end of life. The trust did not use the gold standards framework or an end of life care patient register. The development of this was part of the strategy action plan however we did not see any details about when this would be completed and implemented
- As part of the end of life strategy implementation, the trust had identified seven work streams, each of which had developed key performance indicators to measure

the trust performance and patient outcomes. We saw that each working group had developed an action plan and where applicable data collection tools that were being implemented and monitored.

- We saw a copy of an end of life care dashboard and found that the data appeared to show that this related to low numbers of patients. In order to collate patients' outcomes effectively the trust had developed a deceased patient audit tool however, senior staff we spoke with told us that this was not being routinely completed and therefore the capture of information related to the care provided was not robust. Further awareness and reinforcement of the need for accurate completion of this form was ongoing through the quality and operational matrons.

Competent staff

- We found that some staff did not have an up to date appraisal. However, there were low numbers of staff employed within the chaplaincy, bereavement team and mortuary teams and there had been significant absence within the chaplaincy and bereavement team. Appraisal rates were 38% for the chaplaincy and bereavement team and 53% for mortuary staff.
- End of life care was part of all staffs' statutory and mandatory training. We were told that this was a recent addition and that very few staff had completed the training.
- Staff on some wards told us that they felt they needed more training in care at the end of life however on one ward, a senior nurse told us that ten registered nurses from the ward had been able to attend an externally run nine day end of life care course.
- Staff on the wards, where care at the end of life was provided, were receiving additional educational sessions on the end of life care plan, from the MacMillan end of life care clinical coordinator and the practice facilitator.
- There was no formal link nurse group for end of life care however; the Macmillan coordinator and the practice facilitator told us that they were keen to introduce these.

Multidisciplinary working

- Staff from the wards we visited told us that they were able to refer patients to the SPCT for advice. In addition to the support provided by the external SPCT provider,

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the trust employed specialist nurses covering a wide range of disciplines who were also able to support with the management of palliative and end of life care patients.

- Staff from the bereavement team and the mortuary told us that they had close working relationships and we witnessed this during our inspection. These teams also told us that they had good working relationships with local undertakers.
- Staff on one ward told us that a local funeral director offered health care assistants the opportunity to spend time with the service so that they could learn their role.
- The trust did not use an electronic palliative care co-ordination system however; the development of this was part of the strategy action plan.

Seven-day services

- The National Institute for Health & Care Excellence (NICE) guidelines state that palliative care services should ensure provision to visit and assess people approaching the end of life face-to-face in any setting between 9am and 5pm, seven days a week. Provision for bedside consultations outside these hours is considered to be high-quality care by NICE. The guidelines also state that specialist palliative care advice should be available, at any time of day or night, which may include telephone advice.
- The specialist palliative care nurses employed by the external provider were available seven days a day from 9am-5pm.
- There was no out of hours telephone advice service available.
- Information received from the trust indicated that 86.5% of patients referred to the SPCT were seen within 48 hours.
- The mortuary provided a seven-day service, with staff on call out of hours for relatives who wished to attend the hospital to see their loved one after they had died.
- The bereavement service was available Monday to Friday during normal office hours and operated an appointment system to ensure that relatives did not attend when the office was not open or when relevant paperwork was not available to collect.
- The chaplains offered a seven-day service but were unable to achieve this due to the low numbers of chaplains employed by the trust, absence and vacancy within the team.

- The trust had seven day services for imaging, pharmacy and therapy services such as occupational and physiotherapists.

Access to information

- Staff on the wards we visited told us that they were able to access palliative and end of life care policies and guidelines on the trust intranet.
- Some wards we visited had resource folders available for staff.
- We saw information about the five priorities of care displayed on some of the wards we visited.
- The trust had an electronic system that allowed patients who were on the last days of life document or who had a do not attempt resuscitation decision in place, to be flagged.
- The bereavement team were able to access the electronic patient records to ensure that they received details of patients who had died in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
- We saw staff seeking verbal consent before providing any care or treatment.
- All adults are presumed to have sufficient capacity to decide on their own medical treatment, unless there is significant evidence to suggest otherwise. Capacity can sometimes change over time and should therefore be assessed at the time that consent is required. If a patient is assessed as lacking capacity and has not made an advance decision or formally appointed anyone to make decisions for them, careful consideration is needed to determine what is in their best interests before making a decision.
- The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. In certain cases, the restrictions placed upon an individual who lacks capacity to consent to the arrangements of their care may amount to "deprivation of liberty" (DoLs).

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- When a deprivation of liberty might occur, the provider of care must apply to their local authority, who will then assess the individual's care and treatment to decide if the deprivation of liberty is in the best interests of the individual concerned.
- Staff at the trust completed MCA and DoLs training as part of their mandatory training.
- During our inspection, we looked at 13 do not attempt cardiopulmonary resuscitation (DNACPR) forms at this hospital.
- Two forms indicated that the patient lacked capacity. We were not able to find any evidence within the notes that formal capacity assessments were completed for these patients. In both cases, we could see no evidence that deprivation of liberty safeguards or best interest had been considered.
- The trust's resuscitation policy stated that it is essential that a discussion with relevant others takes place where a patient lacks capacity. We found that patient records did not always have evidence that these discussions had taken place.
- The trust audited completion of DNACPR forms each year. We looked at the audit results for 2014, 2015 and 2016. The trust's own summary of the audit indicated findings similar to those found during our inspection, in that significant improvement was required in relation to the documenting the mental capacity of the patients.
- Staff we spoke with on the accident and emergency department told us that they have high staffing levels that meant that there was always someone available who is confident in discussing resuscitation options with patients.

Are end of life care services caring?

Good



At the inspection in 2014, we rated End of Life Care services as good for caring. At this inspection we rated caring as good because:

- We observed staff being compassionate and caring to patients and their families without exception.
 - We found that staff were sensitive to the needs of the patients and their families.
 - One patient we spoke with told us that the staff were lovely and that they attend to their every need. Another said the staff were 'brilliant' and that the nurses were 'angels'.
 - We spoke to members of the housekeeping teams and they told us that they are involved in the care of families, one member of staff told us they provided hot drinks and a biscuit and that they felt that it was the 'little things' like that and supporting 'with kind words' that were important.
 - We visited the mortuary at the hospital and found that the staff were caring and compassionate when dealing with the deceased and their families.
 - Staff provided emotional support to patients and their families.
- However:
- The trust were unable to provide evidence of the feedback they sought from bereaved relatives as indicated in the National End of Life Care Audit – Dying in Hospital.

Compassionate care

- We observed ward staff being compassionate and caring to patients and their families without exception.
- We found that staff were sensitive to the needs of the patients and their families.
- One patient we spoke with told us that the staff were lovely and that they attend to their every need. Another said the staff were 'brilliant' and that the nurses were 'angels'.
- We spoke to the relatives of a patient who was approaching the end of their life and they said that their relative had received outstanding care. They told us that they felt the unit leader was exceptional, that shift changes are seamless and every member of staff had been compassionate and professional without exception. The family also praised the cleaning and catering staff saying that they were also excellent. The family told us that 'staff check on us all the time' and that their relative had received 'authentic and genuine care'.
- Another relative told us that they could not fault the care their family member had received.
- We saw staff caring for patients and their families and speaking to them in a respectful and compassionate manner.

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- We spoke to members of the housekeeping teams and they told us that they are involved in the care of families, one member of staff told us they provided hot drinks and a biscuit and that they felt that is was the 'little things' like that and supporting 'with kind words' that were important. We were told that they enjoy their work and feel that they make a difference.
- We visited the mortuary at the hospital and found that staff spoke compassionately about the care of the deceased and their families. We were told that every death was personal and everyone was treated as an individual and that they like to 'go the extra mile' to ensure the service runs smoothly for the families of the deceased.
- We were told about examples of outstanding care. For example when a family member had made the deceased persons coffin and a member of staff collected this for the family and another when a family wanted a copy of their relative's finger prints and staff helped to find a kit and did this for them.
- The trust participated in the National End of Life Care Audit – Dying in Hospital. The National report for England 2016 indicated that the trust sought feedback from bereaved relatives; however when asked, the trust were unable to provide any evidence of this feedback.

Understanding and involvement of patients and those close to them

- In an audit carried out in May 2016 only 20% of the records indicated that there had been communication with the patient to inform them they were in the last days of life however, 100% of records we looked at showed that discussion had taken place with the patient or their family.
- Staff on one ward told us that they feel that it is important to have open and honest conversations with patients who are palliative or approaching the end of their life.
- Families and patients we spoke with told us that staff discussed their care with them. One relative told us that a senior doctor had arrived within 15 minutes when they had asked to speak to them; this family also told us that staff had discussed using a syringe driver for symptom control, with them before this was started.
- Staff on accident and emergency told us that care at the end of life was extremely important no matter which environment the person is in and they saw this as big part of their role.

Emotional support

- We saw staff providing emotional support to patients and their relatives during our inspection.
- The bereavement team had recently updated their help for bereaved relatives leaflet. We found that this contained valuable information to support those close to patients who had died.
- We saw that documentation for the general wards had emotional and anxiety assessments that staff completed on admission. A psychological and emotional assessment was completed as part of the care in the last days of life document.
- A family member told us that staff treated their relative with respect and that they protected their dignity. They said that staff always knock on the door before entering and always introduce themselves.

Are end of life care services responsive?

Good



At the last inspection in 2014, we rated End of Life Care services as good for responsive. At this inspection we rated responsive as good because:

- Staff on the wards told us that the SPCT were visible, available and that they regularly reviewed end of life patients and had discussions with patients and their families.
- Information received from the trust indicated that 86.5% of patients referred to the SPCT were seen within 48 hours.
- On all wards we visited staff told us that whenever possible end of life care patients would be cared for in a single room.
- We visited the bereavement office and found that robust processes had been developed to support bereaved relatives.
- Staff from any ward or department could refer patients to the SPCT for advice and support.
- We were told that the discharge and liaison team were responsive to the needs of patients at the end of life and priority was given to these patients' discharge.
- Information provided by the trust showed that 82% of patients audited had been asked about and 71%

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achieved their preferred place of death. However we had concerns that due to the issues identified about the completion of data collection tools, this figure did not include all patients who had died in the hospital.

- The trust had robust processes for identifying patients with dementia and learning disabilities.
- There had been no complaints relating to the SPCT, mortuary, bereavement service or chaplaincy teams in the 12 months prior to our inspection.

Service planning and delivery to meet the needs of local people

- Care at the end of life care was provided on many wards at the hospital, staff were able to refer patients to the specialist palliative care nurses, from the external independent health provider, if they needed advice and support to care for any patients with complex needs including symptom management.
- Staff on the wards told us that the specialist palliative care nurses from the external independent health provider were visible, available and that they regularly reviewed end of life patients and had discussions with patients and their families.
- Information received from the trust indicated that 86.5% of patients referred to the SPCT were seen within 48 hours
- Staff we spoke with told us that the discharge liaison team were very responsive when support was needed to achieve a patient's preferred place of care at the end of life.
- Information collated by the trust indicated that, between December 2015 and July 2016, 82% of patients records showed that the 71% patients preferred place of death was documented and achieved. However we had concerns that, due to the issues identified about the completion of data collection tools, this figure did not include all patients who had died in the hospital.
- We saw that conversation about patients preferred place of care were documented in patients' notes.
- The trust had a 'my future care plan - making plans for my care' document that they gave to patients who were recognised as approaching the end of their life. This document was designed to allow patients to specify their preferences and wishes for future care and treatment.

- As part of the end of life strategy, an information technology sub-working group had been set up. This group were working on improving systems and processes for staff that were caring for patients at the end of their life.
- The bereavement team were able to access the electronic patient records to ensure that they received details of patients who had died in a timely manner. The new processes being developed would enable general practitioners and other external care providers to access the information.
- We spoke to members of the portering team who told us about the processes they used when deceased patients needed to be transferred to the mortuary. We found that this was done in a dignified and respectful manner.
- We looked at the relative's room within the mortuary and found this to be well maintained and tastefully decorated.

Meeting people's individual needs

- On all wards, we visited staff told us that whenever possible, end of life care patients would be cared for in a single room.
- Accident and emergency had side wards that were available when patients approaching the end of their life were admitted to the unit. There was also room available for relatives. Information leaflets about organ donation and bereavement booklets were available in this room. The unit also had a bright and tastefully decorated viewing room, where relatives could spend time with their loved one.
- One family told us that their relative had to be moved out of a side ward, they said that they had found this hard but staff had explained the reason for this and they understood.
- All staff we spoke with told us that open visiting was available for end of life care patients. Staff also told us that relatives receive a concessionary parking pass. Relatives we spoke with told us that staff provided warm drinks and snacks whilst they were visiting.
- The hospital had a chapel and a separate multi faith room. Information about the hospital religious services were displayed as well as an up to date list of religious festivals. Holy books were available in the multi faith room including Qur'an and Buddhist teaching. Memorial books were available in the chapel.

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- A wedding kit for end of life patients wanting to get married was available for patients and families to use on any of the wards. This consisted of items needed for a wedding reception, flowers and cards. We were told that the wedding kits had been used several times.
- We visited the bereavement suite and found that robust processes had been developed to support bereaved relatives including the implementation of an appointment system for relatives to attend to collect paperwork and the patients' belongings.
- People with dementia or a learning disability were flagged through an electronic system, this was then visible to staff on display screen on the ward. We also saw that patients were identified using a 'My Life' symbol which was displayed near their bedside.
- Audits completed in October 2015 and May 2016 showed that patients' spiritual needs were not always considered during end of life care. The lack of chaplaincy cover was also of concern.
- The chaplains were able to conduct funerals on behalf of the trust if requested.

Access and flow

- Staff from any ward or department could refer patients to the SPCT for advice and support.
- Staff told us that the discharge team were very responsive when patients needed to be fast tracked to a preferred place of care.
- We were told that when the local NHS ambulance trust was not able to provide transport in a timely manner, other resources were available for staff to use.
- We spoke with staff at the mortuary who told us that they had never had any capacity issues.

Learning from complaints and concerns

- There had been no complaints relating to the SPCT, mortuary, bereavement service or chaplaincy teams in the 12 months prior to our inspection.
- We saw Patient Advice and Liaison service information displayed on the wards we visited.
- During our inspection, we discussed complaints with the senior management team and were told that they would be involved in any complaint that involved a patient at the end of life. We were also told that complaints were analysed for themes where necessary the senior management team would be involved in the response to the complaint.

- The senior team told us that they had recognised that complaints that related to the service were not always identified because they were addressed to the ward or department where the patient had been cared. In order to ensure that they were made aware of all complaints relating to the service, they had worked with the complaints team to filter the relevant complaints.

Are end of life care services well-led?

Good



At the inspection in 2014, we rated End of Life Care services as good for well led. At this inspection we rated well led as good because:

- The trust had been involved in the development of a multi-agency end of life strategy that encompasses the whole of the local health economy.
- The trust was collating and monitoring quality measures such as patient outcomes through seven strategy sub-working groups. A quarterly update on the progress of each working group was reported to the board.
- There was a non-executive director, at board level, who challenged and supported the leadership team.
- Staff reported a positive culture and good working relationships between teams.
- The trust was supporting the development of staff that were caring for patients at the end of life.
- We saw good examples of innovation and staff whose purpose was to maintain and improve the services provided to patients and their loved ones.

However,

- That the risk register for the end of life care service did not identify all of the services risks, for example the delayed roll out of the last days of life document and completion of the deceased patient audit tool were not on the risk register.

Leadership of service

- We found that the trust had a robust end of life care management structure supported by the chief nurse and the deputy medical director at board level.

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- The trusts chief nurse was the executive lead for end of life care. The deputy chief nurse was a member of the multi-agency strategy group and had responsibility for the bereavement work stream and the line management of the mortuary and bereavement teams.
- Staff in the mortuary told us that since the deputy chief nurse had been allocated as the lead for bereavement 'things had started to move forward'.
- The end of life clinical care coordinator and the practice facilitator were line managed by the Macmillan lead cancer nurse.

Vision and strategy for this service

- A multi-agency group had been set up to devise and implement an end of life care strategy that encompassed the whole of the local health economy. We looked at the document and found that the vision and purpose of the strategy was to ensure that appropriate care was provided in the appropriate setting at the right time, and to ensure that access to care was seamless and easy, and that the patient's needs and wishes were central.
- Multi-agency strategy group meetings were held on a monthly basis. Trust attendance at these meetings included the deputy chief nurse, the deputy medical director, the associate chief nurse for community and therapies, the Macmillan lead cancer nurse, the specialist palliative care team and the end of life clinical coordinator.
- Following ratification of the end of life care strategy. The trust had developed seven work streams with senior staff from the team having overall responsibility for a sub-working group. These included education, bereavement, palliative care, do not attempt resuscitation, long-term conditions, children and neonatal and IT. Each group met separately and had developed action plans to meet the required outcomes of the strategy.
- We saw that some of the working groups had developed a vision for their area of responsibility.
- We saw the trust vision and values displayed throughout the hospital. Staff we spoke with were aware of these.
- The trust had a non-executive director with responsibility for end of life care. Senior staff we spoke with told us that this provided challenge and support at trust board level.

Governance, risk management and quality measurement

- A palliative care business and governance meeting, was held bimonthly. We looked at the minutes from these meetings and saw that governance, risks and quality measures were discussed. This included complaints and incidents as well as human resource issues such as sickness and recruitment.
- The trust was collating and monitoring quality measures such as patient outcomes through the seven sub-working groups. A quarterly update on the progress of each working group was reported to the board.
- We looked at the risk register for the end of life care service and found that not all risks were identified, for example the delayed roll out of the last days of life document and completion of the deceased patient audit tool. We did see that these risks had been identified on the action plans of the sub-working groups. Following our inspection, we received information that indicated that these risks would be added to the overarching risk register for the service.

Culture within the service

- We found that staff were consistently positive, friendly, helpful and approachable in all areas we visited. All staff were team focused.
- Staff working in the SPCT told us that they were building strong positive relationships with other teams and they felt that this was making a difference for patients.
- All staff we spoke with told us that the senior staff were visible and approachable.
- Staff we spoke with told us that the palliative care consultant was supportive and approachable.
- Staff we spoke with told us that sometimes staffing was an issue but that the trust is a good place to work.
- The senior team told us that they felt the service had 'come a long way' since the last inspection and that whilst they were proud of the achievements so far they recognised that there was still 'work to do'.

Public engagement

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

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- The palliative care consultant had shared two patient stories at the trusts quality and patient experience meeting.
- The trust had a range of leaflets available for patients and their loved ones including information relating to specific conditions, as well as the recently updated bereavement booklet and advice and support leaflets for tissue and organ donation.
- The trusts website had a news and events page which patients and carers could access.

Staff engagement

- Staff told us that they felt that communication between the team members and the information received from the trust had improved.
- Staff we spoke with told us that they were supported to professionally develop.
- The trust had appointed a MacMillan end of life care coordinator whose role was largely to educate staff and implement the new last days of life document on wards where patients did not need referral to the SPCT. This was being completed on a ward-by-ward basis. In addition we were told that all new starters attended 'care camp' where education about care at the end of life and the five priorities of care was provided.
- We were told that the palliative care consultant was planning to increase awareness about the new documentation amongst medical staff by attending medical education sessions that were planned for January 2017.
- Staff from the SPCT told us that they had recently had trust board agreement to implement and facilitate a six-week end of life care course that would incorporate education for ward nurses on symptom control, communication, ethics and spirituality.
- Compliments from patients and other services were discussed at the SPCT meetings.
- Porter staff explained that they helped new members of staff by supporting them in the role until they were confident.
- The multi-agency health economy wide strategy was an innovative project to ensure that all relevant stakeholders and partners were working together to improve end of life care delivery.
- The trust held an annual best practice day for end of life care, staff we spoke with who attended this told us that it was valuable and that they cascaded the learning to other members of their teams.
- The Macmillan end of life care clinical coordinator had been in post for ten months. During that time, 400 staff had attended educational sessions and the new end of life care plan had been implemented on 12 wards. An end of life care facilitator had also been appointed recently. We were told that this role would expedite the role out of the end of life care documentation.
- The bereavement team attended the trust induction to ensure that staff were aware of the processes required following the death of a patient. In addition to this, they had also developed guidelines for the completion of death certificates to support the medical staff and to ensure that the certificates were completed accurately and fully to prevent any delays for bereaved families.
- The bereavement team had also implemented an electronic appointment system for families to collect relevant paperwork following the death of a loved one. This meant that families were seen in a timely manner and that all relevant documents were ready for collection at their designated appointment.
- Some staff we spoke with told us that they attended training at the local hospice and they found this very useful to help them in their practice. One example of a course offered by the hospice was breaking bad news.
- Staff from the mortuary told us that they had been nominated for a trust star award a few times; they explained that they had not won the award but said that it was nice to have been nominated.
- We were told that the intensive care unit were having discussions with a local hospice around the possibility of developing a protocol for the transfer of patients from the unit to the hospice for removal of tracheostomy and end of life care.

Innovation, improvement and sustainability

Outpatients and diagnostic imaging

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Inadequate	
Well-led	Inadequate	
Overall	Inadequate	

Information about the service

The Diana, Princess of Wales Hospital (DPoW) in Grimsby had outpatients (OP), radiology, and phlebotomy departments. These were part of clinical support services within the trust. Pathology services were provided by 'Path Links' a service hosted and managed by the Trust and providing pathology services to other organisations.

The outpatients department (OPD) held a range of outpatient clinics, which included ophthalmology, general surgery, elderly medicine, cardiology, dermatology, gastroenterology, respiratory, diabetes, urology, neurology and ENT. The OPD also held clinics off-site at Cromwell Road; we did not visit this location during the inspection. There were four zones in the OPD at DPoW; zone one was ophthalmology outpatients and zones two to four were general outpatients.

The radiology department had general X-ray, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine and ultrasound. Ultrasound (USS) had two areas, one for general ultrasound work and the other for family services (baby scans, gynaecology, ectopic pregnancy and termination of pregnancy). Mobile vans provided additional CT and MRI scans.

There was a pathology laboratory 24-hour seven-day service on site that included a phlebotomy service. The phlebotomy service held clinics five days a week and provided a service to the inpatient wards six days a week.

Between 1 April 2015 and 31 March 2016, the OPDs at this trust saw 430,847 patients (new and follow up). Around 9%

of patients did not attend (DNA); around 30% were new patients and 61% follow-up patients. Radiology attendance figures between January 2016 and December 2016 were 405,662.

Between 1 April 2015 and 31 March 2016, the OPD at DPoW saw 218,758 patients. The three specialities with the highest number of patients were ophthalmology (22,184), trauma and orthopaedics (21,484) and gynaecology (13,472). Around 10% of patients did not attend (DNA); around 30% were new patients and 60% follow-up patients. Between January 2016 and December 2016, there were 215,761 radiology attendances at DPoW.

During the inspection, we visited the ear nose and throat (ENT), ophthalmology, diabetic centre, diagnostic imaging and phlebotomy departments; all five domains were included at this inspection visit.

We spoke with six patients and relatives in the outpatient clinics, including ophthalmology, and three patients in the radiology waiting areas, who shared their views and experiences of the service with us. We also spoke with 36 staff including radiologists, consultants, managers in diagnostic imaging and outpatients, nurses, radiographers, support workers, student nurses, other allied health professionals and administrative staff.

We reviewed 10 patient care records and reviewed performance data regarding the outpatient and diagnostic imaging services.

Outpatients and diagnostic imaging

Summary of findings

When we inspected this service in October 2015, we rated this service as inadequate overall. At this inspection, the rating overall rating remained unchanged at inadequate. Safe was rated as requires improvement, responsive and well-led were rated as inadequate and caring was rated as good. At this inspection, we found that whilst the trust had made progress in some areas the response to concerns in other areas had been slow and significant concerns and risks were still apparent. We found that;

- There was evidence of harm to patients because of poor management of follow up appointment systems and ongoing significant risk of harm to patients, posed by increasing referral to treatment times and patients waiting past their due date for follow up appointments or with no due date.
- In January 2016 the trust told us that the concerns raised at the October 2015 inspection had been addressed. However, prior to the inspection and following the inspection further cohorts of patients were identified which were not being effectively managed. Audits of follow up lists was ongoing in August 2016 and a number of cohorts of patients were discovered in unmonitored systems. This amounted to around 18,000 patients (6,000 of these were ophthalmology patients).
- The trust had not significantly reduced the high number of cancelled clinics overall although this was improved in some areas.
- Referral to treatment times were worsening and the trust told us they were unlikely to recover a good position until March 2018.
- There continued to be large numbers of patients who were overdue follow up appointments or with no due date on the patient administration system.
- There was a significant risk of potential harm to patients waiting long periods of time for first and follow up appointments.
- The trust had not validated the clinical risk within waiting lists in a timely manner.

- Although the trust had appointed an internal lead to oversee the administration teams and drive the required improvements in OPD booking systems, there appeared to have been little additional support available until autumn 2016.

However:

- The trust had stopped the practice of non-clinical staff cancelling clinics.
- The OPD had addressed the issues relating to the facilities and environment; systems for sharing learning from incidents and complaints was evident and issues relating to the safe storage of refrigerated drugs had been addressed. Staff at all levels were aware of the issues relating to waiting lists for new and follow up patients and there was a shared responsibility and working together to make improvements.
- 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.
- Action had been taken to ensure all radiology staff had received training regarding the ionising radiation (medical exposure) regulations (IR (ME)R 2000) and this had been made mandatory.
- Systems were in place in radiology and outpatients to ensure that the service was able to meet the individual needs of people such as those living with dementia or a learning disability, and for those whose first language was not English.
- Abandoned call rates were now being monitored and patient tracker lists (PTLs) had been developed and were monitored on a weekly basis as part of a performance dashboard.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



At the last inspection of this service in October 2015, we identified significant safety concerns and this domain was rated as 'Inadequate'. During this inspection, we rated the service as requires improvement for safe. This was because;

- There was one serious incident (SI) relating to an ophthalmology patient who had potentially suffered harm due to delayed outpatient follow-up at this hospital. This was still under investigation at the time of this report writing. We noted that this incident was reported to the Strategic Executive Information System (STEIS) around two months after the incident was reported on the trust system. A second SI was a trust wide incident report regarding the discovery, in August 2016, of a previously unknown backlog of around 6,000 ophthalmology patients waiting for an outpatient appointment. The trust made this report due to the high risk of potential harm to patients waiting to be seen.
- There was a subsequent SI in October 2016 relating to missed referrals across the trust; this was undergoing investigation into the scale and causes of the issue at time of writing this report.
- Safeguarding training compliance for the outpatient staff was 83%, which was below the trust target of 95% compliance.
- The trust had been slow to implement clinical validation and assessment of risk within waiting lists, across all specialities.

However,

- Cancellation of clinics by non-clinical staff had ceased
- We found that sharing lessons from incidents had improved and staff reported departmental patient safety incidents and radiation incidents in the appropriate way. These were investigated appropriately.
- The facilities and premises had been improved since our last inspection and were suitable for differing patients' needs.
- Action had been taken to ensure recording of minimum and maximum fridge temperatures, necessary for safety and efficacy of the medicines, and staff knew what to do

should temperatures go outside of the correct range. The trust had also introduced an IT system that enabled monitoring and recording to be undertaken by the pharmacy team.

- Although there were 5.02 unfilled vacancies for radiologists (46% vacant posts), the department was managing this shortfall by the radiologists from DPoW and Scunthorpe general hospital (SGH) working as one team and providing cross cover. The trust was continuing to try to recruit and reporting work was outsourced to alleviate workload. We found no detrimental effect on the care and treatment of patients due to this shortage.
- All radiology staff had received training regarding the ionising radiation (medical exposure) regulations (IR (ME) R 2000) and this had been made mandatory.

Incidents

- Between October 2015 and September 2016, the outpatient and diagnostic service across the trust reported no incidents that were classified as never events. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- We saw that the quarterly newsletter for all staff gave detailed information regarding serious incidents, recommendations, actions taken and lessons highlighted. The newsletter contained information from incidents, complaints and audits undertaken across the trust.

Outpatients

- In accordance with the NHS England Serious Incident Framework 2015, the service across the trust reported five serious incidents (SIs) that met the reporting criteria set by NHS England between October 2015 and September 2016. One of these related to a patient being seen and treated at DPoW and the other was a trust wide issue.
- The incident was an ophthalmology incident reported in September 2016 where a patient had potentially suffered harm due to delayed outpatient follow-up at DPoW hospital. This was still under investigation at the

Outpatients and diagnostic imaging

time of this report writing. We noted that this incident was not reported to the Strategic Executive Information System (STEIS) until around two months after the incident was reported on the trust system.

- The second incident was a trust wide incident report regarding the discovery, in August 2016, of a previously unknown backlog of around 6,000 ophthalmology patients waiting for an outpatient appointment. The trust made this report due to the high risk of potential harm to patients waiting to be seen.
- Subsequently the trust reported an additional SI in October 2016 relating to missed referrals from GPs to the trust. The trust was in the process of working with GP practices and CCGs to identify any patients' referrals that had been missed and to provide appointments. The trust was also still investigating the reasons for the lost communications and liaising with individual GP practices when issues were identified. There had been no harm to patients identified at the time of writing this report.
- Between September 2015 and August 2016 the outpatient service at DPoW reported 196 incidents; one was classified as severe harm two were classified as moderate harm, 21 low and 172 no harm. Both of the moderate harm incidents related to MRI delayed reporting and a subsequent delayed treatment which could have prevented or compromised the chance for successful treatment
- Between August 2015 and August 2016 the outpatient service, across the trust, reported 527 incidents; one was classified as severe harm, three were classified as moderate harm, 139 low and 384 no harm.
- Of these, the ophthalmology service across both sites reported 97 incidents; one was classified as severe harm (February 2016), two were classified as moderate harm, 18 low and 74 no harm.
- The most frequently reported low and no-harm incident categories were;
 - 114 Patient accidents (21.6%).
 - 91 Documentation (including electronic & paper records, identification and drug charts).
 - 83 Clinical assessments (including diagnosis, scans, tests, assessments).
 - 58 Access, admission, transfer, discharge (including missing patient).
 - 55 Treatment, procedure
- Staff confirmed incidents were discussed at staff meetings and that they knew how to report incidents.

Staff told us they also received feedback and learning from incidents via briefings, newsletters from the intranet and at team meetings. However, one member of staff told us they did not always receive automatic individual feedback from incidents they may have reported. They went on to say that, if they asked for feedback it was always given.

- Staff told us they were aware of debriefs and learning taking place from a recent cyber-attack.
- We saw from incident reports that duty of candour requirements had been adhered to.
- Staff told us that they now had a new process for porters to use following an incident where some medicines had been left on the open reception desk.

Diagnostic Imaging

- The diagnostic imaging department had one serious incident that met the STEIS criteria. This related to a delay in acting on test results leading to a delay in treatment.
- There had been no 'Never Events' in the diagnostic imaging department.
- There were six IR(M)ER incidents reported by the trust since March 2016. The CQC's IR(M)ER team reported that this was about average for a trust of this size. There were no concerns however, a trend was identified. This was of putting the wrong patient sticker on to referrals. Patients were not wrongly x-rayed and feedback was given to referrers to ensure that correct stickers were used.
- There had been two incidents recorded by the diagnostic imaging departments. The incidents related to; a patient with a pacemaker referred for MRI and a possible missed CT. Both were classified as no harm.
- Between 8 October 2015 and 28 August 2016, 148 low and no-harm incidents had been reported in radiology across both hospital sites. The categories with the highest numbers of incidents were:
 - 57 Clinical assessments (including diagnosis, scans, tests, assessments). Nine of these were patients who attended MRI with a pacemaker in situ; this is a contraindication for MRI scanning. Radiographers identified these prior to the scan, therefore there was no patient harm.
 - 35 Documentation (including electronic & paper records, identification and drug charts). The majority of these incidents related to identity issues such as wrong patient details on referral forms.
 - 21 Patient accident

Outpatients and diagnostic imaging

- 10 Treatment, procedure.
- Incidents were discussed at the monthly governance meetings and we saw minutes of meetings that confirmed this. There was evidence of discussions about RCA (root cause analyses) being carried out, serious incidents and monitoring of action plans.
- Staff told us that they were able to access the electronic reporting system and knew how to report any incidents. They told us that feedback was given at team meetings along with any changes to practice. The staff we spoke with were unable to give any examples of changes because of an incident they had reported.
- Staff we spoke with knew that they should be open and honest with patients if anything went wrong with their treatment or care. Departmental managers took responsibility for ensuring that the duty of candour processes were carried out appropriately.

Cleanliness, infection control and hygiene

Outpatients

- Clinical and non-clinical areas in OP appeared visibly clean and tidy, with equipment stored appropriately. Staff told us domestic staff cleaned the department.
- We saw staff complied with infection prevention and control policies, for example wearing personal protective equipment (PPE) and participation in hand hygiene audits
- In July and August 2016, we saw that DPoW OPD had an overall score of 100% and 97% respectively on the trust's infection control and prevention (IPC) 'Frontline ownership audit tool.' The issue identified in September reducing the score was to do with the general environment.
- In OPD at DPoW between March 2016 and July 2016, hand hygiene audits showed 100% compliance for before and after patient contact and bare below the elbows. However, in August 2016 compliance with handwashing before and after patient contact fell to 55% and 69% respectively. Compliance with washing hands after removal of gloves was 11.1%. Staff were 100% compliant with bare below the elbows.
- Overall hand hygiene compliance for audiology staff was 100%.
- We did not see specific training figures for infection control but this would be covered as part of mandatory training.

Diagnostic Imaging

- Personal protective equipment (PPE) such as gloves and aprons were used appropriately and available for use throughout the departments and, once used, was disposed of safely and appropriately. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- We saw that staff washed their hands regularly before attending to each patient.
- Hand gel was available for patients, visitors and the public to use. Dispensers were clean and well stocked.
- The department's different areas such as changing rooms and reception were clean and tidy and we saw staff maintaining the hygiene of the areas by cleaning equipment in between patient use, reducing the risk of cross-infection or contamination. Staff placed 'I am clean' stickers on equipment after it was cleaned.
- Imaging equipment was cleaned and checked regularly. Rooms used for diagnostic imaging and interventional radiology such as angiograms were decontaminated and cleaned after use.
- Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly.
- Training compliance for infection prevention and control was 96%.
- In radiology at DPoW the hand hygiene audits between April 2016 and August 2016 showed 100% compliance for before and after patient contact and bare below the elbows. In ultrasound, the audits for July 2016 and August 2016 showed 100% compliance with bare below the elbows and handwashing after patient contact. Hand washing before patient contact however was 48% and 80% compliance for respective months and 43% and 60% for washing hands after removing gloves.

Environment and equipment

- Outpatient and radiology departments were clearly signposted throughout the hospital.
- Staff told us that the majority of equipment used in outpatients was disposable / single use and any equipment needing sterilisation after use was collected daily and by the central sterile service department on site and returned sterile and repackaged.
- We saw and staff told us that equipment was serviced annually and there were contracts in place with manufacturers for maintenance and repair of specialist equipment such as microscopes and visual field machines.

Outpatients and diagnostic imaging

- There was a clear process in place for decontamination of endoscopes.

Outpatients

- We saw that work had been undertaken since our last inspection to provide more designated waiting areas for patients and patients were no longer waiting in corridors. Access was improved for patients in wheelchairs, or with mobility difficulties.
- We checked the resuscitation trolleys and found medications were in date, all the checks were completed, and up to date, there was a paediatric trolley in the ophthalmology outpatient's area and one adult trolley on each floor.
- We saw that the hypoglycaemia boxes were checked daily.

Diagnostic Imaging

- Resuscitation trolleys and equipment including suction and oxygen lines were all checked and cleaned daily and checklists were signed and found to be up to date. Trolleys were locked and tagged and staff made weekly checks of contents and their expiry dates.
- Reception areas experienced busy periods however; there was sufficient seating to meet demand. The department had designated trolley areas and wheelchair spaces marked on the floor. This made sure that the privacy and dignity of patients was preserved.
- Seating was in good condition and there was a mixture of standard and high chairs to help people with mobility problems to stand more easily.
- Water fountains were provided for patients' use and there was a shop and café where people could purchase drinks, snacks and meals.
- The Radiology department had a small area of the main waiting room orientated towards young patients with wall-mounted toys, which were regularly cleaned.
- During our observations, we saw that there was clear and appropriate signage regarding hazards in the imaging department.
- Staff wore dosimeters in radiology. This was to ensure that they were not exposed to high levels of radiation.
- In diagnostic imaging, quality assurance checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protected patients against unnecessary exposure to harmful radiation.

- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging.

Medicines

Outpatients

- We checked medicines storage in the OPD; all medicines stored were found to be stored securely and in date. Prescription pads were stored securely and there was a tracking system in place.
- We saw staff were recording minimum and maximum fridge temperatures and staff we spoke with were aware of this requirement and knew what to do should temperatures go outside of the recommended range. The trust was in the process of implementing a new remote monitoring system for fridges, which will be overseen by pharmacy.
- The nurses told us that although pharmacy would now alert them if there were issues with the fridges they were continuing with paper recording for the time being until the new system was fully embedded and tested.
- We noted that medicines were stored at room temperature and the temperature of the room was being monitored.
- A safe and secure medicines audit in February 2016 found DPoW outpatients areas were 92% compliant with the standards.

Diagnostic Imaging

- In the diagnostic imaging department, some interventional procedures required sedation, and a consultant, nurse and allied health professional such as a physiologist or radiographer were present and observations were carried out and recorded.
- PGDs (patient group directions) for drugs used commonly in the department were in place for adrenaline and saline.
- Radiology staff administration of medication competencies were checked, recorded and reviewed.

Records

Outpatients

- At the time of inspection, we saw patient personal information and medical records were managed safely and securely within the OPD. All patient records were paper-based.

Outpatients and diagnostic imaging

- Staff told us that if records were not located before a clinic then the administration team would make up a temporary set of records, which would be merged, with the original set when located.
- The trust did not collect data regarding the percentage of patients seen without a full medical record.
- Staff told us there was an escalation process in place for them to use when notes were unavailable for clinics.
- We looked at the medical records of ten patients attending the ophthalmology outpatient clinic. We found these were of a good standard. They contained sufficient up to date information about patients including referral letters, copies of letters to GPs and patients, medical and nursing notes.
- We saw from incident records that staff would sometime see patients without their notes, if these could not be located. We saw examples where medical staff saw patients using only their referral letter. This meant there was a risk the staff member carrying out the consultation did not have all of the patient information required.

Diagnostic Imaging

- Diagnostic imaging and reports were stored electronically and available to clinicians via PACS (Picture Archiving and Communications System).
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were stored electronically and were easily accessible to all diagnostic imaging staff.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation were recorded. Maximum dose levels were displayed in each of the imaging rooms.

Safeguarding

Outpatients

- Level 2 children's safeguarding training was mandatory for all staff in the department. Adult safeguarding training was also mandatory. The trust submitted combined training data for the outpatient service, which showed safeguarding training compliance, was at 83% for DPoW, the trust target was 95%.
- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and children.

- Staff knew how to access policies and senior specialist safeguarding staff within the organisation who they could speak with for advice.
- The healthcare assistants we spoke with told us they would escalate any concerns to the nurse in charge of the clinic, in the first instance.
- Staff were aware they needed to identify children who did not attend their outpatient appointment to their safeguarding lead.

Diagnostic Imaging

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults or children. Staff knew that there was a policy on the intranet and staff within the organisation who they could speak with for advice. All of the staff we spoke with said they would escalate any concerns to their manager in the first instance.
- All staff groups in the department were meeting the trust standard of 90% of staff being up to date with safeguarding training requirements at level two for children and level one for adults.

Mandatory training

Outpatients

- Staff we spoke with told us their mandatory training was either up to date or any missing elements were booked.
- Staff told us that there was some delay in being able to access manual handling training.
- Data submitted at 31 October 2016 showed overall compliance with mandatory training was 81% for nursing staff, 87% for audiology staff and 98% for reception staff.

Diagnostic Imaging

- Mandatory training was well managed. The diagnostic imaging departments had systems and processes to ensure staff training was monitored.
- Training was accessed via e-learning and classroom-based training sessions.
- Mandatory training compliance for radiology varied and the rates were: for Fire Safety 77%; Infection prevention and control 83%; Slips, trips and falls 91%; mental capacity 91%; Deprivation of liberty 100%; Conflict resolution 94% and information governance 100%.

Outpatients and diagnostic imaging

- Staff told us that they were allocated time to complete mandatory training and only occasionally experienced problems attending mandatory training.
- All radiology staff had received IR(ME)R training and this was now part of mandatory training.

Assessing and responding to patient risk

Outpatients

- To manage the risks posed by lengthy waiting lists, the outpatient management team told us they had developed a clinical validation policy that had been agreed by all clinical groups.
- Clinical staff were validating waiting lists with a view to prioritising patients for clinic review and discharging patients where appropriate. Alongside this, administrative staff were also reviewing waiting lists with a view to cleansing data, i.e. closing down pathways that had been left open in error.
- We saw evidence that clinical validation was ongoing in a number of specialities. Consultants and managers told us of a number of ways in which validation was being managed and risks mitigated.
- We saw that the majority of clinical validation was undertaken by consultants although they did delegate some of this work to other medical staff and some clinical nurse specialists. Junior staff were expected to discuss any case they were unsure about with the lead consultant.
- We saw that some patients were discharged following a case review, others received a telephone consultation prior to discharge or appointment and others were given appointment due dates depending on the urgency of their clinical need. The trust was writing to the GP of all patients who were discharged asking them to re-refer if warranted by the patient's current condition.
- November 2015 to November 2016, discharge and referral data for DPoW indicated that after an initial peak of activity in December 2015 the numbers of discharges declined again until June 2016 when they started to rise gradually reaching a peak in September 2016. This corroborated what staff had told us about clinical validation of waiting lists stalling for several months following the initial activity following our last inspection.
- Re-referral rates within six weeks were usually between 3.1% and 4.4% with one exception in June 2016 when this rose to 5.2%.
- We looked at data that showed validation of Cardiology lists was limited before July 2016 despite the waiting list issues being raised following the October 2015 inspection. There were 1,258 patients discharged between September 2015 and September 2016, the majority of these (1,161) since July 2016. Sixteen of the discharged cardiology patients had been re-opened or referred back into the service (around 1.5%).
- Weekly meetings were being held with managers, consultants and admin staff in the SAT to review the waiting list position and manage / prioritise capacity and demand for appointments.
- The trust had outsourced some new ophthalmology referral work to an independent provider to help address the waiting list issues and was looking at possibilities to outsource work from some other specialities such as gastroenterology.
- Nurse specialist roles were being developed in ophthalmology to run injection clinics to reduce the risk to patients by reducing lengthy waits.
- Managers told us the pain team had been asked to explore options for their service to improve things for the long waiters for their service and to consider any work that could be undertaken by or in partnership with primary care.
- Managers told us that the work with NHS improvement had included looking at the reasons why there was a mismatch between demand and capacity, quantifying the capacity and demand in each speciality and risk rating each of the specialities.
- Managers told us the SAT teams were now ready to start real-time validation of patient tracker lists (PTLs). This would ensure waiting lists were managed appropriately and the quality of data input was improved i.e. to ensure that patient outcomes (e.g. whether discharged or for further investigation, treatment or appointment) were correctly coded to prevent issues such as no due date and pathways left open incorrectly did not happen in the future.
- Staff told us that if a patient became unwell during clinic they would seek immediate assistance from medical staff in the department. The patient would then be transferred to A & E for assessment.
- In the case of a patient collapse in the outpatient department, all staff we spoke with were aware how to raise the alarm and raise a crash call.

Outpatients and diagnostic imaging

- Diabetic patients were given contact details for the specialist nurses so they could escalate any change in condition or seek advice when they needed to.

Diagnostic Imaging

- The department had a process for prioritising the urgency of diagnostic imaging referrals and requests. All urgent referrals were flagged and escalated to ensure they were given an early appointment. All other requests were triaged and appointments were allocated accordingly.
- There were emergency assistance call bells in all patient areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- Staff were aware of actions to take if a patient's condition deteriorated while in the department and explained how they could call for help, access the cardiac arrest team and the process for transferring a patient to the Accident and Emergency Department. There were also a number of resuscitation trolleys and defibrillators across imaging departments.
- There were policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances was managed and minimised.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation Medical Exposure (2000) regulations. IR(M)ER.
- Managers told us that the heads of service were trained Radiation Protection Supervisors and that all staff but 1 had now had IR(M)ER training.
- The department underwent an IR(M)ER audit in March 2016. The audit provided an assurance level of 'Significant'.
- There were named certified Radiation Protection Supervisors to give advice when needed and to ensure patient safety at all times. The trust had radiation protection supervisors (RPS) and liaised with the Radiation Protection Advisor (RPA). The RPA was employed by another trust and there was a service level agreement in place.
- There were two Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holders in the trust; one person was employed by the trust and was responsible for cardiology and the other was an external person responsible for medical physics.
- The ASARC holder for the Medical Physics elements of diagnostic imaging was employed by another trust with

a service level agreement in place. This was because the two previous holders had retired. There are plans in place to identify and train a new radiologist employed by the trust however this has not yet happened. The role of the ARSAC advisor is to be contactable for consultation and provide advice on aspects relating to radiation protection concerning medical exposures in radiological procedures. Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and imaging work to national guidance and vary depending on setting. Policies and processes were in place to identify and deal with risks. This was in accordance with (IR(M)ER 2000).

- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and if the x-ray was still necessary, could wear a lead apron to protect their unborn baby.
- Staff told us that the risks of undergoing an x-ray whilst pregnant were fully explained to patients.

Nursing and allied health professional staffing

Outpatients

- There was a dedicated team of outpatient nurses, receptionists and support workers working in the OPD.
- Staffing information submitted by the trust showed there were 14.2 whole time equivalent (wte) nurses in post in the OPD at bands 5 and above against an establishment of 14.8 wte.
- There were 18.9 wte staff at bands 1 to 4 in post and the establishment was 22.3 wte.
- Total staffing establishment was 37.7 and there were 33.9 wte in post, leaving a shortfall overall of 3.7 wte.
- Between October 2015 and September 2016, the trust reported an overall vacancy rate of 3% in and a turnover rate of 18% in outpatients.
- Between October 2015 and September 2016, the trust reported a sickness rate of 3% in outpatients
- Between October 2015 and September 2016, the trust reported a bank and agency usage rate of 0.1% in outpatients.

Outpatients and diagnostic imaging

- Nursing staff told us they were able to use agency staff when needed but usually clinics were covered by regular staff working flexibly or by working additional hours.
- The department manager told us that additional clinics were run by substantive staff working additional shifts.
- The manager told us that the establishment of qualified staff had been improved in her department and now she was able to allocate one registered nurse to supervise four HCAs, which was a good improvement.
- The clinical staffing review was ongoing across the whole of outpatients.

Clinical administrative staffing

- There were 18 speciality admin teams (SAT) across the trust who booked appointments, dealt with referrals, discharges and clinic letters and managed waiting lists for outpatients.
- Staff told us that there were vacancies in medical secretary posts and in the SATs, which were covered by bank and agency workers. Some staff told us they were still unsure of their roles and responsibilities and had concerns that agency and bank staff lacked the experience needed for some roles and responsibilities.

Diagnostic Imaging

- We looked at the staffing levels in each of the diagnostic imaging departments. There were a total of almost 12 wte vacancies across the various imaging and scanning teams. Percentage wise, the biggest vacancy rate was in ultrasound with 21% (three staff). Numbers wise the main radiology department had the most wte vacancies with five (16%).
- However, all department managers told us that staff were flexible to be able to ensure cover was available. There were no departments with significant vacancies that would affect the way they were able to function. Staff told us they were very busy but had sufficient staff to meet service and patient needs and that they had time to give to patients.
- The radiology department had nurses and health care assistants who assisted with interventional procedures. There was very little nurse agency use in the department.
- Radiographers staffed the department over two shifts, including a night shift. There were sufficient staff on duty to meet the needs of the service.

- Radiographers and radiography assistants were registered with the hospital bank and carried out additional shifts if needed. The department also worked with a local university to train student radiographers.
- The department employed reporting radiographers. This helped to alleviate the pressure on radiologists and radiologist vacancies.

Medical staffing

Outpatients

- Medical staffing for OP clinics along with clinic capacity and demand were managed within each clinical division, such as medicine and surgery. The divisions reviewed and managed their own mandatory training, appraisal and revalidation for medical staff.
- Between October 2015 and September 2016, the trust reported a vacancy rate of 25% and a turnover rate of 23% in outpatients.
- Between October 2015 and September 2016, the trust reported a sickness rate of 0% and a bank and locum usage rate of 0.2% in outpatients.
- We were told that there was a high turnover in the cardiology team with three consultants leaving in less than a year.

Diagnostic Imaging

- The Radiology Service was delivered as one service across all three trust sites. The diagnostic imaging service across the trust had a funded establishment of 21.7 whole time equivalent (wte) consultant radiologists. There were 8.6 wte vacancies across the service at the time of the inspection.
- At DPoW, there was funded establishment of 10.9 wte consultant radiologists. They employed 5.5 wte staff at the time of the inspection. This meant there were 5.3 wte vacancies.
- The number of radiologists in post enabled the service to provide a core service cover from 9am until 5pm Monday to Friday. Outside these hours, there was a radiologist on call. Radiologists all had viewing stations at home should an urgent report be required.
- The department contracted the reporting of some X-rays and scans to external companies to enable them to meet the demands on the service. There were formal service level agreements (SLA) in place for this process.
- There was a national shortage of radiologists however; the trust had held recruitment events worldwide to

Outpatients and diagnostic imaging

encourage radiologists to join the trust. These had some limited success. There was an ongoing recruitment drive to attract radiologists. The trust was also in discussions with other trusts regarding the possibility of joint appointments.

- The trust had not recorded any sickness levels for radiologist staff.
- Between August 2015 and July 2016, locum use varied between 2.6% and 4.7%.

Major incident awareness and training

Outpatients

- Service staff had access to major incident and business continuity plans.
- Staff and managers told us there had been a recent major incident declared as a result of a cyber-attack. They told us they felt the incident had been managed well and they were aware of debriefings and activities in place to learn from the event and improve the response to any future incidents of this type.

Diagnostic Imaging

- Staff were aware of the action they should take in the event of a radiation incident. There were standard operating procedures in place.
- The various teams within the diagnostic imaging department had business continuity plans in place. In the event of equipment failure, the trust had agreements with local providers to allow them access to equipment such as MRI scanners. There were also maintenance contracts in place to ensure that any mechanical breakdowns were fixed as quickly as possible.
- Staff knew their roles in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Outpatients & diagnostic imaging services were inspected but not rated for effectiveness in both 2015 and 2016. At this inspection we found;

- Staff had access to policies and procedures and other evidence-based guidance via the trust's intranet. Staff we spoke with were aware of National Institute for Health and Care Excellence (NICE) and other guidance that affected their practice.
- The staff working in outpatients and diagnostic imaging departments were competent and there was evidence of multidisciplinary working across teams and local networks.
- Nursing, imaging, and medical staff understood their roles and responsibilities regarding consent and the application of the Mental Capacity Act.
- Staff undertook regular audits in imaging departments regarding quality assurance to check practice against national standards.

Evidence-based care and treatment

Outpatients

- Staff had access to policies and procedures and other evidence-based guidance via the trust's intranet. Staff we spoke with were aware of National Institute for Health and Care Excellence (NICE) and other guidance that affected their practice.

Diagnostic Imaging

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.
- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other guidance that affected their practice.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The imaging department carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

Outpatients and diagnostic imaging

Outpatients

- Pain relief medication was not routinely administered in the outpatient departments we visited.

Diagnostic Imaging

- Pain relief medication was not routinely administered in the radiology department unless the patient needed to be sedated.
- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures. Inpatients received pain relief on the ward prior to arriving in the department and outpatients were asked to bring their normal medication with them. Additional pain relief for procedures such as biopsies was prescribed by radiologists and administered safely as required.

Patient outcomes

Outpatients

- Patient Reported Outcome Measures (PROMS) were collected and reported nationally in line with Department of Health requirements.
- Between April 2015 and March 2016, the follow-up to new rate for DPoW was higher than the England average.
- The diabetic specialist nurses were involved in auditing management of hypoglycaemia and the podiatrists collected data for the National Diabetes Foot audit. Podiatrists told us locally, time from first presentation of disease to referral to podiatry was worse than the national average.
- The staff in the diabetic centre were also contributing to a piece of work within the Yorkshire and Humberside Strategic Network collecting data regarding amputees to identify if there delays within their journey and whether amputation could have been avoided.

Diagnostic Imaging

- All images were quality checked by radiographers before the patient left the department. National audits and quality standards were followed in relation to radiology activity.
- Audits carried out in Radiology included an audit of MRI patient safety questionnaires and referrer errors. Managers gave examples of audits carried out such as the appropriateness of ankle/ foot x-rays, they also told us that there were processes in place for peer review.

- Discrepancy reports were made for example if a multi-disciplinary team MDT picked up something on an image that had not been reported.
- The diagnostic imaging department was not Imaging Services Accreditation Scheme (ISAS) accredited however, the trust employed an ISAS assessor.
- We saw evidence of clinical audits being carried out by the imaging department. Audits carried out were based on adherence to Royal College of Radiologists' standards of practice.
- Where audits had taken place, there were action plans to assist with service improvements.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging this included radiology related to head injury clinical guidance and stroke thrombolysis and non-thrombolysis imaging times.

Competent staff

Outpatients

- Data submitted at 31 October 2016 showed outpatient nursing staff and reception staff were 100% compliant with appraisals at this site. Audiology staff were 88% compliant.
- Health care assistants were trained and assessed as competent to carry out decontamination of endoscopes. Competence was audited six-monthly and 100% of staff were assessed as competent at the last audit.
- Staff told us that HCAs were trained and had been assessed as competent to undertake visual field tests in ophthalmology outpatients.
- Specialist nurses in ophthalmology had received additional training to enable them to run nurse-led clinics. They told us they felt well supported and there was always a consultant available if they needed advice or support regarding a patient.
- Some members of the SATs told us that they had not had appraisals in the last 12 month and that this was largely due to pressure of work.
- The senior nurses for outpatients received 1:1 support from their line manager.
- The band 6 nurse in outpatients was a trained supervisor and was responsible for providing clinical

Outpatients and diagnostic imaging

supervision for nursing staff in the department. There were identified people in the department to help nurses with revalidation. Nurses told us they could choose a supervisor from another area if they wished.

- The nursing staff we spoke with told us they had received an appraisal in the last 12 months.
- We saw that there was succession planning among the nursing staff in the department and the department manager was training up the band 6 nurse to be able to take over in her absence.
- Specialist nurses were members of networks and gained professional support and development by attending these.
- Podiatrists working in the diabetes centre were qualified independent prescribers.

Diagnostic Imaging

- By August 2016, 75% of medical staff across the trust had undergone their annual appraisal. For allied health professionals, this was 86% and for nursing and midwifery staff this was 93%. This information was not split by site.
- There were plans in place to ensure that this was 100% for all staff by the end of the year.
- Data submitted at 31 October 2016 showed staff groups in nuclear medicine; ultrasound, radiology nurses and the diagnostics admin team were 100% compliant with appraisals at this site. CT staff were 94% compliant, medical staff were 80% and staff in general radiology 75%.
- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.
- Allied health professionals were supported to maintain their registration and continuous professional development.
- Radiographers working in interventional roles were trained in specialist areas by the clinical leads, for example in angiography, USS and CT.
- In all departments, staff were encouraged to discuss development needs at appraisal and as opportunities arose. Trust funds were made available for staff to attend external courses including postgraduate qualifications although there were strict criteria for accessing these funds. The department had paid for some radiographers to train to become reporting radiographers.

- There were formal arrangements for induction of new staff. All staff completed full local induction and training before commencing in their role.

Multidisciplinary working

- Managers told us about a 'perfect week' where radiology and outpatients staff had worked with GPs to look at capacity and demand issues and referral processes. There was ongoing work to improve referral pathways and develop alternatives other than outpatient and diagnostic referral.

Outpatients

- A range of clinical and non-clinical staff worked within the outpatients department. Staff were observed working in partnership with people from other teams and disciplines, including radiographers, nurses, booking staff and consultants.
- We saw that staff worked well together as a team and that this helped the clinics run smoothly.
- There was evidence of multidisciplinary team (MDT) working in the outpatients and imaging departments. Staff also told us how they worked with ward staff and those from theatres and day case.
- We saw that a multidisciplinary team consisting of doctors, specialist nurses, dieticians and podiatrists delivered diabetic services. Nurse led clinics ran at the same time as other clinics so patients could have multi-disciplinary input as required. Members of this team visited wards to assist with the discharge and future outpatient management of diabetic patients. The service had two volunteers helping with reception two mornings in the week.

Diagnostic Imaging

- There was evidence of multidisciplinary working in the imaging department. For example, nurses, radiographers and medical staff worked together in interventional radiology theatres.
- We saw that the diagnostic imaging departments had links with other departments and organisations involved in patient journeys such as GPs and support services. For example, the radiology department worked with the Accident and Emergency department to ensure that X-rays, CTs and other scans were carried out and reported in a timely manner.

Outpatients and diagnostic imaging

- Radiologists attended multi-disciplinary meetings to discuss diagnosis and treatment plans for suspected cancer patients.
- Managers told us that due to vacancies the radiologists needed to work across both hospitals to cover MDT meetings (particularly breast staging) and that this work was given priority.

Seven-day services

Outpatients

- This service had held weekend clinics for ophthalmology patients since September 2016 and a subcontracted provider was now running these.

Diagnostic Imaging

- The imaging service was delivered as one service across all trust sites. The two radiology departments at SGH and DPoW were open and staffed 24/7, providing service for the trauma units and inpatients.
- CT at SGH and DPoW were staffed 7.30am to 8.30pm, and had an on call service outside these hours. Because the hyper acute stroke unit was at SGH, there was 24/7 cover of CT by CT trained radiographers. This ensured that the trust met the NICE target of patients undergoing CT within 60 minutes of admission.
- MRI at SGH and DPoW is open 7.30am to 10.30pm at least 5 days per week, and 7.30am to 8.30pm on the remaining days. Ultrasound is open 8am to 6pm 7 days. The trust had arrangements in place to transfer patients to another trust should the patient need an urgent MRI scan.
- The imaging department provided general radiography, CT, magnetic resonance imaging (MRI), ultrasound scanning and fluoroscopy services for outpatients and inpatients every day. There was a rota to cover evenings and weekends so that patients could access diagnostic radiology when they needed to.
- The different diagnostic imaging departments had different opening hours and there was information available to staff about opening hours. A standard operating procedure was in place to make sure that staff were aware of who could make referrals for the different tests and when these services were available. It also clearly set out who was responsible for reporting the images and who was responsible for acting upon the image reports.

Access to information

Outpatients

- The ophthalmology SAT team staff told us that there had been improvements to the IT system, which meant they could easily view their active workload and the patient tracking lists (PTLs) to enable them to be more effective in booking appointments and managing waiting lists.
- For example, the team could see what workload there was regarding clinic letters to GPs. They could see how many notes were at what stage, i.e. awaiting transcription, admin review or clinical approval. They could identify individuals where work was outstanding and provide reminders, help or escalate issues as appropriate.
- The PTLs enabled staff to view things such as the overdue position for each clinician for new and follow up patients, longest waiting patients and shortfalls in capacity. The staff told us this enabled them to escalate shortfalls in capacity and identify vacant slots to discuss with managers and any need for additional appointments or lists and assignment of vacant slots to priority patients.
- The staff were aware of the recently discovered patient lists from unmonitored systems which were being added back into tracked PTLs
- The staff told us that weekly meetings were held to discuss this information and prioritise and plan work for the week ahead.

Diagnostic Imaging

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as imaging records and reports, medical records and physiotherapy records appropriately through electronic records.
- Radiologists had viewing stations at home. This meant that they could look at images and submit reports without the need to be in the hospital. This meant that cover was more flexible.
- Diagnostic imaging departments used picture archive communication system (PACS) and radiology information system (RIS) to store images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient

Outpatients and diagnostic imaging

information quickly and easily. The systems also flagged outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met.

- Diagnostic imaging departments outsourced reporting of out of hours urgent CT scanning to a private provider. There was a service level agreement (SLA) in place. Turnaround times for their reports were a maximum of 60 minutes. This was in line with NICE guidance (CG68) relating to the management of stroke.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients

- Staff told us that written consent was always taken for laser treatment.
- Staff were aware of the Mental Capacity Act and what this meant for valid consent. They told us that patients were always consented before attending the department for their treatment.

Diagnostic Imaging

- Mental Capacity Act and Deprivation of Liberty Safeguards were discussed as part of the trust induction process.
- Information sent to us by the trust showed that 20% of appropriate staff in Radiology had attended deprivation of liberty training.
- Mental capacity training was part of mandatory training. Staff compliance was at 84% with 12 staff yet to undertake or update their training.
- Imaging and medical staff we spoke with understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us that, in diagnostic imaging departments, consent was obtained verbally, although consent for any interventional radiology was obtained in writing on the ward prior to attending the imaging department. Staff told us that patient consent was confirmed before carrying out any personal care or interventional procedure. Patients told us that staff had asked for consent before undertaking any examinations or procedures.

- Staff we spoke with were aware of who could make decisions on behalf of patients who lacked or had fluctuating capacity. They were aware of when best interest decisions could be made and when Lasting Power of Attorney could be used.

Are outpatient and diagnostic imaging services caring?

Good



At the last inspection of this service in October 2015, we rated caring as good. During this inspection, we rated caring as good. This was because:

- We observed staff in all areas treating patients with kindness and respect. Staff were friendly, kind and professional.
- Privacy and dignity was maintained at all times.
- Patients were very happy with their care and information from all professional groups.
- Patients told us they understood the information that was given to them and what was happening to them.
- Staff were able to signpost patients to support groups and counselling services when necessary.

Compassionate care

Outpatients

- We spoke with six patients and their relatives in the OP general waiting area and in the ophthalmology; waiting area and they gave good feedback about the service provided.
- They were all positive about the care they received from all staff. They told us the staff were caring and the service was good to excellent.
- There was only one patient who mentioned a cancelled appointment but due to the phone system, they did not receive the message as their phone had been engaged and no one called back. One patient told us that sometimes the doctors seemed rushed and the department understaffed. When the department was like this they did not like to ask questions, however this was not the case every time. Patients told us they felt 'kept in the loop' and were well informed.

Outpatients and diagnostic imaging

- Patients told us they were put at ease, received good explanations and felt well cared for. Most of the patients had visited the department a number of times and felt that care was consistently good.
- Friends and family data for outpatients across the trust had shown a decreasing trend in satisfaction from 96% likely to recommend the service in January 2016 to 73% in October 2016. The most recent data showed this had increased to 80% would recommend in November in comparison to the national average of 93% would recommend.
- There were very positive patient comments and a high level of satisfaction to do with staff friendliness from the trust outpatient department in August 2016.
- We made one negative observation regarding an elderly patient at reception in a wheelchair. The patient had visible injuries to their face and appeared to be dressed in nightclothes. The patient was accompanied by two ambulance crew. The patient appeared to lack capacity and was clearly a vulnerable adult. The receptionist did not seem to notice this and repeatedly asked the patient who their GP was. We observed the patient was moved to the outpatient waiting area at 14.25 we were in the department until 14.50 and no member of hospital staff spoke to her or offered her a drink during this time. We returned at 15.15 the patient had not moved. We asked the receptionist what was happening with her and the reply was they did not know and the patient had not been seen yet. As we were concerned that the patient may have lacked capacity, we asked that the hospital Dementia lead nurse be contacted and to attend outpatients.
- Senior nurses told us they staffed each room with a HCA to act as a chaperone for patients and assist doctors as needed.

Diagnostic Imaging

- We observed patients being supported in a way that preserved their privacy and dignity.
- Staff were kind and patient with patients. They welcomed patients with a smile and a cheerful manner.
- Staff ensured that patients felt comfortable and safe in the department and were good at putting patients at ease.
- There were gowns available to patients to maintain their dignity.
- There were designated areas for patients on trolleys to maintain their privacy.

Understanding and involvement of patients and those close to them

Outpatients

- Patients told us they understood what the nurses and doctors had told them and they understood what was to happen next. They told us doctors explained things in plain English so they could understand the information given.
- We observed staff giving explanations to patients in a way they could understand.

Diagnostic Imaging

- We saw staff explaining procedures to patients and supporting them both prior to and after their scan or treatment in interventional radiology.
- Upon the agreement of the patient, family members were able to be present with the patient to discuss any concerns or raise any questions.

Emotional support

Outpatients

- We observed and heard staff speaking with patients in a kind and caring manner.
- Patients told us they were happy with the care and support from staff.
- There were specialist nurses available to be with patients when being given bad news.
- Staff were able to signpost patients to support groups and counselling services when necessary.

Diagnostic Imaging

- Staff told us that on request, if someone was anxious about a procedure such as a scan, they could visit the department first to look at the equipment and understand what to expect. This was also available for patients living with a learning disability.
- In the case of children, parents could be in the x-ray room, protected by a lead apron to ensure that the child felt safe.
- There was a similar process in place to support patients living with dementia or a learning disability to give extra support in the scanning or x-ray room.

Are outpatient and diagnostic imaging services responsive?

Outpatients and diagnostic imaging

Inadequate



At the last inspection of this service in October 2015, we rated responsive as inadequate.

During this inspection, we rated again responsive as inadequate. This was because;

- The trust had a continuing high number of cancelled clinics although this was improving in some areas (particularly ophthalmology).
- Referral to treatment times were worsening and the trust told us they were unlikely to recover a good position until March 2018.
- There continued to be large numbers of patients' overdue follow up appointments or with no due date on the patient administration system.
- There was a significant risk of potential harm to patients waiting long periods of time for first and follow up appointments and the trust had not validated the clinical risk within waiting lists in a timely manner.
- Clinical validation of waiting lists / overdue patients was ongoing but had been slow to commence in some specialties.

However:

- There were facilities and processes in place to support the individual needs of patients and staff worked hard to meet individual patient needs.
- Improvements had been made to facilities and waiting areas to improve capacity and better meet the individual needs of patients.
- Imaging services were planned in such a way as to ensure that urgent referrals were given a priority.
- Concerns and complaints were taken seriously and staff and managers responded positively to patient feedback. There were low levels of complaints for imaging services.

Between September 2015 and August 2016, the trust consistently performed better than the operational standards relating to cancer waiting times, for people being seen within two weeks of an urgent GP referral and

Service planning and delivery to meet the needs of local people

Outpatients

- Following the October 2015 inspection the trust was asked to ensure outpatient backlogs were addressed promptly and that patients were prioritised in order of clinical need. They were asked to ensure that the governance and monitoring of outpatients bookings were operated effectively reduce the number of cancelled clinics, patients who did not attend and assess systems and take action to protect patients from unsafe care and treatment. This was to prevent further occurrences of significant harm because of long referral to treatment times and lengthy waits for follow up appointments.
- Recovery plans were developed and as part of this; clinical validation of waiting list patients was commenced, there was some outsourcing of appointments and the trust undertook an administration review and developed speciality administration teams (SATs) with the aim of more effectively managing and monitoring of waiting lists. Weekly patient tracking lists and meetings were introduced in September 2016 for surgical specialities and October 2016 for medical specialities.
- The RTTs have fluctuated over the year and the position has worsened since March 2016. Although the trust felt the RTT position would be fully recovered by the end of December 2016, it announced to commissioners in November 2016 that full recovery would not be possible in the financial year 2016/17. The trust anticipates recovery of their RTT position by March 2018 except for trauma and orthopaedics, which may be later.
- In September 2016, the trust had enlisted the help of the NHS intensive support team from the NHS Improvement to work with them to look at the RTT and other waiting list issues and appointed a manager to look at RTT across the whole of the trust in October 2016.
- Because of the data quality issues and need for large-scale validation, the trust has been unable to produce a robust recovery plan or trajectory. The trust told us they would need to engage with external stakeholders regarding validation.
- A task and finish group reporting to the Executive contract board was set up in November 2016 with members from the trust and both of its commissioning groups to develop a single recovery plan. The trust told us the recovery plan would be fully developed by the end of March 2017.
- We spoke with members of staff in some of the SATs regarding service planning and delivery to reduce

Outpatients and diagnostic imaging

waiting lists. While the members of the ophthalmology team were very positive and told us of many changes made to the way they worked and were able to show us the progress they had made reducing lists for new and follow up patients other teams were less positive and felt that there were still issues with the systems in place. Staff identified issues including; locum doctors not discharging patients when they should and placing unnecessary demand on the services, lack of clinic slots and weekend / evening clinics, lack of leadership and lack of conviction that not being able to make follow up appointments in clinic (if outside of four weeks) was the best way of managing follow up appointments. Administration team members, managers and clinicians all told us that validation of clinic waiting lists was in process and good progress had been made.

- Managers had recognised that there was inconsistency between the SATs and were developing a training and support plan to improve performance and consistency across the teams.
- The ophthalmology service had outsourced new referrals to a third party provider and consultants and managers told us that this was helping manage demand and having a positive effect on reducing the waiting list. They recognised that this was not a sustainable long-term solution to the issues of capacity and demand however; this was proving beneficial in the short term.
- Staff told us that patient referrals were screened against set criteria before they were passed on to an independent provider, patients not meeting the criteria were given appointments in the usual ophthalmology clinics.
- The ENT service was discussing with another NHS provider and an independent provider how they could work together to support the service.

Diagnostic Imaging

- Diagnostic imaging services operated extended opening hours. For example, the x-ray department was open 24 hours per day. Other scanning services such as MRI and CT operated clinics on weekends and from early in the morning until late at night. This meant that people who worked were able to arrange their scans outside of working hours.

- The imaging department had good processes in place and although it was very busy, there was capacity to deal with urgent referrals. There was a service level agreement in place with a private provider to use their scanners in times of demand surge.

Access and flow

Outpatients

- The trust had recently introduced a new email central referral gateway. GPs and other healthcare professionals could refer directly into this system and would receive an immediate automatic response to say the referral had been received. The system would also automatically alert the relevant SAT and initiate the cancer tracking system. Managers told us they were confident in the new system and that referrals could not be lost.
- The piloting of the new system had led to the discovery of a cohort of missed referrals from GPs. Managers told us they were confident in the new system and that referrals could not be lost.
- The trust also continued to receive paper referrals from GPs and dentists, and referrals from choose and book.
- There was an internal trust target that all referrals would be registered within 1 working day of receipt.
- Between November 2015 and October 2016 the trust's referral to treatment time (RTT) for incomplete pathways showed a worsening trend over time from around 92% in February 2016 to 84% in September and October 2016. The trust's RTT was higher (better) than the England average between November 2015 and January 2016 but fell below between February 2016 and October 2016. The latest figures for October 2016 showed 81.5% of this group of patients were treated within 18 weeks versus the England average of 90.1%.
- The specialities of; ear, nose and throat, urology, cardiology, thoracic medicine, trauma and orthopaedics, oral surgery, dermatology ophthalmology and 'other' were all performing below the national average for incomplete pathways. 'Other' was the worst performing speciality at 79%.
- Specialities performing better than the England average were geriatric medicine 99.7%, gynaecology 98.9%, rheumatology 97.8%, gastroenterology 92.8%, neurology 91.5% and general surgery 89%. General medicine was at 94.9%, which was slightly below the England average.

Outpatients and diagnostic imaging

- Between November 2015 and October 2016 the trust's referral to treatment time (RTT) for non-admitted pathways showed a worsening trend over time from around 95% in March 2016 to around 86% in October 2016. The trust was higher (better) than the England average between November 2015 and April 2016 but from May 2016 the trust performance has been worse than the England average. The latest figures for October 2016 showed 83% of patients were treated within 18 weeks versus the England average of 89.4%. General medicine was at 93% and 'other' was at 92.6%, which were worse than the England average.
- The specialities of; oral surgery, urology, cardiology, gastroenterology, thoracic medicine, ophthalmology, neurology and dermatology were all performing below the national average for non-admitted RTT. Dermatology was the worst performing speciality with 73% of patients seen within 18 weeks of referral.
- The specialities performing better than the England average were; geriatric medicine 99.8%, gynaecology 99%, ear, nose and throat 95.7%, general surgery 93.2% and trauma and orthopaedics 92%.
- The trust told us there were 2,371 patients waiting for over 18 weeks, for their first appointment, at the 11 December 2016.
- The trust told us there were 21,434 patients overdue their follow up appointment, at the 11 December 2016. The majority of the longest waits for follow up appointments were within surgical specialities; ophthalmology, colorectal, ENT and urology. There were 3,947 ophthalmology patients overdue with 105 more than 34 weeks overdue. There were 2,702 colorectal patients overdue their follow up appointment and 247 of these were more than 34 weeks overdue. There were 2,289 ENT patients overdue with 98 of them more than 34 weeks overdue and 1,589 urology patients overdue with nine patients overdue by 34 plus weeks.
- There were a further 11,208 patients who did not have a due date on the patient administration system, 5,097 were booked but with no due date and 6,111 had no appointment and no due date on the system. The most affected surgical specialities in this cohort were ophthalmology (1,777), colorectal (942), urology (874) and trauma and orthopaedics (749). The most affected medical specialities were rheumatology (950) and cardiology (846).
- Recent work with NHS Innovation (NHSI) had unearthed data quality issues, which highlighted two actual, and other potential and previously unknown, 52-week breaches and around 12,000 patients in unmonitored systems. The trust informed the CCGs of this on 21 November 2016.
 - There were; around 430 patients on incomplete pathways whose waiting time clock had been stopped in error, around 5,800 patients showing as inactive and not being tracked (this cohort poses a significant risk of 52 plus week waiters) the full scale of this problem is unknown at the time of writing this report as this cohort of patients require validation.
 - A further waiting list of around 6300 patients was also discovered outside of the patient administration system (PAS) and the patient tracker lists. These patients are those who have had an inpatient episode / treatment but gone on to require a further elective pathway or follow up. From the investigation of two SIs it seemed there was an expectation that ward clerks added these patients to lists but there had been a lack of clarity regarding who monitored this or ensured bookings were made.
 - A further two cohorts of patients were identified as inpatient planned (1,093) and diagnostic planned (13,024) that were not on active tracker lists. Work was needed to assess length of waiting times beyond due date and for these lists to be added back in to the active tracker lists.
- There was also an SI reported in August 2016, which identified an overdue and un-booked cohort of 6,000 ophthalmology patients.
- There was an ophthalmology recovery plan in place for the 6,000 overdue patients identified in August 2016, the trajectories had been followed and the department was a month ahead of plan with no patients left to book at DPoW by December 2016.
- Although the cohort above had been dealt with, there were still 2,173 overdue review and 566 no due date patients in Ophthalmology at DPoW (correct at 11 December 2016).
- Trust wide there were 3,481 patients' overdue review and 1510 no due date patients in Ophthalmology at DPoW (correct at 11 December 2016).
- Across all specialities an audit of overdue patients in August 2016 showed that 18,833 follow up patients, had no appointment and were overdue, following validation

Outpatients and diagnostic imaging

17,827 required an appointment. The trust has reduced this to 22 as of 12 December 2016. The reduction is due to patients moving to either an appointment given or the patients being discharged.

- Between September 2015 and August 2016, the trust consistently performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The trust also consistently performed better than the England average for this standard, over this time.
- Administration staff confirmed that two-week referral patients were prioritised by clinical staff and appointments were accessible.
- Between September 2015 and August 2016, the trust consistently performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis (decision to treat). The trust also consistently performed better than the England average for this standard, over this time.
- Since Q3 2015/16, the trust has performed similar to the 85% operational standard for patients receiving their definitive treatment within 62 days of an urgent GP referral. The trust consistently performed better than the England average for this standard, over this time.
- Between April 2015 and March 2016 the 'did not attend' (DNA) rate for Diana, Princess of Wales Hospital was worse than the England average, which was 7%. The rate had fluctuated during this time just above and below 10% coming down to around 9% in March 2016.
- Staff in outpatients told us that patients were sent text messages to remind them of their appointment details and this seemed to reduce the numbers of patients who DNA. Other initiatives to reduced DNAs and cancelled appointments included the introduction of new booking rules, which meant that patients could not be given an appointment more than six weeks ahead.
- Administration staff in ophthalmology told us that now, all cancelled clinics were impact assessed by a consultant and patients were reassigned to other clinics. The team told us that they felt there were much fewer cancellations and that the monitoring and reassignment of these patients was much more effective, than it had been previously.
- The Trust has seen an overall downward trend in the rate of hospital cancelled appointments across all sites October 2015 to September 2016, despite slight peaks in April 16 and July 16. The overall cancellation rate for this period was 11%. The overall cancellation rates between August 2015 and July 2016 were 9.9% within 6 weeks and 3.8% over 6 weeks.
- The main reason(s) for cancellations as reported by the trust were:
 - Clinic session amended
 - Clinic session cancelled
 - Clinical reason for slot change
 - Annual leave
- For the 12 months to the end of October 2016 the cancellation rate was around 11%.
- The four specialities with the highest cancellation rates across the trust were as follows. Community paediatrics was the speciality with the highest outpatient cancellation rate of 25% over this time. Anaesthetic appointment cancellation rate was 22% over the year but had shown improvement since May 2016. The pain management service had a similar rate over the year with significant fluctuations above and below this throughout the period. Rheumatology cancellation rate was 19% over the year.
- There were a number of speciality admin teams (SATs) who coordinated clinics, made appointments, prepared clinic lists and ordered records. These teams worked closely with the outpatient nurses and consultants and helped manage waiting list initiatives which included the implementation and monitoring of patient tracker lists (PTLs) and agreeing with consultants extra clinics and urgent appointment slots.
- We were told that PTLs were monitored weekly and long waiting patients were reviewed daily by the SAT team leaders. They would alert the consultants' secretaries, patients to be discussed with the consultant and clinically reviewed as appropriate.
- The SATs told us that there had been a significant turnaround in the last 12 months with changes to rotas and clinic timetables, changes to booking rules, extra clinics, validation of waiting lists and outsourcing of new ophthalmology patients all of which had helped greatly reduced waiting lists.
- The newly discovered cohorts of patients in unmonitored systems were not on the PTLs prior to their discovery in August 2016. It was unclear whether the trust had added all of the previously unmonitored lists back into the active PTLs by the time of this inspection.
- The ophthalmology team hoped that the backlog of patients would be cleared by December 2016.

Outpatients and diagnostic imaging

- Dermatology and orthoptic clinics were offered from one of the GP surgeries in the area.
- A one stop laser clinic had been introduced which had reduced the need for multiple appointments and staff told us that there was now direct referral into this clinic. Other one-stop clinics were running or being piloted.
- Clinical nurse specialists ran clinics alongside consultants to improve capacity and access.
- The department manager told us that by working together the service had run 111 additional clinics during September 2016.

Diagnostic Imaging

- Diagnostic waiting times against the 6-week standard, between November 2015 and October 2016 were generally lower (better than) than the England average, with the exception of April and May 2016, and October 2016 when it was higher (worse). With the exception of April and May 2016, all other months showed less than 0.025% of patients waited more than 6 weeks for a diagnostic test.
- Subsequent data provided by the trust showed that the number of patients waiting more than six weeks for a diagnostic test was high. As at 4th December 2016 there were 799 patients waiting more than four weeks for a diagnostic test. There were 12130 waiting less than four weeks.
- As at December 4th 2016, 589 patients were waiting more than 6 weeks for a CT, 82 patients waiting more than 6 weeks for an MRI and 145 waiting more than 6 weeks for a non-obstetric ultrasound. There were 483 patients waiting for radiology 'other' diagnostic test.
- The latest weekly active waiting list report 11 December 2016 indicated that 93% of patients waited five weeks or less for diagnostic imaging. At this time, 732 patients had waited between five and eight weeks and 147 patients had waited over nine weeks for their test.
- We identified no concerns about patients breaching the two week urgent referral timescales and in the case of lung x-rays, where a concern was identified, the patient was automatically referred for a chest CT so that by the time they attended their outpatient appointment, the Dr had a diagnosis and was starting to create a treatment plan.

- Staff carried out a continuous review of planned imaging sessions in relation to demand and 7-day working arrangements. Staff organised additional evening sessions to accommodate urgent diagnostic imaging requests as necessary.
- Waits in diagnostic imaging once in clinic were short. We observed that patients often waited no more than 10-15 minutes. The trust told us they did not collect this information. We did see inpatients waiting for porters to return them to their ward following procedures. These patients were placed in designated trolley areas with curtains to protect their privacy and dignity.
- Referrals to diagnostic imaging were actioned by the clerical team who liaised with the radiography staff to check the urgency of the referral. Staff liaised with the wards to request a porter to bring inpatients into the department near the time of the procedure.
- Reporting times for diagnostic images were overall around a day for non-specialist imaging such as x-rays and ultrasound. The trend for CT, MRI and radioisotopes reporting times performance had increased from 1.27 to 5.13 for CT between March 2016 and August 2016, for MRI from 2.6 to 6.48 days in the same period and for radioisotopes from 2.06 to 10.24. These figures were across both sites and there was no specific information for this site.
- Managers told us that if reporting of plain films looked like it would exceed a 10 working day period then they would outsource additional work to keep within this limit.
- The department offered outreach USS from a GP practice and there covered a small radiology department which included USS at Goole hospital.

Meeting people's individual needs

Outpatients

- We saw a number of self-check in kiosks at DPoW, which allowed patients to check in for their outpatient appointments with instructions in six languages.
- We saw that there were signs on the wall to encourage people to ask about interpreting services if needed
- We saw there was access to hearing loops for patients with hearing difficulties and appropriate signage for people who are visually impaired. However, reception staff we spoke with were not aware of the hearing loop or what it did.

Outpatients and diagnostic imaging

- We saw there was a photographic board for patients to be able to identify staff and what uniforms meant.
 - There were patient leaflets available and information boards including a display of patient experience information. We noticed that all leaflets and notices were in English.
 - Staff were aware they could access the 'bigword', a telephone translation service and other independent face to interpreters including a service for British sign language (BSL) and they knew how to do this. They were also aware they could get written patient information translated.
 - Waiting areas had televisions to occupy patients who were waiting.
 - There were drinks dispensers available in waiting areas.
 - Although there were no bariatric chairs available in the waiting areas there were a selection of chairs in different sizes and with or without arms, so patients could choose a seat appropriate to their needs. There were wheelchair spaces which would accommodate patients own wheelchairs including bariatric wheelchairs.
 - Patients waiting the ophthalmology area told us they sometimes had to stand during busy times.
 - We saw that staff kept a notice board on display regarding clinics running and expected waiting times if clinics were running late.
 - There was a small children's waiting area in the ENT clinic. Staff told us they were hoping to have this refurbished from charitable funds.
 - Staff told us that they held a children only ENT clinic every Monday and alternate Tuesdays. A paediatric nurse from elsewhere in the hospital came to run these clinics.
 - The people with a learning disability (PWLD) lead for the organisation was based at DPoW and covered all hospital sites. Staff told us that one of the HCAs had been nominated as a PWLD champion for the department.
 - The nursing staff we talked with told us they had received some awareness / training regarding dementia. The senior nurses in the department were aware of the need to make their environment as dementia friendly as possible and this needed to be taken into account when planning improvements.
 - We saw that the new waterfall waiting area was dementia friendly and nursing staff had sourced a dementia friendly clock for the wall.
 - The reception staff we spoke with told us they had not received any training regarding assisting people with additional needs and they said they would find this beneficial.
 - Staff told us they had pagers, which they gave to patients if they thought there was going to be a long wait so that they could leave the department without missing their appointment.
- ## Diagnostic Imaging
- Vulnerable patients such as those living with dementia or learning disabilities were identified as part of their referral and given longer appointment times. Their relatives, carers or social workers were accommodated to attend with them in consulting and treatment rooms. Often quiet areas of the department were used to help these patients feel safe.
 - Patients, who were required to be at the hospital for a long time, for example those with multiple appointments or waiting for ambulances, were able to access food and drinks from vending machines, the café and a shop.
 - Staff told us that prisoners with escorts used separate areas of the department for their dignity and to reduce the anxieties of others.
 - Bariatric furniture and equipment was available and accessible.
 - Patients for diagnostic imaging who met bariatric weight and size limits could be accommodated with some of the newer imaging tables and equipment but the current MRI scanner did not meet bariatric needs. Patients were offered the choice to access a different service or a private provider who had an open scanner, which was suitable for larger patients or those who suffered from claustrophobia. A replacement MRI scanner was being researched and both of these needs were being given consideration.
 - Staff were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly.
 - Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient designated space to manoeuvre and position a person using a wheelchair in a safe and sociable manner. There were allocated bays for patients in hospital beds.

Outpatients and diagnostic imaging

- Patients had access to a range of information. Information was available on notice boards and leaflets. There was information that explained procedures such as x-rays. There was information about various illnesses and conditions including where to go to find additional support.
- Patient information leaflets could be accessed in formats and languages other than English if required. There were posters displayed about general health advice.
- The bookings teams organised interpreter services for patients who did not speak or understand English well. Staff told us that they experienced no difficulties in accessing interpreters. However booking staff had to rely on GPs and hospital referrers ensuring that the trust was aware of a patient's requirements. Staff told us that interpreters were preferable to friends and family to ensure that clinical messages were put across correctly and also to maintain patient confidentiality.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at team meetings, actions agreed and any learning was shared.
- Information was accessible on the Trust web site including the complaints policy. We saw posters distributed within the departments. Most patients we asked did not know how to make a complaint but said that they would initially complain to the clinician seeing them or at reception.

Are outpatient and diagnostic imaging services well-led?

Inadequate



Learning from complaints and concerns

Outpatients

- Between September 2015 and August 2016 there were 119 complaints about outpatients. The trust took an average of 575757 working days to investigate and close complaints, this was not in line with their complaints policy, which states category one complaints (single issue) should be completed within 30 working days. The most common complaint theme was regarding clinical treatment.
- DPoW had 54 complaints during this time taking an average of 59 working days to close.

Diagnostic Imaging

- The diagnostic imaging department received five written complaints about services between September 2015 and October 2016. None of these required a complaints action plan. Two complaints were for ultrasound, one for MRI, one for CT and one for general radiology.
- We looked at three months of business meeting minutes and saw that complaints were not part of the agenda however, complaints and PALS (patient advice and liaison service) contacts were a standing item on the governance meeting minutes.
- Staff told us that complaints were rare.

At the last inspection of this service in October 2015, we rated well-led as inadequate. During this inspection we rated well-led as inadequate. This was because;

- The trust had failed to address the following actions, from the October 2015 inspection, in a timely manner:
 - Audit patients on the follow-up lists. This had led to the discovery of cohorts of patients overdue and in unmonitored systems during August 2016.
 - Strengthen the monitoring arrangements in place in relation to OPD follow-ups; this had led to two SIs in the trust where patients had suffered harm because the booking of outpatient appointments following discharge from hospital was not monitored.
 - Strengthen arrangements for monitoring of short notice clinic cancellations, although we did note areas of good practice such as ophthalmology where all cancellations had to be approved by the clinical director, clinic cancellation rates remained high.
 - Appoint a senior over-arching lead to drive the required improvements in OPD booking systems. Although the trust had appointed an internal lead to oversee the administration teams and drive the required improvements in OPD booking systems there appeared to have been little additional support available until autumn 2016.
 - Clinical validation of clinical services other than ophthalmology was not started in earnest until August / September 2016.

Outpatients and diagnostic imaging

- RTTs were worsening and the trust was struggling to match capacity and demand. The trust did not expect to recover a good position until March 2018.
- Prior to the inspection and following the inspection further cohorts of patients were identified which were not being effectively managed.
- There was mixed feedback from staff in a number of roles regarding leadership and an expressed reluctance to raise concerns regarding management or services, for fear of negative repercussions.

However:

- The diagnostic imaging department had a five-year strategy in place to ensure that the department was future proof and had governance processes in place to ensure that risks were mitigated.
- Improvements had been made in OPD to ensure there were systems and processes in place to facilitate shared learning from incidents and complaints.
- The diagnostic imaging and OP departments had actively sought and acted on patient feedback.
- All staff were now aware of the problems relating to RTTs and waiting lists of follow up patients, we saw staff felt a sense of shared responsibility and were working together to make service improvements.
- The trust was working closely with commissioners, other providers (NHS and independent) and NHSI to make improvements to outpatient services.
- Staff we spoke with felt supported by their immediate line managers and colleagues.

Action had been taken to ensure all radiology staff had received training regarding the ionising radiation (medical exposure) regulations (IR(ME)R 2000) and this had been made mandatory.

Leadership of services

Outpatients

- We found there were clear lines of management responsibility and accountability within the outpatient's services.
- The senior nurse in outpatients told us they had had a new line manager who was very supportive and approachable.
- Administration staff gave us mixed feedback about leadership, some felt empowered, supported, and told us that they were very much involved with service improvements. They felt a shared ownership of waiting

list issues, list management and their ideas were welcomed to help improve the current situation. They felt their efforts were appreciated and success was acknowledged. One of the SATs had been nominated for a trust award for their hard work and success. Other staff told us they still felt unsure in their roles following the previous admin review, unsupported and that managers had not shared any learning from the previous administration review with them.

- They said this had been like a 'car crash' and had left some teams with vacancies, too many bank or temporary staff and people were not clear in their roles or familiar with the complex administration and booking systems. They told us support had been lacking for staff moved to new areas.
- Some admin staff felt there was a threat in the air about performance, and that communication from higher up in the organisation was poor about lessons learned from the last admin review
- However, we spoke with other admin staff who told us their managers were supportive and listened to staff ideas for improving services and concerns and worries.
- The ophthalmology team told us that the clinical lead for this speciality was leaving the trust and they had put a proposal together for a new leadership model for their team. We were told that the board had accepted in principle the proposal for a 'collective leadership model'. The team would nominate the lead from within the team and this would shift to another clinician when felt appropriate by the team.
- The Cardiology Management structure changed in January 2016 which saw the introduction of a group manager with managerial responsibilities for the Cardiology Service.
- There was mixed feedback from senior managers and clinicians regarding the trust executive team. Some told us they felt well supported, that their services had significant investment and they were appropriately challenged while others described a difficult relationship where they felt unsupported and intimidated. Some were concerned that that the general culture / atmosphere would have an adverse effect on the retention or return of junior medical staff and locums.
- Some senior managers spoke highly of the medical leadership and felt that they had responded appropriately when they had raised concerns.

Outpatients and diagnostic imaging

- Nursing staff we spoke with and most of the administration staff we spoke with were positive of their immediate line managers and support available to them. They told us they felt included as part of the team and felt part of the wider MDT with a shared responsibility for improving patient waiting lists in particular.
- We were told there had been no clinical manager for cardiology for around two years.
- We were told about succession planning and that training and coaching was available for nurse managers and their juniors.
- We had concerns about the leadership of the outpatient department because after our previous inspection the trust was slow to react to some actions and appointments to key positions to support the administrative function had not taken place until July and August 2016, some eight months after our inspection.

Diagnostic Imaging

- Diagnostic imaging was managed as one service across the trust with a single senior leadership team. There was a diagnostic imaging site manager and a service lead for each of the specialities at SGH and DPoW.
- Overall, staff were happy with the support they received from the line managers. However, some staff raised concerns to us about the management style of some managers. They felt that some managers were confrontational and unaccepting to reasonable challenge. This had not been escalated, by those involved, because some of the managers involved were senior to the department.
- Departmental managers were supportive in developing the service and practice, and staff felt the trust as a whole valued its staff. Staff felt that they could approach most managers with concerns and feel listened to. We observed good, positive and friendly interactions between staff and managers.
- The associate chief operating officer (ACOO) held monthly staff meetings where finance, departmental problems and pressures, complaints, recruitment and vacancies were discussed.
- All the staff we spoke with told us they were content in their role and many staff we spoke with told us that they had worked at the hospital for many years.

- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Staff told us that they were encouraged to manage their own personal development.
- Staff were able to access some training and development provided by the trust, although some staff told us this was not as easy as it had been in the past due to staffing level and time pressures.

Vision and strategy for this service

Outpatients

- The trust was continuing to work closely with the commissioners to address the significant capacity and demand issues within ophthalmology. An Ophthalmology focus group had been established to review potential models of care to support delivery of Ophthalmology services in the future.
- The trust was exploring sub-contracting options for colorectal work.
- The trust had recently held a workshop to review clinical pathways and models of care and was linked to the Healthy Lives Healthy Futures work streams.
- The managers of the clinical services and the administration / performance managers were aware it needed to review outcome of the Clinical Admin Review (CAR) in November 2015 and the effectiveness and consistency of the SATs. Managers and staff told us that a support / training programme had been piloted with one of the SATs and was to be rolled out to the others in order of priority.
- Staff we spoke with knew what the issues were with relation and waiting lists and RTTs and there was a feeling of shared ownership to make improvements. This was particularly evident through the whole of the ophthalmology team from administrators to consultants.
- The expressed, shared vision at all levels of staff was to effectively manage waiting lists (to provide patients with a good, safe service) and eradicate data quality issues.
- We were told there was a lack of vision and strategy regarding cardiology due to vacant posts and turnover in senior clinical posts.

Diagnostic Imaging

- The management team of the department were keen to tell us about the five-year strategy they were working on

Outpatients and diagnostic imaging

to ensure that the department was able to cope with future demands on services. This involved the expansion of the diagnostic imaging department and the purchase of further MRI and CT machines.

- The trust was carrying out a review of the administrative and clerical function within the trust. A full staffing workforce review to plan for future needs and identify any gaps had begun. Succession planning was ongoing with human resource input. Diagnostic imaging reporting was electronic.

Governance, risk management and quality measurement

Outpatients

- Prior to the inspection and following the inspection further cohorts of patients were identified which were not being effectively managed. There were patients in unmonitored systems and new systems to ensure this did not happen in the future were in their infancy.
- There had been a lack of oversight of a number of systems and processes such as monitoring of appointments booked following an inpatient episode, data quality and receipt of GP referrals.
- Staff involved in waiting list management and performance told us they had weekly meetings to review the PTLs, look at performance and prioritise actions for the coming week. However, the trust acknowledged that this was not yet fully embedded and effective across all SATs.
- The trust had developed new processes and standard operating procedures following incidents but these had not had time to become embedded.
- Following the inspection in October 2015 the trust told us they would:
 - Audit patients on the follow-up lists. We saw that audits were not completed until August 2016 and had led to the discovery of cohorts of patients overdue and in unmonitored systems during August 2016.
 - Strengthen the monitoring arrangements in place in relation to OPD follow-ups. Two SIs resulted this year following lack of monitoring of patients who needed an appointment following an inpatient episode.
 - Strengthen arrangements for monitoring of short notice clinic cancellations. We saw that clinic

cancellations were being closely monitored and administration staff felt numbers of cancellations had improved, however, this was not yet evident in the data provided.

- Appoint a senior over-arching lead to drive the required improvements in OPD booking systems. Although the trust had appointed an internal lead to oversee the administration teams and drive the required improvements in OPD booking systems there appeared to have been little additional support available until Autumn 2016. Include call abandon rates as part of the key performance indicators to be monitored monthly. We saw that this action was complete.
- Provide waiting list information in a more 'user friendly' dashboard. We saw that this action was completed.
- Explore the additional validation resources required to look at other OP specialty areas. Both clinical and data validation was ongoing in all specialities although it was acknowledged that some of the SATs needed support and training.

Diagnostic Imaging

- The department had a risk register that it shared with the outpatient department. There were six identified risks specific to the diagnostic imaging department. Two were rated high, two moderate and two low. These had been reviewed regularly. There was evidence of mitigation in place and action taken to reduce risks to patients.
- Serious incidents were discussed at multidisciplinary clinical governance meetings and where appropriate, escalated through the governance committees.
- Department managers carried out investigations of incidents and reported back to teams. Incident investigations were undertaken by managers and reports fed back to staff at team meetings. Where necessary, policies and procedures were updated in line with guidance received.
- There were governance arrangements, which staff were aware of and participated in.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging, these included radiology related to head injury clinical guidance and stroke thrombolysis and non-thrombolysis imaging times.

Outpatients and diagnostic imaging

- Within the imaging department, there were examples of audits taking place to ensure that NICE and other guidance was being adhered to. For example, an audit of MRI patient safety questionnaires had been carried out in 2016 and was due to be presented to staff after our inspection. The auditor had identified areas for improvement and identified the person responsible for their implementation.
- Bimonthly discrepancy meetings were held to discuss the quality of images and reporting. This forum was used to promote learning. Both radiologists and radiographers were able to attend.

Culture within the service

Outpatients

- We had mixed feedback regarding the culture of the organisation.
- All staff felt they were open and honest and incidents were reported, investigated fairly and any issues dealt with proportionately.
- All staff we spoke with clearly wanted to deliver a safe service and give patients the best experience possible.
- However, a number of staff in different job roles did not feel confident to raise concerns, about service delivery or management, as they were not confident that they would not suffer any repercussions.

Diagnostic Imaging

- During our inspection we identified some concerns about the culture of the trust however all of the staff we spoke with told us that this diagnostic imaging department had a good culture.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Staff were passionate about their patients and felt that they did a good job. Staff in all the diagnostic imaging departments said that they felt part of a team and empowered to do the job.
- Staff told us that they felt there was a culture of staff development and support for each other, however, some expressed frustration at not being financially recompensed for the skills they used as part of their role.
- We saw that there was a friendly but professional working relationship between consultants, radiographers, nurses, healthcare and support staff.

Public engagement

Outpatients

- We saw that staff displayed friends and family feedback results in patient waiting areas with you said we did information. Patient experience posters encouraged patients to give feedback.
- Managers told us there was ongoing public consultation regarding the centralisation of ENT services at DPoW.
- Managers told us the trust was sharing waiting list positions with GPs and had notified them of changes to booking rules.
- The outpatient service had carried out their annual patient satisfaction survey in August 2016. More than 80% of patients rated the service as satisfactory, good or excellent across all elements of the survey. We saw that the main issues from patients were to do with appointment cancellations and waiting times. There were some comments that the department manager told us had not been addressed yet due to lack of available funding, they were regarding toilets and baby changing facilities which needed improving.
- The outpatient manager was working with the charitable funds department to develop the children's waiting areas in the ENT and ophthalmology areas.

Diagnostic Imaging

- The trust provided us with three examples of patient engagement carried out at Diana Princess of Wales Hospital. These involved patients visiting the CT department, ultrasound department and general radiology department. Results of these were positive with only a small number of individual concerns raised.
- There was recurring, annual programme of patient satisfaction surveys that included all of the specialities.

Staff engagement

Outpatients

- We were given mixed feedback about levels of engagement in service delivery and improvement. Some staff felt very empowered and involved while others did not.
- The ophthalmology SAT were clearly engaged in the improvement of their service and evidently felt a shared

Outpatients and diagnostic imaging

ownership in the problems and shared pride in the improvements made to date. The team had been nominated by their managers for a trust award for their hard work and success.

- Staff told us of some of the staff benefits / activities in place at the trust. For example, there was a staff lottery, Christmas shopping trips had been arranged and a consultant who told us a free staff eye clinic had been provided at no cost to the trust.
- The ophthalmology nurse specialist told us they were involved with the transformation group for the service.

Diagnostic Imaging

- The department distributed team briefs to ensure that staff were up to date with any issues or changes in the department.
- Staff had regular team meetings and we saw minutes of these.
- The trust was in the process of undertaking a staff survey at the time of inspection.
- The senior management team were clearly proud of their team and told us of a number of staff who had been nominated for awards from the trust and the 'Health Service Journal'.

Innovation, improvement and sustainability

Outpatients

- Staff and managers told us that work was ongoing to develop a virtual clinic for patients suffering from macular degeneration.

- The trust had a number of working groups set up and was working with staff, stakeholders, other providers and NHSI to streamline pathways to address capacity and demand issues and to ensure services were sustainable.

Diagnostic Imaging

- This site has introduced a radiographer-led hysterosalpingogram service including performing and reporting of these studies. This releases Radiologist time, as well as releasing time back to the Gynaecology medical team.
- The diagnostic imaging departments have begun a pilot in conjunction with primary care for radiologists to refer patients straight to CT following an abnormal chest x-ray. When patients are seen in clinic as a two week wait, they already have a CT scan & results available for the clinician at their first appointment. This potentially reduces lung cancer patients' length of pathway.
- Reporting radiographers were being trained to undertake reporting responsibilities to support the department's shortfall of radiologists.
- The ultrasound department has started to develop a specialist practitioner role to extend staff competencies and release radiologist time. It is also envisaged that this will assist with recruitment and retention of staff.
- General radiology have started two trainees working toward Assistant Practitioner qualifications, this will add to the skill mix in the department and help alleviate some of the radiographer recruitment problems at the DPoW site, as well as providing a cost saving.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that the service risk registers are regularly reviewed, updated and include all relevant risks to the service.
- The trust must monitor and address mixed sex accommodation breaches.
- The trust must continue to improve its paediatric early warning score (PEWS) system to ensure timely assessment and response for children and young people using services.
- The trust must ensure that, following serious incidents or never events, root causes and lessons learned are identified and shared with staff, especially within maternity and surgery.
- The trust must ensure that effective processes are in place to enable access to theatres out of hours, including obstetric theatres, and that all cases are clinically prioritised appropriately.
- The trust must ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist is implemented consistently within surgical services.
- The trust must ensure there are effective planning, management oversight and governance processes in place, especially within maternity, ED and outpatients. This includes ensuring effective systems to implement, record and monitor the flow of patients through ED, outpatients and diagnostic services.
- The trust must ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medication are checked on a daily basis in line with the trust's policy.
- The trust must ensure that there are effective processes in place to support staff and that staff are trained in the recognition of safeguarding concerns including all staff caring for children and young people receiving the appropriate level of safeguarding training and in outpatient services.
- The trust must ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions.

- The trust must ensure that a patient's capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the Mental Capacity Act (2005).
- The trust must ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies.

Emergency and Urgent Care

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

Critical Care

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

Maternity

Outstanding practice and areas for improvement

- The trust must ensure that effective timely assessment and/or escalation processes are in place, including the use of the Modified Early Obstetric Warning Score (MEOWS).
- The trust must continue to improve obstetric skills and drills training among medical staff working in obstetrics.
- The trust must continue to improve midwifery and medical staff competencies in the recognition and timely response to abnormalities in cardiotocography (CTGs) including the use of 'Fresh eyes'.

Children and Young People's Service

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

Outpatients and diagnostic imaging

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

Action the hospital SHOULD take to improve

- The trust should continue to address the areas where they do not meet the Guidelines for the Provision of Intensive Care Services (2015), for example, supernumerary nurse, medical staffing and work patterns that deliver continuity of care.
- The trust should ensure the structural work in ITU is completed within the planned timescales.
- The trust should ensure that patients are assessed for delirium in line with national guidance.

- The trust should monitor the number of patients ventilated outside of critical care.
- The trust should review the formal processes in place to collect patient or relative feedback.
- The trust should identify a board level lead for paediatric services.
- The trust should ensure that access to breast milk fridges is risk assessed and secured.
- The trust should complete a risk assessment to ensure that the two bedded rooms on Rainforest ward are safe to use for patients.
- The trust should take steps to ensure that an appropriate environment and staff are available for children and young people receiving anaesthesia and recovering from surgery, in accordance with national guidance.
- The trust should ensure that it completes risk assessments concerning the risks posed by the ward environment to children requiring child and adolescent mental health services (CAMHS).
- The trust should take steps to ensure that appropriate numbers of play specialists are available in accordance with the national framework.
- The trust should take steps to ensure that appropriate transition pathways are in place for children and young people moving from paediatric to adult services.
- The trust should ensure that medical records are appropriately completed by medical staff.
- The trust should ensure that staff complete Mental Capacity Act training.
- The trust should ensure that mandatory training rates are improved for all staff.
- The trust should take steps to improve its staff and public engagement activities.
- The trust should ensure that resuscitation equipment is regularly checked and tested consistently and in line with trust policy.
- The trust should ensure that clinical supervision is regularly recorded and monitored.
- The trust should ensure that patient group directives (PGDs) for nursing staff are completed and up to date.

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 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>How the regulation was not being met: The care and treatment of patients in ED did not always meet their basic care needs.</p> <p>The trust must:</p> <ul style="list-style-type: none">• Ensure that patients in ED are assessed for pain relief; appropriate action is taken and recorded within the patients' notes. Regulation 9(1)(a) and (b).• Ensure that patients in ED receive the appropriate nursing care to meet their basic needs, such as pressure area care and being offered adequate nutrition and hydration and, that this is audited. Regulation 9(1)(a) and (b).
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>How the regulation was not being met: We found that on occasion, people's right to privacy and dignity was compromised.</p> <p>The trust must:</p> <ul style="list-style-type: none">• Ensure that mixed sex accommodation breaches are monitored, addressed and reported. Regulation 10(1).• Ensure that the number of non-clinical transfers from critical care units are reviewed and reduced. Regulation 10(2)(a).
Regulated activity	Regulation

Requirement notices

Treatment of disease, disorder or injury

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

How the regulation was not being met: Some patients did not have clearly documented when they lacked capacity to make decisions which was not accordance with the Mental Capacity Act (2005).

The trust must:

- Ensure that patients' capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the 2005 Mental Capacity Act. Regulation 11(1) and (3).

Regulated activity

Regulation

Treatment of disease, disorder or injury

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

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

The trust must:

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

Requirement notices

- Ensure that ambulance staff are able to promptly register and handover patients on arrival at the ED. Regulation 12(2)(i).

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

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

The trust must:

- Ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies. Regulation 17(2)(a).
- Ensure it audits compliance with NICE CG83 rehabilitation after critical illness and acts on the results. Regulation 17(2)(a).
- Ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist is implemented consistently within surgical services. Regulation 17(2)(a).
- Ensure that effective processes are in place to enable access to theatres out of hours, including obstetric theatres, and that all cases are clinically prioritised appropriately. Regulation 17(2)(a).
- Ensure that timely initial assessment of patients arriving at ED takes place and that the related nationally reported data is accurate. Regulation 17(2)(a).
- Ensure that the service risk registers are regularly reviewed, updated and include all relevant risks to the service. Regulation 17(2)(b).
- Ensure there are effective planning, management oversight and governance processes in place, especially within maternity, ED and outpatients. This includes ensuring effective systems to implement, record and monitor the flow of patients through ED, outpatients and diagnostic services. Regulation 17(2)(b).

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- Complete the clinical validation of all outpatient backlogs and continue to address those backlogs, prioritised according to clinical need. Regulation 17(2)(b).
- Continue to take action to reduce the rates of patients who do not attend (DNA). Regulation 17(2)(b).
- Continue to take action to reduce the numbers of cancelled clinics. Regulation 17(2)(b).
- Continue to strengthen the oversight, monitoring and management of outpatient bookings and waiting lists to protect patients from the risks of delayed or inappropriate care and treatment. Regulation 17(2)(b).
- Continue to work with partners to address referral to treatment times and improve capacity and demand planning to ensure services meet the needs of the local population. Regulation 17(2)(b).
- Ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions. Regulation 17(2)(e).
- Ensure that, following serious incidents or never events, root causes and lessons learned are identified and shared with staff, especially within maternity and surgery. Regulation 17(2)(f).

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

The trust must:

- Ensure that there are effective processes in place to support staff and that staff are trained in the

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recognition of safeguarding concerns including all staff caring for children and young people receiving the appropriate level of safeguarding training. Regulation 18(2)(a).

- Ensure the number of staff who have received training in advanced paediatric life support in line with national guidance and the trust's own target. Regulation 18(2)(a).
- Continue to improve obstetric skills and drills training among medical staff working in obstetrics. Regulation 18(2)(a).
- Continue to improve midwifery and medical staff competencies in the recognition and timely response to abnormalities in cardiotocography (CTGs) including the use of 'Fresh eyes'. Regulation 18(2)(a).