Northern Lincolnshire and Goole NHS Foundation Trust

Inspection report

Diana Princess Of Wales Hospital
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Northern Lincolnshire and Goole NHS Foundation Trust provides acute hospital services and community services to a population of more than 450,000 people across North and North East Lincolnshire and East Riding of Yorkshire. The trust has approximately 750 beds across three hospitals: Diana Princess of Wales (DPoW) Hospital at Grimsby in North East Lincolnshire, Scunthorpe General Hospital in North Lincolnshire and Goole and District Hospital (based in the East Riding of Yorkshire).

The leadership of the trust had improved since our last inspection in 2019 but this was not yet enough to make an impact on the trust overall rating, however, we did see some areas improvement in ratings for core services from our previous inspection. Members of the board articulated they felt much more enabled, supported, listened to and empowered to undertake their roles than previously. The leadership team led by the CEO and chair had identified that the trust needed to continue with existing plans and strategies in order to improve both the people's experience of services and the culture within the organisation more broadly. This was a message we heard consistently throughout our inspection.

It was recognised by the board there had been challenges regarding the trust's organisational culture over the last few years. To address this, targeted and focused work had been undertaken with the board and executive team. The trust had made good progress in strengthening its operational financial management and governance arrangements but there was further work needed to ensure new arrangements and ways of working were embedded at all levels throughout the trust.

Whilst the improvements in leadership and culture were evident since our previous inspection, the trust recognised more work needed to be done to embed service improvements and for these changes to be reflected in positive patient outcomes. When inspecting the core services at the trust we saw that some of the changes that had happened at a senior level in the organisation had not yet become embedded at ward/department level. There continued to be a slow progress in some areas against our previous inspection findings particularly in urgent and emergency care, medicine and end of life.

Our findings

Information and data overall were well managed across the trust. New systems had been developed to strengthen data collection, analysis and we saw evidence of information being used to drive improvements and demonstrate sustained successes. However, we did see instances on wards and departments where patient information was not stored securely.

The trust was committed to continually learning and improving services. Quality improvement methods had been introduced and staff understood the skills needed to use them, and the trust recognised that there was a need to sustain and continue this commitment to improvement overall.

Whilst we inspected during the COVID 19 pandemic the risks and concerns identified by CQC during the inspection were not the result of the immediate pressures faced by the trust as a result of the COVID pandemic. The trust has reported the long-lasting impact of the COVID 19 pandemic for the preceding two years. These included the significant impact on staffing, increase in overall attendances, sub-optimal patient flow throughout services, ambulance pressures, increased wait times, the prolonged period of command and control arrangements and service remodelling.

We carried out this unannounced inspection of acute services provided by this trust as part of our continual checks on the safety and quality of healthcare services and as at our last inspection we rated the trust overall as requires improvement. The trust was in special measures to help it improve

We also inspected the well-led key question for the trust overall.

Our rating of some services improved. We rated them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good.
- At Diana Princess of Wales Hospital, we rated six core services as requires improvement and one core service as good. At Scunthorpe General Hospital, we rated five core services as requires improvement and three core service as good. At Goole and District Hospital, all core services are now rated as good. In rating the trust, we took into account the current ratings of the services (including Community Services) not inspected this time.
- Across most services there was still insufficient numbers of staff within the right qualifications, skills, training and experience to provide the right care and treatment. We observed issues in relation to staffing levels, vacancies and saw gaps in both nursing and medical rotas.
- The services provided mandatory training in key skills to staff but had not ensured everyone had completed it. Across most services there were continued low levels of mandatory training.
- Within urgent and emergency care people could not access the service when they needed it and continued to experience long delays waiting for treatment. The departments continued to experience long ambulance handover times as a result of access and flow issues.
- Waiting times, referral to treatment and arrangements to admit, treat and discharge across several core services continued to be a challenge. We noted that that across both sites, there were long lengths of stay which impacted negatively on access and flow throughout the hospital.
- The trust was continuing to develop a more open culture and improve communication with patients, their families and staff but there was more work required to progress this and have an impact.
- Visibility of senior leadership team was variable across the services we inspected.

However:

Our findings

- We saw good examples of patients receiving compassionate care, with staff ensuring patients privacy and dignity was maintained. Patients and partners were happy with the care provided.
- We saw that the trust had worked hard to improve performance in terms of elective pathways and complaints management.
- Since the last inspection there had been a marked improvement in actions to address the backlogs for waiting times and reporting times within diagnostic services.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:
Diagnostic Imaging – Scunthorpe General Hospital

- Staff met regularly with colleagues at other Trust sites within the Yorkshire Imaging Collaborative to share learning and provide peer support.

Diagnostic Imaging – Diana Princess of Wales

- Staff met regularly with colleagues at other Trust sites within the Yorkshire Imaging Collaborative to share learning and provide peer support.
- CT and MRI staff had implemented the use of transparent face masks to enable patients to lipread whilst maintaining infection control.

Diagnostic Imaging – Goole and District Hospital

- Staff met regularly with colleagues at other Trust sites within the Yorkshire Imaging Collaborative to share learning and provide peer support.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements. This action related to the following services.

Trust wide

Our findings

- The trust must ensure that the systems in place to support the management of governance, risk and performance are sustained and fully embedded so that they are positive outcomes for patients. (Regulation 17)
- The trust must continue its work to improve its reporting of performance information to enable easier oversight and governance and continue its work to improve its digital systems and processes. (Regulation 17)
- The trust must continue its work to improve and transform the culture within the organisation. (Regulation 17)

Scunthorpe General Hospital

Urgent and Emergency Care Services

- The trust must ensure that effective and robust systems are in place to support the management of governance, risk and performance. (Regulation 17 (2) (b)).
- The service must ensure that all staff complete mandatory training to meet the trust's set standard of 85%. (Regulation 12 (2) (c)).
- The service must ensure that all staff have an up to date appraisal completed. (Regulation 18 (2) (a)).
- The service must continue to appropriately recruit staff (specifically registered sick children's nurses (RSCN) and ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients. The emergency department was not meeting the Intercollegiate Emergency Standard to have sufficient RSCNs to provide two per shift. (Regulation 18 (1)).

Outpatients

- The service must continue to address the challenges regarding overdue new and follow up appointments and ensure patients receive their appointment in a timely way across outpatient specialties. (Regulation 12).
- The service must ensure the 62-day cancer waiting times target for appointments is achieved (Regulation 12).

Diagnostic Imaging

- The trust must ensure there are effective governance systems and processes to make sure criteria is consistently followed regarding equipment safety and quality assurance, including Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). (Regulation 17)
- The trust must ensure that there is consistent recording of patient consent for all procedures in line with trust policy and national body recommendations. (Regulation 11)

Medicine

- The service must continue to monitor registered nurse establishment on the hyper acute stroke unit (HASU) and the stroke assessment unit to ensure adherence to best practice in line with national guidance recommendations of one to two patients. Regulation 12 (1) (a) (b)
- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. Regulation 12 (2) (c)
- The service must ensure that the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance. Regulation 12 (2) (h)

Our findings

- The service must ensure that medicine reconciliation is conducted in line with the National Institute for Health and Care Excellence Quality Statement 120 (NICE QS) and audited in line with trust policy. Regulation 12 (2) (g)
- The service must ensure that medicines are being stored and administered safely as per manufacturing guidance. Regulation 12 (2) (g)
- The service must ensure that all staff have safeguarding training at a level that is appropriate to their role in line with national guidance. Regulation 13 (2)
- The service must ensure patient records are stored securely and confidential waste is stored securely and disposed of in line with national guidance. Regulation (17) (2) (d)
- The service must ensure there are appropriate numbers suitably qualified, competent, and experienced medical staff to enable them to meet the needs of patients in their care. Regulation 18 (1)
- The service must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. Regulation 18 (1), (2) (a) (b)

Surgery

- The trust must ensure control of substances hazardous to health (COSHH) cupboards are locked and not accessible to patients in theatres or on wards.
- The trust must ensure environmental issues in theatres do not pose risks to patient safety.
- The trust must be assured medicine reconciliation is being conducted in line with the national institute for health and care excellence (NICE) quality standard (QS120) and audited as per trust's own policy.
- The trust must ensure root causes and conclusion findings identified from never event and serious incident investigations are actioned.

Maternity

- The trust must ensure that all staff who require level 3 safeguarding adults training are compliant (Regulations 18(1) and 18(2)).
- The trust must assess risks associated with the ineffectiveness of the baby-tagging alarm system and put suitable controls in place, to further mitigate the risk of abduction. (Regulation 15(1))
- The trust must ensure there is a robust consumable stock management system in please to reduce the risk to patients from staff using expired items, expired medicines and inappropriate equipment. (Regulation 15(1))
- The trust must ensure that they have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. (Regulation 18(1)).
- The trust must ensure bank and agency staff receive a full, formal induction, so they are assured bank and agency staff are familiar with equipment, policies and emergency escalation procedures. (Regulations 18(1) and 18(2)).
- The trust must ensure that all staff receive an annual appraisal. (Regulations 18(1) and 18 (2)).
- The trust must ensure safe storage of expressed breast milk to reduce risks to women and their babies. (Regulations 12(1) and 12(2)).
- The trust must ensure patient records are stored securely. (Regulations 17(1) and 17(2)).

Our findings

- The trust must ensure all identified risks affecting the service in line with trust policy are escalated to the risk register. (Regulations 17(1) and 17(2)).

End of Life

- The service must ensure equipment used to deliver end of life and palliative care are used in accordance with trust policy and national best practice. (Regulation 12)
- The service must ensure that there are sufficient staff with the right qualifications, skills and training to keep people safe from harm. (Regulation 12).
- The service must ensure that patient records are completed consistently and appropriately. (Regulation 12).
- The service must ensure there is a formalised referral processes to the EoL teams with effective cross site cover. (Regulation 12).
- The service must ensure there is a consistent approach to the monitoring of pain relief and the reassessment of pain. (Regulation 12).
- The service must ensure the design and maintenance of the mortuary environment meets met the national standards. They must ensure all areas of the mortuary are clean and that equipment is fit for purpose. (Regulation 15)
- The service must have an effective system which accurately identifies and tracks end of life and palliative care patients. (Regulation 17(1) (2)
- The service must ensure clinical care and treatment are delivered in accordance with national guidance and best practice. (Regulation 17).
- The service must ensure that robust systems are in place to monitor the effectiveness of care and treatment delivered to achieve good outcomes for patients. (Regulation 17).
- The service must ensure robust governance processes are in place to lead, manage, risk assess and sustain effective services. (Regulation 17).
- The service must collect reliable data to understand performance, make decisions and improvements. (Regulation 17)

Diana Princess of Wales Hospital

Urgent and Emergency Care Services

- The service must ensure that effective and robust systems are in place to support the management of governance, risk and performance. (Regulation 17 (2) (b)).
- The service must ensure that all staff complete mandatory training to meet the trust's set standard of 85%. (Regulation 12 (2) (c)).
- The service must ensure that all staff have an up to date appraisal completed. (Regulation 18 (2) (a)).
- The service must continue to appropriately recruit medical staff to ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients and to ensure there is a consistent and sustainable workforce available. (Regulation 18 (1), (2) (c)).

Our findings

- The service must continue to appropriately recruit staff (specifically registered sick children's nurses (RSCN) and ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients. The emergency department was not meeting the Intercollegiate Emergency Standard to have sufficient RSCNs to provide two per shift. (Regulation 18 (1)).

Outpatients

- The service must continue to address the challenges regarding overdue new and follow up appointments and ensure patients receive their appointment in a timely way across outpatient specialties. (Regulation 12).
- The service must ensure the 62-day cancer waiting times target for appointments is achieved (Regulation 12).

Diagnostic Imaging

- The trust must ensure that there is consistent measurement and monitoring of safety of all equipment and environments. (Regulation 12)
- The trust must ensure there are effective governance systems and processes to make sure criteria is consistently followed regarding equipment safety and quality assurance, including Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). (Regulation 17)
- The trust must ensure that there is safe storage of medicines in all areas. (Regulation 12)
- The trust must ensure that there is consistent recording of patient consent for all procedures in line with trust policy and national body recommendations. (Regulation 11)

Medicine

- The service must ensure that persons providing care or treatment to service users have the qualifications, competence, skills, and experience to do so safely. Regulation 12 (2) (c)
- The service must ensure that medicine reconciliation is conducted in line with NICE quality statement (QS) 120 and audited in line with trust policy. Regulation 12 (2) (g)
- The service must ensure that medicines are stored and administered safely as per manufacturing guidance. Regulation 12 (2) (g)
- The service must ensure that oxygen is prescribed as required by national guidelines. Regulation 12 (2) (g)
- The service must ensure that the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance Regulation 12 (2) (h)
- The service must ensure that all staff have safeguarding training at a level that is appropriate to their role in line with national guidance and trust policy. Regulation 13 (2)
- The trust must ensure that version-controlled documents are reviewed in line with trust policy and national guidance. Regulation 17 (2) (a)
- The service must ensure patient records are stored securely and confidential waste is stored securely and disposed of in line with national guidance and trust policy. Regulation (17) (2) (d)
- The service must ensure there are appropriate numbers suitably qualified, competent, and experienced medical staff to enable them to meet the needs of patients in their care. Regulation 18 (1)

Our findings

- The service must ensure that persons employed receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform and be enabled where appropriate to obtain further qualifications appropriate to the work they perform. Regulation 18 (1), (2) (a) (b)

Surgery

- The trust must ensure control of substances hazardous to health (COSHH) cupboards are locked and not accessible to patients in theatres or on wards (Regulation 15).
- The trust must ensure environmental issues in theatres do not pose risks to patient safety (Regulation 15).
- The trust must ensure the WHO checklist is completely embedded within theatres and ensure staff complete the theatre register and patient marking verification (Regulation 17).
- Divisional and theatre leads must monitor the risks of theatre staff omitting or not documenting the WHO checklist stages in practice (Regulation 17(2)c).
- The trust must ensure service staff have access to specialist equipment such as hoists to accurately weigh patients. (Regulation 15).
- The trust must be assured medicine reconciliation is being conducted in line with the national institute for health and care excellence (NICE) quality standard (QS120) and audited as per trust's own policy (Regulation 12 (2)g).
- The trust must ensure root causes and conclusion findings identified from never event and serious incident investigations are actioned (Regulation 17).

Maternity

- The trust must ensure that all staff who require level 3 safeguarding adults training are compliant (Regulations 18(1) and 18(2)).
- The trust must assess risks associated with the ineffectiveness of the baby-tagging alarm system and put suitable controls in place, to further mitigate the risk of abduction. ((Regulation 15(1))
- The trust must ensure there is a robust consumable stock management system in please to reduce the risk to patients from staff using expired items, expired medicines and inappropriate equipment. (Regulation 15(1))
- The trust must ensure that they have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. ((Regulation 18(1)).
- The trust must ensure bank and agency staff receive a full, formal induction so they are assured bank and agency staff are familiar with equipment, policies and emergency escalation procedures. ((Regulations 18(1) and 18(2)).
- The trust must ensure that all staff receive an annual appraisal. ((Regulations 18(1) and 18 (2)).
- The trust must ensure patient records are stored securely. (Regulations 17(1) and 17(2)).
- The trust must ensure all identified risks affecting the service in line with trust policy are escalated to the risk register. ((Regulations 17(1) and 17(2)).

End of Life

Our findings

- The service must ensure equipment used to deliver end of life and palliative care are used in accordance with trust policy and national best practice. (Regulation 12)
- The service must ensure that there are sufficient staff with the right qualifications, skills and training to keep people safe from harm. (Regulation 12).
- The service must ensure that patient records are completed consistently and appropriately and are easily accessible when needed. (Regulation 12).
- The service must ensure there is a formalised referral processes to the EoL teams with effective cross site cover. (Regulation 12).
- The service must ensure there is a consistent approach to the monitoring of pain relief and the reassessment of pain. (Regulation 12).
- The service must ensure the design and maintenance of the mortuary environment meets met the national standards. They must ensure all areas of the mortuary are clean and that equipment is fit for purpose and that waste is disposed of safely. (Regulation 15)
- The service must have an effective system which accurately identifies and tracks end of life and palliative care patients. (Regulation 17(1) (2)
- The service must ensure clinical care and treatment are delivered in accordance with national guidance and best practice. (Regulation 17).
- The service must ensure that robust systems are in place to monitor the effectiveness of care and treatment delivered to achieve good outcomes for patients. (Regulation 17).
- The service must ensure robust governance processes are in place to lead, manage, risk assess and sustain effective services. (Regulation 17).
- The service must collect reliable data to understand performance, make decisions and improvements. (Regulation 17)

Goole District Hospital

Outpatients

- The service must continue to address the challenges regarding overdue new and follow up appointments and ensure patients receive their appointment in a timely way across outpatient specialties. (Regulation 12).
- The service must ensure the 62-day cancer waiting times target for appointments is achieved (Regulation 12).

Diagnostic Imaging

- The trust must ensure there are effective governance systems and processes to make sure criteria is consistently followed regarding equipment safety and quality assurance, including Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). (Regulation 17)
- The trust must ensure that there is consistent recording of patient consent for all procedures in line with trust policy and national body recommendations. (Regulation 11)

Action the trust SHOULD take to improve:

Our findings

Scunthorpe General Hospital

Urgent and Emergency Care Services

- The service should ensure that medical staff compliance with Mental Capacity Act training meets the trust target.
- The service should ensure that documentation completed upon patients' arrival within the department is comprehensive and initial physical observations are clearly recorded.
- The service should ensure that all patients deemed to be at risk of falling have a risk assessment completed upon initial assessment.
- The service should ensure that a record of patients' prescribed medications is completed upon initial assessment within the department.

Outpatients

- The trust should consider ways to improve visibility of the senior leadership team.
- The trust should ensure all key policies and guidance documents are up to date.

Diagnostic Imaging

- The trust should ensure that initiatives to address trust wide shortages of radiologists continue to develop.
- The trust should ensure Safeguarding leads complete Safeguarding Children Level 3 training.
- The Trust should ensure cleaning checklists are completed and made available to department staff to provide assurance of cleanliness.
- The Trust should ensure protocols for ultrasound and x-ray equipment are adapted for each piece of equipment, so staff are aware of specific requirements of the equipment they use.

Medicine

- The service should ensure that fire doors are closed at all times in line with trust policy
- The service should ensure clinical utility room temperatures are routinely monitored daily to ensure medications are stored in line with individual pharmaceutical manufacturer guidance.

Surgery

- The trust should ensure the division's overall mandatory training and role specific training compliance meets trust targets, particularly for medical staff.
- The trust should ensure staff wear personal protective equipment correctly and follow infection prevention control (IPC) principles.
- The trust should have accurate, and current records of patients' weights to ensure safe prescribing.
- The trust should ensure medicines with changes in expiry dates as per manufacturers' instructions, are correctly managed.

Our findings

Maternity

- The trust should ensure all key policies and guidance documents are up to date.
- The trust should consider ways to increase ultrasonography provision, to ensure standards set by RCOG, NICE and Saving Babies Lives are met.
- The trust should risk assess the need for triage and consider ways to expediate its implementation.
- The trust should consider ways to improve visibility of the senior leadership team.
- The trust should consider ways to promote an open culture to enable staff to raise concerns without fear.

End of Life

- The service should ensure all medical staff receive training to ensure they have the skills and knowledge to recognise and identify those patients approaching EoL.
- The service should ensure that prescription charts are always completed when oxygen is prescribed.
- The service should ensure there are formalised referral processes to the chaplaincy teams.
- The service should ensure that bereavement staff are invited to relevant end of life team meetings.

Diana Princess of Wales Hospital

Urgent and Emergency Care Services

- The service should ensure that medical staff compliance with Mental Capacity Act training meets the trust target.
- The service should ensure that nutrition and hydration audits are completed on a consistent basis.
- The service should ensure that all patients deemed to be at risk of falling have a risk assessment completed upon initial assessment.
- The service should ensure that a record of patients' prescribed medications is completed upon initial assessment within the department.

Outpatients

- The trust should consider ways to improve visibility of the senior leadership team.
- The trust should ensure all key policies and guidance documents are up to date.

Diagnostic Imaging

- The trust should ensure that initiatives to address trust wide shortages of radiologists continue to develop.
- The trust should ensure temperatures are measured in environments where contrast agents are stored to ensure manufacturers' guidance is followed.
- The trust should ensure that initiatives to reduce waiting lists and backlogs for reporting continue.

Our findings

- The trust should ensure Safeguarding leads complete Safeguarding Children Level 3 training.
- The trust should ensure service level agreements with external providers for radiation protection and telereporting accurately reflect safe practice, RPS training, and quality assurance requirements.
- The Trust should ensure protocols for ultrasound and x-ray equipment are adapted for each piece of equipment, so staff are aware of specific requirements of the equipment they use.

Medicine

- The trust should ensure that oxygen cylinders are stored securely in line with trust policy
- The trust should ensure that fire doors are closed at all times in line with trust policy

Surgery

- The trust should ensure the division's overall mandatory training and role specific training compliance meets trust targets, particularly for medical staff.
- The trust should ensure staff wear personal protective equipment correctly and follow infection prevention control (IPC) principles.
- The trust should have accurate, and current records of patients' weights to ensure safe prescribing.
- The trust should ensure medicines with changes in expiry dates as per manufacturers' instructions, are correctly managed.
- The trust should complete and sign controlled drugs books in theatres in line with national policy.

Maternity

- The trust should ensure all key policies and guidance documents are up to date.
- The trust should consider ways to increase ultrasonography provision, to ensure standards set by RCOG, NICE and Saving Babies Lives are met.
- The trust should risk assess the need for triage and consider ways to expediate its implementation.
- The trust should consider ways to improve visibility of the senior leadership team.

End of Life

- The service should ensure all medical staff receive training to ensure they have the skills and knowledge to recognise and identify those patients approaching EoL.
- The service should ensure all staff follow trust policy with regard to infection prevention and control.
- The service should ensure that patient's medical records are stored securely and appropriately archived.
- The service should ensure that prescription charts are always completed when oxygen is prescribed.
- The service should ensure there are formalised referral processes to the chaplaincy teams.
- The service should ensure that bereavement staff are invited to relevant end of life team meetings.

Goole and District Hospital

Our findings

Outpatients

- The trust should consider ways to improve visibility of the senior leadership team.
- The trust should ensure all key policies and guidance documents are up to date.

Diagnostic Imaging

- The trust should ensure that initiatives to address trust wide shortages of radiologists continue to develop.
- The trust should ensure Safeguarding leads complete Safeguarding Children Level 3 training.
- The Trust should ensure protocols for ultrasound and x-ray equipment are adapted for each piece of equipment, so staff are aware of specific requirements of the equipment they use.

Is this organisation well-led?

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, leaders need to develop further from being reactive to the challenges and issue to being more proactive and innovative. Feedback regarding the visibility and approachability of senior leaders within the service was mixed from staff. They supported staff to develop their skills and take on more senior roles.

The leadership of the trust had improved since our last inspection in 2019. The executive team was more stable and there have been joint appointments made with a neighbouring trust for the posts of Chair, Chief Financial Officer and Chief Information Officer. Members of the board articulated they felt much more enabled, supported, listened to and empowered to undertake their roles than previously.

The trust had several challenges in terms of culture, performance, quality of patient care, sustainability and its role in the Integrated Care System (ICS). The board was sighted on these challenges and reacted appropriately to these current concerns. However, there was further development needed to ensure that the board had the capacity to become more proactive and innovative in some areas. For example, end of life services. The executive team had developed a set of priorities for 2022-2023. At the time of inspection these needed to be embedded and become operationalised.

Since our last inspection, clinical leadership, both medical and nursing, had become more embedded with an established divisional management structure. The Chief Operating Officer had also strengthened their divisional management structure which was becoming more embedded with a focus on performance. In addition, there had been new appointments to senior positions within the trust-wide pharmacy leadership team.

There had been changes with the non-executive directors. A new Chair has been appointed which was a joint appointment with a neighbouring trust and there had been appointments of other non- executive directors, one of whom was the chair of the Quality and Safety Committee. There were currently no vacancies for non-executive directors within the trust.

Our findings

During our inspection there was mixed feedback regarding the visibility and engagement of the executive team, with some staff expressing that at times there was a barrier to getting and receiving information from ward to board. An example of this was in maternity services at Scunthorpe General Hospital (SGH) where there was an issue with flooring and staff we spoke with told us they reported the poor flooring in 2017 and it was still not replaced.

In addition, staff we spoke to during the inspection were not always positive about the visibility or availability of senior pharmacy team members. The chief pharmacist told us that they were planning to address staff engagement concerns.

During our inspection we found that local leadership at core service level varied. For example, in urgent and emergency care at Diana Princess of Wales Hospital there was a lack of consistent management oversight of the Same Day Emergency Care (SDEC) unit which was having a significant impact upon access and flow within the emergency department. Plans that had been put in place to manage the unit were not consistently undertaken and were not embedded or sustained. We raised this with the executive team at the time of inspection who responded promptly with immediate and short-term actions including strengthening the operational oversight of the unit.

Board development was in progress, however there had been some delay with this due to the Covid-19 pandemic. Since our previous the trust had a leadership strategy and approach which was signed off by the board in April 2022. This set out their approach to leadership development and succession planning – with an added emphasis on values-based leadership. Board development sessions were scheduled and delivered regularly to ensure that both strategic and developmental improvements were made. The Trust Board Development sessions had been designed to link to key areas within the Board Assurance Framework.

There were also leadership development programmes for medical and nursing staff. The trust had implemented a clear career progression pathway within pharmacy for band 4-5 technicians to improve retention and maximise skills.

Providers are required to ensure that directors were fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience to ensure compliance with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). During the inspection we carried out checks to determine if the trust was compliant with this regulation. We reviewed four director files, two executive and two non-executive directors. All files reviewed contained the employment checks for executive and non-executive staff in line with the Fit and Proper Persons Requirement (FPPR) Regulation 5. The trust had a policy for the requirement of the Fit and Proper Persons Test (FPPT) for directors.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. Whilst this was in place, some strategies required further embedding. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress, however not all staff we spoke with did.

Since our last inspection, the trust had developed a suite of strategies. These included the nursing, midwifery and allied health professional strategy, leadership strategy, governance and risk management strategy, safeguarding and vulnerability strategy, People Strategy, Estates and Facilities Strategy, Patient Safety Strategy and a Quality Improvement Strategy; along with a Strategic Framework.

Our findings

Most core services now had a vision and strategy. For example, family services, which included maternity, had a formal vision and strategy described in the annual divisional business plan with supporting objectives which were: to give great care, to be a good employer, to live within our means, to work more collaboratively and to provide strong leadership. However, there were some core services that did not have an embedded strategy, these included surgery and end of life.

The current medicines optimisation strategy was in draft form, it was a five-year strategy and would be going to staff for discussion and consultation in the near future. This strategy was not yet signed off by the board.

The executives and non-executives were developing an approach of collaboration through partnership working. This was evident in the development of a Humber Acute Services reconfiguration programme with a neighbouring trust. It was also providing mutual aid to other organisations. The trust's strategic plans were aligned with those of the integrated care system (ICS) and Place.

The Trust agreed seven priorities, set out in the Strategic Plan 2019 - 2024:

1. Integrated urgent and emergency care
2. Transformed outpatient services
3. Improved partnerships with community, primary and social care networks
4. Enhanced in patient services
5. Reconfigured specialties onto one site where appropriate
6. Restructured cancer services
7. Establish a workforce to support sustainable service models in line with CQC recommendations and transformation plans, including non-clinical structures and functions.

The chief pharmacist articulated the key priorities around medicines in the trust as; collaborative working across directorates, service transformation utilising technology (ePMA), learning from best practice, high quality care and staff wellbeing. A business case had been developed for next year's business cycle to expand the pharmacy team workforce. A recent successful bid had resulted in funding to additional staffing in the acute assessment units (although not yet had funding released).

From our interviews with executives, non-executives and senior managers they could articulate what the priorities for the organisation were. However, not all staff understood how their roles helped in achieving the vision, values and strategic goals. This was reflected in some of the core services including medicine, surgery and end of life.

Culture

Staff felt more respected, supported and valued than during previous inspections. The trust was focused on the needs of staff and patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development, but further work was required to improve experiences of Black, Asian and Minority Ethnic (BAME) staff. The trust was continuing to develop a more open culture where patients, their families and staff could raise concerns without fear but there was more work required to progress this and have a demonstrable impact.

The Board signed off its Leadership Strategy in April 2022. The board had placed emphasis on staff engagement and

communication which was evident in the work to develop the trust`s strategic framework - whilst acknowledging this as an area for ongoing improvement.
The trust had developed clear strategies and programmes to address concerns highlighted in relation to the organisational culture, however the operationalising, delivery and embedding of these workstreams and initiatives lacked pace and had not yet been reflected in measures such as the most recent NHS staff survey.

The leadership team outlined the progress the organisation had made to improve the cultural challenges. This included more than 2200 staff who had voluntarily attended pride and respect workshops, strengthening the freedom to speak up guardian role, introducing 'ask Peter' which had attracted more than 1000 questions from staff to the CEO and the introduction of the top 200 leader's programme. In addition, the trust had held board development days with culture as a specific area of focus and had introduced other initiatives across the organisation such as Thank you Tuesday, thumbs up Friday and Team Brief Live to promote openness and increase accessibility to senior leaders.

Non-executive directors demonstrated awareness of the challenges the organisation faced in terms of its culture, but that there had been tentative progress in the right direction. They reported they were involved in the undertaking of the trusts 15-step challenge and the associated ward visits and ensured visibility with staff across the organisation. Non-executive directors were also buddied with respective operational teams

At the time of our inspection, the trust was preparing to commence a wider Culture Transformation Programme. The Culture transformation programme links into the wider trust priorities and people strategy, as continuing to improve culture and staff engagement for 2022/23 is an area of particular focus within the trust's priorities. Senior leaders that we spoke with during the inspection cited the Cultural Transformation Programme as being a key step in addressing long standing concerns in relation to poor staff survey results, compliance with the Workforce Race Equality Standards (WRES), and concerns regarding diversity and inclusion across the organisation.

In the North East region, Northern Lincolnshire and Goole NHS Foundation Trust had the lowest overall score in the NHS Staff Survey 2021 (53.3). The national average was 56.3. The trust scored significantly below average in all areas, and there was a significant deterioration for two themes – moral and staff engagement. The trust acknowledged that further work would be required in order to improve some of the metrics highlighted within the staff survey and had specifically ensured that when designing the cultural transformation programme – this paid particular focus to dealing with concerns around behaviours and relationships which impact on performance.

Senior leaders told us that the work was ongoing in relation to freedom to speak up and an increased focus on diversity and inclusion within the organisation. At the time of our inspection, the trust had relaunched various staff network groups in order to facilitate greater communication and conversations around culture and behaviours. The trust's induction programme was in the process of being redeveloped to help tackle concerns regarding poor staff retention, with the aim of the new induction programme being to help ensure staff feel welcomed and included within the trust from the commencement of their employment.

Staff and senior leaders throughout the organisation commented positively on the changes to approach when looking at when things have gone wrong particularly that the attitude across the organisation had shifted to focusing on improvement and learning, as opposed to a culture of blame and punitive outcomes.

The trust had developed and implemented a freedom to speak up (FTUSU) strategy for 2020-2024, which linked into the current trust-wide workforce strategy. In addition, the FTSU strategy was designed to enable the delivery of the trust strategic objective of 'Being a good employer'.

Our findings

Since our previous inspection the trust had appointed a permanent full-time freedom to speak up guardian (FTSUG). We spoke with the guardian who demonstrated a passion and drive to improve the culture of the organisation. We found that having a designated full-time role for freedom to speak up had ensured greater engagement with the process.

A Freedom to Speak Up report was presented quarterly to the Trust Management Board and Trust Board by the Freedom to Speak Up Guardian and the Executive Director for FTSU. We reviewed a sample of the quarterly reports produced by the FTSU guardian for all divisions. The reports enable FTSU information to be used at divisional level to triangulate other data sources such as HR information (grievances, disciplines, staff sickness rates and information from exit interviews). This allowed for the identification of potential hotspots within the trust and appropriate interventions were implemented where required.

The trust had a strategy in place in relation to Equality, Diversity and Inclusion at the time of our inspection, however this was due for review in December 2022. Of the four indicators from the NHS staff survey 2022, the following indicators showed a statistically significant difference between white and BME staff;

- 31.9% of BME staff experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, which was significantly higher when compared to 22.0% of white staff.
- 38.1% of BME staff experienced harassment, bullying or abuse from staff in the past year (2021 NHS staff survey) which was significantly higher when compared to 28.8% of white staff.
- 40.1% of BME staff believed that the trust provides equal opportunities for career progression or promotion, which was significantly lower when compared to 53.5% of white staff.
- 21.4% of BME staff experienced discrimination from a colleague or manager in the past year (2021 NHS staff survey), which was significantly higher when compared to 8.5% of white staff.

At the time of our inspection, there were no BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff (Source: NHS Staff Survey 2021; NHS England). The trust had ensured that a staff network was in place for BME colleagues within the organisation but acknowledged previous initiatives had not gone far enough to improve the experience for BAME colleagues working within the trust. At the time of our inspection, there were two disabled voting board members, making the trust one of only 23 trusts in the country with more than one disabled board member.

Whilst awaiting the formal launch of the cultural transformation programme, the trust had implemented measures such as an Equality Impact Assessment (EIA) policy and procedure had been put in place to ensure policies, procedures and functions do not discriminate against any groups. In addition, a repository to support EIA governance had been developed to monitor and review completed EIA's, and any remedial actions required.

In the last eight reporting months (August 2021 to March 2022), trust wide sickness rates for nursing and midwifery staff has remained around 7%, which was statistically similar to the sector averages. Trust wide sickness rate for medical and dental staff has consistently been similar to the sector average for the past 12 months. In the latest month, March 2022, sickness rates were 2.6%, compared to 1.7% sector average. Across all core services, staff and senior leaders articulated the challenges they had faced over the past 12 months in relation to staffing and sickness levels. Staff and senior leaders shared that this had at times impacted negatively on morale, as in order to ensure safety across services staff had at times been re-deployed to areas that they were unfamiliar with.

Our findings

To mitigate against the risk posed by staff sickness, the trust had utilised bank and agency staff to fill any gaps within staff rotas. This had at times caused challenges within teams to ensure substantive staff and bank or agency staff worked together cohesively. In addition, this also posed challenges to the trust in terms of the long-term financial impact of using bank and agency usage.

Governance

Leaders had established effective governance processes throughout the service and with partner organisations, but these required further embedding. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust had undertaken a significant review of existing governance arrangements since our last inspection. Work had been completed to ensure the establishment of robust and effective governance, reporting and assurance arrangements and these were in place across all divisions. The trust senior leadership team comprised of a clinically led, fully substantive (since January 2021) board and executive team. In addition, the trust board was supported by a range of sub-committees. There were appropriate arrangements for board committees which included the provision for an annual review of effectiveness and a standardised approach for reporting to the board. All the board committees were chaired by a non-executive director and governors were able to attend these committees in an observer capacity. At divisional level, governance arrangements were clinically led, as was trust-wide quality governance.

The board received information through a newly revised integrated performance report (IPR), which provided a high-level summary of key updates relating to access and flow, quality and safety and workforce. This was regularly presented to the trust board to ensure members were sited on key risks and mitigating actions. In addition, the trust had recently refreshed the Board Assurance Framework and reviewed the board position in relation to risk appetite. The trust had also developed a new overarching strategic framework, with nine corresponding strategies outlining how the trust would deliver their priorities and objectives.

The trust ensured that senior leaders supporting executive portfolios were clear on their objectives to support delivery of trust priorities, identified risks and areas for improvement. We saw that where improvement plans had been developed, these included identified leads who were responsible for maintaining oversight of progress. In addition, senior leaders were kept informed and updated on key strategic issues through the monthly senior leadership community (SLC) forum. The Chief Pharmacist and Medication Safety Officer reported good relationships with the trust management board and links with the trust governance lead. The chief pharmacist was the Controlled Drugs Accountable Officer and reported directly to the medical director. The pharmacy team and senior management were well represented on groups relating to medicines safety. Clinical engagement in the Safer Medicines Group had improved with good attendance from divisional governance leads and medical staff. This meeting reported through to the Quality governance group.

The trust had continued with and embedded regular Performance Review Improvement Meetings (PRIMS) at divisional level. We observed a shift towards clinical leadership that was driven by an established clinical divisional management structure. Staff across all core services inspected commented positively on the abilities of leaders across the divisions.

The trust had moved to a new incident reporting system in December 2021. Pharmacy staff told us that since changing systems, the Safer Medicine group has not been able to access databases previously used to identify trends. This issue had been raised prior to our inspection, and work had commenced to reinstate these databases. As an interim measure to mitigate risk, a narrative report was provided for each group, recent trends had related to infusion errors and omitted doses (due to better means of identification). When themes had been identified via the safer medicines group these

were published in a learning lessons newsletter that was distributed across the trust.

Whilst we observed that work had taken place to strengthen governance arrangements, and that these were in place at the time of our inspection further work was required to ensure that these worked effectively and were embedded. Governance arrangements at core service level had not identified patient safety and clinical effectiveness concerns and issues raised during the inspection. We observed that governance arrangements within End of Life were not well embedded, and there was a lack of clarity amongst staff regarding these. For example, we found that leaders within the medicine division, surgical division, and maternity divisions did not have sufficient oversight of risks regarding the security of records.

The trust had ensured that they received external scrutiny of their current governance arrangements. The trust utilised an independent appraisal service to review internal controls. The purpose of external audit was to objectively examine, evaluate and report on the adequacy of the trust's internal controls to provide assurance on their effectiveness and contribution to the proper economic and efficient use of resources.

The Audit Risk and Governance Committee received reports from auditors and during the 2021-22 review all but one of the reports received significant assurance. We reviewed the content of the report which summarised concerns regarding medical staff job planning, as the overall progress at completing job plans has been poor in recent years and only 24% of 2021/22 job plans had been signed off as complete at August 2021. This had been an issue at our previous inspection and the trust had not worked at sufficient pace to address this. The review also found that there was no formal system in place to monitor and report performance against planned activity in order to inform the appraisal, remuneration and job planning processes. Thirteen recommendations were made to support the Trust to improve their processes.

A total of 137 audit recommendations had been live during 2021/22 (this included recommendations from previous years' reports that were still live at 01 April 2021).
The external review concluded that overall, the trust had made good progress with regards to the implementation of recommendations. Most recommendations had been implemented on a timely basis. The Trust undertook an additional piece of work at year end to ensure accurate recording of completed recommendations and ensure there was clear rationale for any revised completion dates.

We reviewed five serious incidents investigations during the inspection, that included both initial reports (72-hour reviews) and completed investigations. The trust reported incidents on an electronic system and followed a root cause analysis (RCA) approach. In the sample we reviewed, we found the quality of reports was good and followed trust policy. They included detailed information and actions were identified. We found evidence that families were informed in each of the reports reviewed. Duty of Candour was applied appropriately. There was a clear focus on improving and sharing learning across the trust.

The Board Assurance Framework (BAF) and strategic risks were reviewed by the relevant Board Sub Committee and by the Audit, Risk and Governance Committee quarterly and Trust Board each meeting. The Finance and Performance Committee also reviewed the BAF quarterly, but also undertook a specific deep dive into a chosen strategic risk each month. The BAF was supported by a developed risk management process and a structure was in place to escalate risks from directorate to corporate level. The trust provided their Board Assurance Framework, which detailed five strategic objectives within each and accompanying risks;

1. To give great care

2. To be a good employer

Our findings

3. To live within our means

4. To work more collaboratively

5. To provide strong leadership

A review of the Governance Framework was undertaken in 2021/22 with a specific audit on the Board Assurance Framework and a separate audit of the Risk Management process. The audit of the BAF indicated that this was fit for purpose and was designed to provide the Board with sufficient and timely assurances on its system of internal controls to manage its strategic risks. Arrangements were in place to provide sufficient oversight of the Assurance Framework. The Assurance Framework was designed in accordance with NHS requirements and met all the elements required. We found the Assurance Framework covered the organisation's key risks.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. However, they did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. Whilst there had been some improvements in the services we inspected, we remained concerned about the pace of improvement in services, as challenges remained.

Since the last inspection the trust had further developed and embedded systems and processes to manage risk and performance. The integrated performance report (IPR) had been reviewed and revised to make it more timely, accurate and comprehensive. The divisional monthly performance meetings (PRIMS) covered all aspects of performance. There were clear, developed and embedded lines of reporting through the trust management board and assurance provided to the board committees. These meetings had comprehensive oversight of performance across all divisions.

At this inspection we saw improvements in some core services. In diagnostic and imaging, referral to imaging times were better than regional averages and continued to show an improving trend for patients waiting for a diagnostic test. The trust compliance rate for reporting times was 98.6% of all images reported on time in line with trust policy. This was better than regional and national standards. Waiting times for non-urgent ultrasound scans had reduced from 12 weeks in March 2022 to seven weeks at the time of the inspection. Within outpatients, there were improved, robust mechanisms in place to clinical prioritise and risk stratify patients to ensure that the most urgent were treated appropriately. Waiting lists were managed and patients were prioritised.

The trust used risk stratification protocols to give all patients a risk prioritisation status. Patients were subsequently monitored on waiting lists. Patients at most risk of potential clinical harm if not treated had enhanced monitoring and there were escalations procedures to follow. Progress and performance for each clinical speciality was overseen at weekly performance and planning meetings. Patient initiated follow-up (PIFU) had been introduced using readily available technology to give patients and their carers the flexibility to arrange their follow-up appointments as and when they needed them. This meant patients did not routinely sit on waiting lists but requested an appointment bespoke to their symptoms and needs. Elective performance had improved with increased focus and oversight.

Within the surgical division, their referral to treatment times on completed admitted pathways within 18 weeks (%) had improved from June 2021 to June 2022. Their latest performance was 71.4%. This was well above the national average of 54.7%.

Our findings

Whilst there had been improvements in some of the service inspected, we remained concerned about the trusts pace of improvement across other services as significant challenges remained. Within end of life services, there were areas of the service which continued to be of concern and had been previously identified during our previous inspections. There was limited evidence at the time of the inspection to show quality improvements had been embedded into practice and further work was required within governance processes to improve the audit results and compliance. The service continued to achieve poor outcomes and there was no formalised process to identify patients who had been started on the end of life pathway or referred to this team. There was no available data to measure the responsiveness or availability of end of life services.

In urgent and emergency services, Patients accessing the service continued to experience extended waiting times in excess of the four-hour benchmark and ambulance handover times were frequently in excess of the national standards. However, patients told us that despite the long wait for treatment, they were happy with the care provided to them and it was evident that staff worked hard to achieve the best possible outcomes for all patients.

Within medicine, there were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be arranged. Patients were being moved sometimes multiple times in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment. Due to the complexities in assessing patients who needed onward care, and the lack of care packages available to be arranged by out of hospital services, there were long delays in discharging patient's home. The staffing shortages in adult social care had a detrimental effect on the whole system of access and flow for medical care. Significant pressures on partner organisations for home care & domiciliary care, resulted in significant discharge delays. Working closely with system partners the trust had implemented a discharge to assess (D2A) model. The trust created two hubs one at Scunthorpe General Hospital and one at the Diana Princess of Wales hospital. The hubs received electronic D2A requests internally and facilitated the discharges by linking with community and social care. The Trust had effective links with local authorities and had implemented processes to monitor and manage delayed discharges and had clear oversight of this.

Workforce was a challenge and risk across the organisation, but in particularly within the urgent and emergency care, medical and end of life services. Within the medicine core service, due to national shortages of nursing and support staff and high levels of staff absence the service did not always have enough nursing and support staff to keep patients safe. Managers of the service told us they had increased nurse staffing establishment to allow for absences and vacancies so they could provide safe care. However, staff in the clinical areas we inspected told us they were often short of qualified nursing staff. Medical staffing did not always match the planned numbers; we found issues when talking to medical staff about day and out of hours cover, particularly overnight.

In the end of life service, there was not enough nursing staff within this team to meet the demand of patients and there was only one consultant based at SGH covering three hospital sites.

Although the urgent and emergency service ensured paediatric patients were supported by nursing staff with adequate skills in caring for children when attending the department, the trust still did not meet relevant standards in regard to ensuring enough registered sick children's nurses cover was available. However, they were aware of this and had put in some mitigating measures to support this. Similarly, specialist medical support for paediatric patients was obtained from in-patient wards within the wider hospital, which did not meet relevant standards.

Within pharmacy services, the trust had poor rates of medicines reconciliation and attributed this to lack of staff to deliver the service despite their intention to 'frontload' their pharmaceutical input to ensure medicines were correct for patients on admission. We saw evidence of incidents being reported relating to delayed medicines reconciliation

contributing to medicines being missed. The annual safe and secure handling of medicines audit had identified concerns across a range of wards, so a quality improvement approach was used to improve this. A change in approach was piloted across a small number of wards and improvements were seen and maintained so this approach had been extended across further wards.

Service and divisional level risks were identified from business meetings, governance, incidents, serious incidents and audit. Once a risk was identified, the risk register template was populated and when completed was taken to the relevant speciality business meeting for their review and sign off. Once risks had been ratified, they were sent to the clinical governance meeting for final review and ratification. Each division had their own risk register. Most, but not all, captured the relevant risks. For example, in surgery, some relevant risks, were not being discussed at divisional level and we identified areas of risk that were not on the risk register. Within Maternity at SGH the baby tagging and alarm system and risk of baby abduction, the flooring on ward 26, and lack of maternity triage provision had not been included in their risk register.

Finance Governance & Leadership

The Finance Director was appointed substantively in November 2020 - and was a joint Finance Director appointment with a neighbouring trust. A new finance team structure had been established including some joint senior roles with the neighbouring trust and some functions had moved or were in the process of moving from internally to externally provided. This move was aimed at addressing the known weaker areas of the NLAG finance and procurement function.

The Finance Director and Deputy Director of Finance had the full confidence of the Chairs of the Finance and Performance Committee and Audit Risk and Governance Committee. Board level Finance leadership was considered strong with the Finance Department having experience, depth and a valuable corporate memory.

The Finance and Performance Committee rotated the Finance, Performance & Estate items on its agenda to ensure each area's major risks were monitored comprehensively. The senior leadership from underperforming divisional areas were invited to the Committee meeting to explain how they intended to recover their position.

The core Finance Team was very stable, the auditors identified a future risk as being the difficulty in replacing these experienced finance team members, should they leave or retire.

The External Auditors felt the Audit Committee had a heavy agenda, but that it was well run and effective. Audit Committee members asked relevant questions and meeting attendees had clearly read the papers and were expected/ and did contribute to discussion on agenda items.

The Finance and Procurement and ARG Chairs both identified that the biggest risks facing the Trust going forward were workforce related, with the difficulties of being able to recruit and retain the necessary clinical skills and keep the costs within the financial resources available.

Revenue Position

The 2021/22 final accounts submission confirmed that the financial plan was delivered. In 2021/22 the Trust had invested in additional nursing the recurrent cost in 2022/23 being over £5m, with an additional 86 FTEs. The full cost was included in the Trust's 2022/23 financial plan.

Our findings

The Trust had submitted a balanced financial plan for 2022/23. The main risks were understood by both Executives and Non-Executive Directors. The risks identified were; Escalation beds (60) open in Quarter 1, receipt of funds from the Elective Recovery Fund delivery, cost improvement plans (CIP) slippage on a programme of £12m and increasing Agency premium costs.

The underlying financial position was a deficit of £25m with about half of which related to uncertainties over Covid income. The underlying position was being managed from year to year and was not increasing.

The Trust incurred agency costs of around £30m (medics & nursing) per year which equated to about 10% of payroll costs which was high but reflected the need to meet safe staffing levels and the difficulties faced by the Trust in terms of retention and recruitment. Agency costs were rising year on year. The Trust had a good record over the last three years of CIP delivery although around 40% of delivery has been non recurrent. The Finance & Performance Committee Chair and the Deputy Director of Finance were confident that financial risk would be managed in year and the annual financial plan will be met.

The ICS also had a balanced financial plan for 2022/23. Both Executives and Non-Executives talked of their commitment to help manage the financial position of the System as well as their organisation.

Capital Investment

Financial challenges in the lead up to financial special measures had led to a long period of under-investment in capital equipment, estate and infrastructure with increasingly adverse quality and financial consequences.

The main elements of the current capital programme were the two new (£30m each) Emergency Department (ED) and Ambulatory Assessment Units (AAUs); one each on the Scunthorpe and Grimsby hospital sites. The developments allowed for a change in the delivery model for emergency and urgent care.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure, however patient records were not always stored securely. Data and notifications were consistently submitted to external organisations as required.

The trust had in place an ambitious and comprehensive digital strategy which had been approved in January 2021 by trust board. The strategy also included a corresponding roadmap, detailing the proposed stages to conclude by 2024. This had been developed in consideration and alignment with Humber Coast and Vale (HCV) Partnership Long Term Plan, the HCV Integrated Care System (ICS) Digital Strategy “Fast Forward” plan and deliverables being set by NHS England and NHS (X) digital plans**.**

We observed across all core services inspected, a marked improvement in the collection, analysis and usage of data. We saw that there was an increased availability and reliability of core performance and activity information. The trust had implemented and embedded dedicated workforce analysts, who worked directly with human resources (HR) services which had enabled the scope of reporting to be widened to integrate workforce analytics into existing reporting on activity, performance and quality. Overall, there had been a demonstratable increase in reporting usage across the trust.

Information management systems were used effectively to support patient care and for audit purposes to monitor

quality and drive improvement. Information and technology systems had been recently updated to enable teams to monitor and improve the quality of care provided. The trust had taken action to implement a system to record, monitor and action audits. Regular updates regarding audit results, themes and trends and progress against action plans were presented at both trust board sub-committees and trust board. The trust had engaged an independent provider to support the review of the current clinical coding and mortality improvement project. Following the collaborative work, the project had been recognised at the Health Service Journal Awards in 2021.

The trust had focused on ensuring that staff at all levels throughout the organisation had opportunities to develop and enhance skills in relation to data collection, analysis and information management. A dedicated board development session had been held with NHS Providers on Digital Transformation focusing on outlining the impact of high-quality data and insight and how this can improve care delivery and decision making.

Senior leaders, Non-Executive Directors and members of the executive team commented that they had seen a marked improvement in both the timeliness and quality of data provided to enable decision making. A revised business reporting framework ensured the trust board received the relevant statutory and regulatory reports. Chairs of board sub-committees presented highlight reports to the trust board to ensure the board had oversight of the key issues. Managers used information to manage the performance in most divisions and against local and national indicators.

At the time of the inspection, systems were being implemented with the aim to help modernize the trust's data collection, reporting and insights. The trust was in the process of moving to a new patient administration system (PAS) to improve the quality, timeliness and accuracy of data captured. In addition, the existing internal electronic patient record (EPR) (WebV) had been upgraded to include more structured data such as Sepsis/VTE. During the transition to the new systems, the trust had continued to engage clinicians to assist the trust in reviewing existing processes and adapting the current WebV system. In addition, nursing analysts were working directly in collaboration with ward managers to help them understand data collected in relation to their areas and enable them to implement any required actions. Senior leaders across all core services inspected demonstrated an increased awareness and usage of systems such as Power BI and WebV.

We observed that leaders at all levels within the trust (including executives and board members) had access to readily available data which was presented in a more accessible way to enable leaders to make informed decision and assess and monitor performance. As a result of this, the divisions were using data to drive improvement and monitor compliance and evidence sustained areas of success. Further training and learning had been made accessible to staff in relation to digital systems, as the trust had obtained platinum status with the with BCS Chartered Institute of IT.

The trust had a single electronic patient record which was used as an administration system and electronic patient record. This single system could be accessed by all staff involved in patient care. However, the records management system within the trust was currently a hybrid system of electronic and paper. Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on the medical, maternity and surgical wards. Medical notes trollies were not locked on most wards inspected within the medicine division and maternity services, records were stored underneath and on IT trollies. This was highlighted at the last inspection as a must do action

Electronic prescribing and medicines administration (ePMA) had improved the level of medication related information available to the pharmacy staff but this was not yet being used fully to explore the quality of care being provided around medicines. In moving from Datix to Ulysses the trust had lost the medicines dashboard that was used at safety medication groups meetings to discuss trends and allocate actions. The dashboard was to be reinstated in the coming months. The pharmacy team and A&E doctors used the summary care records (with appropriate consent) to ensure

medicines information about patients was up to date.

The trust had undertaken work to improve their position in relation to Cyber Security, staff education and staff awareness in order to protect the trusts information assets. The trust utilised regular reporting on concerns relating to potential data breaches and examine any lessons learnt. Assurance was provided to the Audit and Risk Committee on matters such as Information Governance; Cyber Security and protection of data. As a result of an increased focus in this area, the trust had seen a consistent improvement in their cyber standards and reduction in the number of cyber vulnerabilities.

However, during our inspection we observed that within the medicine division several version control documents had passed the revision date; however, these records were still in use on all ward areas. For example, bed rails assessment (review date September 2021), endoscopy referral request form (review date February 2021) and intravenous cannulation record (review date August 2021). This was highlighted as a should do action at the last inspection.

In addition, during inspection of all medical wards we observed confidential waste was stored in paper bags which were unsecured and within easy reach of patients and visitors. We observed confidential ward and patient hand over documents for three consecutive days listing patient names, dates of birth, medical history and treatment plans on the HASU unit. This was highlighted as a concern at the last inspection.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. Engagement both internally and externally needs to be ongoing and sustained to ensure key messages are delivered to patients, staff and the public.

The trust had completed comprehensive engagement with patients, staff and other stakeholders on the design of clinical services, in particular, urgent and emergency care, planned care, maternity and paediatrics. This work was completed as part of the Humber Acute Service Review. This engagement was through surveys, focus groups and online events. Over 6,000 people participated in the “What Matters to you” survey, over 1,300 women give their views on their maternity preferences, and the trust completed 72 focus groups.

The trust now had positive relationships with its local authorities and commissioners. This was an improvement on the legacy position and since our last inspection.

There was a well-established council of governors who reported that working relationships with the board were constructive and there were good opportunities for engagement and holding the non- executive directors to account. The executive and non-executive directors acknowledged that they needed to continue to ensure that the governors were fully involved in developments within the trust and wider healthcare system.

The trust had a patient experience strategy (2021-2024) with associated patient experience priorities. These were monitored and reviewed at patient experience group, which fed into the quality and safety committee. The patient experience team reported they had involved service users, staff members and external partners such as the clinical commissioners in the development of the patient experience strategy.

Our findings

The senior leadership team reported close working relationships with Healthwatch and the local independent consumer champions for health and social care. A patient story framework, which incorporated a quarterly report to the trust board had been developed. A 15-steps ward assurance programme was in place and embedded, with supportive measures to aid improvements where needed. The fifteen steps programme measured the first impressions of what people saw and felt when on wards.

The trust had numerous staff engagement strategies including staff stories at board meetings, leadership engagement through senior leadership community sessions, chief executive briefings and "Ask Peter" sessions. However, this had had limited impact on the NHS Staff survey 2021 results where the trust ranked 122 out of 126 for staff engagement. The executive team acknowledged there was more work to be done to improve this.

At the time of this inspection medical engagement was improving but there was more to do to ensure that safe and quality patient care, and performance were sustained.

The chief pharmacist described a good working relationship with local trusts and community and council services, as well as being a member of the Humber services review group working with a neighbouring trust to develop joined up services for haematology, dermatology and oncology. The chief pharmacist was also working with a neighbouring trust's chief pharmacist to look at joint posts for staff, for example a joint lead pharmacist for haematology.

The medicines safety officer was actively involved in the regional medicines safety officer meetings and the Controlled Drug Accountable Officer (CDAO) attended regional controlled drug local intelligence (CDLIN) meetings. The trust was also represented on the regional antimicrobial pharmacist group

The trust has policies and procedures in place to support patients in line with the accessible information standards. These included access to interpreter and translation services, British sign language signers, using larger fonts for letters for visually impaired service users. The trust had applied "Browse Aloud" to its external web pages to enable the audio capabilities for people with visual impairments and for language translation. Patient lifts had voice and braille instructions and easy read signage had been placed on all toilets and bathrooms.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research

The trust had embarked on the roll out of a continuous improvement methodology. The trust supplied a copy of their quality improvement academy projects and associated tracker, which outlined current and completed quality improvement (QI) initiatives across all trust divisions. A Quality Improvement Strategy had been launched in early 2022 to identify and share the trusts vision across the organisation for an ongoing practice of continuous improvement within the Trust.
A Research Strategy was also in place at the time of our inspection which had been designed to link to the trusts strategic plan and delivery of priorities within the Nursing, Midwifery and APH strategy.

The trust had recently held a Quality Improvement Conference in April 2022, to engage with staff regarding progress made in relation QI and allow the opportunity for teams to present examples of staff led Quality Improvement projects.

Our findings

The trust undertook an evaluation of those in attendance of the conference and received strong positive feedback. A dashboard had been developed to maintain oversight of all ongoing, completed and in development quality improvement projects.

In addition, the trust had held regular collaborative quality improvement events such as the safe and secure medication collaborative. This involved multiple wards applying QI Methodology, tools and approaches to identify their problems and potential solutions as well as introducing their change ideas. As a result, there had been significant improvements from baseline position of March 2021.

Staff and senior leaders across the organisation demonstrated knowledge of improvement methods and the skills to use them. Quality Improvement Training had been undertaken trust-wide and over 80 staff trained and supported in turning their ideas and/or issues into Quality Improvement Projects, with 61 projects either completed or in development at time of writing. In addition, all foundation doctors had been provided with QI training and given support to develop Quality Improvement Projects, with 30 either completed in development at time of writing.

Examples of recent quality improvement projects included work to reduce the average days for patients to be on steroids during the management of steroid induced hyper-glycaemia in an inpatient setting.). All QI projects both in progress and completed had a designated leader and sponsor. In addition, the trust had received HSJ shortlisting for work done in relation to BAME risk assessments during the pandemic, Infection Prevention and Control work and also as the Community Provider of the Year.

Pharmacy staff shared that through introduction of the ePMA system the team had been able to develop a link into Web-V allowing discharge information to be transferred, reducing the risk of transcription errors and ensuring discharge medicines are accurate. The pharmacy team trust wide had undertaken a QI approach to reviewing the safe and secure handling of medicines audit and this has resulted in significant sustained improvements in the metrics. The pharmacy team had been supported in this by the trust QI team.

The internally devised quality times newsletter was shared with staff across the organisation outlining regular updates from across the trust regarding progress with the 15-step challenge. This included details of any identified themes observed as part of ward visits and outlines how staff can contact the QI teams to register potential new projects. The newsletter encouraged staff to undertake their own mock visits to embed the notion of quality improvement as part of ongoing developments.

The trust made effective use of internal and external reviews, and learning was shared at location level to make improvements. However, it was not clear that learning had always been shared across divisions with services at numerous sites. We observed some differences in patient outcomes and performance metrics across multiple core services, and where actions had been taken to identify and implement learning this had been location specific and not shared trust wide.

The trust complaint process was supported by a centralised complaints and patient advice and liaison team who work with all divisions across the trust. Both the centralised team and the divisions worked collaboratively to ensure complaint timescales, quality of responses and learning were a priority. The trust monitored these priorities through weekly support and challenge meetings that utilised a visual tracking tool to monitor week by week progress in line with a 12-week framework.

During the inspection, CQC reviewed five complaints. We found the overall quality of the complaint responses and the tone of the letters were appropriate. An apology was included where necessary and needed. The letters included advice

on next steps and signposting both internally and externally, if not satisfied with the outcome or response provided.

The trust had received 344 formal complaints during the 2021/22 reporting period. This was a 19% increase from previous year. Overall, 74% of complaints were managed within designated timescales, however it was acknowledged that clinical pressures from the COVID-19 pandemic had presented challenges to response times. To mitigate against these challenges, the trust had established a Family Liaison Assistant role, with the aim to support key ward areas with a staff resource to keep communication channels open and focus on patient wellbeing.

The trust had also implemented as direct result of feedback through the complaints process a digital outpatient system, which enabled greater communication with patients regarding managing appointments. The trust had also gone live with the national "My Planned Care" portal which detailed waiting times that could be accessed by patients. The trust also had future plans to implement a patient experience triangulation group to collate and triangulate the various amounts of patient feedback data that was collected within the trust in differing formats (such as formal complaints, PALS, compliments).

Since April 2017, the national 'learning from deaths' framework has stipulated that trusts must collect and publish, via quarterly public board papers, information related to deaths of patients

The trust had in place a learning from deaths process. Deaths of patients with a learning disability were notified appropriately and families and carers were given the opportunity to be involved in the investigation process. On a monthly basis, the Trust's performance with learning from deaths KPI's were reported within the monthly mortality report. The report outlined performance in relation to the following key metrics;

- Key mortality statistics/trends overview
- Key indicators from learning from deaths
- Number of deaths, deaths reviewed and number of deaths potentially avoidable
- Summary of problems in care
- Number of 2nd reviews undertaken for those with problems in care identified
- Number of SIs identified
- Summary of good practice
- Summary of key learning points
- Mortality KPIs in relation to Q&S meeting performance; sharing/learning lessons.

The mortality report was provided to the Quality & Safety Committee a sub-committee of the Board for their information.

We undertook six mortality reviews as part of our inspection. All cases reviewed demonstrated a good quality of investigation, with evidence of lessons being identified and
corresponding action plans that demonstrated how learning had been implemented. The trust had implemented a Mortality Review Standardised Operating Policy which involved a rigorous six stage process (screening, 1st Structured Judgement Review 2nd Structured Judgement Review, Serious Incident Panel, Learning from Death review, Mortality Improvement Group). We observed evidence that supported the trust's structured judgement review process was well embedded and credible.

Our findings

There are two main measures used nationally; the hospital standardised mortality ratio (HSMR) and the summary hospital level mortality indicator (SHMI). The HSMR is worked out according to observed deaths divided by expected deaths, multiplied by 100. A score of 100 means that the number of deaths is similar to what would be expected. A higher score means more deaths; a lower score, means fewer. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. From October 2020 to September 2021, SHMI and HSMR were both within expected range. At the time of the inspection, the most recent SHMI score was the lowest SHMI on record for the Trust and had been in as expected for 24 months.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↑ Dec 2022	Requires Improvement ➔➔ Dec 2022	Good ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Ambulance	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Adult social	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Mental health	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Community	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Primary medical	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement ↑ Dec 2022	Requires Improvement →← Dec 2022	Good →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diana Princess of Wales Hospital	Requires Improvement ↑ Dec 2022	Requires Improvement →← Dec 2022	Good →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022
Goole & District Hospital	Good ↑↑ Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Good ↑↑ Dec 2022	Requires Improvement →← Dec 2022	Good ↑ Dec 2022
Scunthorpe General Hospital	Requires Improvement ↑ Dec 2022	Requires Improvement →← Dec 2022	Good →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022
Overall trust	Requires Improvement ↑ Dec 2022	Requires Improvement →← Dec 2022	Good →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Diana Princess of Wales Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Dec 2022	Good → ← Dec 2022	Good → ← Dec 2022	Requires Improvement → ← Dec 2022	Requires Improvement → ← Dec 2022	Requires Improvement → ← Dec 2022
Services for children & young people	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
Critical care	Requires improvement Feb 2020	Requires improvement Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
End of life care	Requires Improvement → ← Dec 2022	Inadequate → ← Dec 2022	Good ↑ Dec 2022	Inadequate ↓ Dec 2022	Requires Improvement ↑ Dec 2022	Inadequate → ← Dec 2022
Surgery	Requires Improvement → ← Dec 2022	Requires Improvement → ← Dec 2022	Good → ← Dec 2022	Good ↑ Dec 2022	Requires Improvement → ← Dec 2022	Requires Improvement → ← Dec 2022
Urgent and emergency services	Requires Improvement ↑ Dec 2022	Requires Improvement → ← Dec 2022	Good → ← Dec 2022	Requires Improvement → ← Dec 2022	Requires Improvement → ← Dec 2022	Requires Improvement → ← Dec 2022
Diagnostic imaging	Requires Improvement ↑ Dec 2022	Not rated	Good → ← Dec 2022	Good ↑↑ Dec 2022	Requires Improvement → ← Dec 2022	Requires Improvement ↑ Dec 2022
Maternity	Requires Improvement → ← Dec 2022	Good → ← Dec 2022	Good → ← Dec 2022	Good ↑ Dec 2022	Requires Improvement → ← Dec 2022	Requires Improvement → ← Dec 2022
Outpatients	Good ↑↑ Dec 2022	Not rated	Good → ← Dec 2022	Requires Improvement ↑ Dec 2022	Good ↑ Dec 2022	Good ↑↑ Dec 2022
Overall	Requires Improvement ↑ Dec 2022	Requires Improvement → ← Dec 2022	Good → ← Dec 2022	Requires Improvement → ← Dec 2022	Requires Improvement → ← Dec 2022	Requires Improvement → ← Dec 2022

Rating for Goole & District Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Minor injuries unit	Good Jul 2014	Good Apr 2016	Good Jul 2014	Good Jul 2014	Good Jul 2014	Good Apr 2016
Surgery	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Diagnostic imaging	Good ↑↑ Dec 2022	Not rated	Good →← Dec 2022	Good ↑↑ Dec 2022	Requires Improvement →← Dec 2022	Good ↑↑ Dec 2022
Maternity	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Good Feb 2020
Outpatients	Good ↑↑ Dec 2022	Not rated	Good →← Dec 2022	Requires Improvement ↑ Dec 2022	Good ↑ Dec 2022	Good ↑↑ Dec 2022
Overall	Good ↑↑ Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Good ↑↑ Dec 2022	Requires Improvement →← Dec 2022	Good ↑ Dec 2022

Rating for Scunthorpe General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔➔ Dec 2022	Good ➔➔ Dec 2022	Good ➔➔ Dec 2022	Good ↑ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022
Services for children & young people	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
Critical care	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
End of life care	Requires Improvement ➔➔ Dec 2022	Inadequate ➔➔ Dec 2022	Good ➔➔ Dec 2022	Inadequate ↓ Dec 2022	Requires Improvement ↑ Dec 2022	Inadequate ➔➔ Dec 2022
Surgery	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Good ➔➔ Dec 2022	Good ↑ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022
Urgent and emergency services	Requires Improvement ↑ Dec 2022	Requires Improvement ➔➔ Dec 2022	Good ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022
Diagnostic imaging	Good ↑↑ Dec 2022	Not rated	Good ➔➔ Dec 2022	Good ↑↑ Dec 2022	Requires Improvement ➔➔ Dec 2022	Good ↑↑ Dec 2022
Maternity	Requires Improvement ➔➔ Dec 2022	Good ➔➔ Dec 2022	Good ➔➔ Dec 2022	Good ↑ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022
Outpatients	Good ↑↑ Dec 2022	Not rated	Good ➔➔ Dec 2022	Requires Improvement ↑ Dec 2022	Good ↑ Dec 2022	Good ↑↑ Dec 2022
Overall	Requires Improvement ↑ Dec 2022	Requires Improvement ➔➔ Dec 2022	Good ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022	Requires Improvement ➔➔ Dec 2022

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community dental services	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Community health services for children and young people	Good Apr 2017	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2017
Community health services for adults	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020
Community end of life care	Requires improvement Feb 2020	Requires improvement Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Goole & District Hospital

Woodland Road
Goole
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www.nlg.nhs.uk

Description of this hospital

Goole and District Hospital (GDH) is one of the three hospital sites for Northern Lincolnshire and Goole NHS Foundation Trust. It is located in Goole and serves the population of East Riding of Yorkshire and North Lincolnshire.

GDH is the trust's smallest hospital. The hospital provides non-acute medical care, elective surgery, outpatients and diagnostic imaging and midwifery led maternity services for children, young people and adults primarily in the North East Lincolnshire area. The neuro rehabilitation centre is at GDH, the centre offers specialist services for individuals following severe brain injury and a range of other neurological conditions.

Outpatients

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was provided as a mixture of e-learning and face to face learning. Staff felt supported to access mandatory training and were able to keep up to date with their training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Each department manager had oversight of mandatory training compliance. Management provided assurance that where any staff members were not up to date with training, they had been booked on to complete it.

Staff received and kept up to date with their mandatory training. The trust set a target of 85% for completion of core mandatory training. The trust monitored mandatory training for all staff across the three outpatient departments rather than by location.

Overall, the outpatient department met completion of core mandatory training with values ranging from 87% to 100 % in all core subjects.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

The chief nurse was the executive lead for safeguarding at trust board level. There was a trust-wide safeguarding team available to provide advice and support to staff.

There were safeguarding policies for both adults and children, which were accessible to staff on the trust intranet. The policies contained a flowchart for practitioners to follow if they had any concerns. Children attended some outpatient clinics. Some senior registered nurses were trained to level 3 in safeguarding adults and children. Staff requiring level 3 safeguarding for children had completed their training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could describe the safeguarding process and gave examples of safeguarding concerns that they had escalated.

Outpatients

Staff followed safe procedures for children visiting the department. Staff had an awareness and understanding of female genital mutilation, which was covered as part of their safeguarding training.

Staff gave an example of how they had used the safeguarding process to protect a patient whose first language was not English, from alleged domestic abuse. The patient had sought help from a staff member once in a consulting room away from family. The local safeguarding team had thanked those involved for making the referral and protecting the individual.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas visited were visibly clean and tidy. Clinical areas were clean and had suitable furnishings which were in good condition and well-maintained. The cleaning staff were all trust employees. Each area had a routine cleaning schedule to follow and managers audited how well the areas were cleaned. Results from these audits were positive.

The trust had a '15 step challenge' approach to cleanliness and infection control. Areas were award ratings based on how well they performed at these audits. All areas visited had received either a good or outstanding rating for level of cleanliness.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Disposable antimicrobial curtains were used in all outpatient clinics.

Staff adhered to 'bare arms below the elbow' protocol. Hand sanitiser was available for use throughout the department and there were hand washing sinks available in areas visited.

Hand hygiene audits were completed regularly, and trust data showed that compliance with this was also positive. Feedback was given to staff at team meetings and improvements needed were discussed.

There were designated waiting areas for patients with children which were clean and tidy. All toys and games available were easy to keep clean.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. Staff reported they had access to equipment for bariatric patients, for example, appropriate scales and seating. There was a range of seating provided including high back chairs and seating of appropriate heights for patients with orthopaedic conditions.

Resuscitation equipment was available on trolleys at various locations in the main outpatient areas and near other clinics. Daily checks were completed and tamper proof tags were used to show if the contents had been accessed. Full checks of the trolleys were completed weekly. We examined checklists covering the previous three months and saw that appropriate stock was in place and this was regularly updated. Trolleys were clean and dust free.

We checked electrical equipment and found them to be within their service date and that they had been safety tested. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. Staff told us equipment was promptly repaired or replaced if required by the estates department.

We checked a range of items including dressings and syringes. All items were within their expiry date and staff confirmed processes were in place to check that stock was regularly rotated to ensure the use of short dated items.

Sharps bins were properly assembled, stored off the floor, not over full and signed and dated. There was waste disposal in the department for clinical and non-clinical waste.

There were self-check in desks in the outpatient department but these were not in use. They had been placed out of action during the Covid-19 pandemic and now needed a software upgrade before patients could use them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

The trust had a clinical prioritisation system for patients overdue their appointment dates. The trust had a backlog of patients waiting to be seen. The backlog was in part incurred as a result of the cessation of services during the Covid-19 pandemic.

The trust had implemented risk stratification systems to help ensure patients were seen in order of clinical need and had strategies to reduce the waiting lists for each clinical speciality. However, there remained risk due to the volume of patients waiting and the service not meeting the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for a suspected cancer diagnosis. There was an national shortage of oncologists that meant the trust did not have enough medical staff to treat cancer patients. However, the trust was working with another hospital trust to remedy the risk and were continually undertaking validation of the waiting lists.

Safety checklists were used in some areas such as ophthalmology prior to intravitreal injections. Ophthalmology was managed by the surgery division and therefore the surgery division managed the safety checklist audits. The trust provided WHO checklist audit results which showed compliance with WHO checklist procedures.

There was a clear trust-wide pathway and process for the assessment of both adults and children within outpatient clinics who became clinically unwell while in attendance. All staff we spoke with could describe the pathway, which involved contacting the trust resuscitation team or emergency service dependent on location.

Staff were aware of sepsis and could describe the signs and symptoms to be aware of. We saw posters on walls to raise awareness of sepsis and staff told us sepsis was included in mandatory training.

Clinical nurse specialists gave patients their contact details so they could escalate any change in their condition or seek advice when they needed to.

There was a policy for staff to follow if a child or young person did not attend their appointment. The policy described that the clinician must consider whether there was a safeguarding risk for any nonattendance in the case of children and young people and then act accordingly in following any concerns up, liaising with the referrer to assess the risk and consider further actions if appropriate. The policy directed clinicians to the trust policy for safeguarding children and young people for guidance.

Outpatients

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Nurse vacancy rates were low and staff turnover rate at 4.3% was low across all departments. Staff sickness ranged between 5.5% and 9% for the previous 12 months. This was a lower sickness rate than most other directorates within the trust.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance.

Managers could adjust staffing levels daily according to the needs of patients. When extra clinics were added, managers used their own bank staff to fill these shifts. Managers limited their use of bank and agency staff and if using agency workers, they requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the department.

The number of nurses and healthcare assistants matched the planned numbers and rotas were refreshed on a weekly basis. Managers held weekly clinical utilisation meetings and these meetings shaped where there would be either an increased need for staff or a reduction if a clinic was cancelled. Clinical nurse specialists were not managed by the individual outpatient departments but had rooms allocated to them when they held clinics.

There was no staffing data for medical staff in outpatients due to medical staff being assigned to their individual speciality rather than the outpatients department.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient records were paper based, however patient letters including referral letters and all diagnostic results were easily accessible via electronic systems.

Staff told us that there were rarely missing records and would contact medical records to locate patient notes if necessary. If records were not located before a clinic, the administration team would make up a temporary set of records, which would be merged with the original set when they were located.

Records were stored securely in locked areas and were not accessible to the public. We observed that covers for notes trolleys were used to maintain confidentiality when moving notes in trolleys within the department.

We looked at the medical records. We found that they contained up to date information about patients including referral letters, copies of letters to GPs and patients' medical and nursing notes. There was a plan of care documented for each patient. Records were always dated and signed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Outpatients

Medicines were stored in locked cupboards and refrigerators. We checked a range of medicines and found them to be in date and stored appropriately in locked cupboards.

No controlled drugs (CDs) were stored in the areas we inspected.

Staff monitored and recorded the temperature of the rooms where drugs were kept. We reviewed the temperature records in clinic rooms and saw that daily checks had been completed. We saw the temperatures were within acceptable limits. Staff we spoke with could explain the process to follow should temperatures fall outside the required range.

Clinicians used a mixture of electronic prescribing and FP10 prescriptions. The FP10 prescriptions were securely stored in a locked cupboard. Prescription records were kept securely and separately from prescription books.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff used the electronic incident reporting system to report incidents and near misses.

At the previous CQC inspection, it was noted patients had come to serious harm due to delays in receiving treatment. There were no such incidents noted at this inspection and the process for incident management had improved.

Staff gave us examples of how to report an incident. We were told of one incident where a sick patient that had attended their local outpatient department by default because an accompanying family member thought that the hospital had an emergency department. The outpatient department was near the hospital main entrance so the first staff on scene were from outpatients. This incident was reported and recorded. As a result of this, changes were made and lessons shared to ensure staff were ready to respond in the event of an unexpected patient attending in need of emergency care.

Staff understood the duty of candour. Some staff were aware of the concept and had not needed to act on it. Others understood the process but not the term. Staff told us they were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents or through team meetings, staff huddles or from information displayed in staff areas. The trust had introduced a patient safety bulletin and a learning lessons bulletin that shared incidents that had occurred, their root causes and their conclusions.

Managers debriefed and supported staff after any serious incident. Staff told us that they would be given the opportunity to discuss concerns following an incident.

Is the service effective?

Inspected but not rated

Outpatients

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. The policies and protocols we reviewed were mainly in date and all available on the hospital's intranet. However, the resuscitation policy was due for review in October 2021 and the UK resuscitation guidelines seen on the resuscitation trolley were dated 2015. The most recent version was published in 2021. This was a trust wide issue.

The oncology clinic issued patients with information cards that alerted them to potential infection. This followed the NICE guideline for neutropenic sepsis: prevention and management in people with cancer.

The trust medicines management policy ensured that staff administering intravenous medicines and fluids were compliant with the NICE guidelines for healthcare professionals' competencies in hospitals.

Pain relief

Staff accessed pain relief within outpatient clinics in line with individual needs.

Staff told us that patients were advised on pain relief during appointments if it was required.

Pain relief was not generally provided in outpatients, although there were medical staff available in outpatients for advice should need arise.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The directorates participated in their own speciality national audits as required, for example in general surgery and medicine. Other areas were required to provide information to various national audits included ophthalmology for the national ophthalmology database.

The service used the NHS benchmarking network to understand their position monitored against other trusts nationally.

Managers used information from the audits to improve care and treatment. There were a series of local audits undertaken within the outpatient departments. These included an ID audit to ensure staff were making the correct patient checks, an ENT (ear, nose and throat) audit to check that scopes were being cleaned correctly after use and documentation audits to monitor whether notes were completed thoroughly.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. All departments had ensured that staff had had an appraisal. Data showed that over 85% of staff had undergone an appraisal. We spoke to different grades of staff who told us that they had yearly appraisals and were able to raise concerns.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There was the option to attend team meetings virtually if staff were unable to be in the department when they occurred. Team meetings had standard agenda items and minutes reviewed that we reviewed referenced lessons learnt from incidents, patient waiting times and news from the trust.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Some staff had been able to progress within the department by undertaking additional study. We met individuals who had been supported to undertake nurse training and had developed from health care assistant to registered nurse. Staff had also the undertaken professional nurse advocate training programme. The trust supported this training which gave staff skills to facilitate restorative supervision to their colleagues and teams.

Managers made sure staff received any specialist training for their role. There was additional training for staff working in areas such as ophthalmology or ear, nose and throat clinics. These staff needed extra competencies to be able to fulfil their roles.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was multi-disciplinary team working across the specialities providing outpatients. Where required there were multi-disciplinary team meetings in the directorates. There were specialist registered nurses working in clinics across outpatients to provide care and treatment to patients. Staff in orthopaedic outpatients worked with the medical staff and physiotherapy staff to provide care to patients.

There were a number of nurse led clinics across the trust. Different staff groups and professionals worked together across the services to provide care, treatment and support to patients.

Cardiologists told us they offered a service where GPs and community nursing teams were able to support patients in the community with guidance from the hospital team. This reduced the need for patients to attend appointments at the hospital.

Seven-day services

Key services were available seven days a week to support timely patient care.

The service provided outpatient clinics routinely between 8:30am and 6pm between Monday and Friday. However. there were evening clinics and some weekend clinics provided in the various specialities to afford patients the opportunity to attend appointments at convenient times. This was pertinent for patients needing regular appointments for frequent treatments.

The service also added extra clinics at weekends and in the evenings to help reduce the waiting list and backlog of patients needing appointments.

Outpatients

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas. We saw patient information displayed in all clinics. This included guiding patients and carers to support services, information on conditions, smoking cessation and drink awareness. We saw clinics that had seasonal displays, for example how to keep safe in the sun. Staff told us that there were similar displays at other times of the year.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There was a trust-wide consent policy, which staff could access through the trust intranet. We saw that this policy included obtaining consent for treating all patients including adults with reduced capacity to make independent decisions, patients with communication difficulties and children and young people.

Staff made sure patients consented to treatment based on all the information available. We were told by staff that appropriate consent was obtained from the patient prior to any examination or treatment. All records checked contained documentation to show consent was obtained. In clinics where children were treated outside of the paediatric department, staff described how they would discuss the appointment with the child and explain the equipment in the room so the child was not scared or uncomfortable. Staff were able to contact the paediatric clinic if they needed advice.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a trust wide MCA DoLS team and access to a Mental Health Liaison in-reach team. Staff told us they knew how to contact them if they needed advice or had concerns about a patient.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We saw staff taking time to interact with patients and those close to them in a respectful and considerate way. Staff greeted patients and introduced themselves. Staff cared about their patients and patients were pleased to see faces they recognised. We saw patient thank you cards which thanked staff for their care and compassion.

Outpatients

Staff were discreet and responsive when caring for patients. Patients said staff treated them well and with kindness. We read cards given to staff in clinics thanking them for their care and support. Patients told us that reception staff were welcoming and friendly

All patients we spoke with during the inspection told us that staff treated them with respect and maintained their dignity and privacy, for example, through ensuring clinic doors were closed during appointments and using curtains in treatment rooms.

Chaperones were available and provided as necessary across the outpatient department. There was a chaperone policy available for reference and to support staff.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

There was a quiet room available with seating for patients to use if they were anxious or worried when visiting the department and staff told us this room was available to patients as needed. Staff used this room for private discussion with patients and for patients who had received bad news to provide privacy if they were distressed.

Staff described being adaptable to the needs of patients, for example, providing separate waiting areas for distressed or anxious patients, and fast tracking patients through outpatient clinics if they were anxious or phobic.

There were specialist nurses in some clinics who were able to provide care and support for patients. Patients were offered contact details so they could call specialist nurses if they had any questions or concerns.

There were leaflets available throughout clinic areas signposting other emotional support services for patients, for example, local support and listening groups.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients' told us that if there was a delay to a clinic they were informed by the staff or by messages on the display board.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw posters in clinics advertising the friends and family test.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

Outpatients

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service had reacted to the challenges created by the Covid-19 pandemic by being inventive with ways to contact and treat people using technology and new pathways.

There were outpatient specialities which held clinic appointment slots for urgent appointments. There were speciality administration teams which booked and assisted in managing appointments for the specialties.

The clinic utilisation group and speciality administration teams were involved in managing the clinic bookings. Additional clinics were put on for specialities and extra staff would be scheduled to those clinics.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. There were virtual clinics which reduced the need for patients to attend departments unnecessarily by having a consultation over a video link or by telephone. The departments worked closely with GPs via the Connected Health Network project which meant that patients were seen promptly, and treatments or investigations might happen closer to home.

The outpatient department could provide patients with a pager, so patients could leave the waiting room for a break and could be contacted when their appointment was imminent.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Some areas had dementia friendly environments, for example clocks and toilet signage. There was a trust wide dementia strategy. There was a trust wide senior nurse for vulnerable people who led on dementia and learning disabilities. There were dementia champions who could be contacted for advice and support and the department worked as needed with the trust learning disability and dementia matron. Electronic referrals could be made through the system to the clinical nurse specialist. Patients with learning disabilities could also be highlighted on the electronic systems.

The outpatient patient survey showed that 100% of respondents found the environment in the waiting room pleasant and comfortable.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation services via an interactive electronic tablet that was quick and easy to use. British sign language interpretation could be requested.

Outpatients

There was a quiet room available in the department which could be used for patients who may be anxious or where patients required a quieter room than the waiting room. Additional time could be provided in the clinic for patient's appointments if required. Appointment times varied depending on whether the appointment was a new appointment or a follow up appointment and depending on the speciality.

The service had information leaflets available in languages spoken by the patients and local community. There were a range of patient information leaflets available throughout the department.

There was a trust patient advice and liaison service (PALS) which provided advice and support regarding concerns.

Staff told us that they worked closely with the services that provided patient transport to clinics to help patients access transport to and from their appointment. They would contact transport services if there was a delay in collection or appointments. Staff always waited with patients until transport arrived to take them home.

Letters were sent to patients from the bookings and administration teams following appointments or before appointments.

Access and flow

People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. However, this was an improvement on the previous inspection in 2019.

Although the trust were struggling to meet the demand for outpatient appointments, they had strategies and mitigations in place to help remedy this. This was an improvement from their previous inspection and much work had been undertaken as part of the outpatient transformation programme.

From February 2021 to January 2022, the total number of appointments in outpatient services was 420,283.

Medical specialties had seen the largest increase in appointments (27%), compared to the previous 12 months. This was followed by dermatology (22%) and surgical specialties (21%).

Ophthalmology (6%) and oncology (6%) were the only specialties to see a decrease in the total number of appointments, compared to the previous 12 months.

Specialty Number of appointments Proportion of appointments

Surgical specialties 160,299 38.1%

Medical specialties 96,246 22.9%

Other 92,697 22.1%

Ophthalmology 46,434 11.1%

Oncology 19,027 4.5%

Outpatients

Dermatology 5,580 1.3%

Total 420,283 **100.0%**

Managers monitored waiting times and although patients could not always access services when needed, there were systems in place to keep checks on this.

Managers were monitoring numbers of patients on all the waiting lists, waiting times, breaches and people who do not attend appointments (DNA's). There was also robust monitoring of the numbers of outpatients overdue their follow up appointment, which was a challenge for the trust.

Waiting lists were managed and patients were prioritised. The trust used risk stratification protocols to give all patients a risk prioritisation status. Patients were subsequently monitored continuously on waiting lists. Patients at most risk of potential clinical harm if not treated had enhanced monitoring and there were escalations procedures to follow.

Progress and performance for each clinical speciality was overseen at weekly performance and planning meetings.

Patient initiated follow-up (PIFU) had been introduced using readily available technology to give patients and their carers the flexibility to arrange their follow-up appointments as and when they needed them. This meant patients did not routinely sit on waiting lists but requested an appointment to befit their symptoms and needs.

The Connected Health Network project meant that cardiologists worked actively with GP partners to help improve services for patients. The patients involved in this project did not need to come into the hospital or wait on a list for treatment or advice but could access this locally.

The trust aimed to undertake 25% of its outpatient consultations virtually. Patients could receive advice and treatment via video call or telephone without the need to attend hospital.

However, there was a shortage of oncology doctors which impacted on the trust's ability to reduce the wait time for cancer treatment appointments. The trust was also providing mutual aid to this speciality for another NHS trust which affected their data and wait times.

In March 2022, the percentage of patients receiving Cancer treatment within 62 days at Northern Lincolnshire and Goole NHS Foundation Trust was 64%, compared to the National average of 67%. When comparing this trust to its peer group (based on activity), it had the second worst performance rate (out of 30 trusts). However, performance had improved by 7% since January 2022 (57%).

From October 2021 to April 2022, the trust's referral to treatment time (RTT) had generally improved (except for January where there was a slight decline). The figures for April 2022 showed 73.1% of this group of patients were treated within 18 weeks, which was similar to the England average of 74.0%.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Outpatients

Patients, relatives and carers knew how to complain or raise concerns. Patients could give feedback via the trust website and the service clearly displayed information about how to raise a concern in patient areas.

There was a policy and procedure for the management of complaints, concerns, comments and compliments. Staff understood the policy on complaints and knew how to handle them. Patients were kept informed about progress with the investigation of their complaint and received an outcome.

Leaders and the patient advice and liaison service (PALS) received formal complaints which were investigated by the leaders of the outpatient department and leaders told us learning was shared at the team meetings or with staff individually if required. Complaints were part of the agenda for team meetings where required and were part of senior leaders' meetings.

Complaints had been mainly about waiting times and car parking facilities. Staff could give examples of how they used patient feedback to improve daily practice. Managers shared feedback from complaints with staff and learning was used to improve the service.

Managers investigated complaints and identified themes. The trust had information boards on departments titled 'You say, we did'. These identified thematic feedback and reported improvements made as a result of this.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, staff told us that senior managers were less visible in the service.

Staff we spoke with were positive about local leadership within their teams and told us team leaders were supportive and available when required. However, the service was in a state of transition and moving to a new directorate structure, so this made staff unclear about who their divisional leaders were. Staff told us that they were able to talk to the senior leadership team but reported that the trust executive team were never seen around the departments.

Outpatient services had been previously managed under one directorate. Outpatient departments were now divided across three directorates. Diana Princess of Wales outpatient department in Grimsby was in the medicine directorate, Scunthorpe General Hospital was in the surgical directorate and Goole Hospital sat within the community services directorate. This divisional restructure was in its infancy and under review. The divisional matrons across these areas would work together to ensure consistency across the outpatient teams. At the time of inspection, it was too early to say whether this had been successful or not.

There was a structure for the management of outpatients. There was a matron for outpatients covering each site and each outpatient department had an individual manager.

Outpatients

Senior managers we spoke with were aware there were challenges with waiting lists for outpatient appointments and issues with referral to treatment indicators.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

As part of the NHS Ten Year Plan, the trust pledged to make changes to outpatient services and detailed intentions in its Strategic Plan (2019-2024). This strategy included information on the trust strategic framework, the current outpatient position and the outpatient objectives and priorities over five years. In all areas that we visited, information was available for staff to read about the transformation aims.

The outpatient transformation programme 2022/2023 had aims, ambitions and outcomes. We saw that some of these aims had come into fruition and had been achieved. Some aims remained a work in progress.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff in departments told us there was good teamwork, openness and honesty within their teams. Overall staff were positive about working in their departments. Most staff told us they felt supported.

Staff told us morale was generally good, however, the recent reorganisation of directorates was causing some concern as outpatient staff aligned to their new leaders. The service was getting used to a restructure although this did not seem to impact on the day to day running of departments.

Staff told us that they were proud to work in the trust. We spoke to staff who told us ‘I love my job’. Another staff member told us they would not want to work anywhere else. Staff also told us they would be happy to have their own family treated at the trust

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders described governance arrangements for the outpatient departments. Governance meetings and governance issues fed into quality and safety meetings which were held every week.

At this meeting incidents and complaints were discussed. This meeting was attended by senior staff who could then escalate governance issues through this meeting to the performance improvement meetings, trust management board and the clinical quality board.

There was a clinical utilisation group who supported the work around capacity and demand challenges in outpatients. A breach review meeting was held weekly as was a planning and delivery meeting.

One report was published for all these meetings which was the integrated performance report so that there was a 'single version of the truth'.

The trust had engaged with the Getting It Right the First Time (GIRFT) national programme and had a dedicated GIRFT team to support improvement. The trust had governance arrangements for oversight for the GIRFT program.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were risk registers that detailed issues pertinent to the service. Risks were rated and had actions associated with them. Staff were aware of top risks such as capacity for appointments, staffing, estates and facilities and information technology.

The outpatient services monitored performance through performance reports and regular meetings. Progress was monitored by the planning and performance function at weekly divisional and trust meetings. The executive team had monthly formal Performance and Improvement meetings (PRIMS), with the divisions. Any escalations or concerns were made to the Finance and Performance Committee which was a sub-committee of the board. Monthly integrated performance reports were also provided to the Finance and Performance Committee for oversight of performance, including key performance indicators relating to the backlog of waiting appointments.

There was a trust business continuity plan that detailed how the outpatient departments would continue to operate during an unplanned disruption in service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff could access the trust intranet for information and news about the trust. Policies and procedures were available on the trust systems to staff. Staff had access to an internal information technology team for support as required.

The service had performance reports, for example patient tracking list reports which enabled the service to monitor the waiting lists and understand where there were challenges.

Information systems were used across the departments to provide patient care. For example, there was access to electronic patient records and the trust had an electronic incident reporting system.

The service collected reliable data and analysed it. Senior staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. We were shown data bases used in different departments to gather information on performance and used for audit. The information systems were electronic and secure. Staff told us that these audits were shared with the trust management and submitted to external organisations as required. For example, compliance with the National Institute for Health and Care Excellence (NICE) standards in rheumatology.

Outpatients

Engagement

Leaders and staff actively and openly engaged with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The leadership team had discussed methods for helping staff to understand the new structure. They told us that they were in the process of spending time with staff to increase their visibility.

Staff were able to feedback using staff surveys. We were told that staff completed a trust staff survey every three months and a national staff survey each year. The results were fedback to the staff and actions that needed to be taken as a result were shared.

The Connected Health Network project meant that cardiologists worked actively with GP partners to help improve services for patients.

The trust commissioned an audit to review performance and systems to ensure that they were aligned to the outpatient transformation programme.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The Connected Health Network project was developed in partnership with another organisation. This was a new model of care in which GPs and hospitals worked together as one clinical network. It meant that GPs no longer needed to make a referral into a hospital. Instead, they worked directly with trust specialists to agree how to safely deliver your care. A shared admin team helped ensure a streamlined pathway for patients. The project picked up an award in the early-stage pilot of the early adopter of the year category.

Diagnostic imaging

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Compliance for radiographers and sonographers (allied health professional (AHP staff)) was 98% which exceeded the Trust target of 85%. Compliance for the majority of e-learning courses was 100% with compliance for face to face courses in individual departments ranging from 40% for moving and handling for patients using a chair, to 84% for Mental Capacity Act training.

Medical staff training compliance exceeded the Trust target of 85% and staff achieved 100% for nine out of 18 courses. Compliance for the remainder ranged from 71% (five out of seven staff) for antimicrobial stewardship to 86% (six out of seven staff) for adult basic life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers and staff confirmed face to face courses were becoming more accessible and staff were rostered and booked to attend as soon as new courses became available.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding Adults and Children training compliance met the Trust target of 85%. Compliance for AHP staff was collated for Scunthorpe General Hospital and Goole General Hospital. Staff achieved 92% compliance for Adults Safeguarding Level 2 training and 99% had completed Children's Safeguarding Level 2. Medical staff compliance met the Trust target at 86%. Six out of seven radiologists had completed Adults and Children's Safeguarding training to Level 2.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Data provided by the trust showed, and staff confirmed, none of the staff in the service had completed Children's Safeguarding to level 3, although the Trust Safeguarding Children's policy was comprehensive and included Trust safeguarding contacts and processes to follow and staff gave examples of how they had put this into practice. Staff and managers used the Trust safeguarding team guidance to mitigate any risk.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Diagnostic imaging

Staff could access safeguarding advice via the Trust's lead nurse for safeguarding. Staff explained some vulnerable patients may come to the department with a signed consent form from the referrer if they were unable to give consent themselves. There were a small number of children referred to diagnostic imaging for suspected physical abuse checks. If these patients did not attend (DNA) staff would send a DNA report back to the referrer.

Staff followed safe procedures for children visiting the department. Images taken for babies and children when non-accidental injuries were suspected were reported by consultant radiologists and the Trust had a service level agreement for these images to be double-reported (two radiologists reported the same image independently) by radiologists at a neighbouring NHS Trust.

Staff attended paediatric multidisciplinary meetings to discuss referrals, images and reports relating to children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises clean.

Staff provided records to show cleanliness of equipment had been checked. All rooms and public areas were cleaned daily by hospital domestic staff, and cleaning checklists were available to staff.

Clinical area cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed staff cleaned equipment after every patient contact. Ultrasound staff cleaned and checked all probes were disinfected before use.

The latest PLACE assessment had been carried out in 2019 and the overall hospital scores showed:

Goole and District Hospital was within the top 25% of hospital sites for five out of six domains – (A) cleanliness, (C) privacy, dignity & wellbeing, (D) condition, appearance & maintenance, (E) dementia and (F) disability. Goole and District Hospital was above the median for all six domains.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact. Staff disposed of ultrasound gels in bottles at the end of every day. Sonographers cleaned and disinfected ultrasound probes before use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff and managers maintained appropriate records of checks of specialist equipment. Staff managed clinical waste well.

All clinical areas we inspected were clean and well-kept and patient areas were spacious and bright. Domestic cleaning records and checklists were available to staff so they knew what should have been cleaned or when. Treatment rooms and storerooms were well stocked, clear of clutter, tidy, and appeared clean. The layout of departments was suitable for following patient pathways. There was sufficient space and furniture in waiting areas.

Patients could reach call bells and staff responded quickly when called. However, patients were not left alone for long periods and seldom had to wait at all.

Diagnostic imaging

The design of the environment followed national guidance. There was clear signage throughout the departments where ionising radiation or magnetic resonance imaging (MRI) equipment was used and there were controls to restrict access to patients and staff. Equipment used in MRI environments were suitable for use and labelled as MR safe. There was appropriate PPE available including lead aprons and coverings. We observed no obvious environmental hazards during our inspection.

Staff wore dosimeters (small badges to measure radiation) to ensure that they identified and accurately recorded any exposure to higher levels of radiation than was considered safe. Radiology staff collected dosimeters and sent them for testing. Results were all within the safe range.

The trust had a radiation safety policy, which met 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.

There were radiation protection supervisors for each modality to lead on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(ME)R. Staff demonstrated safe working methods to record patient doses for radiation.

We saw radiation protection supervisor reports showing reviews undertaken against IR(ME)R and learning shared with staff through team meetings and training.

Staff carried out daily safety checks of specialist equipment. Service and maintenance reports were easily available to staff and managers. They were completed with details of equipment condition and any work carried out. Staff provided servicing and maintenance documents for all equipment. Staff were able to raise any immediate concerns to managers who took action to rectify faults quickly.

Staff completed quality assurance (QA) checks on all equipment. These were mandatory (must do) checks based on the Ionising Radiation Regulations 2017 and IR(ME)R 2017. These protect patients against unnecessary exposure to harmful radiation. X-ray equipment had been measured by the regional medical physics advisor and had been found to be safe including newly installed x-ray equipment.

The service had suitable facilities to meet the needs of patients' families. There was sufficient space for carers to accompany patients if required and a small area in the main waiting area for use by families and children with some toys which were kept clean and in good condition.

The service had enough suitable equipment to help them to safely care for patients. The service had an equipment replacement schedule with a five-year plan and a central Trust equipment fund. Equipment service and maintenance contracts were in place and trust medical engineering supported the service for non-radiation checks and repairs. Resuscitation trolleys were well stocked, locked and tagged. Equipment was clean.

Staff told us protocols for ultrasound and x-ray equipment were available on the shared drive, but we found these were out of date by a few months for x-ray equipment and by a year and a half for ultrasound equipment. Protocols were not adapted solely for each piece of equipment, so staff were not aware of specific requirements of the equipment they were using.

Diagnostic imaging

There was guidance for quality assurance and diagnostic reference levels (DRL) for equipment. DRLs were present in main x-ray rooms but both rooms displayed identical levels to those at Scunthorpe General Hospital. Each piece of equipment should have separate and specific DRLs so the manager informed us they would contact their medical physics expert for advice.

The adult and paediatric resuscitation trolleys were well stocked, locked and tagged. Equipment including suction and oxygen lines were clean. There were anaphylaxis and cardiac arrest kits kept with the trolleys. The checklists for resuscitation trolleys had no missing entries for the months of May and June 2022.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient's health. The trust had clear policies and guidance in place for managing medical emergencies. Staff received basic life support training as a minimum and there was an emergency crash team who could be called to assist.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a standard document for all examinations consistently across all sites. This document was uploaded to the patient record and there was a standardised process to check patient identification, contrast safety and World Health Organisation (WHO) safer steps to surgery checks.

Staff knew about and dealt with any specific risk issues. Radiology equipment had been risk-assessed and portable equipment tested to ensure the safety of staff and patients. Specific testing and reporting on equipment included radiographic tubes and generators and ultrasound machines.

Staff asked patients if they were or may be pregnant. If patients could not be sure, staff ensured a pregnancy test was completed before carrying out any examination involving exposure to radiation. This met with the radiation protection requirements and identified risks to an unborn foetus. Staff followed different procedures for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and staff completed checklists to record them.

Staff knew what actions to take if a patient's condition deteriorated while in each department. There were enough resuscitation trolleys across all departments. All staff had completed basic life support as a minimum and could follow hospital procedures to call switchboard for help if necessary.

Staff completed risk assessments including National Early Warning Score (NEWS), pre-assessment for interventional procedures. Staff recorded these in patient records and escalated any concerns to medical staff. There were emergency assistance call bells in patient areas in radiology but we rarely saw patients unaccompanied or left for long periods in waiting areas. Staff confirmed that, when patients activated emergency call bells, they answered them immediately. There were emergency call buttons for staff use in all departments.

Staff followed the radiation protection policy and procedures in the diagnostic imaging department. Managers ensured that roles and responsibilities of all staff including clinical leads were clear and therefore managed and minimised risks to patients from exposure to harmful substances.

Diagnostic imaging

Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. The trust had named and certified radiation protection supervisors and liaised with the radiation protection advisor (RPA). There were three RPA's based at a local NHS trust, one of whom would attend patient safety meetings every two months. These were minuted and shared with staff including radiation protection supervisors (RPS) for each modality, for example general x-ray and CT, who provided advice when needed to ensure patient safety. Staff described a good relationship with the RPA's. Arrangements had been agreed via the RPA for reporting and assessment of radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Staff had written and agreed policies and processes to identify and deal with risks. This met with Ionising Radiation Regulations 2017 and IR(ME)R 2017.

Staff shared key information to keep patients safe when handing over their care to others. Images and reports were made immediately available to all referrers and clinicians. Previous images and reports were also available to help staff check previous findings for clinical checks and comparison.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended a "huddle" every morning before the main shift began to exchange information on equipment, expected patients, any identified risks, and to prepare for the day ahead.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction.

Allied health professional (AHP) staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough AHP staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of AHP staff and healthcare assistants needed for each shift in accordance with national guidance. Reporting radiographers reported all plain film x-rays except for babies and head and neck images which were always reported by consultant radiologists.

The service had one vacancy due to staff development and opportunities for moving to new modalities. Managers told us this meant there were always continuous vacancies in diagnostic imaging that could take several months to fill. Apart from this there was generally low turnover trust-wide and low sickness rates. Two staff had volunteered to work on rotation from Scunthorpe General Hospital until the vacancy was filled.

The service had low rates of bank staff. Some senior staff had left and returned as bank staff.

Managers made sure all bank staff had a full induction and understood the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience. Managers reviewed the skill mix and were able to keep patients safe from avoidable harm and to provide the right care and treatment.

Diagnostic imaging

There were six consultant radiologists based between Scunthorpe General Hospital and Goole and District Hospital, but medical staff did not match the planned number. Although there was a shortage of radiologists, the service had enough medical staff to keep patients safe. Radiologists reported specialist x-rays including all head and neck images and examinations of babies. Reporting radiographers reported all other plain film x-rays.

All radiologists and some reporting radiographers were able to access images from home and report them remotely. Home reporting stations had been set up during Covid-19 restrictions so that staff could continue to work when they could not access the department. Two radiologists continued to work from home permanently and some on-call work was completed remotely.

The service had high vacancy rates for medical staff. The trust had recently appointed three new radiologists, but medical staff told us there was a 50% vacancy rate for radiologists in the Trust.

The service had low turnover and sickness rates for medical staff.

The service used no locum staff and there were no specialist radiology trainees.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient referrals, reports and images were stored electronically and all staff could access them easily at any time and from any location.

When patients transferred to a new team or department, there were no delays in staff accessing their records. The record system was accessible and reliable, and images could be viewed and reported on remotely by all registered clinicians.

Records were stored securely. Staff accessed records using their own login and password.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff were confident to raise concerns and reported incidents and near misses in line with trust policy.

The service had no never events.

Staff reported all incidents of repeated or excessive radiation dose to the RPA who advised if any reached a notifiable dose and no incidents required Ionising Radiation (Medical) Regulation (IR(Me)R) notification.

Diagnostic imaging

Managers shared learning with their staff about incidents and never events that happened elsewhere. Staff attended Yorkshire network meetings and discussed learning from incidents across the region.

Staff reported serious incidents clearly and in line with trust policy. There had been four incidents for radiology throughout the trust that had been escalated to determine if they met the criteria of a serious incident. Three were declared as serious incidents. The other, although determined as not meeting the SI criteria, required an appropriate level of local investigation to identify learning and key actions. Staff involved had completed investigations, action plans, and reflection exercises with learning identified for the future.

Following serious incidents, a lead individual was nominated to investigate, and a panel assigned. Diagnostic imaging staff met with specialty doctors to complete the investigation and write up the findings within agreed timeframes. An extension had been requested following the most recent incident due to its complexity and number of departments involved.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers and staff told us Duty of Candour had been followed for all serious incidents.

There was evidence that changes had been made as a result of feedback. Following previous incidents where images had been taken of the wrong side of the body, staff had displayed posters in patient areas to encourage people to challenge staff if they felt the wrong area was being x-rayed.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Staff told us about an incident at Scunthorpe General Hospital where a patient received the wrong examination using a mobile x-ray machine. The radiographer had gone to the ward to carry out the exam and learned afterwards there had been two inpatients who both required a mobile x-ray. Learning from this incident meant all radiographers telephoned the department to check patient details before carrying out any mobile exams.

Radiologists and reporting radiographers attended monthly discrepancy meetings where findings were discussed, actions agreed, and learning was shared. Reporting radiographers liaised with staff regarding poor image quality, identified trends, and led workshops on making improvements.

Managers investigated incidents thoroughly.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Inspected but not rated

We do not rate effective in diagnostic imaging, however we found:

Diagnostic imaging

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured updates to clinical practice.

The departments were adhering to local policies and procedures.

Staff were following procedures regarding National Institute for Health and Care Excellence guidance to prevent contrast induced acute kidney injury and completed evidence-based documentation before, during and after interventional procedures which included NEWS (national early warning system) assessments.

We saw reviews against IR(ME)R and learning shared to staff through team meetings and training. The trust had a radiation safety policy, which met 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.

Radiation protection supervisors (RPS) for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(Me)R. One radiographer had recently completed RPS training and was receiving support from the manager until they felt fully competent.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The trust provided water fountains for patients' use and there was a shop where people could purchase drinks and snacks.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. A radiographer had carried out an audit of primary markers, where radiographers attach a marker before an image is taken to show which side of the patient is left and right. All images had digital markers but results of a previous audit completed at Scunthorpe General Hospital in January 2022 had shown only 21% of images had primary markers. This was a poor result and was shared with all staff through team brief and emails. Results of the second audit at Goole and District Hospital had shown a marked improvement in compliance and results were shared with staff at all trust sites.

The Radiology department was part of all major pathways in the hospital. Examples included the minor injuries pathway and the stroke pathway which staff helped develop through involvement of specialist staff across trust sites.

Diagnostic imaging

Outcomes for patients were positive, consistent and met expectations, such as national standards. Image quality audits were completed monthly and IR(Me)R procedures were audited bi-monthly with a yearly report and results were consistently good.

Managers and staff used the results to improve patients' outcomes. An audit completed at Scunthorpe General Hospital resulted in the implementation of a coloured flag system for the picture archive communication system (PACS) where a draft policy had been compiled for all reporters. This policy was undergoing governance checks prior to full implementation. Staff reported this was part of learning identified through the patient pathway and would include checks to be carried out by all reporters and for all examinations.

Managers and staff carried out audits to check improvement over time. Consultant radiologists and reporting radiographers attended discrepancy meetings, undertook quality checks, and double reported (an independent report was carried out by a second member of the team) 20% of images in line with the departmental discrepancy policy.

Staff carried out quality assurance of home equipment using light meters.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All new staff followed the trust competency framework where staff must perform a number of observed procedures to gain competency in that particular area. Designated supervisors approved and signed off the competency framework. Radiographers and sonographers told us the department supported them to complete competencies.

The service was committed to developing the skills, knowledge and competence of its students, staff and managers. Students enjoyed their placements and took up permanent posts once trained. All staff were able to make use of opportunities to learn, develop, and share good practice.

Managers gave all new staff a full induction tailored to their role before they started work.

Newly qualified staff told us the department had offered them a good level of competency training.

The service was committed to develop its students, staff and managers through their skills, knowledge, and competence. Students enjoyed their placements and took up permanent posts once trained. All staff were able to make use of opportunities to learn, develop, and share good practice. Staff were recruited following completion of university courses as assistant practitioners and then, once qualified, they progressed to radiographer posts. Staff were also recruited from overseas and several staff said they were very happy to work at the Trust. Managers reported staff tended to stay with the Trust but moved to different modalities as part of their development.

Managers supported staff to develop through yearly, constructive appraisals of their work. The performance and development review compliance rate for the previous 12 months was calculated as a joint rate for Scunthorpe and Goole staff at 89%. The trust target was 95% and managers said those staff who had not yet had a PDR had one booked. The trust carried out medical revalidation for all consultants.

All staff had completed performance and development reviews. The trust carried out medical revalidation for all consultants.

Diagnostic imaging

The service provided specialist information and guidance in radiology on areas such as radiation protection and education for referrers. Radiation protection supervisors received training from the RPA.

Radiographers followed the trust competency framework where staff must perform a number of observed procedures to gain competency in that particular area. Designated supervisors approved and signed off the competency framework. Radiographers told us the department supported them to complete competencies. Radiography students told us the department had offered them good opportunities to achieve the required learning for their placement.

Consultant radiologists had annual appraisals with a named appraiser.

The education lead supported the learning and development needs of staff and managers made sure staff received any specialist training for their role. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had a good relationship with Health Education England and had secured funding for professional development of AHP staff. Managers encouraged staff to take advantage of this opportunity to undertake postgraduate training certificates, ultrasound scanning training, reporting radiographer training and to attend conferences and present any learning to peers.

Managers identified poor staff performance promptly and supported staff to improve. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The service had created some Band 6 posts to enable staff to progress and take on additional responsibilities.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There was a staff meeting once a month which was minuted and notes shared with all staff. Staff attended daily huddles prior to the main morning shift where they discussed plans for the day ahead and shared any concerns or incidents throughout the week. At the end of each week managers provided a summary via email to all staff and a printed version for staff noticeboards in each department.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Medical staff could contact a duty Radiologist any time to discuss issues and to provide support to other doctors and staff throughout the trust.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Reporting radiographers attended specialty MDTs for chest and abdominal imaging as well as local trust MDTs.

Patients could see all the health professionals involved in their care at one-stop clinics.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

The hospital provided a service for minor injuries, inpatients, and outpatients and five days a week from 8.30 am to 5pm and 10 am to 12 noon at weekends for minor injuries and inpatients. They provided x-ray imaging, portable images and ultrasound. Staff also provided radiology services to GP patients from Monday to Friday.

Diagnostic imaging

Staff could find all patient information such as diagnostic imaging records and reports, other diagnostic tests, medical records and referral letters through electronic records. Diagnostic imaging departments used picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff used systems to check outstanding reports and staff could prioritise reporting and meet internal and regulator standards.

The diagnostic imaging department kept an electronic list of approved referrers and practitioners and senior staff vetted internal and external staff against the protocol for the type of requests they were authorised to make.

There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent but did not always record it. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal consent from patients for care and treatment in line with legislation and guidance. Diagnostic imaging, and medical staff understood their roles and responsibilities and knew how to obtain consent from patients. They could describe to us the various ways they would do so. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain x-rays. In some general cases this was inferred consent.

However, staff did not always adhere to the Trust Consent Policy. Staff did not always clearly record consent in the patients' records. Staff and managers told us consent was always taken, and documents showed consent was recorded. However, staff told us they did not always record consent even when intimate procedures were carried out. Trust policy stated: "For significant procedures, it is essential for health professionals to document clearly … in the patient's notes that they have given verbal consent." Staff recognised the need to audit this as they had not realised it was being done inconsistently.

Staff made sure patients consented to treatment based on all the information available. Patients told us that staff were good at explaining what was happening to them before asking for consent to carry out procedures or examinations.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Diagnostic imaging

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patients and relatives said the service had “excellent, caring staff” and staff were “professional, caring and explained the procedure”.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff interactions with patients in all areas we inspected were polite, courteous, and respectful. We heard staff introducing themselves when dealing with patients and relatives. Staff greeted patients in a kind and friendly manner. We spoke with four patients and two relatives and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.

Reception staff respected patient privacy when they were checking personal details on arrival for their appointments, although glass screens to protect people from infection sometimes made this more difficult.

Staff respected patients’ privacy, dignity, and confidentiality at all times.

Staff organised imaging times to ensure patients did not have to wait unnecessarily and there were no queues of inpatients waiting for imaging or to return to the wards.

Staff collected patients from waiting areas and took them to private changing facilities.

Patients told us, and we saw without exception that staff treated them kindly, and in a consistently caring and compassionate way.

Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

Diagnostic imaging

Staff at all levels helped and supported patients in all aspects of care. Staff reacted compassionately to, or pre-empted, patient discomfort or distress by using appropriate communication methods to suit individual needs. We spoke with two children and their parents who had sustained minor injuries and both told us they had a good experience. One said “it was easy”.

Patients and their relatives told us staff had treated them with dignity and respect and overall, they were happy with the service provided. They also told us that the staff were, caring, and friendly but professional. Staff confirmed that patients would have a chaperone made available when intimate examinations were performed or at any time on their request.

An action plan to improve communication with patients was created to address changes to practice across all sites at the Trust following a general patient satisfaction survey carried out in general radiology at Diana, Princess of Wales Hospital in December 2021. Results had shown 10% of patients said staff had not introduced themselves and about 8% said they were not told how they would receive their test results. All recommendations were met within the agreed timescale. Staff followed the “hello, my name is” campaign and were reminded of the importance of letting the patient know how they will be informed of their results.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff could support patients suffering from anxiety.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We observed staff providing care before, during, and after procedures and showing consideration to patient’s emotions, allowing them time to ask questions or comply with requests. Staff were aware some positioning could be uncomfortable and allowed patients to be independent or made adjustments where possible.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Staff in x-ray informed us that they spent whatever time necessary to ensure that the patient understood and consented to the procedure. Staff also confirmed that should they have any concerns about a patient who did not fully understand what their care entailed then they could delay or cancel the procedure to suit the patient.

Staff made sure patients and those close to them understood their care and treatment. Staff made sure that people understood any information given to them before they left the departments.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff used a simple picture board so patients who were unable to communicate through speech could convey their feelings.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were patient suggestion boxes in waiting areas which staff checked regularly.

Diagnostic imaging

Patients gave positive feedback about the service. There was a blackboard in the patient changing area for patients to write comments on their care. We saw comments including: “thank you for your kindness and care”.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

The departments were accessible for people with limited mobility and people who used a wheelchair.

Diagnostic imaging reporting and record keeping was electronic and the department used paperless methods to reduce time and administration.

Managers monitored all targets and reported to the trust board through their overall performance reports.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. There were sufficient facilities to meet the needs of inpatients rooms large enough to wheelchairs and staff accompanied patients from wards.

Managers monitored and took action to minimise missed appointments. Staff respected inpatient mealtimes and, where possible, organised inpatient imaging to avoid them.

Managers ensured that families of children or vulnerable patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. Reporting radiographers checked suspected fractures straight away and provided results back to the minor injuries department to ensure efficient patient care or discharge.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Diagnostic imaging

The main waiting area had sufficient seating and a small area with children's toys which were clean and well maintained. Patients attending the department had access to drinks and snack facilities, and a shop. The department was well signposted.

Patient toilets (including disabled facilities and baby changing) were easily accessible.

The department was designed to meet the needs of patients living with dementia. Referrers informed departments in advance of patients with special needs attending for procedures and reception staff informed radiographers if patients attending had any additional needs. Staff could offer flexibility in terms of appointment times if a patient had a particular need, such as a learning difficulty or dementia, where waiting in a busy waiting area could be distressing. Staff confirmed that priority was generally given to people with additional needs.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The reception staff organised interpreter services for patients who did not speak or understand English. Staff told us they did not have trouble in booking interpreters.

The service had information leaflets available in languages spoken by the patients and local community. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Bookings staff provided leaflets to patients with their appointment information. If referrers provided information on the language required or any specific patient needs, leaflets would be printed accordingly.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Referral to treatment (RTT) rates were measured against national targets for all patients on cancer pathways, two week waits, urgent and planned care, and routine images. Referral to imaging times were better than regional averages and continued to show an improving trend for patients waiting for a diagnostic test. The trust compliance rate for reporting times was 98.6% of all images reported on time in line with trust policy. This was better than regional and national standards. All referrals were triaged by radiographers and the service used monitoring, oversight and escalation processes with time-based triggers to identify and prevent delays.

GP patients we spoke with had waited a maximum of three days from their GP appointment to their x-ray or ultrasound scan.

All patients who attended from minor injuries or for urgent referrals from clinics had images completed the same day. If radiographers identified suspicious findings on chest x-rays they were able to share the image immediately with a reporting radiographer or radiologist to generate a report or make an instant referral for CT.

Managers worked to keep the number of cancelled examinations to a minimum. When patients had their examinations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. A booking team worked with patients and referrers to ensure appointments met local and national timeframes. Appointments were managed according to priority such as unplanned care, urgent and routine.

Diagnostic imaging

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff told us there were no formal written complaints direct to the service in the 12 months prior to our inspection. However, staff contributed to complaint responses regarding specialty care for any parts that were relevant to diagnostic imaging. Staff had carried out a telephone conversation to better understand their needs and concerns regarding a long complaint where diagnostic imaging was a component of the patient journey. An appointment had to be changed to a week later than originally planned because the patient required a specialist treatment that involved additional staff. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leaders had the skills and abilities to run the service. They understood and managed most of the priorities and issues the service faced. However, senior managers lacked clear oversight of some governance processes. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There had been recent changes in divisional leadership and diagnostic imaging had recently been included within the division of surgery and critical care. Senior leaders were aware of and supported teams to improve regarding high-level performance of the departments including national targets.

There were new, interim managers in each department whilst colleagues undertook secondment opportunities or other leave.

Staff described managers as being accessible and approachable. Although new divisional leaders were relatively new to the service, staff knew who they were and how to contact them should the need arise.

Diagnostic imaging

Interim managers performed well, provided clear leadership, and were highly valued by staff. Staff raised concerns during the inspection that the opportunities for learning and sharing these experiences had gained could be lost at the end of the secondments.

However, managers for ultrasound were not aware that although verbal consent was gained it was not always recorded.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

A five-year trust radiology strategy had been launched in 2019 which was relevant to diagnostic and interventional radiology at all sites within the Trust. The strategy described patient centred care as being the bedrock with a system wide approach to service delivery and providing efficient care. There were clear objectives and priorities with benchmarking against national quality standards. Partnership working with other local providers was identified as an opportunity for future working.

Managers were aware of challenges and risks to providing an improved service and had identified and implemented changes to meet some priorities and planned outcomes early which included investment in additional equipment including MRI and CT scanners at Diana, Princess of Wales Hospital and Scunthorpe General Hospital. An independent health provider staffed and managed mobile CT and MRI scanners at Goole and District Hospital.

Radiologists supported the strategy and, although the team was pressured and short of staff due to a shortage of radiologists, they had been able to make some recent appointments and make improvements to rotas to support emergency access to care, timely discharges, and significantly reduce reporting times.

The department reported good relationships with clinical commissioning groups (CCGs) who had allocated funding for provision of independent healthcare to support patient access and the reduction of waiting lists.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were proud to work at the trust and within their departments. Staff, from students to senior staff were loyal to the trust and chose to develop and progress within the service and across modalities. Staff reported an improvement in culture between all levels and disciplines of staff since the last inspection. Staff told us that working relationships were professional and friendly. One member of staff said working within the department “often felt like being with friends and family rather than working with colleagues”.

Staff supported each other and would often work extra hours to support colleagues and enable patients to receive the best service. All staff we spoke with said they felt able to raise any concerns to colleagues or managers and were aware of how to contact the Freedom to Speak up Guardian.

Diagnostic imaging

Managers described how they supported serious incident investigations with specialty colleagues and followed Duty of Candour where appropriate. We saw examples of letters provided to patients regarding incidents that included openness and honesty.

Staff explained managers and the Trust had supported them during difficulties and in particular during COVID-19 additional pressures.

Equality and diversity were clearly promoted to patients, students, and staff throughout the service. There were no barriers to progression or development and staff were proud of their diverse recruitment and development experiences. Qualified staff recruited from overseas were supported to complete competencies to enable them to work independently and progress or specialise throughout the service.

Governance

Leaders operated effective governance processes for most requirements throughout the service and with partner organisations. However, there was a lack of oversight regarding quality and safety checks and the consent process. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At the time of the inspection diagnostic imaging was managed by a new directorate; surgery and critical care. However, staff explained governance was still managed via the directorate of clinical sciences.

Managers, heads of departments, and deputies attended monthly governance meetings and submitted monthly activity figures along with data on sickness, vacancies, training and development, finance and waiting times. The head of governance attended and the regular agenda included serious incidents, new policies and regular reviews, audits and opportunities for learning. Deputies shadowed department leads to review serious incidents and gain experience of root cause analysis (RCA) investigations.

Staff carried out governance responsibilities and completed effective audits to ensure they were carried out correctly and consistently. However, there was a lack of clear oversight regarding diagnostic reference levels (DRLs) for items of radiological equipment and protocols and managers in ultrasound did not have clear oversight to ensure quality assurance checks were being completed according to national guidelines.

There was no clear oversight of documentation reflecting the consent process. Staff did not always follow the Trust consent policy completely by documenting consent had been taken, but managers and senior managers were unaware this was happening. Records were not effectively audited to identify issues regarding documentation of consent.

Senior managers told us they would need to make changes to the agenda of the weekly management meeting to ensure crosschecking was carried out in future. They believed the business meetings and governance structure could also help pick up non-compliance.

There were radiation protection committee meetings attended by the RPA, RPS for each modality, senior managers, and the trust medical physics expert. Minutes from the meeting in March 2022 included equipment faults and checks, radiation incidents, none of which required IR(Me)R reporting, audit results and actions, new non-medical referrers, risk assessments and staff competency records.

Diagnostic imaging

Managers, heads of departments, and deputies attended monthly governance meetings and submitted monthly activity figures along with data on sickness, vacancies, training and development, finance and waiting times. The head of governance attended, and the regular agenda included serious incidents, new policies and regular reviews, audits and opportunities for learning.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk register identified risks which were categorised according to potential impact. These were mainly regarding staffing, ageing equipment, and capacity and demand. Risks from individual department managers were included in the directorate risk register. The register showed actions taken and any remaining gaps were identified with dates for review. There were plans in place for equipment failure.

Staff managed performance effectively and had achieved better than regional average referral to imaging times. There was an improving trend for patients waiting for diagnostic tests with a reduction of the waiting list for non-urgent ultrasound from12 weeks to 7 weeks over a period of two months. Staff monitored performance against key performance indicators (KPI) and took action to avoid breaches before they occurred such as provision of additional scanning sessions, and an independent healthcare contract for CT imaging.

Staff described good IT support and no recent breakdowns or failures in the picture archiving and communications system (PACS). Images were available at all times to all relevant professionals.

Service leads and managers worked together to provide information to the executive performance meeting. They monitored performance and provided information to the directorate leads, along with identified risks and issues for escalation. Service leads reported a good level of support in planning for the future including finance and workforce planning.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff could find all patient information such as diagnostic imaging records including previous images, and reports, medical records and referral letters through electronic records.

All staff had access to the trust intranet to gain information on policies, procedures, National Institute for Health and Care Excellence guidance, and e-learning.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust and its staff were part of the Yorkshire Imaging Collaborative, a partnership of nine local trusts who met monthly to benchmark performance and share learning and good practice.

Diagnostic imaging

Radiographer ambassador meetings had been established monthly via Teams calls and staff explained these enabled radiographers to have a voice regarding departmental matters. Staff said they could discuss their opinions on staffing, morale, and ideas for improvements to patient care. Staff reported this helped them feel they were listened to but also that changes often took a long time to action.

Staff satisfaction surveys and "innovation stations" had been implemented throughout diagnostic imaging departments and were in very early stages. However, staff were aware of them and had engaged positively with them. Staff said they used them to share ideas.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff explained suggestions for service improvements came from radiographers who see the needs of patients first-hand and who want to become better radiographers. Staff took ownership of projects and ideas for change and felt self-motivated and empowered to implement change within their service.

Staff felt proud of how they had worked throughout the COVID-19 pandemic and supported each other.

There had been a marked improvement in actions to address the backlogs for waiting times and reporting times. These had reduced significantly since the previous inspection and, at the time of the inspection, the trust performance was better than the regional average. The Trust consistently and continuously explored opportunities and initiatives to improve their reporting capacity.

Scunthorpe General Hospital

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Description of this hospital

Scunthorpe General Hospital (SGH) is one of the three hospital sites for Northern Lincolnshire and Goole NHS Foundation Trust. It is located in Scunthorpe and provides acute hospital services to the local population.

SGH is the trust's second largest hospital. It offers a range of inpatient and outpatient services including urgent and emergency care, medical care, surgery, critical care, maternity, end of life and outpatients and diagnostic services for children, young people and adults primarily in the North Lincolnshire area.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff; however not all staff had completed it in line with trust guidance.

The trust set a target of 85% for completion of core mandatory training.

Not all nursing and medical staff had completed their mandatory training. The trust sent evidence to support training compliance within the medicine division for nursing and medical training. Mandatory training for nursing staff showed a compliance rate of 79.42%. Mandatory training for medical staff showed a compliance rate of 63.20%.

At the last inspection we told the trust they must ensure mandatory training compliance met the trust target. At this inspection both nursing and medical staff did not meet the trust target range.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. We reviewed the trust action plan to address concerns raised following the last inspection regarding training compliance. A number of training modules had been transferred to online learning to allow greater access for staff. Training was monitored divisionally and discussed at monthly divisional performance review meetings.

Workforce development plans were being developed for each speciality within medicine supported by senior leaders from human resource business partners (HRBP) down to clinical leads to ensure a clear downward message to achieve engagement and compliance.

Managers told us difficulties that had impacted on compliance included, high patient acuity, staff sickness, staff isolation due to COVID 19 and operational pressures. The trust had reported several episodes of Operations Pressure Escalation Levels (Opel) level four where the trust had increased operational demand due to pressures. This impacted on staff training which had to be cancelled. Opel level is a method used by the National Health Service to measure the stress, demand and pressure a hospital is under, with Opel 4 representing a high escalation level. Opel 4 is declared when a hospital is “unable to deliver comprehensive care” and patient safety is at risk.

Mandatory training was on the risk register, the division had developed a task team. The human resource business partner was working closely with the head of nursing to improve staff compliance. The division had plans in place to provide trainee doctors access to the training platform in advance to commencing employment with the trust. Rotation of doctors had impacted on the data.

Managers were focused on training which carried the most risk, where compliance was below target range. Senior leaders met weekly to review training compliance with a rotating agenda.

Train the trainer models had commenced for moving and handling and resuscitation training to address low compliance.

Due to staffing pressures, staff across wards could have time allocated (one day) on the rota to complete online training outside of their clinical shifts. This was included in their working hours and supported flexible learning.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it; however not all staff had completed the training in line with trust guidance.

Nursing and medical staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

At the last inspection we told the trust they must ensure safeguard training compliance met the trust target. At this inspection we saw nursing and medical staff received training specific for their role on how to recognise and report abuse; however, the trust target of 85% was not met for all safeguarding training modules. Safeguarding adults' level two training was below the trust target at 81.22%, and safeguarding children level two was 84.24%. There were plans in place to improve training compliance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff discussed safeguarding risks during patient handovers and staff huddles.

Staff demonstrated awareness and understanding of safeguarding. Most staff knew how to make a safeguarding referral and who to inform if they had concerns. Some staff on ward 23 were unaware who the safeguarding lead was within the hospital.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Medical care (including older people's care)

The service generally performed well for cleanliness.

The patient led audit of the care environment (PLACE) audit had not re-started since the suspension because of the COVID 19 pandemic. The formal PLACE audit was planned to re commence in 2023.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning staff were able to articulate the differing cleaning solutions used in line with guidance.

There were adequate supplies of hand gel and PPE in all areas we visited but we did not see prompts at some ward entrances to remind or encourage staff and visitors of hand hygiene. This put staff and patients at risk of potential harm from cross infection.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Differing staff at all levels did not always wear face masks correctly in clinical areas in line with trust and national guidance. All clinical staff were bare below the elbow to enable effective cleaning of their hands.

Patients deemed to be a high risk due to exposure of infectious disease or potential to infectious transmission were isolated (barrier nursed) appropriately.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw a number of examples where domestic staff and nursing staff had cleaned equipment and clinical areas.

There were designated isolation side rooms for patients with COVID-19 symptoms or who were known to be COVID-19 positive. Staff knew which side rooms were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy.

Wards we visited reported low or no cases of clostridium difficile (C. diff) and methicillin resistant staphylococcus aureus (MRSA). Staff described how they worked with the trust's infection prevention control team on a programme of quality improvement at ward level.

We reviewed the trusts infection rates from June 2021 to May 2022. The trust provided trust wide figures within this timeframe which evidenced reported infection rates as MRSA bacteraemia 0.

We reviewed the trusts hand hygiene audit results which demonstrated compliance rates on individual wards for hand hygiene compliance. Individual wards are requested to complete 10 hand hygiene assessment audits per month. Trust level data (May 2022) demonstrated a compliance level of 95%.

The trust undertook audit for sepsis screening in line with the National Institute for Health and Care Excellence (NICE). Guidance for sepsis stipulates that patients presenting with one or more high risk criteria should receive antibiotics within an hour of it being identified.

Sepsis is a common condition where the body's immune system goes into overdrive in response to an infection. Septic shock is a subset of sepsis, which describes circulatory, cellular, and metabolic abnormalities which are associated with a greater risk of mortality than sepsis alone.

The most common sites of infection leading to sepsis are the respiratory, gastrointestinal, renal, and genitourinary tracts.

We reviewed the trusts training compliance figures for sepsis training (May 2022) which evidenced trust wide training compliance of 71% for nurse and medical staffing against a target rate of 85%. The compliance rate at site level demonstrated a compliance rate of 45.87%. Senior leaders told us operational system and staffing pressures impacted on the low compliance rate. The division was sighted on the need to improve training compliance.

Registered general nurses (RGN) and clinicians undertook sepsis training as an E-learning package. The training was mandatory, and renewal was required every four years. Healthcare assistants/ care navigators completed sepsis awareness using a work booklet.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well; however, did not always adhere to trust policy.

Staff did not always dispose of clinical waste safely. At ward entrances face masks and hand gel were readily available; however, we observed bins for face mask disposal had domestic waste bin liners and not clinical waste bin liners in line with trust guidance.

The door entrance to the acute stroke unit was not secure and was left open. We observed a dirty utility door was left open at the entrance to the integrated acute assessment unit and stroke assessment unit. The room contained clinical waste bins and soiled linen, clinical waste was stored on the top of clinical waste bins and on the floor. This was a risk as the storage of clinical waste and linen was not in line with trust policy.

Wards we visited had boards to display public information about the staff on the ward, visiting times, who was in charge, and other useful information, such as mandatory training compliance.

All equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers.

Managers assured us repairs were made promptly if a piece of equipment developed a fault. Medical devices we looked at were mostly labelled to indicate when they were last serviced or checked for electrical safety, and to identify next test dates.

Patients could reach call bells; however, some call bells were not answered immediately due to staffing and operational pressures.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. Emergency resuscitation equipment on each ward had daily and weekly checks completed in line with policy. We checked the resuscitation policy which had a named author, version control and review date in place. We saw that daily checks were recorded as being completed. We checked consumable items, such as medicines, gloves, oxygen masks and suction equipment.

Staff on most wards told us that they had enough equipment to support them to safely care for patients, for example for use when moving and handling or caring for bariatric patients. This included pressure-relieving aids.

Staff in endoscopy received training for specialist equipment from the manufacturers who came into the hospital when necessary. The endoscopy unit had Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards.

Sharps bins were properly assembled, stored off the floor, not over full and signed and dated. Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients' families. The oncology and haematology ward had pull out beds available for patient relatives if they required to stay overnight.

Assessing and responding to patient risk

Staff did not consistently assess and manage risks to patients. However, staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients (NEWS2). This helped staff to identify and escalate deterioration in a patient's condition. The NEWS2 alert system was embedded into practice with individual electronic ward boards providing oversight of the clinical area.

Patient risk assessments were completed on admission, where appropriate, for falls, nutrition and hydration, pressure area care, dementia and moving and handling. We saw evidence that these risk assessments were used to plan individualised care for each patient and relevant pathways were initiated when required.

The avoiding falls level of observation assessment tool (AFLOAT) pathway included regular observations, physiotherapy assessment and physiological tests such as lying and standing blood pressure monitoring. Staff assessed how often a patient would need to be observed to avoid potential falls during their stay in hospital. The tool has four 'levels' of varying degrees of intensity: two hourly (least intense), hourly, line of sight and arms reach (most intense). An icon on the electronic patient system was used to identify patients at risk of falls.

Other falls prevention measures included low level beds, pressure pads, sensor clips, identification on boards in bays using coloured magnets, non-slip socks and coloured wristbands for patients. Availability of some items varied between areas and staff told us they often applied to a charity for funding for new equipment for example sensor alarms and clips. Some patients required one to one observation but, due to staffing pressures, this was not always possible. Staff told us they would try to cohort patients at risk in the same bay.

At the last inspection the trust received a must do action to continue to monitor registered nurse establishment on the hyper acute stroke unit (HASU) to ensure adherence to best practice in line with national guidance recommendations of one nurse to two patients.

The hyper acute stroke unit (HASU) was located on the stroke rehabilitation unit. On the day of inspection nurse staffing did not meet planned verses actual with one RGN down on the day shift. The enhanced care bay on this unit provided two registered general nurses (RGNs) and one healthcare assistant (HCA) to six patients.

The unit had six patients (level 1) on the day of inspection. The unit was staffed with two registered nurses (RGN) and one healthcare assistant (HCA) band 2. One of the registered nurses was a junior nurse and the other was an agency nurse.

This did not meet recommended staffing requirements for level 2 patients according to the National Institute for Health and Care Excellence (NICE) guidelines (NG128, May 2019). The guidelines recommend one RGN to two patient ratio within the first 72 hours following diagnosis of haemorrhagic stroke.

Thrombolysis was carried out in a dedicated unit which was separate to the HASU main stroke unit. The unit had direct access for patients 24 hours a day 7 days a week with access to dedicated neurological imaging services during this time. Patients were then transferred to the HASU unit on the stroke ward for ongoing monitoring when beds became available.

Staffing shortages on the main stroke unit had been escalated to the senior team; however, no cover was available to support the gap. Staff told us that the unit had five registered nurse vacancies and staffing did not meet establishment with planned verses actual staffing was often not met. Staffing establishment on the unit was expected to cover the stroke assessment unit for breaks and cover when the stroke responder nurse was required in UEC.

The division had instigated a dedicated stroke assessment unit which was separate to the HASU unit. Staff told us that the unit had been open since October 2021. The division had a stroke assessment pathway which demonstrated access and flow for patients admitted into UEC with transfer to the acute assessment unit. We saw evidence of the divisions dedicated stroke assessment relocation action plan. The plan included the staffing of the unit highlighting one RGN and one HCA 24 hours a day 7 days a week.

The unit had three beds and one reclining chair for patients admitted with stroke requiring thrombolysis treatment and ongoing care. On the day of inspection, the unit had four patients (level one). The unit was staffed with one stroke responder nurse & one HCA (band 2). This did not meet recommended staffing requirements for level two patients according to the National Institute for Health and Care Excellence (NICE) guidelines (NG128, May 2019).

The stroke responder nurse was required to attend UEC if medics required assistance with thrombolysis treatment within the department. Staff on duty on the day of inspection told us they escalated with senior managers to request additional cover if required; however, this was not always met due to operational pressures. Cover for breaks was provided by the stroke unit, staff told us cover was often not met due to staffing challenges on the stroke unit itself.

Second checks for prescribed medications ie, pain medications, controlled drugs, thrombolysis etc had to be completed by doctors to ensure adherence to trust policy. Staff told us this was challenging at peak times due to the availability of medics on the unit.

Staffing shortfalls were reported and escalated through a red flag report using the safecare electronic system. The stroke unit had reported four red flag incidents in May/June 2022 highlighting nurse staffing did not meet planned on the main stroke unit. This was a risk as the main stroke unit staffing numbers were expected to cover the assessment unit to cover breaks or when the stroke responder was required in UEC.

We raised concerns with the trust on the day of inspection. The trust provided data post inspection to support the decisions regarding the management and senior oversight of the unit. Actions were put in place to mitigate the risk. For example;

- Break and escalation cover had been added to the daily allocation of staff list kept on the stroke unit. This identified the person responsible for cover and had been communicated to staff.

- The need for clear communication between the stroke assessment unit (SAU) and stroke unit shift lead had been reinforced with the teams to ensure support, when required, was available promptly.
- The stop and check process had been introduced into the SAU to support review and escalation.
- Increased awareness of patients awaiting transfer to beds, this was now recorded in the operations centre and a decision to admit time was logged in the SAU diary.
- Staff had been requested to incident report delayed transfers.
- Recruitment of registered nurses and healthcare staff was ongoing to meet vacancy gaps

The trust undertook audit for sepsis screening in line with the National Institute for Health and Care Excellence (NICE). NICE guidance for sepsis stipulates that patients presenting with one or more high risk criteria should receive antibiotics within an hour of it being identified.

Sepsis is a common condition where the body's immune system goes into overdrive in response to an infection. Septic shock is a subset of sepsis, which describes circulatory, cellular, and metabolic abnormalities which are associated with a greater risk of mortality than sepsis alone.

The most common sites of infection leading to sepsis are the respiratory, gastrointestinal, renal, and genitourinary tracts.

Mandatory training on sepsis had been introduced. Sepsis formed part of the acute life-threatening events recognition and treatment (ALERT) course training for nursing staff. This had changed in February 2018 and incorporated a formal competency assessment with staff having to achieve a certain level to pass the course. The trust provided evidence of staff compliance at trust level for deteriorating patient training which demonstrated a compliance rate of 52%. Site level training compliance evidenced nursing and medical staff compliance of 57.27% against a trust target of 85%.

Senior leaders told us face to face training had been impacted due to the COVID pandemic. Additional courses had been planned for 2023.

We reviewed the trust wide training compliance figures for sepsis training (May 2022) which evidenced trust wide training compliance of 71% for nursing and medical staffing against a target rate of 85%. The compliance rate at site level demonstrated a compliance rate of 45.87%. Senior leaders told us operational system and staffing pressures impacted on the low compliance rate. The division was sighted on the need to improve training compliance.

Registered nurses and clinicians undertook sepsis training as an E-learning package. The training was mandatory, and renewal is required every four years. Healthcare assistants/ care navigators completed sepsis awareness using a work booklet.

Staff knew about and dealt with any specific risk issues.

Data at site level from the falls and pressure ulcer dashboard showed monthly data from June 2020 to May 2022. The data evidenced 14 hospital acquired pressure ulcers (grade 2) were reported in May 2022 with an additional three hospital acquired pressure ulcers (grade 3). The division had reported 36 patient falls with no harm and 12 with minor harm in May 2022.

Recording of physiological observations was audited and reported as part of the nursing audit dashboard. Site level data for April 2022 demonstrated a compliance rate of 89.7%. The trust target rate was 85%.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff could make referral requests on the IT platform or paper and also had the option to request over the telephone.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. We reviewed the hand over sheets on all wards we inspected. We observed that key risks were discussed, and information disseminated to reduce risks. Staff told us that individual wards instigated safety huddles as part of the daily handover process where patient risks were discussed including: staffing, number of patients, risk of falls, enhanced care patients, high NEWS, end of life, cannula care, pressure ulcers, infections, infection control and COVID 19 swab status and do not attempt cardiopulmonary resuscitation orders.

Staffing

Nurse staffing

It was recognised by senior management that the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift. However, this did not always provide established safe levels of staffing.

Due to national shortages of nursing and support staff and high levels of staff absence the service did not always have enough nursing and support staff to keep patients safe.

There were continuous advertisements for nursing and healthcare assistant vacancies. Managers of the service told us they had increased nurse staffing establishment to allow for absences and vacancies so they could provide continual safe care as much as possible. However, staff in the areas we inspected told us they were often short of qualified nursing staff. The trust undertakes yearly staffing reviews, 2021 review had received a number of challenges with regard funding; however, leaders told us funding had been approved and recruitment was underway. All wards inspected had completed establishment review data collection in May 2022.

During inspection five out of the nine wards we visited did not meet planned verses actual staffing numbers which included registered nurses and healthcare assistants. Ward leaders were not always supernumerary due to low staffing numbers. Ward managers told us they were allocated dedicated managerial hours; however, these hours were often used to work clinically due to staffing shortages and patients requiring enhanced care due to frailty.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior leaders told us they used the electronic

staff record (ESR) when redeploying clinical staff to other wards to assess skill and competency. Discussions with ward managers/matrons/bleep holders and risk assessments are completed, based on ward requirements and the staff competency and skill set. Leaders looked across the whole division and moved staff across site when needed based on skills available.

The ward manager could adjust staffing levels daily according to the needs of patients.

SafeCare live was used to support the deployment of staff on a daily basis to keep wards safe and mitigate or reduce risks, it takes into account acuity and dependency of patients and available staff.

SafeCare is a unique daily staffing software matching nursing staffing levels to patient acuity, in real time, allowing informed decision making on staffing levels across the hospital. It enabled visibility and tracking of staff attendance, recording of red flags and professional judgement. Staffing shortfalls were reported and escalated through a red flag report using the SafeCare electronic system.

A short-term nurse staffing standard operating procedure (SOP) was in place to support decision making requirements and responsibilities in and out of hours and actions to be taken when considering opening escalation beds. This included a risk assessment which required senior management approval.

A supportive care policy was in place to support identification of patients requiring a heightened level of support and care to ensure safety was maintained and to ensure staffing resources are appropriately allocated through a robust assessment and escalation process.

Divisional morning 'huddles' were instigated with the matron of the day attended by the ward shift leads to highlight concerns they may have in relation to dependency, acuity and staffing levels. This enabled an early response and support to be planned by the divisional senior nursing team.

Matrons ensured acuity and dependency levels had been updated on Safecare live and added mitigation, their professional judgement, and changed the risk/colour appropriately to reflect the staffing risk level following the actions taken.

SafeCare data was reviewed at the trust wide safe staffing meeting (attended by matrons and chaired by deputy or associate chief nurse) where deployment of staff and mutual aid across divisions was agreed. The meetings were also attended by a representative from the temporary staffing office to support timely actioning of requests and issues.

An overview of staffing risks and any potential operational implications that may require additional mutual support or system support was also shared at trust operational meetings held three times a day. Matrons and site duty managers (out of hours) liaised across divisions and sites to ensure all possible mitigating actions were taken.

The Safecare model was used by all wards and reviewed as part of staffing meetings. The trust had a clear escalation process for making staff moves and recorded this on the rostra to ensure oversight of staff moves.

The number of nurses and healthcare assistants did not always match the planned numbers.

At the last inspection we told the trust they must continue to monitor registered nurse establishment on the respiratory ward (ward 17) and the hyper acute stroke unit (HASU) to ensure adherence to best practice in line with national guidance recommendations of one nurse to two patients.

Medical care (including older people's care)

At this inspection we noted the nursing establishment on the respiratory ward had been reviewed following the last inspection where an increase in registered nurses had been recognised and approved. There were four dedicated beds on the respiratory ward to care for patients requiring non-invasive ventilation (NIV) care, staffing on the day of inspection was in line with best practice guidance. Staff told us nurse staffing was protected in this area to ensure adherence to trust policy and best guidance was maintained. The trust had instigated a further establishment review in May 2022, ward managers told us the data was under review with the senior team.

The division had a matron of the day role within medicine with responsibility for nurse staffing allocated on both sites across the trust.

Staffing levels for medical, nursing and allied health professional roles were discussed at trust wide operational meetings three times a day to understand gaps and mitigations in place.

We observed a bed meeting where matrons and senior staff discussed staffing and acuity across the wards on both hospital sites.

The trust provided vacancy, sickness and turnover rates at trust level from June 2021 to May 2022 for registered nurse.

Nursing staff vacancies in May 2022 showed a vacancy rate of 13.70% against a target rate of 8.00%.

Nursing staff turnover in May 2022 showed a turnover rate of 11.96%

Nursing staff sickness in April 2022 showed a sickness rate of 7.97%. In the last eight reporting months (August 2021 to March 2022), trust wide sickness rates for nursing and midwifery staff ranged between 6.5% and 6.8%, which was statistically similar to the sector averages.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe.

Medical staffing did not match the planned numbers; we found issues when talking to medical staff about day and out of hours cover, particularly overnight. At our last inspection we said the trust should ensure safe medical staffing levels were maintained and every effort should be made to recruit to vacancies.

At this inspection junior doctors at both sites said that there were vacant posts with no appointments and when they were on call especially at night and weekends there was always gaps in rotas. Junior doctors told us they received emails daily from the medical rota co coordinator asking juniors to agree to extra shifts.

The trust provided site level data to evidence the numbers of rota gaps in the medical rota from July 2021 to June 2022. Rota gaps were impacted due to vacancies, COVID, Isolation and other sickness. The data for June 2022 highlighted 213 rota gaps were covered by agency staff and 215 gaps were covered by internal bank staff.

Medical care (including older people's care)

Leaders told us short notice gaps are immediately added to the locum management system (LMS) and emailed out to all local clinicians to try and fill rota gaps. Gaps are also shared with the clinical lead and medical director at the daily rota meeting and escalated throughout the day until shifts are covered. This was reflective of what we saw on inspection.

Senior leaders told us there were consultant vacancy gaps in the gastroenterology service due to recent staff turnover. The division had advertised the posts and had covered the gaps with locums.

The division had recruited advanced clinical practitioners (ACP), two had been appointed at SGH. A business case was ongoing to cover funding to recruit 13 additional ACP's to work across both sites.

The guardian of safe working (GoSW) at the trust was managed by a consultant doctor. The guardian of safe working hours ensures issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.

We reviewed the guardian of safe working report (April 2022) which evidenced (January 2022 to March 2022) there had been a total of 89 exception reports submitted through the allocate exception report system. Exception reporting is a contractual mechanism which doctors in training can use to report patient safety, rostering and training concerns. This showed an increase of five exception reports from the last quarter (October 2021 to December 2021). Of the 89 exception reports submitted, 77 of these were linked to hours. This showed a decrease of 11 reports from the previous quarter. The exception reports relating to hours had been agreed by the GoSW for either payment or time off in lieu (TOIL).

From January 2022 to March 2022 there were two exception reports submitted where doctors raised an immediate safety concern in addition to either a concern around working hours or clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern.

Any exception report which flagged immediate safety concerns was investigated by the GoSW administration and progressed appropriately. The two safety concerns related to staffing. Both were from the same department. One concerned a lack of staffing at a junior level, and one concerned a lack of consultant cover. Both of these issues had been addressed and the situations resolved by the GoSW.

The trust provided vacancy, sickness and turnover rates at trust level from June 2021 to May 2022 for medical staff; however, this was not site specific

Medical staff vacancies in May 2022 showed a vacancy rate of 14.12% against a target rate of 15.00%.

Medical staff turnover in May 2022 showed a turnover rate of 9.38%.

Trust wide sickness rates for medical and dental staff have been consistently similar to the sector averages for the past 12 months. In the latest month, March 2022, sickness rates were 2.6%, compared to 1.7% sector average. Sickness rates for medical staff in April 2022 showed a sickness rate of 3.67%.

The division had dedicated rota coordinators in post to support medical staffing.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Records

Staff did not always keep detailed records of patient's care and treatment. Not all records were completed in line with trust policy or stored securely, however they were easily available to all staff providing care.

Staff used an electronic patient record supported by paper records for each patient. The trust had implemented a medical assessment document which was available on the IT platform. The trust had plans in place to trial a paperless record system.

Patient notes were mostly comprehensive, and staff could access them easily. We reviewed 10 full sets of patient notes and sections of patients records when looking at examples of care we had observed across the medical wards inspected. We saw gaps in recording in patient's records for example, ReSPECT forms were not always fully completed, some entries were not always signed and dated, and some entries did not have the consultant name documented.

We reviewed the trust wide audit of adult nursing documentation 2020/21. The audit highlighted areas of compliance on individual wards. Areas of low compliance were reviewed on the trust's records audit clinical action plan. Findings were reflective of what we found during inspection for example, entries not signed and dated and entries missing consultant name.

Information governance training for both nursing and medical staff showed a compliance rate of 82.83% which did not meet the trust target of 85%.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. At our last inspection we said the trust must ensure confidential records are stored securely in line with national guidance. At this inspection on wards we visited notes trollies were mostly left unlocked and unattended with patient notes stored underneath trollies, easily accessible to visitors. This was in breach of trust policy and General Data Protection Regulation (GDPR).

Individual patient paper records were stored in folders outside of each bay, or in folders not stored securely in the bay. We also saw a number of computers left unlocked allowing easy access into confidential patient records.

During inspection of all medical wards we observed confidential waste was stored in paper bags which were unsecured and within easy reach of patients and visitors. We observed confidential patient hand over documents for three consecutive days listing patient names, dates of birth, medical history and treatment plans on the stroke unit. This was highlighted as a concern at the last inspection.

We noted that version-controlled documents were reviewed in line with trust policy and national guidance. This was an improvement since the last inspection where we highlighted this as a should do action.

Electronic whiteboards were used on all wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Medical care (including older people's care)

Medicines

Staff followed some systems and processes to prescribe and administer medicines safely. However, we found clinical treatment rooms were not routinely monitored for room temperatures in line with best practice guidance and the process of checking patients' medicines was not audited in line with trust policy.

Staff followed systems and processes to prescribe and administer medicines safely. Electronic prescriptions reviewed on inspection all had allergy status records completed. We found oxygen being prescribed appropriately, where it was being administered to patients.

Staff reviewed some patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacists provided a targeted review of those patients on critical medicines as a priority; however, they were not always able to provide a review of each patient due to time constraints.

Staff completed medicines records accurately and kept most of them up to date. Electronic prescriptions reviewed on inspection all had administration records completed.

Registers for medicines that required extra checks were completed and stock audited regularly.

On ward 24 we found three patient prescriptions still recorded as being on the ward's electronic prescribing record. The three patients were no longer on the ward and had been either discharged or transferred. Staff were not aware of the records, one being in place for two months since discharge. We escalated this to the site matron on the day of inspection.

Staff stored and managed some medicines and prescribing documents safely.

Fridge temperatures were monitored centrally, and the system sent the ward personnel deviation warnings for them to action. Medicines requiring specific secure storage were managed appropriately and records of their administration maintained.

Emergency medicines were stored on resuscitation trolleys in accessible areas with regular checks on content and expiry dates an all wards inspected. Amendment of expiry dates on liquid medicines after opening was not completed routinely. This would be where manufacturers required specific change in expiry dates. This included furosemide, gabapentin and haloperidol.

We found the temperature at which medicines were being stored in two of the clinical utility rooms was not being monitored (stroke unit and ward 16). The clinical utility rooms were very warm and did not have ventilation, for example an opening window or air conditioning. The trust medicines code states that: In extreme weather conditions where very hot or very cold temperatures may affect the medicines, appropriate measures should be taken to protect the stability of the medicine.

The trust took immediate action by developing a room temperature policy to identify appropriate maximum / minimum temperatures within clinical treatment rooms. The policy was currently under development. Following approval and ratification room temperature thermometers were scheduled be installed. The policy/process included escalation should the temperature fall outside ranges and was scheduled to be audited with the safe and secure medicine audit. The plan was discussed and agreed with divisions at the operational management meeting.

Staff told us they followed national practice to check some patients had the correct medicines when they were admitted, or they moved between services. Pharmacy technicians and pharmacists told us they provided the medicine reconciliation service for patients. Pharmacist additionally, completing targeted reconciliation of specific patients.

Errors relating to medicines reconciliation are reported via the trust incident system and investigated and followed up with the pharmacy staff involved.

We reviewed the trusts medicine reconciliation policy (December 2020) which evidenced medicine reconciliation requires an audit to be performed and reviewed by the trust's safer medication group. National Institute for Health and Care Excellence, Quality Statement 120 (NICE QS) recommends checks to be completed within 24 hours of admission.

We received trust wide reconciliation audit data (Quarter 1 2022-2023) which evidenced in June 2022 medicines reconciliation compliance was 70%.

Senior leaders told us the trust target was to undertake medicines reconciliation within 24 hours of admission. This was not always possible. Medicines reconciliation was completed at the earliest opportunity when the pharmacy team reviewed the patient.

Audit data on completion rates was not currently available at the time of inspection. The trust provided a summary statement post inspection evidencing that medicines reconciliation was not audited currently.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they felt incidents were dealt with appropriately and that learning was taken from them.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Ward leaders could give some examples of recent incidents that had resulted in shared learning for the ward. Feedback and learning from incidents were cascaded to staff both individually and via team meetings. Staff could request to receive feedback via an email linked to the electronic reporting system.

Staff reported serious incidents clearly and in line with trust policy. From 01 May 2021 to 30 April 2022, in accordance with the Serious Incident Framework 2015, the trust reported 54 serious incidents (SIs) in medical care which met the reporting criteria set by NHS England. 72% of these were 'pressure ulcers' (39), 13% were 'slips, trips and falls' (seven) and 6% were 'treatment delay' (three).

Serious incidents were discussed at the weekly SI panel meeting. The governance team received incidents from the division and triangulated within 24 hours for incidents that are not reported as moderate/severe harm. Anything above were reviewed by the panel for transparency.

Medical care (including older people's care)

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Incident learning was shared on individual ward boards for openness and transparency.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour principles. They were open and transparent and gave patients and families a full explanation when things went wrong. Ward managers and most of the staff we spoke to knew of the Duty of Candour (DoC) requirements. They understood that this involved being open and honest with patients and had been involved in investigations and responding to patients and families.

Managers debriefed and supported staff after any serious incident.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Patient safety data was displayed on wards for staff and patients to see. The service continually monitored safety performance. All wards inspected had information to evidence the number of patient falls, pressure ulcers, NEWS audit compliance and hand hygiene audit results.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust's intranet, guidelines, policies, and procedures relevant to their role.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible evidence and in line with national guidance, for example, the acute ischaemic stroke thrombolysis integrated care pathway.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Teams had access to a psychiatric liaison team on site.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary; however, fluid balance and food charts were not consistently completed. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff did not always fully and accurately complete patient's fluid and nutrition charts where needed. We observed several fluid balance charts which were incomplete or had no information recorded. Ward managers and matrons completed weekly ward assurance (WAT) audits covering four aspects of care: quality, safety, environment, and patient experience. Audit results were reviewed, and action plans instigated on individual ward areas to address low compliance. We requested the divisions site level WAT audit data to evidence compliance rates.

The trust provided site level compliance from March 2022 to May 2022 which evidenced average compliance rates of 75.6% for the key question surrounding 'have fluid balance charts commenced as per patients needs and completed accurately'.

We observed some gaps in the recording of food charts. Site level compliance from March 2022 to May 2022 evidenced compliance rates of 86.1% for the key question surrounding 'have food charts been implemented for patients identified as a nutritional risk and completed accurately'. We reviewed the ward governance report (March 2022) on ward 22 which highlighted low compliance with regard the completion of fluid and food charts. We requested action plans to evidence actions taken to address low compliance; however, did not receive these at the time of writing this report

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and patients requiring this were frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff used a pain-scoring tool, from one to 10, to assess a patient's level of pain. All staff we spoke with knew about pain assessments and how to score patients level of pain.

Staff prescribed and administered pain relief. Pain relief was prescribed, and staff would request additional pain relief from medical staff, if required. Some staff told us that some pain medications were often given late due to medic requests for prescribing being delayed due to system pressures.

Patients we spoke with told us staff managed their pain in a timely way.

We asked the trust to provide pain management audits where they had checked the compliance score of pain management. We reviewed the trusts ward assurance tool data for May 2022. The trust provided site level compliance from March 2022 to May 2022 which evidenced 100% compliance for the key question surrounding pain management.

The trust had instigated an acute and end of life pain assessment audit in January 2022. The results evidenced pain assessment charts had been commenced for 92% of patients across the trust demonstrating an increase from 86% in the previous audit in 2021.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant local and national audits and managers and staff used the results to monitor and improve care and treatment. We saw audit information displayed in ward areas and ward managers discussed results with staff.

The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards.

Northern Lincolnshire and Goole NHS Foundation Trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in the latest audit, October to December 2021 at Scunthorpe General.

When comparing the latest audit to the previous audit, July to September 2021, there had been a decline in performance in one domain, speech and language therapy (SALT). Senior leaders told us the decline was due to staffing the service. The SALT team were now available Monday to Friday with an on-call service out of hours and at weekends due to funding and recruitment. The service had previously been a six-day service. Recruitment and funding plans were in place to address this. One domain saw an improvement in standards by discharge.

Data from October to December 2021 indicated that SGH was able to achieve a timely admission to a stroke unit for 58% of patients, with performance declining by 11% when compared with the previous audit (July to September 2021: 67.6%).

The trust provided venous thromboembolism (VTE) risk assessment audit data at individual care group level. Data referred to the number of patients who had received a VTE risk assessment within 24 hours of admission. The compliance result (May 2022) demonstrated 97% compliance. The trust standard was 95%. Medical staff completed VTE assessment, information was uploaded onto the trust electronic platform. We saw evidence of this on inspection.

The national Institute of Clinical Excellence (NICE) state ‘all patients should receive a VTE risk assessment as soon as possible after admission to hospital or by the time of first consult review by a medic.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Medical care (including older people's care)

Ward managers and matrons completed monthly ward assurance tool (WAT) covering four aspects of care: quality, safety, environment, and patient experience. The results of the WAT are discussed at ward managers/matron governance meetings with the head/deputy head of nursing. Work was ongoing to make the electronic pull of the WAT data timelier as at the time of writing this report nurses reviewed the latest paper copies during their discussions.

The service had systems and processes in place to monitor patient outcomes including both trust-wide initiatives and ward-based actions, including reducing falls and pressure ulcers. On all wards visited we observed the 'future five'; an initiative introduced by the chief nurse in 2019. Staff told us that aspects of the future five plan included pressure area care and falls, and each ward team was requested to use the programme to develop ideas for improvement around the key points.

We observed different initiatives including implementation of additional training, purchasing of falls equipment and developing a more robust approach to delivering effective pressure area care.

In March 2022, there was a 17% increase in the number of patients seen by a specialist following an urgent GP referral, compared to February 2021 (which was similar to the increase in the North East overall). Total number of patients seen in March 2022 was 1,463, compared to 1,254 in February and around 400 patients less than in March 2019 (pre-Covid-19 pandemic).

The trust was in the middle 50% nationally for the proportion of patients seen by a specialist within two weeks of an urgent GP referral (94%) meeting the national standard.

At the trust 65% of patients seen by a specialist within two weeks following a GP referral for exhibited breast symptoms (cancer not initially suspected), in March 2022, compared to the national average 60%. The trust saw a similar number of patients in March 2022 (69), compared to the previous month (63), but 20% less than in March 2019 (86).

Over the past three months (January to March 2022), the percentage of patients being treated within 62 days of an urgent GP referral improved by 7%. With 64% in March 2022, the trust is in the middle 50% nationally, but below the regional (69%) and England (67%) averages.*(Source: NHS England)*

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. There were medical patients outlying on non-medical wards on the day of inspection.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

At the last inspection we told the trust they must ensure all staff receive an appraisal. At this inspection both nursing and medical staff did not meet the trust target range of 85%.

The trust shared trust wide appraisal data with us for the medicine division which evidenced nursing appraisal compliance as 75.11%, this did not meet the trust target. The trust did not provide medical staff appraisal data at the time of writing this report. Post inspection senior leaders told us the trust wide compliance rate for staff appraisal for the medicine division was 72% which included both nursing and medical staff. High volumes of sickness due to COVID 19 and staff self-isolation had impacted on appraisal compliance.

Medical care (including older people's care)

Leaders were sighted on the need to prioritise clinical work and training, rather than undertake professional development reviews. Work was ongoing to address low compliance. On all wards inspected ward managers had plans in place to complete appraisals. Managers told us that organisational challenges continued to affect the ability of staff to undertake appraisal due to both availability of appraiser and appraisee, with clinical staff having to work clinically.

Staff we spoke with confirmed that there was a system in place to ensure staff received an annual appraisal.

Senior leaders were aware the system had data issues which required data cleansing. Work was ongoing to address this.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The trust provided newly qualified nurses with preceptorship for a period of four weeks. International nurses were provided with preceptorship up to one year.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. (use this statement if data is divided into medical staff). The division was focused on performance appraisal and development reviews (PADR) for junior doctors looking to provide additional supportive measures to increase compliance in training overall.

The clinical educators supported the learning and development needs of staff. All wards were supported by the trusts clinical practice educators. Clinical areas had substantive band 6 clinical sisters to support the delivery of clinical skills training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff on ward 17 had received additional training in non-invasive ventilation (NIV) and tracheostomy care; yearly competency assessments were completed. The service used an assessment booklet which covered specific competencies such as inhaler techniques, asthma understanding and awareness, chronic obstructive pulmonary disease awareness, oxygen therapy, humidified oxygen, nebulisers, peak flow recording, chest drainage, suction, NIV, and arterial blood gas sampling.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Medical care (including older people's care)

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

We saw there were daily multidisciplinary team (MDT) meetings on each of the wards, attended by a range of nursing and medical staff, clinical support workers, pharmacy staff, occupational therapists and physiotherapists. These meetings included discussions about patients' conditions and needs, clinical care and discharge planning. We observed an MDT meeting and saw that all staff had an input into care and contributions were valued.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We observed an example of a referral during inspection, staff told us the psychiatric liaison team were efficient in streaming referrals to ensure patients were seen and reviewed quickly.

Patients had their care pathway reviewed by relevant consultants

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on acute wards, including weekends. Patients were reviewed by consultants depending on the care pathway. We reviewed the notes of 10 patients and found they all had a clinical assessment undertaken by a consultant as required within 12 hours of admission. Staff could call for support from doctors and other clinical professionals, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Funding had recently been approved by the division to implement an alcohol liaison team at DPoW site with the potential for a future role out at SGH.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients are screened on admission for smoking and alcohol intake as part of the admission pathway and offered advice on cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. However, training compliance did not meet the trust target range.

Medical care (including older people's care)

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We noted examples in nursing notes of staff formally assessing patient's capacity and taking appropriate actions to ensure safe care and treatment. Patient care records reflected day to day decision making in respect to patient care and documentation of capacity for example receiving personal care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There were examples in patient notes where consent had been sought appropriately to enable safe care and treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Nursing staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards; however, staff compliance did not meet the trust target of rate of 85%. Trust wide data evidenced a compliance rate of 80.49% for nursing and medical staff. This training was part of the mandatory core training.

At the last inspection we told the trust they must ensure all staff receive training in Mental Capacity Act and Deprivation of Liberty Safeguards. At this inspection both nursing and medical staff did not meet the trust target range of 85%.

Senior leaders were sighted on the data results and met quarterly to review and discuss compliance rates within the division.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw three examples where staff had completed relevant MCA documentation and followed appropriate guidance to request a Mental Health Act assessment for patients. Information documented was appropriate and legible; however, we did see gaps in the records for example missing signatures and patient information.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Medical care (including older people's care)

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff understood and respected the individual needs of each patient, including personal, cultural, social and religious needs, and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patients said staff treated them well and with kindness.

We observed many interactions between staff, patients and others (for example carers and relatives) during our inspection. We found all staff to be polite, respectful, professional and non-judgmental in their approach. Staff of all grades introduced themselves to patients, and asked what patients preferred to be called. We observed staff responding to patients' needs in a compassionate and timely manner; the patients we spoke with all had call bells available and those that had asked for assistance said they had not waited long before a member of staff attended. Staff conducted regular comfort rounds to assess patients' needs, such as if they required assistance to the toilet, if they were comfortable and if they would like anything to eat or drink.

Staff followed policy to keep patient care and treatment confidential. Patients bed curtains were drawn when providing care and treatment and nursing and medical staff spoke with patients in private to maintain confidentiality.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients we spoke with said staff treated them well and with kindness.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw that patients were well supported emotionally, and staff were caring and empathetic. There was a room available on the wards we visited for the use of patients and families and for staff to hold discussions with patients if they were distressed.

The division had commenced a pilot surrounding the bluebell model. The model was for patients at end of life or living with dementia. Staff had a good understanding of this and we saw good examples of patient centred care. Individual wards across the division had canvas bags available for patient property. The bags contained a teddy bear, a pouch for patient valuables and a remembrance book.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Posters were displayed advertising John's campaign for patients who were living with dementia to allow a carer to stay with the patient. (John's campaign is a national movement to promote the rights and choices of people living with dementia).

The division used the 'my life' document that assists health and social care professionals gain an insight and understanding of who the patient is. It included patient likes and dislikes and their care needs, which can help them deliver care that is person-specific and is tailored to their needs. Staff ensured the document was completed by someone who knows the person best, either before the patient's hospital visit or as soon as possible thereafter.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care. A new process had been introduced in September 2021 to give residents across Northern Lincolnshire more say about what happened to them if they needed emergency care or treatment. Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a nationally developed process led by the Resuscitation Council (UK). ReSPECT creates personalised recommendations for a person's clinical care in a future emergency, where they may be unable to make or express choices.

It was designed to allow patients greater influence on what happens to them, and that their wishes are carried out appropriately, should they ever find themselves in an emergency situation where they are not able to express their wants and/or needs. We reviewed ten ReSPECT care records which had been recorded. There were some gaps in some of the records where staff signature and date had not been documented.

Medical care (including older people's care)

The trust provided training data to support the role out of the respect model. Training was provided on 'the purpose of the document' and on 'how to complete the document' through face-to-face training by the ReSPECT facilitator and online, utilising resources provided by the Resuscitation council. The data evidenced 74% of staff had completed ReSPECT awareness training to date.

ReSPECT authorship training became mandatory for doctors in 2020/21. To date 59% of doctors had completed authorship training.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. From 1 December 2010, the collection of monthly Mixed-Sex Accommodation (MSA) breaches was introduced. NHS organisations were required to submit data on the number of occurrences of unjustified mixing in relation to sleeping accommodation.

The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient.

All trusts were asked to resume data submission on the number of unjustified mixing from October 2021 following a period of suspension due to Covid-19 and the need to release capacity across the NHS. The division have had no breaches in medicine. Breaches are discussed in the morning operations meeting and are reported monthly in nursing assurance report.

Facilities and premises were appropriate for the services being delivered. Capital investments to develop new infrastructure was agreed and approved. Work had commenced on new build accident and emergency, integrated assessment unit and same day emergency care units at both Scunthorpe General Hospital (SGH) and Diana Princess of Wales (DPoW).

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Medical care (including older people's care)

The service had systems to help care for patients in need of additional support or specialist intervention. However, due to staffing shortages, additional one to one or specialised care was not always fulfilled.

The division were working to improve the cancer pathway and had a cancer improvement plan with action plans in place to address cancer appointment waiting times. The division has a dedicated nurse lung cancer lead. The division had funding and plans in place to recruit a lung cancer consultant. The trust worked collaboratively with a joint multidisciplinary team across the Humber network. The gastroenterology service is on the risk register due to consultant gaps. To mitigate this locum doctors had been appointed short term

Managers monitored and took action to minimise missed appointments. Detailed capacity and demand modelling had been completed with elective activity recovery plans in place for all medical specialities.

Managers ensured that patients who did not attend appointments were contacted. The trust offered some outpatient clinics as virtual appointments. Patients are screened by administrative staff to ensure that virtual appointments are convenient and accessible. Traditional outpatient clinics were still operational; however, capacity was limited due to social distancing.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Wards were designed to meet the needs of patients living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The trust had a dementia strategy (July 2021) and worked closely with the carer's association to support carers of people with dementia; an information leaflet had been developed for carers. The trust had appointed two full time dementia clinical nurse specialists based at DPoW and SGH. The service celebrated dementia awareness week each year, undertaking promotional activities.

The service had introduced a flag system within the digital platform and a bedside magnet to enable staff to identify patients with dementia. During inspection we noted that dementia champions were visible in clinical areas.

The trust had introduced a safeguarding and vulnerability strategy (2022/2024). The strategy was developed to embed the safeguarding and vulnerabilities agenda across the trust.

The frail elderly assessment support team (FEAST) were based on the same day emergency care unit where elderly patients were assessed and treated by a multidisciplinary team. This team had established links with acute and community services to initiate speedy treatment and care packages in the patient's home to be able to prevent inappropriate admissions and provide more appropriate care. The patients could return to the ward for day care treatments or further tests as necessary. Staff could admit patients via the site manager if needed.

Medical care (including older people's care)

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed a meal service during inspection and saw examples of differing food options available.

Staff had access to communication aids to help patients become partners in their care and treatment. The trust continued to use software called reminiscence interactive therapy activities (RITA) which helped patients with dementia to recall memories and relax in the hospital environment. It encouraged conversation and interaction between patients, their families and staff, by running reminiscence sessions, creating life stories, playing interactive games, listening to music or watching movies. We saw patients enjoying using the software on the stroke unit.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Patients were being moved sometimes multiple times in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment. However, the trust had implemented additional processes to monitor and manage delayed discharges and had clear oversight of this.

We inspected the pathway of medicine patients from admission in accident and emergency/GP referral to point of discharge. Patients were assessed on admission to determine what treatment pathway was required. There were differing pathway options available within the medicine speciality.

The hospital had significant capacity problems due to the high number of patients who had the right to reside and there was no care package immediately available for discharge to be carried out safely. The situation was made worse by the complexities of COVID 19 pathways and keeping some patients isolated. Staff were required to monitor the number of delayed discharges and look at how to manage these effectively.

We noted a large number of patients on the medicine wards we inspected with the right to reside who had been in hospital over a period of several weeks. ‘Right to reside' means you have the right to live in the United Kingdom. On the day of inspection, the hospital site had 35 patients with the right to reside who were medically optimised patients fit for discharge.

Patients were waiting for a package of care, a discharge to assess bed in the community or continuing healthcare assessments to progress their discharge. There were many patients waiting for community hospital beds for rehabilitation after an acute illness and these patients had complex needs with most wanting to return to their own home.

Medical care (including older people's care)

Due to complexities in assessing patients who needed onward care, and the lack of care packages available to be purchased or arranged by social services, there were long delays in discharging patient's home. The staffing shortages in adult social care had a detrimental effect on the whole system of access and flow for medical care. Significant pressures on partner organisations for home care & domiciliary care, resulted in significant discharge delays.

Working closely with system partners the trust had implemented a discharge to assess (D2A) model. The trust created two hubs one at the Scunthorpe hospital and one at the Diana Princess of Wales hospital. The hubs received electronic D2A requests internally and facilitated the discharges by linking with community/social care.

Daily twelve noon D2A escalation meetings were chaired by clinical commissioning group (CCG) leads Monday to Friday and led by clinical matrons at weekends working with system partners to ensure clear action planning for delayed discharges.

Leaders of the service told us that continued IT system & reporting improvements were required to ensure all data was captured and reported accurately by the trust IT systems.

The trust reported significant system capacity issues across Northern Lincolnshire resulting in delayed discharges for patients on a discharge to assess pathway.

A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available. Barriers to timely discharge included transport delays, completion of an electronic discharge summary, awaiting medication and implementation of care packages.

From December 2021 to April 2022, the percentage of delayed discharges increased from 75% to 82% but had since reduced to 79% (as of May 2022) which was similar to both the regional and national averages of 75%.

At the trust, the top reason for patients continuing to reside for over 14 days was 'pathway 2: awaiting availability of rehabilitation bed in community hospital or other bedded setting' (36%), which was a 10% increase from the previous month and 13% higher nationally. This was followed by 'pathway 3: awaiting availability of resource for assessment and start of care at home' (20%). This was similar to the regional and national levels. A similar picture can be seen for patients continuing to reside over 21 days.

At our last inspection we said the trust must continue to monitor referral to treatment times and the average length of patient stay for elective and non-elective specialties against the England average.

At this inspection data in April 2022 showed that rheumatology had the lowest percentage treated (admitted) within 18 weeks with 50.0%, compared to the regional average of 78.8%.

General internal medicine had the highest proportion of patients treated (admitted) at 52+ weeks with 5.3%, compared to the regional average of less than 1%.

In April 2022, general internal medicine had the highest number of patients on the waiting list (3,703) and was the worst performing in terms of treatment within 18 weeks, with 68.9%, which was lower than the regional average of 78.0%.

Data evidenced from February 2021 to January 2022, the average length of stay for medical elective patients at the trust was 5.1 days, compared to 5.5 days for the preceding 12 month period.

Medical care (including older people's care)

The trust instigated effective meetings to address long length of stay and discharges. A daily patient list was populated identifying all patients in beds identifying length of stay, right to reside and if patients were on the D2A pathway. Final work was underway to ensure there was a live electronically generated list of all patient positions on all wards seven days per week.

Senior leaders were aware of the pressures within the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. During these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the two.

Community and the therapies division were developing six workstreams to support discharge and admission avoidance.

The division had a discharge lounge improvement group to improve quality and utilisation of discharge lounges.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to do this.

The service moved patients only when there was a clear medical reason or in their best interest. It was recognised as adding stress and anxiety for patients if they were moved. Staff tried not to move patients between wards at night. Patients were allocated beds throughout the night with planned moves to take place the following morning. However, staff told us this was not always possible due to the high demand on beds and sometimes patients were moved between wards at night.

The trust provided data which evidenced the number of bed moves undertaken in a 24 hour period in July 2022 for all specialities. The data evidenced 29 patients had been moved within this timeframe, three patients had been transferred throughout the night from midnight up to 08.00am. Senior managers were aware that additional work was required to ensure that patients were not moved out of hours.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

The trust employed care navigators who were responsible for the discharge process surrounding patients who had the right to reside. All wards we visited had full time care navigators in post. We spoke with a member of staff from the team who explained that part of their role was to assist in arranging the transfer of patients to other wards and to facilitate discharge for medically fit patients. We were told that timely and safe discharges were a priority. To achieve this, care navigators liaised with patients' families, social care teams, community nursing teams and care homes. If necessary, they were able to arrange home support and equipment.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number of delays and took action to prevent them. Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Medical care (including older people's care)

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. During the inspection there were four medical outliers at SGH. Outliers were managed by using a 'buddy system' which ensured they were seen by a doctor every day and that tests were initiated, and results were reviewed. We tracked all four patients which evidenced daily medical review with discharge plans in place.

Ward managers cohorted where possible any medical outlying patients on specific wards using as few locations as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. Complaint leaflets were available on all wards inspected.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

The trust shared with us data for complaints and compliments received between April 2021 and March 2022. 45% of all complaints the trust received were related to the division of medicine and 28% of compliments received related to the medicine division.

Information sent from the trust showed that complaints were investigated, and themes were identified. The main themes of complaints were around inappropriate discharge, coordination of medical treatment, lack of explanation of care, poor nursing care and staff attitude.

The service displayed information about how to raise a concern in patient areas in all the wards we visited.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared with us examples of complaints that they had received and investigations and outcomes that came from them.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Medical care (including older people's care)

Leadership

Leaders had oversight of the service as a whole; however, we were not always assured that leaders understood the priorities and risks the service faced at ward level. Staff told us they were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

The division of medicine was led by two divisional medical directors, associate chief nurse, head of nursing, associate chief operating officer (COO) and a general manager.

We saw examples of leadership at site level with regard communication with matrons and ward managers. Specific medical wards had differing leadership from onsite matrons. Staff told us they felt supported by matrons and senior nurses.

Leaders we spoke with felt that they were visible. However, staff on the wards did not feel that there was leadership visibility aside from ward managers and matrons at local level.

The trust had instigated a nursing, midwifery and allied health professional future 5 and beyond strategy 2021-2024. The strategy builds on feedback sought through engagement events including conversations with the chief nursing team, the trusts 15 steps programme, speaking with external partners, surveys and walk arounds in clinical areas discussing key priorities with individual teams.

The 15 steps challenge focused on ward walk-arounds where matrons considered first impressions of the area from the perspective of a service user. The roll out was part of the future 5 nursing and midwifery priorities for 2019 and 2020 which had been developed by the chief nursing team. The 15 steps programme was one of a number of initiatives implemented to provide feedback about the challenges staff faced on wards, as well as the experience patients receive.

The future 5 and beyond aligns with the trusts strategic vision and quality priorities supporting the organisation on its continuous journey of improvement. The strategy aimed to develop practice of continuous learning and development, develop a valued and respected workforce, use resources effectively, continue to embed and raise professional standards and provide high quality innovative care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The medicine division business plan for 2021-2022 (year three of the five year strategy), set out how the trust implement an integrated plan to deliver urgent and emergency care, specialty services, cancer care, and elective and out-patient care at levels commensurate with the Care Quality Commission (CQC) ‘Improving together’ plan. The divisional strategy was published and shared across all staff groups in 2021.

The Trust agreed six priorities, set out in the Strategic Plan 2019 - 2024:

1. Integrated urgent and emergency care
2. Transformed outpatient services

3. Improved partnerships with community, primary and social care networks
4. Enhanced in patient services
5. Reconfigured specialties onto one site where appropriate
6. Restructured cancer services
7. Establish a workforce to support sustainable service models in line with CQC recommendations and transformation plans, including non-clinical structures and functions.

The trusts ambition was to deliver safe high quality patient centred services in line with the trust's key priorities with and in delivering this achieve a rating of 'good' across all CQC domains with a focus of creating and maintaining confidence in our services.

The division aimed to transform its services to improve the acute patient pathway and elective care services and improve the performance against constitutional targets for standards in A&E waiting times, cancer, referral to treatment times (RTT) and zero overdue follow up appointments.

Senior leaders had an annual workforce plan (2021/2022) and were sighted with regard overall recruitment of staff from nursing, medical and non clinical staff. The division had highlighted speciality hotspots and the impact this would have on staff. The trust had an action plan in place to work towards in order to rectify individual concerns surrounding differing skill set.

Culture

Not all staff felt respected, supported, and valued. However, they were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us there was an open culture and they felt confident to raise concerns with their managers.

Staff members that we spoke with expressed their frustrations at the ward moves their team encountered due to short staffing across the division. Staff told us that staff shortages often impacted on patient care as gaps in staffing were not always filled.

Overall, we found staff morale to be low. However, staff spoke proudly of their colleagues and the hard work they encountered during the pandemic, they said they felt valued by their peers but felt there was a disconnect between clinical and executive staff.

Staff were encouraged to share their views and opinions using the 'ask Peter' facility.

Staff survey results were shared as they were received into the division and individual areas had the opportunity to review and discuss their specialty results.

The division reviewed the most recent staff survey and identified the key areas surrounding, visibility and engagement, safety and governance and speciality specific actions

The trust provided evidence to support staff health and wellbeing. For example, senior nurse huddles, wellbeing conversations and support in place for ward managers.

In the North East region, Northern Lincolnshire and Goole NHS Foundation Trust had the lowest overall score in the NHS Staff Survey 2021 (53.3). The National average was 56.3. The trust scored significantly below average in all areas and there was significant deterioration for two themes, morale and staff engagement.

The division reviewed the most recent staff survey and identified the key areas surrounding staff culture and moral. The division commenced monthly staff engagement events from May 2022 and committed to continue these during July, August and September 2022 to focus on both areas.

The division work closely with human resources, occupational health, organisational development, and the freedom to speak up guardian to ensure staff have every opportunity to share feedback and were signposted to appropriate support where necessary.

Metrics for the culture transformation programme were being defined to include; workforce committee metrics, health and wellbeing, inclusion and attraction.

Governance

Leaders operated governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities, however we found examples where processes were not undertaken in line with guidance. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

We found a number of examples on inspection where processes were not undertaken in line with trust and national guidance which had been highlighted as concerns at the previous inspection. For example, at the last inspection the trust received a must do action to continue to monitor registered nurse establishment on the hyper acute stroke unit (HASU) to ensure adherence to best practice in line with national guidance recommendations of one nurse to two patients. At this inspection planned verses actual staffing did not meet best practice guidance (NICE) with regard the care of patients requiring level 2 care.

Mandatory, safeguarding and Mental Capacity Act and Deprivation of Liberty Safeguards training did not meet the trust target. This was highlighted at the last inspection as a must do action. At this inspection some training compliance was below the trust target range.

Medical notes trollies were not locked on most wards inspected, records were stored underneath and on IT trollies. This was highlighted at the last inspection as a must do action. At this inspection patient records were not stored securely.

Nursing and medical staff appraisal rates did not meet the trust target. This was highlighted at the last inspection as a must do action. At this inspection appraisal rate compliance did not reach the trust target rate.

Confidential waste was collected in confidential waste bags, stored under ward reception desks which contained confidential patient information. This was highlighted as a concern at the last inspection. At this inspection we found confidential waste stored in paper bags on all wards we inspected which was not stored securely.

We were not assured that leaders had addressed all the key concerns highlighted at the last inspection. This was reflective of what we found during this inspection.

Medical care (including older people's care)

We reviewed the integrated governance report June 2022. The report included formal complaints, serious incidents, NICE guidance, risk register, mortality update and document control. At trust level the division of medicine had reported 10 serious incidents (seven at SGH). Common trends and themes were highlighted with associated actions assigned.

The service had a series of reports feeding into key meetings within the division, demonstrating the use of performance information to allow oversight and governance of improvement work. The reporting process was reviewed and discussed at a number of forums including medicine board, medicine governance, ward managers meetings and performance review and improvement meeting (PRIM).

We reviewed the minutes of the divisional clinical governance meeting for May 2022. items were aligned to the integrated performance report so that local leaders and the board were aware of the same issues and risks. We noted discussion such as mandatory training, IPC, risk, appraisals, complaints, incidents, and performance were considered at the meetings.

Management of risk, issues and performance

Leaders and teams mostly used systems to manage performance effectively. They did not always identify and escalate relevant risks and issues to identify actions to reduce impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

During inspection we had highlighted concerns regarding the management of the dedicated stroke assessment unit surrounding nurse staffing for patients requiring level two care. At the last inspection the trust received a must do action to continue to monitor registered nurse establishment on the hyper acute stroke unit (HASU) to ensure adherence to best practice in line with national guidance recommendations of one nurse to two patients.

The staffing of HASU was a risk as the healthcare assistant (band 2) was often left on the unit to monitor patients when the stroke responder was required elsewhere in ED or when requiring a break. This was a risk to patients requiring close observation and management and was not in line with best practice guidance National Institute for Health and Care Excellence (NICE) guidelines (2019).

Post inspection the trust instigated action to address the immediate risk; however registered nurse staff vacancies remained a concern as this impacted on staffing both the main stroke unit and the stroke assessment unit to meet national guidance.

During inspection we noted there was no room temperature monitoring in some clinical treatment rooms. This had not been highlighted as a risk or managed in accordance with individual manufacturer guidance.

The trust gave assurance of their intention to develop with immediate effect a room temperature policy and to implement daily readings of maximum/minimum room temperatures in clinical treatment rooms. Following approval of the policy the trust intended to roll out the process to include escalation should temperatures fall outside of range. The trust intended to audit this practice using the safe and secure medicine audit.

The trust Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) had commenced. We saw examples of ReSPECT forms in differing patient notes. The ReSPECT form had been in place for approximately 15 months across the Trust. Training was provided on ‘the purpose of the document’ and on ‘how to complete the document’ through face-to-face training by the ReSPECT facilitator and online, utilising resources provided by the Resuscitation Council. 74% of staff had completed ReSPECT awareness training at trust level.

ReSPECT authorship training became mandatory for doctors in 2020/21. To date 59% of doctors had completed authorship training, this was a 4% increase on the reported position (February 2022).

The ReSPECT model process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

We reviewed the medicine risk register. All the risks had action owners, updates on progress, mitigation, and review dates. There were 67 risks on the medicine risk register in total. Ten risks were rated as high, 53 moderate, four as low.

The leadership team were aware of their main risks and could explain the actions in place to mitigate their risks. Risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk and were regularly reviewed.

We saw governance boards on individual wards which displayed monthly governance and risk information updates. The information included individual wards top three incident themes, falls and pressure ulcer statistics, three things that had gone well and learning from incidents. The boards also included messages for sharing, patient feedback, three things individual wards wanted to improve upon, staff achievements, mandatory training and staff appraisal compliance data.

Individual wards also displayed weekly team huddle information. The information included highlights surrounding star of the week, wellbeing at work, team messages, what's new, hot topics, achievements and performance.

Leaders told us reports were routinely produced and shared at the medicine board and executive performance review meetings. Future performance assurance was provided in the form of agreed trajectories and monitored at these meetings.

Risks were identified and discussed and escalated for consideration for inclusion onto the risk register via divisional governance meetings.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure; however, staff did not always adhere to national guidance and trust policy with regard data security. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on the wards. For example, notes trollies were left unlocked on all the wards we visited. Computers with personal information were left open with staff identification cards.

During inspection paper waste was stored in unsecured bags and boxes beneath nurses' stations in all areas we checked. The areas were not always attended by staff and, upon checking, we found that there were staff handover sheets and other documentation containing confidential patient information.

Staff could access information technology (IT) systems to record and view information such as test and x-ray results and patient records. Patient records were mostly electronic, and many assessments were integrated into the trust's electronic patient record system. However, staff spoke about the difficulties in using both paper and electronic records with many complaining of the system being too slow and difficulties sometimes having access to IT equipment.

Staff we spoke with demonstrated they could locate and access relevant information and records to enable them to carry out their day-to-day roles. This was sometimes slowed down by connection issues with the software system that was in use.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training, and appraisals.

The service managed and used information appropriately to support its activities. The website contained detailed information about the differing wards, site maps, innovation and how to book an appointment.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The division provided patient feedback initiatives which had commenced following feedback, some examples include the purchase of additional wheelchairs and ramps, bluebell pilot model launched for patients at end of life, a pain collaborative quality improvement project is now underway and responsive visiting reviews under way.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust participated in the Friends and Family Test (FFT).

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged quality improvement.

The trust has established routes and continued to innovate by establishing learning networks and groups with representatives from each division. Staff were encouraged to identify quality improvement projects and undergo mentorship through to completion.

We saw evidence to support how new systems and processes were evaluated, implemented and embedded. Recent examples included implementation of the integrated assessment units across site, discharge to assess and the frailty pilot.

The division had launched the medicine and quality safety forum, a bi monthly learning and educational event which was managed across both sites. Staff are encouraged to submit topics for discussion.

Medical care (including older people's care)

Divisional staff meetings are held at all levels. Staff are encouraged to attend meetings in order to share ideas and concerns.

Surgery

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, managers did not make sure everyone completed it.

The trust reported through the integrated performance report (IPR) separately for core training and role specific training. The trust did not report a combined figure for mandatory training.

At the time of our inspection the division's role specific training compliance for nursing staff was 80.34%. This did not meet the trust target of 85%. The hospital's role specific training compliance for nursing staff achieved 80.99% compliance. This did not meet the trust target of 85%. However, the figure was a significant improvement on our previous inspection.

At the time of our inspection the hospital's overall mandatory training compliance for nursing and medical staff was 87.67%. This also did not meet the trust target of 90%.

We reviewed mandatory training figures by module for all divisional staff at the hospital. Staff's highest compliance was 100% for infection prevention and control level 1 (3 years). The lowest compliance was safeguarding adults level 3 (3 years) with 62.22%. Staff achieved the trust target in seven of their 16 modules.

The service had a continued focus on improving mandatory training compliance, especially in safeguarding and PREVENT (anti-terrorism and anti-radicalism of vulnerable people) modules. However, we heard theatre staff had no ringfenced or protected time to complete mandatory training.

Medical staff received but did not always keep up-to-date with their mandatory training. On our last inspection in September 2019 we told the service it did not have effective systems and processes to ensure mandatory training was completed. We found mandatory training compliance was particularly poor for medical staff.

On this inspection we found limited improvement. The division's overall mandatory training compliance for the hospital's medical staff achieved 70.53%. This still did not meet the trust target of 90%.

We heard work was progressing across all specialties to improve medical staff's mandatory training compliance. The division made all mandatory training modules available on work booklets or online.

However, as of 8 February 2022 the division only achieved 42% mandatory training compliance for the deteriorating patients module. This was similar to the previous six months. Divisional leads recognised deteriorating patients training attendance was poor as face to face training was limited during the COVID-19 pandemic. At the time of our inspection they were working through the backlog of staff untrained in this module.

The division's latest sepsis mandatory training data for March 2022 achieved 82% compliance for sepsis awareness and 69% for sepsis training. The division achieved 84% mandatory training compliance for sepsis in January 2022. Sepsis training compliance had decreased by 2% from January to March 2022. This still fell below trust target and needed improvement.

The content of mandatory training was comprehensive and met the needs of patients and staff. Divisional managers were asked to always review mandatory training as part of any staff appraisal and update job plans accordingly. Service managers and secretaries supported consultants by giving them booklets. They cascaded trainers to help their staff complete harder to access courses such as manual handling.

Leads told us their governance lead was undertaking a quality improvement (QI) course on mandatory training to support each specialty to sustain progress.

Managers monitored mandatory training and alerted staff when they needed to update their training. Leads explained some face to face mandatory training availability was reduced during COVID–19, but dates were sent to wards for specific core sessions. Leads were trying to organise face to face divisional sessions by consultant specialty; for example, so all the urologists could complete resuscitation as compliance was low.

Leads were looking at which modules had the lowest compliance to bring these to quality and safety (Q&S) afternoons. For example, their last meeting focused on nasogastric (NG) tube feeding. Another addressed information governance (IG) as 300 staff were non-compliant. Leads picked up touchpoints in specialty performance improvement meetings (PIMs) where they would follow up any issues at the next month's meeting.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it. However, they did not always complete the training.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. However, this was not always completed. On our last inspection in September 2019 we found medical staff's safeguarding training compliance was below the trust target.

On this inspection we still found medical staff did not always complete their safeguarding training. The surgical clinical director acknowledged safeguarding training compliance remained poor amongst medical staff. They confirmed this was significantly below trust target and could offer no solutions for how to improve compliance.

All theatre and recovery staff who worked with children were safeguarding level 3 trained.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We observed four children seen in theatres, two of which had learning disabilities (LD). Staff understood how to safeguard these patients by responding to their needs and involved their families.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We reviewed safeguarding adult concerns raised by surgical ward staff from September 2021 to June 2022. The most common concern category was community-acquired pressure ulcers.

Staff contacted or requested reviews by the hospital safeguarding team to understand the origins of any injury or harm from external sources. Since July 2021 this could be done through a trust database. The most common types of abuse during the nine months was neglect or self-neglect and financial. Staff could request increased support to be offered for social care assessment. Staff also raised section 42 (care act) enquiries.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff kept equipment and the premises visibly clean. However, they did not always use equipment and control measures to protect patients, themselves and others from infection.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Domestic staff in theatres told us they were responsible for clinical waste. Staff told us their deep cleaning team were responsive.

The service generally performed well for cleanliness. We saw 'our commitment to cleanliness' noticeboards on all wards. These detailed a cleaning summary and gave wards a rating out of five stars. All wards were up to date and had achieved four or five stars. This met the trust standard for cleanliness.

Staff identified how well the service prevented infections. However, they did not always prevent their potential spread

We found barriered side room doors on wards were not always kept closed for potentially infectious patients. However, staff told us this was so they could monitor patients at higher risk of falls but no further strategies had been developed to mitigate risk.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We saw two ward 29 staff members not wearing their facemasks correctly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw cleaning staff on most wards we visited who used 'I am clean' stickers and cleaned commodes well.

Staff worked effectively to prevent, identify and treat surgical site infections. The trust submitted data on their elective hip and knee operations and infections to the surgical site infection (SSI) surveillance service at Public Health England (PHE).

We reviewed the division's number of infectious disease cases from June 2021 to May 2022. This meant the hospital met the PHE target of 21 or less healthcare-associated cases in 2022/23.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We saw patient beds on all ward areas had buzzers and red cords patients and their families could pull for emergency help.

The design of the environment followed national guidance. On our last inspection in September 2019 we told the service it must continue to monitor and take action to reduce mixed sex accommodation breaches (Regulation 9).

Surgery

On this inspection we found the service had made some improvement in their number of and response to breaches. However, this was still an ongoing trustwide issue.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The latest breaches had occurred on 25 March 2022 with two high observation bays (HOBs) bedded areas of each sex. At the time the trust was on operational pressures escalation level (OPEL) 4 or a black alert due to their number of COVID-19 positive patients. This is the most severe level, which is a method for the NHS to measure stress, demand and pressure. NHS England classes a black alert as a "serious incident", which means the system is under severe pressure. This meant the hospital site had no bed capacity to support step down patients. Service leads were completing an action plan which contained the actions for these breaches.

Staff told us they followed protocol, completed and signed all necessary paperwork. Managers and ward staff with HOBs were looking to anticipate any breaches before they occurred to respond and resolve faster but this was not always possible

All areas we visited were entirely compliant and functional. All handwash basins were health building note (HBN0009) compliant regarding spacing. Since our last inspection in September 2019 the service had built a new surgical ward 29 and refurbished theatre E to standard specifications.

However, we found environmental issues in theatres which posed a potential risk to patient safety. Anaesthetic rooms had no 'stop before you block' posters (despite recent never events) reminding staff. After our inspection senior staff told us all rooms had these posters. The hospital had outdated and confusing signage, as some wards had changed surgical specialities or departments since COVID-19 and signage had not been updated.

Facilities and premises were not always appropriate for the services being delivered. We observed two general surgery pre-assessment clinics being ran from maxillo-facial rooms which contained a dentist chair, overhead light and vision screen. These rooms' doorframes meant they had no disabled or trolley bed access. We heard a patient transferred on a bed from a neighbouring trust site could not be accommodated so had to be patient transported back again. This meant despite extra staff resource, the unsuitable environment caused an avoidable cancelled appointment.

The service did not always have enough suitable equipment to help them to safely care for patients. We found spare monitors (stored and not in use) in recovery were well past their life expiry dates with no spare parts available. We raised this with staff and a manager who said they were awaiting capital funding. We were not given a timeline of when they would be replaced.Equipment failing or being unavailable was the fifth most common reason for hospital non-clinical cancellations from 1 June 2021 to 28 June 2022. 43 cancellations occurred for this reason.

We found ward 29's dirty utility room was unlocked and the control of substances hazardous to health (COSHH) cupboard inside was closed but unlocked containing hazardous chemicals. Two yellow COSHH cupboards were also unlocked in theatres. This meant patients could potentially wander in and access these substances.

The main theatre's defibrillator and resuscitation trolley was unlocked with no tamper-proof seal tag attached. This meant staff or others could potentially help themselves to stock and not replace it for urgent use in the event of an emergency.

However, staff carried out daily safety checks of specialist equipment. Ward staff completed weekly battery checks on defibrillators.

Surgery

The division's top area of concern noted in the June 2022 trust board papers was equipment noted as a considerable risk. We heard the division prioritised equipment risks and looked for other avenues to replace equipment.

Staff disposed of clinical waste safely. The division's waste streaming service was effective in terms of offensive waste disposal and recycling materials where possible.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. However, staff did not always identify and quickly act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients. However, they did not always escalate them appropriately. Staff followed the national early warning score (NEWS2) pathway. The service had pathways and processes in place to escalate deteriorating patients. These were overseen by the head of nursing.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service completed risk assessments for all patients identified as 'at risk' using a combination of the trust's clinical software system and paper assessments. Patients were escalated through matron huddles, nutrition and monitoring such as NEWS.

All wards we visited had daily team huddles attended by all nursing staff. They discussed any staffing shortages, issues or concerns, patient acuity, patients of concern, definite or possible discharges that day and any patients who needed social care input before updating safe care accordingly. Latest topics and issues discussed at huddles were written on team huddle boards under categories such as performance, achievements, team messages and wellbeing at work.

The service completed risk stratification against national criteria for all their inpatients on the waiting list. Service leads followed up and risk stratified all overdue patients who had waited over 52 weeks. Staff then appointed and manually tracked high risk patients within four weeks of their risk stratification. The service had a dedicated staff member to track overdue patients in ophthalmology due to a high number of patients on the waiting list. They also had failsafe officers in this core speciality for injection P2 patients.

As of 11 March 2022, the division achieved 92.5% overall compliance for staff completing NEWS observations within 30 minutes. This met the trust target of 90%. At the time of our inspection the trust was reviewing an electronic solution for rapid escalation of patients with a raised NEWS in the hope of implementation.

The trust audited their deteriorating patient and sepsis screening as part of their priority audit programme. 11 hospital cases were reviewed with NEWS2 score of 5 or 6 during February 2022. Four of these cases had evidence escalation was not appropriate for the patient; three due to being for ward-based care only. We saw the risk of deteriorating patients not being escalated appropriately was on the trustwide risk register. This risk was added in July 2018 with many controls in place to adequate mitigate the risk.

All wards we visited except the short stay SDEC/IAAU had electronic dashboards to help staff understand their performance against NEWS2 quality metrics. Staff on some wards told us they were given handheld devices for easier monitoring of observations and escalation of deteriorating patients in line with the updated trust policy. However, as these devices had since gone missing, we did not see staff using any. This meant staff access to NEWS monitoring and updates could potentially be delayed.

Surgery

On previous inspections since and including November 2016 we found 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 this was not an embedded consistent process.

We found the hospital theatre staff completed the theatre registers as per policy as well as on the trust's clinical software system.

We found WHO checklists were compliant with the '5 steps to safer surgery' policy. Staff completed checklists on paper rather than on the clinical software system.

For ophthalmic patients needing an injection area, the form had just one tickbox to indicate staff's WHO checklist compliance. As the WHO checklist works by staff reading each prompt aloud and confirming details for each, the absence of a written checklist meant there was no governance/evidence staff completed each step. As ophthalmology is a high-risk specialty this meant there was a greater risk of staff oversight, omission or error as checklist elements were easier to forget or ignore.

Divisional leads told us they did not have a specific standalone '5 steps to safer surgery' compliance audit at the hospital. However, the division did audit the WHO checklist and team brief which essentially covered the '5 steps to compliance'. These were documented as complete and discussed at their confirm and challenge meetings.

However, issues from the 31 March observation were rectified in May and June. The observer noted for both latter procedures all theatre team members introduced themselves and all relevant information for patient safety throughout the list was discussed and documented. All aspects of the WHO form were completed. The multi-disciplinary team worked well together and completed the debrief after the theatre session. This meant theatre observations showed sustained improvement and would continue monthly.

Staff knew about and dealt with any specific risk issues. Nursing staff we asked understood and knew how to respond to symptoms of sepsis. Ward staff followed the sepsis 6 pathway and used red and amber flags to alert them to patients at higher risk of sepsis.

Staff used a power business intelligence (BI) dashboard to monitor the deteriorating patient and sepsis. The trust had implemented a sepsis ICON to provide staff with a visual compliance aid. The division and medicine had appointed a joint lead clinician for the deteriorating patient and sepsis.

We reviewed the trust's sepsis and deteriorating patient meeting minutes which monitored NEWS compliance by exception. As of 8 February 2022, the division had achieved 89.6% sepsis compliance.

However, leads acknowledged further improvements were needed around sepsis such as electronic recording within ED for screening and non-completion of the sepsis six tool's KPI of antibiotics prescribed within one hour. Designated divisional wards were progressing a digital solution for direct transfer of observations to the trust's clinical software system.

Integrated acute assessment unit (IAAU) staff used a falls multifactorial assessment to determine if a patient was a high falls risk. The assessment considered the patient's age, history, risks and environment. If the assessment had any 'yes' responses staff updated their clinical system risk and completed a falls care plan and avoiding falls level of observation assessment tool (AFLOAT). If all responses were 'no' then staff reassessed the patient on transfer, post fall, if their condition changed or weekly.

Surgery

We reviewed some care plans for patients following an inpatient fall on the short stay ward. Staff considered their AFLOAT risk level, visibility by putting the patient in a cohort bay and took lying and standing blood pressure readings. They considered therapy reviews and updated patient relatives when necessary.

We saw pressure ulcer incidents were high on ward 29 during June and July 2022. In response manager implemented refresher teaching and teamwork from the senior nursing and tissue viability nursing teams to improve pressure area assessments and documentation.

Pressure ulcers accounted for 56% of the division's STEIS incidents since May 2021. We followed up with staff how they were working to reduce these. We saw evidence staff completed SSKIN bundles, made timely referrals to the tissue viability nursing (TVN) team and sourced any specialist equipment such as airflow mattresses. SSKIN is a five-step model for pressure ulcer prevention.

Shift changes and handovers included all necessary key information to keep patients safe. We found staff handovers were thorough in theatres.

Nurse staffing

Nursing staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, the service did not always have enough nursing and support staff.

We reviewed the safe staffing dashboard for the four months before our inspection between February and May 2022. Scunthorpe's surgical wards met the overall fill rate for every month between February and May 2022, exceeding 100% in March and May due to allocating extra staff. The fill rate is the proportion of training places that are advertised or offered, and then taken up by trainees or students.

However, the service's workforce was challenged across several services. Ward 19 missed their targets every month during this period and never exceeded a fill rate of 82.4%. The hospital's total care staff fill rate also missed target every month, achieving between 78.8% and 90.4% in the four months.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. All the service's wards and departments used E-rostering with matron oversight and approval. The service had implemented a nationally recognised tool to ensure safe staffing.

Senior lead nurses held daily nurse staffing meetings within the organisation.

Matrons rotated staffing to ensure all areas were clinically safe daily. The ward manager could adjust staffing levels daily according to the needs of patients. Divisional workforce and recruitment meetings took place monthly. Service leads conducted annual establishment reviews.

The chief nurse reviewed skill mix by undertaking periodic nursing establishment reviews. Their latest staffing review did not include theatres where some unregistered staff were added. They planned to carry out another review later in 2022 as a continuous process.

The ward manager could adjust staffing levels daily according to the needs of patients. Divisional workforce and recruitment meetings took place monthly. Service leads conducted annual establishment reviews.

The number of nurses and healthcare assistants matched the planned numbers. Matrons adjusted nurse staffing levels to cover gaps adequately. We saw daily nurse staffing levels displayed on the 'our time to shine' boards. However, on one ward this was left blank.

The service had mostly reducing vacancy rates overall, including for inpatient and day ward nursing staff up to band 7 and for the hospital's medical staff. The service's March 2022 self-assessment stated their nursing vacancies had improved over the last few months. Divisional leads told us the HOBs had increased their vacancy rates as these areas needed higher numbers of protected nursing staff.

We reviewed the divisional nursing staff vacancy rates trustwide for ten months of 2021-22 and the first two months of 2022-23 and found some improvement. The opening month's vacancy rate was 27.35% which rose to its highest point of 31.77% the following month. This reduced to 17.9% by the data's penultimate month of April 2022 (month 1 of 2022-23). However, this was still more than twice above the 8% trust target vacancy rate. We saw the number of divisional medical staff vacancies trustwide for the same period. Rates ranged from -2.23% to 9.83% in successive months July and August 2021 (months 4 and 5). This showed trustwide the division had higher nursing staff vacancies than medical staff.

We reviewed the division's vacancies rate for inpatient wards as of May 2022. This figure was 18.7% which was an increase of 3% on the previous month's rate. The divisional inpatient or day ward with the highest vacancies up to band 7 on 31 March 2022 was on ward 19 with an untrained nurse vacancy rate of 12.42% work time equivalent (WTE). This was above the 8% trust target vacancy rate.

The hospital's vacancy rates were the trust's highest overall. However, these ranged between 16.21% in June 2021 and 6.96% for the latest month of May 2022 which showed significant improvement.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction. However, the service did not have enough operating department practitioners in theatres.

On our last inspection in September 2019 we told the service it did not always have enough medical staff to care for patients and keep them safe.

On this inspection we found the service filled any medical staffing gaps with suitable locum or agency workers once their CV had been agreed and signed off by the clinical lead to ensure the adequate skill mix and knowledge.

The medical staff matched the planned number. We reviewed general surgery rotas and found they were well organised with minimal gaps. The division's number of consultant surgeons (WTE) had reduced by 1% from April 2021 to April 2022. This was in line with the NHS national average.

The theatre manager told us they would like to rescope theatres to reduce and streamline staff.

The service had low and/or reducing rates of bank and locum staff. In their March 2022 self-assessment, the service were working with teams to ensure long-term locums could cover high-risk assessed team members to ensure emergency and elective activity was delivered.

This included plans to ensure the long-term sustainable viability of the rota. The rota was agreed with teams and then followed a robust process at the surgery and critical care (S&CC) board, trust management board, clinical commissioning groups (CCGs) and scrutiny panel.

Managers could access locums when they needed additional medical staff. Divisional leads admitted their locum spend was a e high.

From July 2022 the trust's criteria for COVID-19 risk assessments was being phased out. As a result, leads hoped their approval of doctors would increase so the locum spend could reduce. They explained the DO5 standard meant they must spend more on weekend doctors. NHS England's DO5 referred to adult critical care clinical reference group's recruitment standards of medical staff. The division were in their recruitment plan's final phase. Locums helped to cover the gaps and extra sessions as their business case had a significant uplift around obstetrics and intensivists.

The division's advanced clinical care practitioner (ACCP) roles were reviewed long-term to increase their establishment.

Managers made sure locums had a full induction to the service before they started work. The service used locums familiar with the trust and their systems and processes who had completed foundation training to undertake specialist work.

We heard one consultant trainee (CT) or SHO grade trust doctor had an induction process and an introduction to the department. They were supporting orthopaedics at the hospital and could access a registrar during the day. However, they were unaware of escalation processes for medical emergencies.

The service had a good skill mix of medical staff on each shift and clinical leads reviewed this regularly. At the time of our inspection theatres were allocated by available consultants. In 2021 divisional leads took over scrub nursing competencies to ensure they were signed off to undertake obstetric procedures.

However, the division had significant vacancies in theatres of operating department practitioners (ODPs). In response leads considered ODPs out of hours which caused some unrest. Theatre leads held planning meetings at end of each week to agree cover for this shortfall.

Divisional leads felt some surgical specialities needed more theatre lists. They planned to transfer ODPs from specialities with no waiting lists like ophthalmology to those with a significant 52-week position such as trauma and orthopaedics. Leads felt they had a very strong 6/4/2 process in the planning of their weekly escalation meetings.

Divisional leads were aware of these ODP issues in theatres. They were planning to implement a healthcare assistant (HCA) to ODP pathway. Leads managed to maintain workstreams despite many clinicians not being able to work cross-site.

However, surgeon, theatre staff or anaesthetist unavailability was the reason for 100 hospital non-clinical cancellations between 1 June 2021 and 28 June 2022.

Records

Staff kept detailed clear records of patients' care and treatment. However, records were not always stored securely, up to date or easily available to all staff providing care.

Patient notes were not always comprehensive. However, all staff could access them easily. On our last inspection in September 2019 we found the service's records were poorly organised, not always completed and version control was poor.

On this inspection we found limited improvement as records were not always completed and parts of the patient pathway were lacking. However, we found no pre-operative notes for six patients whose medical records we reviewed, including one patient with no gynaecological records. This meant there was a risk the surgeon or theatre team would miss important information about the patient's background, allergies, medical history or clinical conditions.

The trust had electronic patient records (EPRs) available on their clinical software system and the electronic prescribing and medicines administration system (ePMA) systems. Handovers were consistent with allocated space to record notes. Service staff utilised the clinical system template across all specialities.

We reviewed the divisional documentation audit of medical record keeping approved by governance on 9 November 2021. This was undertaken by six project leads for surgical specialties trustwide. The summary of key findings was split by these specialties and showed good compliance for discharge summaries/copies and notes being filed in chronological order in all six.

However, overall findings showed poor compliance for the ward area/location, the author's name legibly printed, and the clinician's designation documented. The audit recommendations were to disseminate the results and present at clinical audit meetings for the relevant specialties. Project leads planned to prompt clinicians about the documentation audit and the areas of weakness, before collecting data for the next period.

Records were not always stored securely. We saw unlocked trolleys containing medical records on ward 29 and 1 other despite reminder notices to staff to keep them locked. We saw the 15 steps challenge assurance tool reminded staff on one ward to always keep patient notes secure and safe. The code to access medical records trolleys was not secure. This code was issued by the supplier and not changed to improve security.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed some systems and processes when safely prescribing, administering, recording and storing medicines. On inspection we reviewed patient's electronic prescriptions. We found staff had completed all the allergy status records. We checked ten items of medicine stock in the ward 29 clinic room and found all were within their expiry dates. We saw a green box full of medicines was awaiting collection. This was ad-hoc and only when staff called the pharmacy.

However, we found one patient on the orthopaedic ward did not have an electronic prescription chart. Staff were still using the paper prescription written on admission to the hospital.

We also found patient's weights were not always recorded on their electronic prescription charts. Additional records were available on the patient records system. However, some of these were completed by measuring mid upper arm circumference (MUAC). This meant staff recording of patient weights could be less accurate and potentially lead to medication prescribing errors.

However, patient's weights were not always being recorded on their electronic prescription charts. We found no weight recorded on ePMA for three patients we checked on ward 29. The patient's report was documented in their clinical software system notes for one of these patients, the other two patients had their mid-upper arm circumference (MUAC) recorded.

All wards we visited had centralised fridge temperature monitoring. Ward and deputy ward managers along with the sister in charge received automated emails of these temperatures. Wards we visited had no room temperature monitoring for medicines. However, all wards had air conditioning to control these temperatures if they fell out of suitable storage range.

Controlled drugs (CDs) registers had patient's own medicines and stock records. CDs are those for which strict legal control are needed as they may cause serious problems like dependence or harm if they are not used properly. On ward 29 we checked eight items against the register record. All were correct and within their expiry dates. Staff checked the register daily and we reviewed the latest pharmacy check from 27 May 2022.

Ward staff segregated and checked intravenous (IV) fluids. For example, we reviewed five items on ward 29 which were all within date. Ward staff checked fridge temperatures daily. This was also as part of their monthly ward checklist. We reviewed ward 29's checklist from December 2021 to June 2022 and found no errors or omissions.

Blue box contents were not maintained by pharmacy. The ward staff were replacing the contents after use and if stock had expired.

Staff did not always add opened or expiry dates to medicine stock including controlled drugs. On ward 29 we found no opening date on some methadone liquid. Staff had opened and dispensed this on 27 May 2022 which at the time of our inspection was over the 28 days expiry. On the same ward we also found two morphine solutions for daily use were opened with no expiry date. Staff told us they would administer one bottle every four to five days.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

We found ward resuscitation trolleys contained three medicine boxes, blue (anaphylaxis), red (cardiac arrest) and yellow (child). Pharmacy replaced and filled the red and yellow boxes. Staff highlighted any stock running low for pharmacy to bring new contents. We reviewed checklists and saw staff completed trolley and security checks daily. They also completed at least in-depth monthly checks of all the trolley contents.

Staff stored and managed most medicines and prescribing documents safely. The division's fridge temperatures were monitored centrally, and the system sent the ward personnel deviation warnings for them to action. Medicines requiring specific secure storage were managed appropriately and records of their administration maintained.

Emergency medicines were stored on resuscitation trolleys in accessible areas with regular checks on content and expiry dates. However, one medicine on the resus trolley required a new expiry date on removal from fridge. This had not been altered. Staff checking the trolleys were not aware of the required change in expiry date.

The service participated in the trust's routine medications management.

We found paper prescription charts were used on admission through accident and emergency (A&E). Staff then transferred inpatients onto electronic prescription records.

However, we found staff administered oxygen to one ward 29 patient which was not being prescribed.

We saw staff completed venous thromboembolism (VTE) assessments and prescribed the appropriate chemical prophylaxis. On ward 29 the appropriate prophylaxis was prescribed for all three patients' completed VTE assessments we checked.

After our chief pharmacist and medication safety officer interview during inspection, we received the medicines reconciliation audit data retrospectively. The trust policy on medicine reconciliation required an audit to be performed and reviewed by the trust's safer medication group. National practice required checks to be completed within 24 hours of admission as per the national institute for health and care excellence (NICE) guidance quality standard (QS120). This meant we could not be assured this was the case.

Service leads and pharmacists reviewed medication policies and procedures against NICE guidance and these reviews were approved through the appropriate governance committee.

Divisional leads told us staff reported any errors related to medicines reconciliation onto their incident system. The pharmacy staff involved investigated and followed up all incidents.

Ward 29 staff completed patient's allergy status on all three prescriptions we checked. Ward staff used an over labelling stock cupboard with a selection of medicines available to supply patients on discharge. They had supply for at least seven days and 14 days for their patient's care home post-discharge. We saw medics completed discharge letters.

However, we saw ward 29 had a medication error involving drugs with a similar name in June 2022. Ward staff were made aware and what to look for in future. They were also reminded where to find resources such as policies for medication administration and the medication information board.

A pharmacist told us they were picking up issues around prescribing route changes for antibiotics. For example, where intravenous (IV) had changed to oral medications. The electronic system allowed changes in route to be made on an original prescription.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service had governance oversight of medication incidents via summary reports. Medicines alerts were emailed to ward and deputy ward managers.

Incidents

Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.Managers investigated incidents. However, the service did not always manage patient safety incidents well. Lessons learned were not always shared with the whole team and the wider service.

Staff knew what incidents to report and how to report them. On our last inspection in September 2019 we found the service did always respond to safety incidents well or in a timely way.

On this inspection we found staff raised concerns and reported incidents and near misses in line with trust/provider policy. For example;

Surgery

The service had two never events on their wards from August 2021 to July 2022. This had reduced from four during the same period the year prior. Never events were immediately cascaded to the areas where the incident occurred. Managers cascaded never event information to all staff via various channels such as all staff emails, notice boards, monitor screens, business meetings, ward meetings and via media groups.

Managers shared learning about never events with their staff and across the trust. Recent never events were discussed at quality and safety meetings, departmental meetings and directly with staffing groups. Leads compiled a presentation to share and discuss with staff. Completed never event SI investigations were shared at all business meetings. A4 learning the lessons paper copies were placed in the learning the lessons folders in ward areas and speciality areas for all staff to read.

However, the division reviewed their current process of cascading and learning from incidents and investigations. They found the division did not have a robust method for evidencing how they shared all information.

Actions from never event investigation recommendations were not always put in place or detailed enough.

We found root causes and conclusion findings identified from never event and serious incident investigations were l not being actioned. We reviewed one serious incident report The report showed 14 learning actions to be dissemination to staff. However, theatre and ward staff we asked were unaware of any shared key learning.

We reviewed the division's quality and safety committee minutes from 22 March 2022. Attendees discussed and followed up learning from never events. For example, we saw in the minutes the division's four never events were caused by people not following process or feeling they were able to speak up if others were not doing likewise. They felt this culture needed to change.

Managers did not share learning with their staff about never events that happened elsewhere across the Trust.

Staff reported serious incidents clearly and in line with trust policy. Staff we asked said they could access and used the trustwide incident reporting system.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The division adhered to duty of candour for all incidents graded a moderate or above level of harm. All divisional report templates had a section for duty of candour information around discussions with patients and if needed their families. The service appointed family liaison officers (FLOs) to contact any patients involved in incidents.

We reviewed the trust's SI panel meeting notes from 12 May 2022. This showed of their 12 outstanding, the division had nine overdue DoC letters to be dealt with.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Divisional leads assured us they widely shared incident learning. However, theatre and ward staff we asked on inspection could not give any recent examples.

The service shared lessons learnt from incident investigations with the surgery and critical care (S&CC) division through newsletters and business meetings. For example, we reviewed an SI investigation report for delayed treatment within ophthalmology from April 2021. The investigation's key learning and findings were shared at the ophthalmology business meeting.

However, we saw two divisional incidents in ophthalmology were still awaiting the level of harm from urgent clinical review, in one case over a month after they occurred (Ref 267199).

There was evidence that changes had been made as a result of feedback. We saw managers shared themes from divisional incidents. For example, the lessons learnt newsletter from March 2022 contained four such themes with reminders of actions staff should take in response. Staff were reminded of the need for timely escalation to outreach of a deteriorating patient and recognition of sepsis and timely initiation of the appropriate treatment.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We heard the service had improved incident reporting and investigation in conjunction with specialist services such as safeguarding, mental health and other stakeholders.

The service had devised a divisional summary which brought together all monthly data around serious incidents and never events for discussion at the governance meetings where it was a standing item. Data was then fed back through the 6:1 and confirm and challenge meetings to nursing staff.

However, we reviewed the trust's SI panel meeting notes for the three months before our inspection. The 19 May 2022 notes showed there was no ophthalmology clinician to present the two incidents due to clinical commitments, so they were delayed by one week.

Safety thermometer

The service improved safety. Staff collected safety information and shared it with staff, patients and visitors. However, the service did not always monitor results well.

The service continually monitored and displayed safety performance on wards for staff and patients to see. Our time to shine monthly noticeboard on all wards were up to date with useful high-level themes. These outlined the top three incident reported themes, messages for sharing, number of harm free days, patient feedback, the patient advice and liaison service (PALS), complaints and compliments, three things that have gone well, three things staff would like to improve, learning from incidents, staff achievements, core mandatory training, role specific and personal appraisal development reviews (PADR) compliance and sickness.

On our last inspection in September 2019 we told the service they should improve systems for recording venous thromboembolism (VTE) assessments.

On this inspection we found the service had made limited improvement on completing VTE assessments. We found the service still did not always maintain current VTE guidelines, risk assessments and clinically accurate and timely VTE risk assessments.

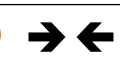
Staff risk assessed patients for VTE on admission to the hospital and at regular intervals. We found this was observed in patient's records on the assessment unit.

Staff used the safety performance data to further improve services. The service planned actions to adapt a guideline on VTE and risk assessments with a neighbouring trust, carry out a gap analysis against the national institute for health and care excellence (NICE) guidance, junior doctors in medicine and surgery would carry out audit on % completed and quality of completion retrospectively; the service undertook various audits to assess the quality of VTE assessment against guidance.

Surgery

The service had developed clinical software system risk assessments. VTE assessments were now mandated on the electronic prescribing and medicines administration system (ePMA) system. ePMA was live trustwide for all inpatients on medical and surgical wards.

Is the service effective?

Requires Improvement  

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The division had sustained improvement of compliance with NICE guidance in June 2022 and were maintaining an average of around 95% compliance. The service held quality and safety audit afternoons reinstated from cross-speciality learning and development.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw attentive theatre staff reassure a very anxious older patient. Staff introduced the patient to the scope team as they requested the company of female staff.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs. However, patients fluid and nutrition intake was not always accurately recorded.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We saw SDEC ward staff gave diabetic patients something to eat with their hot drink. Staff used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. On our last inspection in September 2019 we told the service they must improve the compliance of documenting fluid balance intake accurately (regulation 12).

On this inspection we found some improvement in hourly fluid chart monitoring. For example, we reviewed charts staff completed for a ward 28 high observation bay (HOB) patient who had been on the ward 22 days and found no errors or omissions. Many wards we visited had noticeboard displays on the importance of staff correctly completing fluid balance and weighing body mass index (BMI) for patients.

However, we found staff still did not always fully complete fluid charts for patients. For example, we reviewed one fluid chart which showed no outputs over several days for a patient with renal failure on a fluid restriction of 1.2 litres.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nursing staff carried out malnutrition universal screening tool (MUST) assessments on patients. These were repeated weekly or sooner if the patient's condition changed.

All wards observed protected mealtimes for midday and evening meals. This meant during this hour visitors were not allowed unless they helped with feeding patients.

Wards we visited used cream-coloured trays as opposed to green to help staff identify which patients needed extra attention when eating, or needed foods which had a modified texture such as being mashed or pureed. Patients who needed assistance were marked on the patient menu cards. However, we saw no staff helping patients with their food.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Patients with complex feeding needs were referred to the nutritional support nurses or dietitian for assessment and advice.

Patients waiting to have surgery were not left nil by mouth for long periods. We saw staff gave patients sandwiches to eat after fasting for long periods pre-surgery.

The number of on the day elective cancellations from June 2021 to June 2022 due to the patient eating/drinking prior to surgery was 12. The division had plans in place to complete further pre-operative fasting audits.

Pain relief

Staff gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Staff monitored patients to see if they were in pain. However, staff did not always document their assessment of pain for patients.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients received pain relief soon after requesting it. Patients we asked said they never had to wait more than a few minutes for staff to help them administer painkillers.

Staff prescribed, administered and recorded pain relief accurately. We saw ward staff used the ePMA. We saw an agency staff nurse checking patient's wristband before administering paracetamol. Ward and theatre staff could access a specialist pain team onsite. For example, if patients had epidurals or morphine for pain relief.

We reviewed an acute and end of life pain assessment audit where the division was the lead operational group from January 2022. A summary of key findings showed staff started pain assessment charts for 92% of patients trustwide. This was an increase from 86% in the previous audit.

However, staff completion of the assessment chart showed areas of low compliance. For example, only 58% of patients had a follow up within one hour to record the effect of analgesia. Also, only 33% patients were referred to the acute pain specialists where pain was uncontrolled or persistent. The audit determined results provided 'limited assurance'.

Surgery

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. However, the service did not always achieve good outcomes for patients.

The service participated in relevant national clinical audits. The trust participated in 48 or 100% of the national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The trust performed well in these audits and generally results were above national averages or within the expected range in all except the national oesophago-gastric cancer audit (NOGCA) 2021 report.

We reviewed the trust's national hip fracture database (NHFD) 2021 annual report. This audit gave an assurance level of moderate for the hospital. This remained the same compared to the 2020 report. Most patients met best practice and these results were much higher than the national average (53.8%), and had increased from 64.2% in 2020 to 68.9%. Results were within the top quartile and well above the national average (65.3%).

We reviewed the trust's national bowel cancer audit (NBOCA) 2021 report. The audit's aim was to measure the quality of care and outcomes for these patients. The trust's outlier from their previous year's NBOCA audit 2020 had improved to within the expected range. They planned actions to share and present the audit results at the general surgery audit meeting by 30 September 2022.

However, we reviewed the trust's national oesophago-gastric cancer audit (NOGCA) 2021 report. This covered the quality of care given to patients with oesophago-gastric cancer. The audit found the trust performed badly for the sixth consecutive year with a result of 21.6% which was a 0.2% increase compared to last year and significantly higher than the national average of 12.6%. The length of time from referral to start of curative treatment was longer at the trust than nationally. The audit's only recommendation where the trust and clinical lead felt action was needed was to share learning and distribute results virtually by 30 August 2022. This meant the audit's action was insufficient given how badly the trust has performed for six years.

The division's latest Patient Reported Outcome Measures (PROMs) paper showed the trust had maintained the good scores for knee replacements. The PROMs are a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. These areas are nationally selected procedures. The service performed within the expected range (between highest and lowest) for both primary hip replacement surgery and knee replacement surgery from April 2020 to March 2021.

Patient-reported outcomes after primary hip replacement surgery (published in February 2022) showed a statistical difference to national rates where the trust had fallen slightly outside the 95% control limit. However, the trust remained within the 99.8% control limit of 0.392. The alert prompted the trust to investigate processes surrounding primary hip replacement surgery. Patient-reported outcomes following primary knee replacement surgery remained within the statistically calculated confidence intervals for EQ-5D measures, demonstrating no significantly different performance compared to the UK.

However, outcomes had deteriorated for hip replacements and the team was starting a deep dive into the data in July 2022 to ascertain the underlying cause. Divisional leads had checked their staff had the opportunity to complete the surveys.

At the time of our inspection the trust did not perform varicose vein surgery, so no data was available.

Managers and staff used the results to improve patients' outcomes. We read about service changes and summaries of some actions taken from clinical audits. For example, leads had amended their new NFHD hip fracture pathway at the first opportunity, to allow any nerve block given in A&E or on the ward to be easily documented.

The service monitored their expected risk of readmission for elective and non-elective care. We reviewed the division's total emergency readmissions within 30 days from June 2021 to May 2022. Across all metrics the specialty with the highest rate of readmissions within three and 30 days was general surgery.

However, the division did not separate elective and non-elective figures. The trust's data also did not compare or benchmark to the latest national average or clarify which readmissions were categorised as potentially preventable.

Managers used information from the audits to improve care and treatment. Leads undertook data validation for the NJR audit via a webtool data review system on an ongoing basis, rather than prior to the end of the deadline period. Leads also undertook a review of fracture liaison service database evidence as case ascertainment estimations were hugely overestimated using the hip fracture methodology and fed this back to the audit supplier.

Improvement is checked and monitored. We heard the division had started a joint getting it right first time (GIRFT) for retinal pathway patients with a neighbouring trust. GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

Competent staff

Not all service staff were competent for their roles. Managers held supervision meetings with staff to provide support and development. However, managers did not always appraise staff's work performance.

Staff were experienced and qualified. For example, nursing staff were highly trained in the high observation bays (HOBs) and would update their competencies as needed.

However, not all theatre staff had the right skills and knowledge to meet the needs of patients. We saw surgeons came on shift without knowing their patient lists and specialties. Recovery scrub staff were not trained to care and treat level 3 patients who transferred from ED for stabilisation. They were aware of their limitations and the outreach team also supported these patients.

Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. On our last inspection in September 2019 we found the service's appraisal rates did not meet the trust target.

On this inspection we found limited improvement. We reviewed the quality and safety committee minutes from April 2022. It showed surgery appraisals at 74% as one of only three red actions from our CQC update report. This did not meet the trust target of 80%.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, the service had developed a directorial video for junior doctors to help identify what further venous thromboembolism (VTE) training was required and if any additional resource was required to start embedding change.

However, the division continued to have a high number of staff not attending ALERT courses. This module was not included in mandatory training compliance figures. ALERT trained staff in recognising patient deterioration and acting appropriately in treating the acutely unwell. At the time of our inspection managers were reviewing this course to support e-learning and consider staff completing this 50% face-to-face and 50% virtually. They had contacted staff to find out why compliance was low, and work was ongoing to resolve this issue.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Divisional leads told us the trust's critical care outreach team (CCOT) trained over 800 of their staff with basic critical care skills to support patients within theatres. This was part of the trustwide mutual support during COVID-19 when many staff were redeployed. We heard many divisional staff were also upskilled at an independent hospital.

Managers made sure staff received any specialist training for their role. We saw theatre staff had completed simulation training events. For example, they undertook a paediatric massive haemorrhage simulation which followed the massive haemorrhage in children guideline DCG288 from which what went well, lessons learnt, and final thoughts were shared with further reading links.

However, many theatre staff we asked were unaware they had to complete theatre registers as part of WHO checklist requirements.

Managers identified poor staff performance promptly and supported staff to improve. We heard the anaesthetic consultant's competencies had been questioned by operating department practitioner (ODPs) staff. The ODPs escalated these concerns to the theatre team leader who at the time of our inspection was on long-term sick leave.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed a medical handover which was delayed. Medical staff reviewed all patients in-depth and covered everything relevant. They gave appropriate attention to both end of life care (EOLC) involvement and patient flow discharge options as the hospital was on OPEL 4 status. We saw input from a colorectal surgeon and two advanced care practitioners (ACPs).

We observed good allied healthcare professional (AHP) input to patient's medical reviews on ward 29. However, consultant representation on this ward was poorer.

Seven-day services

Key services were available seven days a week to support timely patient care. However staff could not always call for support from doctors and other disciplines 24 hours a day, seven days a week.

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. We found generally patients of all surgical specialities were reviewed daily. The SDEC ward was available seven days between 8am and 10pm and pulled patients out of the emergency department to improve flow.

The service had revised and raised awareness of their clinical referral pathways and signposting support for both patients and their staff.

However, the division had no OOH interventional radiology or vascular support on either site. Staff had to blue light patients to a neighbouring trust. This arrangement was ad-hoc with no formal service-level agreement in place. This structure meant there was potential risk to patients who needed urgent or emergency urology clinical review or follow up.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. Staff followed national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. On our last inspection in September 2019 we found consent documentation was not always completed in line with national guidance to gain patients' consent. Patients were not always re-consented on the day of surgery and patient consent forms were not always shared with them in line with the trust policy.

On this inspection we reviewed written consent forms for ten patients undergoing surgical procedures. All these were completed and confirmed by the appropriate professional.

However, we found consent forms were still a key learning point to be shared within immediate teams and the wider organisation from never event investigation reports. For example, a never event in ophthalmology from June 2021 shared the importance of staff cross-referencing the consent form, patient notes and theatre list after the patient was not asked to confirm their identity or which eye was to be injected.

We reviewed the divisional documentation audit of medical record keeping approved by governance on 9 November 2021. This showed consent for anaesthetic showed poor compliance. The hospital achieved only eight out of 20 or 40% of records reviewed with consent documented.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We reviewed best interest decision for an orthopaedic patient with a do not attempt cardiopulmonary resuscitation (DNACPR) order in place. Ward staff had completed all the necessary paperwork involving and supported by the family.

Staff clearly recorded consent in the patients' records. We found this was clearly documented in all the records we reviewed.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLs) and made sure staff knew how to complete them. Staff completed DoLS in line with policy and procedure. We reviewed two patient's DoLs/MCA documentation onsite. Staff completed and reviewed these within the set seven-day timeframe. Staff also completed special consent forms for patients who lacked capacity.

The trust monitored their DoLs data in detail including at monthly site-specific and ward-level along with local authority referrals. We reviewed divisional DoLs data from April to June 2022 by site. During this period the hospital had 92 patients placed under DoLs, 17 of which were patients on ward 28.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We reviewed a site-specific qualitative audit of ward staff's reasons for undertaking capacity assessments

between 9 December 2021 and 7 March 2022. Key findings were the MCA/DoLS and vulnerabilities teams had developed and implemented an electronic two-stage capacity assessment tool. Learning points and an action plan were made from the audit. They planned a continued approach to MCA audits to ensure changes and training were useful and could be embedded.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. A patient we asked said they were happy with the care provided by both nurses and medical staff. Staff we observed interacting with patients were friendly, approachable and talkative.

Patients said staff treated them well and with kindness. Patients we spoke to told us nursing staff went above and beyond to care and support them with an attentive bedside manner.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. In theatres we observed a urological consultant developing an engaging and familiar rapport with the patient during their operation.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Where possible offices or meeting rooms were used for personal discussions, and bed curtains were drawn in shared bays to protect patient’s privacy. We saw attentive theatre staff reassuring a very anxious older patient. The patient asked about female staff, so they introduced her to their scope team.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Visiting times on wards were staggered between 2-4pm and 6-8pm seven days a week so as not to be too interruptive to patient care.

Surgery

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, a lack communication meant that patients missed appointments because of known environmental issues.

Managers planned and organised services so they met the needs of the local population. The division had service-level agreements (SLAs) with neighbouring trusts to avoid significant losses in surgical clinical sessions to meet local patient demand. For example, they had priority sessions for cancer and urgent patients and a recovery plan in place for weekend sessions to mitigate the loss of core SLA activity.

Managers monitored and took action to minimise missed appointments. They reviewed the division's number and underlying causes of all cancellations by surgical specialty. Managers ensured patients who did not attend appointments were contacted. The division's number of monthly patient did not attend (DNA) cancellations never exceeded seven.

However, facilities and premises were not always appropriate for the services being delivered. We observed two general surgery pre-assessment clinics being run from maxillo-facial rooms which contained a dentist chair, overhead light and vision screen. These rooms' doorframes meant they had no disabled or trolley bed access. We heard a patient on a trolley bed transferred from a neighbouring trust site could not be accommodated so had to be patient transported back again. This meant despite extra staff resource, the unsuitable environment caused an avoidable cancelled appointment.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff coordinated care with other services and providers. However, they did not always make reasonable adjustments to help patients access services

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Ward staff used a care plan called avoiding falls level of observation assessment tool (AFLOAT) for all patients including those at risk of falls or with dementia. Staff scored this according to patient's clinical presentations such as confusion/delirium, challenging behaviours or postural hypotension to create a total score and would observe patients as frequently as necessary.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. In theatres we saw a child with autism was supported only by a minimum of people such as their mother and the operating department practitioner (ODP) to reduce their distress. Theatre staff helped keep the child occupied in a bed during their surgery.

However, the pre-assessment clinic nurse having to use rooms in maxilla-facial surgery told us these were not wheelchair compatible. We found hearing aids in theatre cupboards were rarely used.

The service had information leaflets available in languages spoken by the patients and local community. We saw a few wards displayed NHS inpatient survey 2021 information called 'how was your experience of the hospital?' in four languages. We asked ward staff where they kept their leaflets to give patients and their families on discharge. Ward staff would print off leaflets according to patient need as they quickly went out of date. Staff could translate the information into any language or sized font accordingly.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The division used the common NHS telephone interpreting service language line. We saw signs on wards directing patients how to use this service with department client ID's they could ring. Ward staff helped patients when needed.

Access and flow

People received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. However, patients could not always access the service when they needed it.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service's specialities with the largest waiting lists as of March 2022 were general surgery (5,163 patients), general surgery service (4,380), and ear nose and throat (ENT) (3,689). The service's total waiting list in March 2022 was 4.7% more than the previous month of February 2022.

At the time of inspection divisional leads told us their waiting lists were in such a good position they had accepted 800 mutual aid patients across several specialties from neighbouring trusts. The other team staff managed to change their working patterns to fill in gaps whilst maintaining their regular elective activity. The division's 52-week waiting list position had deteriorated accordingly, but up until March-April 2022 they only had around 100 patients of this type.

However, theatre planning was limited as leads undertook no full clinical revalidation of patients waiting over 18 weeks.

RTT performance

The division's referral to treatment times on completed admitted pathways within 18 weeks (%) had improved from June 2021 to June 2022. Their latest performance was 71.4%. This was well above the national average of 54.7%.

We reviewed divisional referral to treatment times (RTT) monthly data by site from June 2021 to May 2022. It showed the hospital's performance for the 12-month period, which never dropped below 66% in January 2022. The hospital started the period on 61%. The hospital's overall RTT rates had improved during the 12 months by 8%. Leads reminded us the division's RTT figures were impacted by their mutual aid elective work in three surgical specialties for neighbouring trusts.

The service's 18-week performance showed consultant-led RTT's three lowest performing specialities were other – paediatric (10%), other – other services (48.1%) and T&O (55%). The service's speciality with the most 52-week waits was ENT (275), general surgery (218) and oral surgery (173).

The service had a well-established process for clinical prioritisation at the point of entry onto waiting lists. The prioritisation was reviewed by clinicians at outpatient clinics or with their GP (at the point of entry). Theatre scheduling was a weekly 6:4:2 meeting looking 2 weeks ahead reviewing lists for priorities and long waiters attended by business managers who we were told then linked in with clinical managers.

Surgery

We found some evidence of cross-speciality theatre allocation to address prioritisation and long waiters. The boards were completed every Monday and reviewed by the divisional triumvirate to formulate action plans. The biggest specialty risk areas were urology with 1566 on the patient to list (PTL); 415 of which were priority P2 patients. At the time of our inspection the orthopaedics specialty had 18 patients over 78 weeks resulting from system wide mutual aid.

The service had no system to support effective theatre in-list scheduling. This meant theatre utilisation rates may be less reliable as leads did not have any system data to support which percentage was effective.

The hospital's theatre efficiency was 89% of available sessions. This exceeded the NHS gold standard utilisation rate of 70-80%.

Cancellations

We were not assured the division had a process to address their avoidable same day cancellations and their underlying causes. This was due to limited theatre staff availability, limited theatre planning and the lack of a system to support effective theatre in-list scheduling. We saw the day before we inspected the hospital they had no ENT surgical cover and had cancelled a patient with high body mass index (BMI) on the day. Pre-assessment nursing staff should have noted this observation well in advance.

In the quarter from January to March 2022, cancelled operations for surgical specialties had seen a 7% improvement to 19%, compared to the previous quarter (26%). This was below the national average of 23%.

We reviewed the division's number of surgical on the day (OTD) cancellations from January to December 2021. This was a total of 860 cancelled procedures over the 12-month period, which averaged almost 72 per month. The month with the highest number of cancellations was September 2021 with 114. The month with the lowest number of cancellations was January 2021 with 40.

The surgical specialty with the highest number of cancellations in 2021 was ophthalmology with 209, followed by urology with 168 and general surgery with 130.

Waiting lists

On our last inspection in September 2019 we found the service's patients whose operations were cancelled were not always treated within 28 days and some patients were still waiting more than 52 week waits for surgical treatment.

On this inspection we found the division had made significant improvements with mitigations in place for patients on their waiting lists. For example, the service undertook risk stratification for formal harm review processes for any 52-week wait breach or 104-day breach patients on their cancer pathway. Staff based risk reviews on clinical events; for example, the service identified all P4 laparoscopic cholecystectomy (gallbladder removal) patients as a high-risk group from their harm review case. This was after one of these patients clinically deteriorated prompting an admission.

We reviewed the division's cancer performance report dashboard refreshed on 29 June 2022. The service saw 98.1% of patients with two-week wait referrals within 14 days. This was above the national target of 93%. The service also achieved the national standard of 98% for subsequent treatment (anti-cancer drugs) under their 31-day performance decision to treat to treatment.

However, the service only diagnosed 51.3% of patients within 28 days. This did not meet the national standard of 75%. The service also missed all three national standards for 62-day performance referral to first definite treatment. These were for urgent GP referral, screening service and consultant upgrades. The service narrowly missed national standards for first definitive treatment and subsequent treatment (surgery) under their 31-day performance decision to treat to treatment.

The service red, amber, green (RAG) rated, risk reported and displayed all the outpatient waiting list on their board. The longest wait on this list was one 103-weeks patient in ophthalmology.

The divisional specialties with the largest waiting lists in patient number terms were general surgery, general surgery service and ear, nose and throat service.

In March 2022, some surgical specialties had the largest waiting lists and oral surgery was amongst the worst performing in terms of treatment within 18 weeks. The service also had the highest percentage of zero to under 18-week patients on their waiting list by time band within their Humber, Coast and Vale sustainability and transformation plan (STP).

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The division had good patient prioritisation in place for some specialties.

The division's oncology service waiting times were raised as a risk on the trustwide risk register confirm and challenge in July 2021. It stated the trust's waiting times for oncology patients were longer than expected due to the absence of consultant oncologists at a neighbouring trust. The division had also escalated concerns regarding their urology cancer waiting times and patient treatment delays.

We reviewed the division's bed occupancy summaries by site between September 2021 and June 2022 excluding day case wards. During this period the hospital's bed occupancy across the four wards had risen 2.2% from 95.2% in September 2021 to 97.4% by June 2022. Their occupancy rate over the ten months had reduced by 0.6%.

We also reviewed the hospital' bed occupancy by ward from September 2021 to June 2022. The ward with the highest occupancy for this period was ward 29 which never fell below 96.1%. This ward's highest month for bed occupancy was May 2022 with 99.3%.

Managers and staff worked to make sure patients did not stay longer than they needed to. The division monitored and reviewed their average length of stay (LoS) for elective and non-elective patients by speciality. We reviewed this data from 1 June 2021 to 28 June 2022. The division's overall average LoS was 3.16 days, 2.44 for elective patients and 3.3 for non-elective. The specialty with the shortest average LoS was oral surgery with 0.2 days. The speciality with the longest average LoS was trauma and orthopaedics (T&O) with 5.24 days. Elective T&O patients' LoS spiked to over nine days in December 2021 and to just over four days in May 2022.

The division monitored and reviewed their weekly number of patients stranded for over seven days as part of the mortality and morbidity governance. We reviewed the latest data for 24 June 2022 position. The division added comments to explain why the patients were still stranded and any onward pathway or discharge planning.

We reviewed the trust's patient flow, escalation and surge policy (including full capacity protocol) last issued in December 2020. This policy outlined the triggers and relevant actions required by all areas to effectively manage capacity to meet non-elective demand for trust admissions and maintain patient flow. This included the division's daily

flowchart and escalation process on page 65. This had four stages of escalation led by the matrons for the first operational centre meeting. If the division had significant bed pressures the assistant general managers (AGMs) and matrons liaised with consultants and clinical leads. They requested focused ward rounds prioritising acutely unwell patients and discharges. They then considered possible elective cancellations after reviewing a set of criteria and escalated these to the assistant chief operations officer (ACOO) or associate chief nurse (ACN) and deputy before the final decision was made.

The deputy chief operating officer must make the decision to cancel any elective activity in line with the trust's theatre planning policy after discussion with the relevant ACOO, assistant medical director and ACN. The policy outlined the division's management of activity when responding to OPEL 3 or 4 status. Matrons we asked said they followed this escalation process when their trust or site was in OPEL 4 status.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. On our last inspection in September 2019 we found medical outlier patients on surgical wards did not always receive timely medical reviews.

Managers could not always work to minimise the number of surgical patients on non-surgical wards. Surgical wards we visited had a high number of medical outlier patients.

We reviewed the division's medical outliers data from 1 July 2021 to 30 June 2022. The hospital had a lower outliers rate of 0.79% during the 12 months. Their rates were not consistently decreasing, their rate had improved by about 0.5% from March to June 2022.

Managers monitored patient moves between wards/services. However, these were not kept to a minimum. We reviewed the division's ward transfers (when a patient moved from one ward to another) from July 2021 to June 2022. Their total number of ward transfers had risen by 248 during this period. The month with the highest number of transfers was May 2022 with 1,325.

Staff moved patients between wards at night. We reviewed the division's ward transfers as of 29 June 2022 including between 10pm and 6am (by night). This showed they had a total of 2,839 transfers between these times; 463 of these were due to capacity.

Managers and staff worked to make sure that they started discharge planning as early as possible. The division calculated their total number of lost bed days as per the national discharge policy. This was done by number of days post discharge to assess (D2A) completion minus the first 24 hours. We reviewed these figures for May and June 2022. They showed their number of lost bed days totalled around the 400 mark for the first half of May, then dropped to around 250 for the latter half. The hospital's combined number of lost bed days for June fluctuated between 40-70% and showed some inconsistent improvement.

We were told divisional leads were working with external partners to define delayed discharges and capture this information fully and systematically. However, at the time of our inspection this work was still not completed.

We reviewed the division's delayed discharges on the discharge to assess pathways by specialty for April, May and June 2022. The specialty with the highest number of delayed discharges at the hospital was orthopaedics with 174. This was twice as many as any other specialty.

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Ward patients we asked said they would ask staff members to help them access PALS information if needed.

The service clearly displayed information about how to raise a concern in patient areas. We saw ward areas display patient advice and liaison service (PALS) information on how patients could complain, when their offices were open and where they were based at both hospitals.

We also saw signs for comments, compliments or queries in four steps.

Managers investigated complaints and identified themes. The service's time to resolve complaints had improved since our last inspection in September 2019. The division's average number of days taken to close formal complaints in June 2022 was 44 days. This did not meet the trust target of closing complaints within 40 days.

At the time of our inspection there were 35 complaints open, one was over 60 days and ten were over 40 days.

Divisional leads told us they had undertaken a significant workpiece to improve their complaints position with a changed process. All complaints raised were allocated to a lead investigator within each speciality. Leads received a weekly quad highlight report which showed their complaints position to review and check process. The divisional associate chief nurse and governance lead have looked at how to theme complaints within each speciality to feedback within their respective speciality groups.

The division's top categories of formal complaints received from 1 April to 5 July 2022 were around clinical treatment and patient feedback including communication, patient care, appointments or values and behaviours.

Managers shared feedback from complaints with staff and learning was used to improve the service. The service had several ways to cascade learning division and trustwide as well as escalate staff concerns.

Staff could give examples of how they used patient feedback to improve daily practice. For example, patients told staff that ward 29 was too hot. In response staff installed air conditioning which refreshed patients and improved their experience.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Surgery

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. However, leads were not always visible or responsive. They were not always approachable in the service for patients and staff.

Staff we asked knew who their immediate managers were and these managers understood the challenges for the service. However, managers were not always clear if or when to implement changes.

The service had a fairly new clinically-led divisional management structure.

We found a strong team leadership within theatres. However, leads did not always ensure the hospital's root cause analysis from never event investigations were followed up after learning was shared with staff. The division's never event investigation root causes and recommendations were not always detailed enough. This meant leadership oversight of some environment and equipment issues in theatres was lacking.

The division's senior nursing managers walked the wards at least weekly and when on-call at weekends. However, we saw no senior management or lead visibility above matron level in any areas of the service. Staff also told us they did not see any cross-site management presence.

At the time of our inspection a trustwide rollout of leadership framework was underway to meet all requirements in every division. From 4 August 2022 all staff would be sent a guide outlining how leaders will be developed and supported. This was a grassroots up programme to help identify leadership gaps.

The weekly divisional triumvirate and quad meeting agendas and structure mirrored those of the trust's executive performance meeting. Items for discussions were risk and escalations, performance and finance to ensure the strategy was progressing as planned, along with any issues relating to all specialties.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, leaders and staff did not understand and know how to apply them.

On our last inspection in September 2019 we saw limited evidence the division's draft vision and strategy had been developed with all relevant stakeholders.

On this inspection divisional leads we asked clearly outlined their strategic direction despite not being in their current triumvirate roles when the strategy was built in 2019. However, during inspection no managers or senior staff mentioned this strategy and those we asked were unsure of the strategic priorities. No onsite staff we spoke to could describe the vision for the service.

Leads outlined how their current strategy involved stakeholders. For example, they considered pathways with community primary care partners and collaborative work with the integrated care partnership (ICP) and systemwide. They explained their priorities were keeping 52-week wait patient numbers down, improving staff engagement and the working relationships between their divisional specialities. Leads were proud of their pace of change and marked improvements since 2019.

Surgery

Culture

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, staff did not always feel respected, supported and valued.

We read divisional leads planned to address and improve the culture in theatres, particularly for junior staff in a fast-moving environment.. Leads had an overarching separate action plan for theatres and some cross-site quality improvement work where they linked in with a trust associate director of culture.

The division had the second highest number (26) of FTSUG concerns raised by staff trustwide between 2021 and 2022.

However, some support staff for one specialty told us they had raised issues and made suggestions for improvement but did not feel listened to.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

On our last inspection in 2019 we did not see the service's governance, performance or risk issues escalated and discussed in an effective way. The governance structure internally within the division and externally within the trust needed strengthening to show evidence of risk and performance discussion.

On this inspection we found divisional governance has significantly improved and the triumvirate and quad governance and management structures were now more embedded. Leads told us their governance and performance processes were stronger across all areas and they were better sighted on service issues. For example, on our last inspection the division had no purely governance triumvirate in place. The division had reviewed their governance as one structure with both elements when diagnostics joined the division the month before our inspection.

Leads held a quad meeting every Monday with an embedded agenda which covered finance. Leads reviewed workforce every Tuesday morning including the nursing, medical and allied health professional (AHP) and administrative elements to discuss any issues. The division also held monthly speciality improvement meetings mirrored the same as executive meetings. This meant all leads were sighted on exactly the same things within each specialty as the leadership team. This included the whole process up and down from a quality and safety, performance, and governance perspective. Leads told us they understood their roles scope and would use each other's best qualities.

The division had a tiered structure of governance meetings in place with escalation routes to the divisional management team and from there to the executive team. The structure was supported by the surgery and critical care (S&CC) governance structure which was approved in March 2022.

The divisional board was held monthly for two hours and involved the divisional senior managers and covered governance, performance, operational issues, human resources (HR) issues and finance.

The service held monthly ward managers and monthly ward meetings called 'confirm and challenge' to ensure robust communication was shared.

Surgery

Divisional governance issues were discussed at the S&CC group governance meeting. These meetings were held monthly, chaired by the clinical lead for governance and supported by a 'terms of reference' (updated, awaiting upload to Hub for official date of review). Highlight reports were presented from the speciality meetings as well as reports on patient experience, incidents, serious incidents and the risk register. There was also an associated action plan. Escalation from this meeting went to the monthly quality governance group (QGG) if it was a quality issue and a quarterly report was also presented at QGG. Service leads actively monitored attendance and papers at the divisional governance meeting. The division had only cancelled one meeting in April 2020 during the first wave of COVID-19.

Speciality level governance issues were discussed at the speciality business meetings held monthly. These meetings covered governance, performance and finance items. Highlight reports were completed monthly from these meetings to escalate any risk and issues to the surgery and critical care governance group board meeting. The highlight reports captured performance, safety and quality.

The division held monthly confirm and challenge meetings. The ward manager, associate chief nurse/head of nursing and matron attended. Risk handlers who attended were given an allotted time to provide and further updates, make amendment requests and challenge the documented information quality. The agenda covered key quality and safety issues such as venous thromboembolism (VTE), mandatory training, falls, rosters, the 15 steps action plan, NEWS and sepsis. Notes were taken and sent back to the ward manager as a prompt for actions to be completed by the next meeting. This process ensured frontline to board escalation of risks and information and frontline learning from incidents and complaints. Service leads felt there was variation in quality, frequency and documentation. They noted these meetings were more vulnerable to operational pressures due to attendees being frontline staff.

The 15 steps challenge was the service's ward-based governance review. All ward we visited had achieved 'good' or 'outstanding' ratings in their latest challenge.

Service leads discussed mortality at the divisional governance meeting. At the time of our inspection general surgery and trauma and orthopaedics (T&O) were holding regular mortality meetings. Mortality learning where applicable was also identified from the trust's serious incident panel and from structured judgement reviews. This learning was in the integrated quality report. Leads felt mortality learning was an area which needed further work to collate learning from different sources and to provide assurance it occurred.

We reviewed minutes from the mortality improvement group (MIG) on 6 May 2022. The group had a continued focus on the deteriorating patient (DP) and sepsis with collaborative working between all divisions. The trust employed a clinical educator to support with the deteriorating patient in post until September 2022. The division focused on quality improvement (QI) with a QI lead two days per week to support their improvement plan delivery. Leads had completed a deep dive into all aspects of the DP and sepsis workstream to identify revised overarching objectives. This enabled the further cascade of education. Leads had also embedded stop and check huddles on wards including for the deteriorating patient. The division monitored observations via their DP and sepsis oversight group. Leads reviewed incidents relating to the deteriorating patient to identify if any learning was required.

The service held monthly 6:1 meetings between the head or deputy HoN and the matrons to review key quality and safety issues. The meeting gave senior staff the opportunity to convey crucial messages and set topics were covered such as serious incidents, recruitment and finance.

We reviewed the service's last CQC assurance information on 9 March 2022. Their next steps showed leads would continue to monitor governance performance and any further developments needed.

Surgery

At the time of our inspection divisional governance document control was being overhauled and a new process was in place working towards 100% compliance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

On our last inspection in September 2019 we saw limited evidence of identifying and escalating relevant risks and issues and identified actions to reduce their impact.

The division's actions since have included a governance arrangement documented in a framework format. The division also had an approved in-date terms of reference (ToR) and agenda for governance meetings where minutes followed the set standard and were not cancelled unless by triumvirate agreement. All actions were clearly identified with ownership and target completion timescales.

We felt assured the divisional management triumvirate had competent and capable knowledge and oversight of risks, issues and performance.

We reviewed the trustwide risk register confirm and challenge appendix for the top divisional risks. The shortfall in capacity within the ophthalmology service was added in April 2015 but last reviewed on 30 May 2022 with the risk status unchanged. The service had controls in place, action descriptions and progress. For example, they were working with the clinical commissioning group (CCG) to secure extra capacity within the independent healthcare sector.

The division had a risk around their hospital theatre suite maintenance and disrepair added to the trustwide register in March 2021. Theatres A, B and C at this hospital were in a state of disrepair. This meant there was a risk surgery may be disrupted impacting upon trust's ability to deliver constitutional targets. Controls in place were reorganising activity to other sites and temporary lighting being brought into theatres in case the lights failed during a procedure. Another relevant trustwide risk related to theatre ventilation checks and monthly particulate tests undertaken by the trust's IPC team.

A divisional risk added in June 2017 was around overall performance of their number of cancer patients waiting over the 62-day performance target. The trust was aware their failure to treat these patients resulted in poor patient experience and had the potential for clinical harm in some specialties. The likelihood of continuing to not achieve the 62-day standards was high due to some elements of the diagnostic or staging pathway being outside of the trust's control and sitting with a tertiary provider. However, the trust consistently achieved the 14-day and 31-day standards.

Divisional leads had weekly cancer RTT waiting time meetings to challenge and review all their cancer PTLs. Their cancer performance backlog was reported weekly to the operational management group (OMG) and a trustwide clinical harm review process was in progress.

Service and divisional level risks were identified from business meetings, governance, incidents, SIs and audit. Once staff identified a risk, the risk register template was populated and when completed was taken to the relevant speciality business meeting for their review and sign off. Once risks had been ratified, they were sent to the clinical governance meeting for final review and ratification. If the risk needed to be entered onto the risk register immediately, the risk and governance facilitator (RGF) did so before sign off. An agreement was in place giving them authority to do so, from a senior triumvirate member. However, risks still had to be ratified for approval at both meetings.

All risks on the register were managed by the handler. Each risk was updated before the review date. The service-level risk register was a "live" document and therefore risks were updated as and when required with any changes or updates.

A divisional update in the trust board papers for June 2022 noted quality improvement with deteriorating patient and sepsis was ongoing. Divisional leads raised the issue of adding the deteriorating patient escalation and sepsis pathway management onto the risk register with relevant audit facilitators by 30 October 2021. This meant improved oversight and focus by divisional and risk leads positively impacted patient safety.

We reviewed minutes from the mortality improvement group (MIG) on 6 May 2022. The group had a continued focus on the deteriorating patient (DP) and sepsis with collaborative working between all divisions. The trust employed a clinical educator to support with the deteriorating patient in post until September 2022. The division focused on quality improvement (QI) with a QI lead two days per week to support their improvement plan delivery. Leads had completed a deep dive into all aspects of the DP and sepsis workstream to identify revised overarching objectives. This enabled the further cascade of education. Leads had also embedded stop and check huddles on wards including for the deteriorating patient. The division monitored observations via their DP and sepsis oversight group. Leads reviewed incidents relating to the deteriorating patient to identify if any learning was required.

Staff could also take new risks to the weekly triumvirate meeting if they needed divisional lead input. The trust held quarterly confirm and challenge meetings which the head of nursing (HoN) or deputy HoN attended to discuss their risks. The risk register was also part of the integrated governance report which if necessary, any risk issues were highlighted at the clinical governance meeting.

However, despite our previous inspection findings and legal breaches, we could still see no indication some risk contributory factors and elements were being discussed at divisional level. For example, the SI panel meeting notes from 12 May 2022 showed at least two queries around the wider plan to address the WHO surgical checklist shortcomings in general and human factors were unanswered. After our inspection senior staff clarified these meeting notes were in draft form and further group work had since been carried out on the report.

Information Management

The service collected reliable data and analysed it. Data or notifications were consistently submitted to external organisations as required. However, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated and secure.

We found some of the trust's systems and processes for recording and monitoring clinical information were long-winded and convoluted. Staff often had to duplicate some documentation such as care plans and risk assessments due to delays uploading onto their clinical software system.

The division recognised there was limited interface between software packages which prevented some internal and external trustwide information sharing, including with other trusts or service providers. Theatre staff complained to us their clinical software system information was outdated.

We found some IT systems staff used were incompatible – the trust's clinical software system did not talk to the electronic prescribing and medicines administration (ePMA) so staff had to manually enter drugs for discharge. Ward staff told us uploading treatment sheets for patients from ED onto ePMA was initially an issue when ePMA was first introduced.

However, in February 2022 the service worked with information services and an integrated technology company to produce better data reports of VTE. All previous VTE assessments for current and previous patient visits could be viewed on the system.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The division had appointed professional nurse advocates (PNAs) to most wards to help support staff with their health and wellbeing. We saw ward staff had wellbeing walks and bike rides planned to help work relationships. In theatres we saw all staff names were included in a giant jigsaw which displayed a picture of a theatre.

However, some ward staff told us they were unhappy as they did not have a transfer team so were given multiple workloads.

Maternity

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most completed it.

Midwifery and medical staff received and mostly kept up to date with their mandatory training and we saw improvement since our last inspection. Midwifery staff compliance rate was 74.88% and medical staff compliance was 79.59% against the trust target of 85%.

The mandatory training was comprehensive and met the needs of women and staff.

Staff we spoke with told us managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

Midwifery and medical staff received training specific for their role on how to recognise and report abuse.

The trust compliance target of 85% was met for levels one and two adult and children safeguarding and PREVENT training. PREVENT is a government led programme which aims to safeguard vulnerable people from being drawn into terrorism.

We saw some improvement in the compliance for level three safeguarding children, which was at 77.55%. However, compliance for level three adult training was still low, at 75% against the trust target of 85%.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. We observed safeguarding for women and babies was incorporated into the daily multidisciplinary safety huddles.

The service had a policy for identification of female genital mutilation (FGM) and an escalation pathway. Women were asked routinely, and risk assessed if concerns were raised about FGM. Individualised care plans were made in liaison with gynaecology if required. A family approach to find siblings and protect babies was undertaken. The trust monitored rates of FGM and reported all cases to the Department of Health database.

Safeguarding leads were part of the local network for midwives to help share learning and promote good practice. There was a safeguarding specialist named midwife in post for one day a week. 1.95 whole time equivalent (WTE) across the trust with 0.95 WTE allocated to Scunthorpe General Hospital.

There was a baby-tagging alarm system, abduction policy and the unit now had a schedule for unannounced baby abduction drills. Staff we spoke with told us they participated in a drill in February 2021. However, the drill planned on the schedule for February 2022 did not proceed as facilitators were unavailable and it was not shown as rescheduled. Staff received feedback following a drill at the trust's Diana Princess of Wales hospital in May 2022, via a recently introduced lessons learned bulletin. This highlighted the urgency of ensuring safety of the baby when the baby tagging system alarmed. We also saw a divisional plan with clear actions to address areas of risk. This was last reviewed in June 2022, however, only one of the ten actions was completed by the action due date.

Staff we spoke with shared concerns that the baby-tagging alarm system was not effective due to persistent false alarms and the position of detectors in the ceiling near the exit. Exit was via a green push button. Staff were concerned this could be activated and abduction could occur before the detector triggered the alarm. In addition, the system was designed to lockdown the doors on activation, but staff said this function did not work. Staff said they were unable to check every baby every time there was a false alarm and felt nothing was done about it when they reported their concerns about the system.

We saw reports of two occasions in June 2022 where the tagging system alarmed constantly due to an apparent system error. This meant the alarm system may not be fit for purpose and the risk of baby abduction was still not sufficiently mitigated. This risk was not on the maternity risk register.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment visibly clean.

There was an infection prevention and control policy in place. Compliance with infection prevention training was 100% for level one. However, compliance was low at 68.37% for level two, against a trust target of 85%.

The service participated in 10 hand hygiene audits per month. Hand hygiene dashboard data we reviewed for the period March to May 2022 showed 100% compliance.

All clinical areas we visited were clean and had suitable furnishings which were clean and well-maintained. For example, all seating was impermeable and could be wiped clean.

Environmental cleaning was completed by domestic staff. Cleaning records were up-to-date and demonstrated that most areas were cleaned regularly. The exception was some high surfaces, for example tops of cabinets in the ward clean utility room. These were very dusty and cupboard tops were used inappropriately to store consumables items such as clinical reagents. This meant the surfaces could not be cleaned effectively.

We observed cleaning schedules displayed on wards and posters indicating five-star ratings for cleanliness audits.

Staff followed infection control principles including the use of personal protective equipment (PPE).We observed staff complied with 'bare arms below the elbows' policy, in accordance with National Institute for Health and Care Excellence (NICE) guidance.

Staff cleaned equipment after patient contact and labelled equipment with 'I am clean' stickers to show when it was last cleaned.

We observed public areas had posters which promoted COVID-19 awareness, and hand gel stations.

Maternity

Women were asked to adhere to the trust's COVID-19 infection prevention and control measures as part of the appointments booking process. For example, women were asked not to bring children to their appointments where possible and partners were not able to stay overnight. Women were asked to inform their midwife of a positive COVID-19 test or if living with someone else who tested positive. This information was clearly displayed on the trust website.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The antenatal / postnatal ward (ward 26) had 26 beds arranged as three shared bays and three single cubicles. There were shared bathroom and toilet facilities.

On the delivery suite there were two delivery rooms with shared toilet facilities. Toilets for birth-partners were outside the delivery room. There was a bereavement suite which was separate from other rooms, with ensuite. Across from theatre, there was a high dependency room and a pool birthing room, although we were told this was not used very often.

All fire extinguisher appliances inspected were signposted and serviced within an appropriate timescale. Fire exits and corridors were clear of obstructions.

Access to the ward and central delivery suite and theatre was via a buzzer and camera entry system and staff had a clear line of sight to the entrance doors. Access to restricted clinical areas, for example, the utility rooms, was controlled with key-pad locks.

There were systems for recording the service and planned preventive maintenance of equipment, identified through a central log and equipment compliance stickers, which indicated the dates tests were due. All portable electrical equipment we inspected was tested within due dates. The exception was in theatre where we saw a swab weigh scale with a last test sticker dated 2020, and a syringe driver machine without a test date sticker. We brought this to the attention of staff at the time and arrangements were made with the estates staff to ensure the tests were completed as soon as possible.

However, we were concerned about the poor condition of vinyl floor coverings on ward 26. For example, a shower room situated next to the nurses' station, did not have sufficient drainage and the flooring by the door was fixed with black tape. We saw there was a risk of water escape into the corridor which was a slip hazard and could damage computer equipment stored on the floor nearby. We saw the integrity of the floor covering was also poor in several ward corridor areas and patched with black tape. This meant we had concerns about risk of slips, trips and falls and infection prevention and control (IPC), as the floor could not be cleaned effectively. Staff we spoke with told us they reported the poor flooring in 2017 and were concerned it was still not replaced. We saw the poor condition of the ward floors was not recorded as a risk on the maternity or estates risk registers.

We brought this to the attention of senior managers at the time. Following our inspection, we received written confirmation of arrangements for specialist contractors to assess work required and the bathroom would be closed until the floor was fixed.

Staff carried out safety checks of specialist equipment we inspected. For example, ward checking records for the emergency resuscitation equipment, post-partum haemorrhage trolley, pre-eclampsia trolley and sepsis box had no gaps. All weekly and daily checks of emergency equipment in delivery suite, theatre, out-patient clinics and day unit were complete.

However, the service did not have a robust system in place to manage consumable items. For example, in the clean utility room on the ward, we found many out of date blood sampling bottles mixed with non-expired bottles. We observed staff used these without checking the expiry dates. This meant there was a risk laboratory results may have been affected if out of date sampling bottles were used.

In addition, we found sterile surgical instruments that had exceeded expiry dates, and these were stored with non-expired surgical instruments. Blood glucose monitoring meter test fluids for one machine expired in 2021 and there were no test fluids for the other machine. This meant we were unclear how staff were assured the machines were correctly calibrated for accuracy prior to use.

We found single- patient use soft yellow paraffin tubes were not discarded after use. This meant there was a risk the same tubes were used for multiple patients. We found a part used bottle of hand rub with an expiry date of 2000 and a dispenser used to store plastic aprons was empty. We brought this to the attention of managers at the time. They arranged for the stock to be checked and expired items to be removed. The manager noted this on their handover sheet for communication at subsequent safety huddles.

There were no wipe-clean plastic phlebotomy trays available for staff who undertook phlebotomy (blood sampling). We heard staff remark that plastic trays on order had not arrived and saw they used pulp cardboard vomit bowls to transport phlebotomy equipment to the bedside. These could not be cleaned prior to use and this meant we had concerns about infection prevention and control.

Women we spoke with told us they could reach call bells and staff responded quickly when called.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff mostly completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Staff used a nationally recognised Modified Early Obstetric Warning Score (MEOWS) tool to identify women at risk of deterioration and escalated them appropriately. They used National Early Warning Score (NEWS) to identify babies at risk of deterioration and escalated them appropriately. This was recorded on an electronic platform accessible to all clinical staff.

Staff mostly completed risk assessments for each woman at every contact, using a recognised tool, and reviewed this regularly, including after any incident. The exception was one of nine records had no carbon monoxide monitoring recorded as a minimum at booking and two of nine did not have risk assessments completed, including place of birth, at every contact; only at booking.

Staff knew about and dealt with any specific risk issues. For example, staff used a nationally recognised sepsis six pathway, and completed venous thromboembolism risk assessments for all women. We saw evidence of 'fresh eyes' assessments if cardiotocography (CTG) was performed in accordance with policy and best practice. CTG is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour.

Staff shared key information to keep women safe when handing over their care to others. For example, we observed a night to day team handover huddle on delivery suite attended by consultants, delivery suite coordinator, theatre staff. Staff explained since the pandemic, there was no representation from antenatal ward or neonatal unit. We were unclear why this was but managers we spoke with said they were considering reinstating this.

The service now ensured the risk of delayed access to the central delivery suite and emergency main theatres for women on the antenatal / postnatal ward was minimised. For example, there was now a full obstetric theatre team, available 24 hours, seven days a week to cover elective and emergency cases. There was also a separate lift to enable prompt emergency transfer of women to delivery suite. Managers monitored the use of main theatres as a second theatre and noted it was used very rarely in the last six months.

We saw staff used the SBAR format at multidisciplinary handovers and evidence of escalation of high-risk women, to obstetricians. SBAR is an acronym for situation, background, assessment, recommendation; a technique used to facilitate prompt and appropriate communication.

There was a policy in place for identification of suspected fetal abnormalities which described the escalation and referral process.

We observed shift changes and handovers between midwives and medical staff included all necessary key information to keep women and babies safe.

Nurse Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. The trust was unable to provide assurance that bank and agency staff received a full induction.

Managers calculated and reviewed the number and grade of nurses, midwives, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance and used an acuity tool.

However, the service did not always have enough nursing, healthcare assistants and midwifery staff to keep women and babies safe from potential harm. Staffing and mitigation of associated risks remained a concern. For example, we reviewed planned versus actual staffing percentages for the 12 months to May 2022. This ranged from 80.2% to 92.6% and indicated suboptimal staffing to be a persistent occurrence.

Most staff we spoke with told us staffing was their primary concern. They felt the workload was now more high risk and said staff were regularly deployed to delivery suite from the ward. Staff said they often did not have sufficient rest and meal breaks.

Maternity

Managers monitored the effects of suboptimal staffing on the maternity dashboard. This was used to capture red flag indicators, as recommended by Birth Rate Plus and National Institute for Health and Care Excellence (NICE) guidelines. A midwifery red flag event was a warning sign that there may be concerns with midwifery staffing levels. The data we reviewed showed delayed induction of labour was a persistent issue however, one to one care in labour was achieved consistently.

Staffing was overseen by the shift coordinators, who were mostly supernumerary. There was also a 'matron of the day' who supported clinically when there were gaps in staffing.

Staffing requirements were transcribed manually from the electronic safer staffing tool onto a paper maternity communication tool. Shift coordinators updated the paper communication tool four times a day to reflect changing acuity and staffing needs.

We saw planned and actual staffing displayed and actual levels did not meet planned during our inspection.

Managers we spoke with explained there were daily staffing meetings for oversight of maternity issues and operational meetings three times daily to escalate staffing issues.

The trust had a policy for safe staffing levels and maternity services escalation policy. These detailed how to address any shortfalls in staffing, for example, unexpected absence. An escalation approach via the shift coordinators, senior nurses and midwives on duty or relevant on-call teams was clearly defined. However, staff we spoke with shared concerns that when the unit was at capacity they were not permitted to close. Red flag data confirmed the unit was not closed in the last 12 months prior to our inspection.

Managers used of bank and agency staff and requested staff familiar with the service. Staff we spoke with told us the service often 'relied on goodwill' to cover staffing shortfalls and shifts that required cover were advertised on a staff social media group. Specialist midwives and community staff were also utilised. Red flag data showed there were 131 occasions in the year to May 2022 when community staff were called in to work on the unit.

The service had increasing vacancy rates; currently at 30.48% whole time equivalent posts and the trust continued active recruitment.

The service had increasing sickness rates. The trust sickness absence rate for nursing and midwifery staff within the maternity core service remained between 8-10% from September 2021 to March 2022. This was notably higher than the absence rate in March 2021 of 4%.

Managers we spoke with told us all bank and agency staff had an informal orientation but no formal documented induction. This meant there was a risk of harm to women and babies if staff were unfamiliar with equipment, policies and emergency escalation procedures.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and babies safe.

The medical staff matched the planned number; there were no gaps in the rota.

Medical staff we spoke with told us there was excellent teamworking and they felt well supported. They said, 'everyone is approachable' and they received appropriate supervision. This concurred with the 2021 General Medical Council national trainee survey which showed the overall satisfaction score was similar to the national aggregate.

The service had increasing vacancy rates for medical staff; currently at 12.41%. There were two agency locum registrars employed and they received a full induction.

Sickness rates for medical staff were low. For medical and dental staff within the maternity core service, the absence rate fluctuated between 1 and 5% since March 2021.

Consultant cover on site was 8am to 6pm Monday to Friday with specialist trainee support 24 hours a day. An intensive care consultant covered at weekends until 9pm and there was always a consultant on call during evenings and weekends.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely.

Records were mostly kept on paper. The exceptions were observations and pathology investigations which were recorded on an electronic system.

The service audited records. However, the last trust wide maternity report for the period May to November 2021 provided limited assurance to the trust. We saw an action plan was in place and this included implementation of an electronic maternity records system. Staff we spoke with were aware of the action plan and told us about a planned online portal and application that allowed women to access their real-time maternity records over the internet through computer, tablet device or mobile phone. Managers we spoke with said this would likely improve record keeping compliance.

We reviewed nine sets of women's records and found the quality of record keeping was good. They were comprehensive and all staff could access them easily.

When women transferred to a new team, there were no delays in staff accessing their records.

Staff compliance with mandatory information governance and data security training was 84.31% against the trust target of 85%.

However, we observed records were not always stored securely. For example, on the ward, we found patient records stored in an unlockable filing cabinet and on a chair in the staff rest room. This was not in accordance with the General Data Protection Regulation (GDPR). We brought this to the attention of the ward manager at the time and the records were secured in a lockable filing cabinet by the end of the inspection.

Staff we spoke with shared concerns that there was insufficient administration support and had repeatedly reported this to senior managers as an essential need. However, staff explained there had been no progression with this and we observed there was no ward clerk on the ward during our inspection. We observed health care assistants had to leave the ward to retrieve records.

Maternity

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. Medicines were not always stored safely.

There was a dedicated pharmacist for maternity services.

Staff followed systems and processes to prescribe and administer medicines safely. Staff we spoke with told us the electronic prescribing system, which was stopped due to IT issues, would be relaunched from July 2022.

Midwifery staff worked to patient group directions, and practice was underpinned by the trust patient group direction protocol. We saw guidance around midwifery exemptions was included in the trust's medicines code.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Prescription charts were held as paper records. Staff completed medicines records accurately and kept them up to date.

However, staff did not always store medicines safely. For example, on the ward we saw mixed batches of intravenous fluids stored together, which is not best practice. In addition, staff did not record ambient room temperatures where medicines were stored. This meant the trust was not assured all medicines, for example, intravenous fluids, were stored in accordance with manufacturer's guidance. After our inspection we received assurance the trust was developing a formal policy to address this.

In theatre we found a small quantity of medicines had expired two months previously. We brought this to the attention of staff at the time and the medicines were replaced.

Medicines safety was promoted in a safer medicines newsletter which we saw in staff areas.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

There was an incident reporting policy and electronic reporting system in place. All staff we spoke with knew what incidents to report and how to report them. They gave specific examples of incidents, near misses and red flag staffing incidents they had reported, in line with the trust's policy.

Nine serious incidents relating to maternity were reported by the trust to the NHS Strategic Executive Information System (StEIS) from May 2021 to May April 2022.

Managers shared learning with their staff about serious incidents that happened across the trust and elsewhere. For example, via a recently introduced bulletin called 'learning the lessons following a serious incident' which we saw displayed in staff areas.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Staff we spoke with gave specific examples of incidents where duty of candour was discharged, and this was confirmed in serious incident investigation reports we reviewed.

Maternity

Deaths within the service were investigated as part of the service's serious incident process. Those involving babies were put through a multidisciplinary team (MDT) review using the Perinatal Mortality Review Tool (PMRT). The PRMT is a national programme aiming to standardise perinatal mortality reviews across NHS maternity services. Perinatal mortality review meetings were also undertaken. We reviewed investigation reports for stillbirths and neonatal deaths, including root cause analysis and outcomes and learning. We found managers investigated incidents thoroughly and women and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice.

Staff mostly followed up-to-date policies to plan and deliver high quality care. Most policies we saw referenced evidence-based practice and national guidance. However, not all policies and guidance they used were up to date. For example, the resuscitation policy we saw was due review October 2021 and the UK resuscitation guidelines seen on the resuscitation trolley were dated 2015. The most recent version was published in 2021.

In addition, a lessons learned report we reviewed, from a recent serious incident report stated trust guidelines did not always reflect best practice from NICE Guidance and Royal College of obstetricians and gynaecologists (RCOG), which meant staff were unclear of the actions they should have taken. The trust put an action plan in place to address this.

The service planned to implement additional teams to enable the continuity of carer approach to midwifery care, including for black and minority ethnic women and those from socially deprived areas. The continuity of carer model is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy. The national recommendation was that the birth availability model should be adopted to offer the most flexibility and provide better relational continuity of carer for women. The current team at Scunthorpe General Hospital employed the birth availability model and we saw the service aimed to establish a further two teams. However, plans were paused due to the number of vacancies within the current establishment.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs. However, expressed breast milk was not stored securely.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs, such as diabetes, and food was available to accommodate different cultural choices.

The service was accredited with the United Nations children's fund (UNICEF) Baby Friendly Initiative, a programme that accredits units for supporting best practice in infant feeding.

The service had specialist breast infant feeding midwives and support staff. Systems were in place for following up mothers on discharge.

Women had access to their own expressed milk whenever they needed. A milk fridge and bottles were provided. However, we had concerns about storage and security of expressed milk.

For example, we saw the fridge temperatures recorded consistently exceeded the optimum temperature of below five degrees centigrade and the action recorded each time was to reset the thermometer. The actions did not indicate what staff did with stored milk when temperatures were out of safe range.

In addition, we saw staff consistently recorded in daily checks that the fridge was not locked. This meant there was a risk incorrect milk could be given to a baby and the risk of tampering was not sufficiently mitigated. We brought this to the attention of managers at the time and the fridge was subsequently fitted with a lock and locked. Staff were also informed to help women access their breast milk whenever required.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff prescribed, administered and recorded pain relief accurately. We observed a midwife asking if a woman was in pain and prescribed oral medicines were explained before being given.

Women we spoke with did not highlight any concerns with their pain management.

The service now had access to an anaesthetist 24 hours a day. The service monitored delayed pain relief of 30 minutes or more on the local maternity dashboard. The data we reviewed showed on three delays in the last 12 months. There were no delays to epidurals reported across the trust in the last six months.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits. For example, they regularly submitted key performance indicator data to the NHS screening programmes database.

Local and NHS digital (NHSD) maternity dashboards were used to monitor the service and target areas for improvement. The service used them to maintain oversight of their care against other services.

The maternity dashboard was maintained monthly and reported on clinical outcomes such as level of activity, maternal clinical indicators, (mode of delivery, trauma during delivery (including post-partum haemorrhage and perineal trauma), neonatal clinical indicators and public health information. Trust dashboards also included staffing and incident overviews. Local dashboards were aligned to regional maternity systems dashboards. Senior leaders we spoke to were aware of their position against their own performance and that of services within the local area.

Maternity

Outcomes for women were mostly positive, consistent and met expectations, such as national standards. For example, in the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) perinatal mortality surveillance report published in October 2021 (based on births in 2019), the stabilised and adjusted perinatal mortality rate at the trust was within 5% of the comparator group average for all births and those excluding congenital anomalies. This means, not significantly different to expected.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, they conducted weekly ward assurances surveys to monitor compliance with patient wrist band information, recording allergy status, pain management and fresh eyes documentation.

Competent staff

The service made sure staff were competent for their roles. Managers appraised midwifery staff's work performance and held supervision meetings with staff to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. For example, there was now a duty anaesthetist immediately available to cover emergency work on delivery suite, in line with trust policy and national guidelines.

All staff we spoke with told us they had received a full induction tailored to their role before they started work.

Newly qualified midwives undertook a preceptorship programme and competency assessment. They were supported throughout the programme and met regularly with their supervisor. Staff we spoke with were positive of the programme and the support it provided.

Managers we spoke with told us there were established professional midwifery advocate (PMA) teams, which provided regular clinical supervision to midwives.

Managers supported midwifery staff to develop through yearly, constructive appraisals of their work. Staff reported they were supported to develop and access further training. Appraisal rates for maternity staff at the time of the inspection were 78.75% against a trust target of 90%. All medical staff we spoke with told us they received an annual appraisal. However, we were unclear whether all medical staff had received an appraisal, as appraisal rates we requested for medical staff were not provided by the trust.

The clinical educators supported the learning and development needs of staff, in accordance with the maternity training and skills needs analysis. Staff we spoke with told us they completed skills and drills training, for example, post-partum haemorrhage simulation and pool evacuation. Face to face training that was postponed due to COVID-19 restrictions had just recommenced. We saw the schedule of planned and 'live' training for the year. Staff engaged in multi-professional team training and managers we spoke with told us the service was on trajectory for 90% compliance with practical obstetric multi-professional training (PROMPT) by September 2022. The PROMPT course covered the management of a range of obstetric emergency situations.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There was a human resources process to support management of individual staff members with consistently poor compliance.

Maternity

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.For example, we observed multidisciplinary attendance on all ward rounds and prioritisation of patients depending on risk. We saw handovers followed the recognised SBAR format.

Staff we spoke with said they had a good working relationship with the MDT. Midwives told us they were happy to raise concerns and challenge practice with medical staff where they felt this would help to keep women and babies safe.

Staff reviewed women's mental health and where required the service would work closely with colleagues from the local mental health teams.

We observed good MDT team working within theatre.

The service worked with tertiary centres and neighbouring trusts to support women and babies needing specialist care. Specialist midwives worked alongside consultant leads, community midwives and specialists at regional centres to provide MDT care and care planning for women.

Seven-day services

Not all key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway.

The antenatal day unit operated 8am to 8pm seven days a week and had two ultrasound scanning rooms. However, staff we spoke with said the times varied, for example, due to suboptimal staffing and midwife sonographer availability.

There were multidisciplinary clinics on Tuesday afternoons. Consultant clinics operated Mondays to Thursdays in the morning and afternoon and Friday morning. There were fetal medicine clinics held twice a month.

Staff could call for support from doctors and other disciplines, including mental health services and some diagnostic tests, 24 hours a day, seven days a week. The exception was ultrasound scanning out of hours, which was not available. The lack of availability of ultrasound capacity required to assess fetal wellbeing meant the standards set by RCOG, NICE and Saving Babies Lives were not being met.

There was no maternity triage system in place. We noted triage delays in the emergency department and urgent care was on the trust risk register, but the lack of a maternity specific triage system was not. Managers we spoke with explained triage was expected to be available soon, but they were unaware of a there was no defined start date. After our inspection, the trust clarified Birmingham Symptom Specific Obstetric Triage System (BSOTS) telephone triage (first phase) was due to commence 31/10/2022 and the second phase planned to commence March 2023.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards and departments. For example, we saw nutrition and hydration educational poster presentations displayed and infant feeding information.

There were also links to external leaflets on the trust website. These provided advice on topics such as vitamins in pregnancy, folic acid, flu vaccine, whooping cough and baby immunisations.

In addition, there were informational videos hosted by the UNICEF Baby Friendly Initiative about infant feeding and baby relationship building.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, the service was a national outlier for smoking due to population demographic. In response, the service implemented additional services to reduce the proportion of women smoking at time of book and delivery. We saw staff conducted carbon monoxide testing for women and saw evidence in the records we reviewed, this was being undertaken. Whilst in hospital all smokers were offered nicotine replacement therapy.

The service had information on its website to support women make healthier choices including smoking and diet.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. During our inspection we observed informed consent being taken and written consent being checked for women undergoing elective caesarean section. Consent for screening was also observed and sonographers requested this if not completed.

Staff understood Gillick Competence and Fraser Guidelines and supported young women who wished to make decisions about their treatment. This was recorded in the records we reviewed.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Maternity

Women we spoke with said staff treated them well and with kindness and 'would definitely recommend others to book and deliver here'.

Staff followed policy to keep women's care and treatment confidential. We saw staff maintain women's privacy and dignity whilst in theatre.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it.For example, women who struggled to breast feed told us how the specialist breast infant feeding team had helped them to breast feed successfully.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There was a bereavement specialist midwife in post. Bereavement training compliance was 90%. We saw a dedicated bereavement suite available on the ward which was used when delivering bad news and for parents to spend time with their baby.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service also supported women who had a previous difficult birth or pregnancy through their current antenatal period.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. We saw good practice regarding informed consent. Women's partners we spoke with told us they felt involved in decisions about care.

Staff talked with women, families and carers in a way they could understand. For example, women we spoke with whose babies required neonatal intervention said they were kept up to date throughout. We observed how midwives interacted and communicated with young people who anxious about their pregnancy.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. For example, via friends and family questionnaires and 'you said, we did' boards.

Women gave positive feedback about the service.

The trust performed similarly to other trusts for all 19 questions in the CQC maternity survey (2021).

Maternity

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population.The service worked with their local maternity voices partnership (MVP)

The unit had a continuity of carer team. The continuity of carer approach to midwifery provides women with a named midwife who follows them throughout pregnancy, birth and the postnatal period. The model was aimed at supporting the natural ability of women to experience birth with minimum intervention; the monitoring needed to ensure a safe pregnancy and birth, and the physical, psychological, spiritual and social wellbeing of the woman and family throughout the childbearing cycle. The continuity team was configured to work within areas where women may be at greatest risk including those from more socially deprived areas.

The service had identified where their facilities and premises did not meet the needs of the service. For example, no access to ultrasound scanning out of hours and no triage facility. We were told plans were in place to develop triage and staff told us of plans to convert the ward quiet room to a triage wait area, and a treatment room for triage, however the pandemic had led to delays.

The service had systems to help care for women in need of additional support or specialist intervention. For example, links with mental health teams.

Systems were in place to communicate with a woman's GP if they did not attend an appointment.

Partners were able to visit but were not permitted to stay overnight due to the current COVID-19 guidance. However, women were able to have their partner to support whilst in labour.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

National guidance outlines that women should be provided with choices of places to birth. The service offered women the opportunity to birth at home or in hospital with MDT input. We saw place of birth was documented in all but two records we reviewed.

The service had information leaflets available in languages spoken by the women and local community. There were also leaflets available of the trust website, for example, planned caesarean birth and pain relief in labour. The website had a button which signposted users to use online translators to interpret information on the trust website.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed.These were accessed via telephone or booked to attend in person.

A bereavement room was available support provided to women and their families by a bereavement specialist midwife. However, they worked cross-sites and staff we spoke with shared concerns that the service was 'stretched'.

A birth afterthoughts service was available for women who wished to talk about their previous birth or maternity experience and was run by the central delivery suite manager. a specialist midwife.

There was a perinatal mental health midwife and the service had links with a specialist nurse for learning disability and links with community services via support workers. Women with special needs had enhanced birth plans in place and their partners were permitted to stay following individualised risk assessment. Staff we spoke with explained women with special needs were accommodated in a cubicle rather than a shared bay. Staff received training on recognising and responding to women with mental health needs, and learning disabilities we found compliance was above the trust target at 90%.

Women were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

Most women could access the service when they needed it and received the right care promptly.

From January 2021 to December 2021, there were 3,584 deliveries at the trust.

The service had an escalation policy and procedures in place for the closure of the unit however dashboard data showed there had been no unit closures in the last 12 months. Staff we spoke with were unable to recall the last time the unit was closed.

There was no triage system in place and all calls went through to delivery suite. Managers we spoke with told us a bespoke triage service was under development and almost complete. A report we saw which detailed progress in the last year against the Ockenden report, stated there was progression with quality improvement projects, which included triage. However, we did not see a date for implementation. After our inspection the trust clarified the Birmingham Symptom Specific Obstetric Triage System (BSOTS) telephone triage (first phase) was due to commence 31/10/2022 and the second phase planned to commence March 2023.

Red flag data showed there had been 67 reported episodes of delays of two hours or more to inductions of labour due to staffing, once women had arrived on the unit, in the last 12 months to May 2022.

The service reported five delays of 30 minutes or more between presentation onto the ward and being seen for the year to May 2022.

Staff we spoke with in outpatient areas told us there were processes in place to follow up women who did not attend appointments.

Managers and staff started planning each woman's discharge as early as possible.

Maternity

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. The trust displayed information about how to raise a concern in patient areas and on the website.

The complaints process was embedded, and complaints were dealt with in real time or via patient advice and liaison service (PALS). Staff we spoke with told us concerns were dealt with locally where possible and, escalated to managers if required.

Formal complaints and concerns were raised on the trust's incident reporting system.

For the 12 months to June 2022, family service complaints (which included 5.4 38.4% for maternity), accounted for 15% of the trust's total number.

Data provided by the trust indicated timeliness of managing and responding to PALS and formal complaints improved and the service now consistently met response time targets.

Staff we spoke with told us complaints were rare and were unable to provide any examples of recent complaints.

Data provided by the trust showed the trust received 104 compliments for family services, which included maternity, for the period June 2021 to May 2022. We saw thank you cards displayed on the wards which contained positive feedback for staff.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Ward managers and matrons were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Maternity services operated within the trust's family services division, led by the dDivisional cClinical dDirector, supported by the dDivisional Ggeneral mManager, hHead of Mmidwifery and hHead of Nnursing. There was also a dDeputy hHead of mMidwifery and a site matron responsible for obstetrics and gynaecology. Roles and responsibilities were clearly shown in an organisation chart available to all staff.

Although the service had no direct board level member the hHead of mMidwifery presented to board where maternity was a key part of the agenda, for example, to provide updates about the Ockenden report action plan. The service said they felt supported by the board

Maternity

Several registered and non-registered staff, including new starters and students we spoke with told us ward managers, shift coordinators and matrons were visible and approachable. However, they told us the senior leaders above matron level were contactable but not always visible.

When we discussed this with senior leaders, they told us there was a monthly staff engagement meeting held virtually, to which all staff were invited. Band seven staff attended this mostly and numbers attending were between two and eight. However, these meetings were not minuted and although staff knew about the meetings, staff we spoke with said they did not have time to attend as staffing levels were low.

Safety champion leads for midwifery, obstetrics and neonates where were in place. The service displayed how clinical staff could contact the leads.

We saw the trust's plans for compliance with the NHS England Perinatal Clinical Quality Surveillance Model. This was a quality surveillance model that seeks to provide a consistent and methodical oversight of all services, specifically including maternity services.

Vision and Strategy

The service now had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

During 2019 to 2020, the trust reviewed and aligned its five-year quality strategy in line with the trust's strategic direction. The strategy based upon the National Quality Board's (NQB) 'Shared Commitment to Quality', set long term quality objectives linked to the trust's strategic objectives. Family services, which included maternity, now had a formal vision and strategy as described in the annual divisional business plan.

The supporting objectives were;

- to give great care
- to be a good employer
- to live within our means
- to work more collaboratively
- to provide Strong leadership

Plans and priorities were displayed on posters. These were aimed at development of leaders, recruitment and retention, building professional standards, provision of harm free care and focus on patient centred care.

We saw the trust engaged with the local community on its strategy through the maternity voices network.

Culture

Staff felt respected, supported and valued by colleagues but expressed concerns that they did not feel listened to by senior managers. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service did not always have an open culture where patients, their families and staff could raise concerns without fear.

Maternity

There was an equality and diversity policy and compliance for staff equality, diversity and human rights training was 96.08%. Harassment and bullying training compliance was 98.04%.

Staff we spoke with told us they were supported to access additional training and junior midwives were positive about their preceptorship and progression. For example, the trust had funded external courses, provided study leave and developed staff through clinical leadership training.

The trust hosted a recent listening event for band seven staff, and those who attended told us this had improved communication. However, some staff we spoke with told us they did not feel listened to by senior managers. For example, regarding concerns they repeatedly raised about staffing, the baby-tagging alarm system, the need for administrative support and the flooring on ward 26.

Staff were encouraged to report incidents. However, staff we spoke with shared concerns that they feared being blamed when things went wrong. We saw a safety bulletin in a staff area on the ward which highlighted incident reporting and we noted the bulletin referenced a 'fair blame culture'. When we discussed this specific bulletin with senior leaders, they told us there was no blame culture within maternity and suggested the wording of the document was written without clear understanding of what these words meant.

Staff we spoke with knew about the freedom to speak up guardian.

Managers described local staff recognition initiatives to reward their staff.

Governance

Leaders did not always operate effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and most had regular opportunities to meet, discuss and learn from the performance of the service.

The service had clear governance processes in place which supported performance, recognised safety, patient experience and clinical effectiveness. These were defined in the trust's maternity risk management framework.

We saw evidence that monthly quality and safety committee meetings were quorate and attended by the whole MDT.

Incidents were investigated and reports were produced with recommendations and lessons learned that linked to the findings. Deaths within the service were investigated, where appropriate, using the perinatal mortality review tool, discussed at perinatal mortality review meetings and reported externally in line with national recommendations.

The service engaged with external organisations and reported any notifiable incidents to relevant bodies including the Health and Safety Investigation Branch (HSIB) and learnt from completed investigations.

The service completed the maternity services assessment and assurance tool and submitted this to NHS England. The tool required services to complete a self-assessment against immediate and essential actions arising from the Ockenden report.

Managers, medical staff, Head of Midwifery, Governance Midwife and clinical safety staff reviewed safety incident reports weekly to identify themes and trends and shared learning. However, managers we spoke with explained these meetings were not minuted as actions and learning were added to the incident reports at the time. When we asked senior leaders about this, they told us they would consider recording minutes to evidence the decision-making process.

Learning was cascaded to staff, for example, in a newly introduced bulletin, weekly emailed safety briefing, at daily safety huddles and ward meetings. However, managers we spoke with explained ward meetings stopped during the pandemic and were now more informal briefing meetings when possible.

Team leaders at all sites met formally each month and this was minuted.

Maternity presence at the board was by invitation, for example, to present Ockenden report action plan updates.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated most risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Trust maternity services were supported by NSHE/I colleagues who conducted periodic insight visits; the most recent was in May 2022. The purpose of the visits was to provide assurance against the seven immediate and essential actions from the first Ockenden report. The report showed the trust made satisfactory progress with their actions; six of seven actions were compliant, and one was partially compliant. Risks associated with not completing all actions was noted on the trust risk register.

The trust board had oversight of maternity serious incidents. There was an agreement with the local maternity system (LMS) and process in place for external review of serious incidents to be provided between trusts.

We saw that risk register was discussed within governance meetings. However, we identified areas of risk that were not on the risk register. For example, the baby tagging and alarm system and risk of baby abduction, the flooring on ward 26, and lack of maternity triage provision. This meant we were not assured all identified risks affecting the service in line with trust policy, were escalated to the risk register.

Performance dashboards were used to measure relative performance, rank against benchmarks and national targets, help to identify improvements and show trends for the previous 12 months. Targets were based on those sent by the local maternity system (LMS) and the service reviewed their performance against others within the LMS.

We saw business continuity plans were in place for maternity services trust wide, which were reviewed annually. There was an up to date maternity services escalation policy.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Managers used information to manage the performance of the department against local and national indicators. Staff were made aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance and data security training.

The trust aimed to implement an electronic patient records system but managers we spoke with explained this was delayed due to the pandemic.

The service collated and reported information in line with national requirements and best practice within maternity.

Maternity

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Women could give feedback about the service directly by raising concerns, complaints and compliments.

The service had a strong relationship with their local maternity voices partnership (MVP) which met formally. We saw minutes of these meetings. Managers we spoke with gave examples of how they had influenced the service. For example, changing visiting hours and producing improved, clearer information for women and their families about induction of labour.

Trust maternity services were part of the Humber, Coast and Vale (HCV) local maternity system (LMS). The service actively engaged with their LMS, regional and safety improvement groups to share learning and improve outcomes for women and children.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Staff we spoke with told us they felt supported to develop their career.

The trust maintained close links with local universities and facilitated placements for student midwives. Students we spoke with told us they always worked under supervision of a registered midwife and had enough time to complete academic work during placement. They told us they always had sufficient rest breaks and went off duty on time.

The service participated in the ‘15 step’ ward assurance programme.

Outpatients

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was provided as a mixture of e-learning and face to face learning. Staff felt supported to access mandatory training and were able to keep up to date with their training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Each department manager had oversight of mandatory training compliance. Management provided assurance that where any staff members were not up to date with training, they had been booked on to complete it.

Staff received and kept up to date with their mandatory training. The trust set a target of 85% for completion of core mandatory training. The trust monitored mandatory training for all staff across the three outpatient departments rather than by location.

Overall, the outpatient department met completion of core mandatory training with values ranging from 87% to 100 % in all core subjects.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

The chief nurse was the executive lead for safeguarding at trust board level. There was a trust-wide safeguarding team available to provide advice and support to staff.

There were safeguarding policies for both adults and children, which were accessible to staff on the trust intranet. The policies contained a flowchart for practitioners to follow if they had any concerns. Children attended some outpatient clinics. Some senior registered nurses were trained to level 3 in safeguarding adults and children. Staff requiring level 3 safeguarding for children had completed their training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could describe the safeguarding process and gave examples of safeguarding concerns that they had escalated.

Outpatients

Staff followed safe procedures for children visiting the department. Staff had an awareness and understanding of female genital mutilation, which was covered as part of their safeguarding training.

Staff gave an example of how they had used the safeguarding process to protect a patient whose first language was not English, from alleged domestic abuse. The patient had sought help from a staff member once in a consulting room away from family. The local safeguarding team had thanked those involved for making the referral and protecting the individual.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas visited were visibly clean and tidy. Clinical areas were clean and had suitable furnishings which were in good condition and well-maintained. The cleaning staff were all trust employees. Each area had a routine cleaning schedule to follow and managers audited how well the areas were cleaned. Results from these audits were positive.

The trust had a '15 step challenge' approach to cleanliness and infection control. Areas were award ratings based on how well they performed at these audits. All areas visited had received either a good or outstanding rating for level of cleanliness.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Disposable antimicrobial curtains were used in all outpatient clinics.

Staff adhered to 'bare arms below the elbow' protocol. Hand sanitiser was available for use throughout the department and there were hand washing sinks available in areas visited.

Hand hygiene audits were completed regularly, and trust data showed that compliance with this was also positive. Feedback was given to staff at team meetings and improvements needed were discussed.

There were designated waiting areas for patients with children which were clean and tidy. All toys and games available were easy to keep clean.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. Staff reported they had access to equipment for bariatric patients, for example, appropriate scales and seating. There was a range of seating provided including high back chairs and seating of appropriate heights for patients with orthopaedic conditions.

Resuscitation equipment was available on trolleys at various locations in the main outpatient areas and near other clinics. Daily checks were completed and tamper proof tags were used to show if the contents had been accessed. Full checks of the trolleys were completed weekly. We examined checklists covering the previous three months and saw that appropriate stock was in place and this was regularly updated. Trolleys were clean and dust free.

We checked electrical equipment and found them to be within their service date and that they had been safety tested. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. Staff told us equipment was promptly repaired or replaced if required by the estates department.

We checked a range of items including dressings and syringes. All items were within their expiry date and staff confirmed processes were in place to check that stock was regularly rotated to ensure the use of short dated items.

Sharps bins were properly assembled, stored off the floor, not over full and signed and dated. There was waste disposal in the department for clinical and non-clinical waste.

There were self-check in desks in the outpatient department but these were not in use. They had been placed out of action during the Covid-19 pandemic and now needed a software upgrade before patients could use them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

The trust had a clinical prioritisation system for patients overdue their appointment dates. The trust had a backlog of patients waiting to be seen. The backlog was in part incurred as a result of the cessation of services during the Covid-19 pandemic.

The trust had implemented risk stratification systems to help ensure patients were seen in order of clinical need and had strategies to reduce the waiting lists for each clinical speciality. However, there remained risk due to the volume of patients waiting and the service not meeting the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for a suspected cancer diagnosis. There was a national shortage of oncologists that meant the trust did not have enough medical staff to treat cancer patients. However, the trust was working with another hospital trust to remedy the risk and were continually undertaking validation of the waiting lists.

Safety checklists were used in some areas such as ophthalmology prior to intravitreal injections. Ophthalmology was managed by the surgery division and therefore the surgery division managed the safety checklist audits. The trust provided WHO checklist audit results which showed compliance with WHO checklist procedures.

There was a clear trust-wide pathway and process for the assessment of both adults and children within outpatient clinics who became clinically unwell while in attendance. All staff we spoke with could describe the pathway, which involved contacting the trust resuscitation team or emergency service dependent on location.

Staff were aware of sepsis and could describe the signs and symptoms to be aware of. We saw posters on walls to raise awareness of sepsis and staff told us sepsis was included in mandatory training.

Clinical nurse specialists gave patients their contact details so they could escalate any change in their condition or seek advice when they needed to.

There was a policy for staff to follow if a child or young person did not attend their appointment. The policy described that the clinician must consider whether there was a safeguarding risk for any nonattendance in the case of children and young people and then act accordingly in following any concerns up, liaising with the referrer to assess the risk and consider further actions if appropriate. The policy directed clinicians to the trust policy for safeguarding children and young people for guidance.

Outpatients

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Nurse vacancy rates were low and staff turnover rate at 4.3% was low across all departments. Staff sickness ranged between 5.5% and 9% for the previous 12 months. This was a lower sickness rate than most other directorates within the trust.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance.

Managers could adjust staffing levels daily according to the needs of patients. When extra clinics were added, managers used their own bank staff to fill these shifts. Managers limited their use of bank and agency staff and if using agency workers, they requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the department.

The number of nurses and healthcare assistants matched the planned numbers and rotas were refreshed on a weekly basis. Managers held weekly clinical utilisation meetings and these meetings shaped where there would be either an increased need for staff or a reduction if a clinic was cancelled. Clinical nurse specialists were not managed by the individual outpatient departments but had rooms allocated to them when they held clinics.

There was no staffing data for medical staff in outpatients due to medical staff being assigned to their individual speciality rather than the outpatients department.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient records were paper based, however patient letters including referral letters and all diagnostic results were easily accessible via electronic systems.

Staff told us that there were rarely missing records and would contact medical records to locate patient notes if necessary. If records were not located before a clinic, the administration team would make up a temporary set of records, which would be merged with the original set when they were located.

Records were stored securely in locked areas and were not accessible to the public. We observed that covers for notes trolleys were used to maintain confidentiality when moving notes in trolleys within the department.

We looked at the medical records. We found that they contained up to date information about patients including referral letters, copies of letters to GPs and patients' medical and nursing notes. There was a plan of care documented for each patient. Records were always dated and signed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Outpatients

Medicines were stored in locked cupboards and refrigerators. We checked a range of medicines and found them to be in date and stored appropriately in locked cupboards.

No controlled drugs (CDs) were stored in the areas we inspected.

Staff monitored and recorded the temperature of the rooms where drugs were kept. We reviewed the temperature records in clinic rooms and saw that daily checks had been completed. We saw the temperatures were within acceptable limits. Staff we spoke with could explain the process to follow should temperatures fall outside the required range.

Clinicians used a mixture of electronic prescribing and FP10 prescriptions. The FP10 prescriptions were securely stored in a locked cupboard. Prescription records were kept securely and separately from prescription books.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff used the electronic incident reporting system to report incidents and near misses.

At the previous CQC inspection, it was noted patients had come to serious harm due to delays in receiving treatment. There were no such incidents noted at this inspection and the process for incident management had improved.

Staff gave us examples of how to report an incident. We were told of one incident where a sick patient that had attended their local outpatient department by default because an accompanying family member thought that the hospital had an emergency department. The outpatient department was near the hospital main entrance so the first staff on scene were from outpatients. This incident was reported and recorded. As a result of this, changes were made and lessons shared to ensure staff were ready to respond in the event of an unexpected patient attending in need of emergency care.

Staff understood the duty of candour. Some staff were aware of the concept and had not needed to act on it. Others understood the process but not the term. Staff told us they were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents or through team meetings, staff huddles or from information displayed in staff areas. The trust had introduced a patient safety bulletin and a learning lessons bulletin that shared incidents that had occurred, their root causes and their conclusions.

Managers debriefed and supported staff after any serious incident. Staff told us that they would be given the opportunity to discuss concerns following an incident.

Is the service effective?

Inspected but not rated

Outpatients

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. The policies and protocols we reviewed were mainly in date and all available on the hospital's intranet. However, the resuscitation policy was due for review in October 2021 and the UK resuscitation guidelines seen on the resuscitation trolley were dated 2015. The most recent version was published in 2021. This was a trust wide issue.

The oncology clinic issued patients with information cards that alerted them to potential infection. This followed the NICE guideline for neutropenic sepsis: prevention and management in people with cancer.

The trust medicines management policy ensured that staff administering intravenous medicines and fluids were compliant with the NICE guidelines for healthcare professionals' competencies in hospitals.

Pain relief

Staff accessed pain relief within outpatient clinics in line with individual needs.

Staff told us that patients were advised on pain relief during appointments if it was required.

Pain relief was not generally provided in outpatients, although there were medical staff available in outpatients for advice should need arise.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The directorates participated in their own speciality national audits as required, for example in general surgery and medicine. Other areas were required to provide information to various national audits included ophthalmology for the national ophthalmology database.

The service used the NHS benchmarking network to understand their position monitored against other trusts nationally.

Managers used information from the audits to improve care and treatment. There were a series of local audits undertaken within the outpatient departments. These included an ID audit to ensure staff were making the correct patient checks, an ENT (ear, nose and throat) audit to check that scopes were being cleaned correctly after use and documentation audits to monitor whether notes were completed thoroughly.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. All departments had ensured that staff had had an appraisal. Data showed that over 85% of staff had undergone an appraisal. We spoke to different grades of staff who told us that they had yearly appraisals and were able to raise concerns.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There was the option to attend team meetings virtually if staff were unable to be in the department when they occurred. Team meetings had standard agenda items and minutes reviewed that we reviewed referenced lessons learnt from incidents, patient waiting times and news from the trust.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Some staff had been able to progress within the department by undertaking additional study. We met individuals who had been supported to undertake nurse training and had developed from health care assistant to registered nurse. Staff had also the undertaken professional nurse advocate training programme. The trust supported this training which gave staff skills to facilitate restorative supervision to their colleagues and teams.

Managers made sure staff received any specialist training for their role. There was additional training for staff working in areas such as ophthalmology or ear, nose and throat clinics. These staff needed extra competencies to be able to fulfil their roles.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was multi-disciplinary team working across the specialities providing outpatients. Where required there were multi-disciplinary team meetings in the medical directorate. There were specialist registered nurses working in clinics across outpatients to provide care and treatment to patients. Staff in orthopaedic outpatients worked with the medical staff and physiotherapy staff to provide care to patients.

There were a number of nurse led clinics across the trust. Different staff groups and professionals worked together across the services to provide care, treatment and support to patients.

Cardiologists told us they offered a service where GPs and community nursing teams were able to support patients in the community with guidance from the hospital team. This reduced the need for patients to attend appointments at the hospital.

Seven-day services

Key services were available seven days a week to support timely patient care.

The service provided outpatient clinics routinely between 8:30am and 6pm between Monday and Friday. However. there were evening clinics and some weekend clinics provided in the various specialities to afford patients the opportunity to attend appointments at convenient times. This was pertinent for patients needing regular appointments for frequent treatments.

The service also added extra clinics at weekends and in the evenings to help reduce the waiting list and backlog of patients needing appointments.

Outpatients

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas. We saw patient information displayed in all clinics. This included guiding patients and carers to support services, information on conditions, smoking cessation and drink awareness. We saw clinics that had seasonal displays, for example how to keep safe in the sun. Staff told us that there were similar displays at other times of the year.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

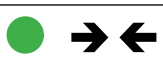
Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There was a trust-wide consent policy, which staff could access through the trust intranet. We saw that this policy included obtaining consent for treating all patients including adults with reduced capacity to make independent decisions, patients with communication difficulties and children and young people.

Staff made sure patients consented to treatment based on all the information available. We were told by staff that appropriate consent was obtained from the patient prior to any examination or treatment. All records checked contained documentation to show consent was obtained. In clinics where children were treated outside of the paediatric department, staff described how they would discuss the appointment with the child and explain the equipment in the room so the child was not scared or uncomfortable. Staff were able to contact the paediatric clinic if they needed advice.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. There was a dedicated MCA DOLS team and access to a trust-wide mental health liaison team. Staff told us they knew how to contact them if they needed advice or had concerns about a patient.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We saw staff taking time to interact with patients and those close to them in a respectful and considerate way. Staff greeted patients and introduced themselves. Staff cared about their patients and patients were pleased to see faces they recognised. We saw patient thank you cards which thanked staff for their care and compassion. Managers told us how kind staff had been by helping a patient pay for their parking fee which they did not have the necessary money on their appointment day.

Outpatients

Staff were discreet and responsive when caring for patients. Patients said staff treated them well and with kindness. We read cards given to staff in clinics thanking them for their care and support. Patients told us that reception staff were welcoming and friendly

All patients we spoke with during the inspection told us that staff treated them with respect and maintained their dignity and privacy, for example, through ensuring clinic doors were closed during appointments and using curtains in treatment rooms.

Chaperones were available and provided as necessary across the outpatient department. There was a chaperone policy available for reference and to support staff.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

There was a quiet room available with seating for patients to use if they were anxious or worried when visiting the department and staff told us this room was available to patients as needed. Staff used this room for private discussion with patients and for patients who had received bad news to provide privacy if they were distressed.

Staff described being adaptable to the needs of patients, for example, providing separate waiting areas for distressed or anxious patients, and fast tracking patients through outpatient clinics if they were anxious or phobic.

There were specialist nurses in some clinics who were able to provide care and support for patients. Patients were offered contact details so they could call specialist nurses if they had any questions or concerns.

There were leaflets available throughout clinic areas signposting other emotional support services for patients, for example, local support and listening groups.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients' told us that if there was a delay to a clinic they were informed by the staff or by messages on the display board.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw posters in clinics advertising the friends and family test.

Patients gave positive feedback about the service. We spoke to seven patients who were positive about their experience. One patient commented to us that the consultant was running late but they knew they would not be rushed when they were seen.

Is the service responsive?

Requires Improvement 

Outpatients

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service had reacted to the challenges created by the Covid-19 pandemic by being inventive with ways to contact and treat people using technology and new pathways.

There were outpatient specialities which held clinic appointment slots for urgent appointments. There were speciality administration teams which booked and assisted in managing appointments for the specialties.

The clinic utilisation group and speciality administration teams were involved in managing the clinic bookings. Additional clinics were put on for specialities and extra staff would be scheduled to those clinics.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. There were virtual clinics which reduced the need for patients to attend departments unnecessarily by having a consultation over a video link or by telephone. The departments worked closely with GPs via the Connected Health Network project which meant that patients were seen promptly and treatments or investigations might happen closer to home.

The outpatient department could provide patients with a pager, so patients could leave the waiting room for a break and could be contacted when their appointment was imminent.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Some areas had dementia friendly environments, for example clocks and toilet signage. There was a trust wide dementia strategy. There was a trust wide senior nurse for vulnerable people who led on dementia and learning disabilities. There were dementia champions who could be contacted for advice and support and the department worked as needed with the trust learning disability and dementia clinical nurse specialists. Electronic referrals could be made through the system to the clinical nurse specialist. Patients with learning disabilities could also be highlighted on the electronic systems.

The outpatient patient survey showed that 100% of respondents found the environment in the waiting room pleasant and comfortable.

Outpatients

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation services via an interactive electronic tablet that was quick and easy to use. British sign language interpretation could be requested.

There was a quiet room available in the department which could be used for patients who may be anxious or where patients required a quieter room than the waiting room. Additional time could be provided in the clinic for patient's appointments if required. Appointment times varied depending on whether the appointment was a new appointment or a follow up appointment and depending on the speciality.

The service had information leaflets available in languages spoken by the patients and local community. There were a range of patient information leaflets available throughout the department.

There was a trust patient advice and liaison service (PALS) which provided advice and support regarding concerns.

Staff told us that they worked closely with the services that provided patient transport to clinics to help patients access transport to and from their appointment. They would contact transport services if there was a delay in collection or appointments. Staff always waited with patients until transport arrived to take them home.

Letters were sent to patients from the bookings and administration teams following appointments or before appointments.

Access and flow

People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. However, this was an improvement on the previous inspection in 2019.

Although the trust were struggling to meet the demand for outpatient appointments, they had strategies and mitigations in place to help remedy this. This was an improvement from their previous inspection and much work had been undertaken as part of the outpatient transformation programme.

From February 2021 to January 2022, the total number of appointments in outpatient services was 420,283.

Medical specialties had seen the largest increase in appointments (27%), compared to the previous 12 months. This was followed by dermatology (22%) and surgical specialties (21%).

Ophthalmology (6%) and oncology (6%) were the only specialties to see a decrease in the total number of appointments, compared to the previous 12 months.

A breakdown of specialties is shown below:

Specialty Number of appointments Proportion of appointments

Surgical specialties 160,299 38.1%

Medical specialties 96,246 22.9%

Other 92,697 22.1%

Outpatients

Ophthalmology 46,434 11.1%

Oncology 19,027 4.5%

Dermatology 5,580 1.3%

Total 420,283 **100.0%**

Managers monitored waiting times and although patients could not always access services when needed, there were systems in place to keep checks on this.

Managers were monitoring numbers of patients on all the waiting lists, waiting times, breaches and people who do not attend appointments (DNA's). There was also robust monitoring of the numbers of outpatients overdue their follow up appointment, which was a challenge for the trust.

Waiting lists were managed and patients were prioritised. The trust used risk stratification protocols to give all patients a risk prioritisation status. Patients were subsequently monitored continuously on waiting lists. Patients at most risk of potential clinical harm if not treated had enhanced monitoring and there were escalations procedures to follow.

Progress and performance for each clinical speciality was overseen at weekly performance and planning meetings.

Patient initiated follow-up (PIFU) had been introduced using readily available technology to give patients and their carers the flexibility to arrange their follow-up appointments as and when they needed them. This meant patients did not routinely sit on waiting lists but requested an appointment to befit their symptoms and needs.

The Connected Health Network project meant that cardiologists worked actively with GP partners to help improve services for patients. The patients involved in this project did not need to come into the hospital or wait on a list for treatment or advice but could access this locally.

The trust aimed to undertake 25% of its outpatient consultations virtually. Patients could receive advice and treatment via video call or telephone without the need to attend hospital.

However, there was a shortage of oncology doctors which impacted on the trust's ability to reduce the wait time for cancer treatment appointments. The trust was also providing mutual aid to this speciality for another NHS trust which affected their data and wait times.

In March 2022, the percentage of patients receiving Cancer treatment within 62 days at Northern Lincolnshire and Goole NHS Foundation Trust was 64%, compared to the National average of 67%. When comparing this trust to its peer group (based on activity), it had the second worst performance rate (out of 30 trusts). However, performance had improved by 7% since January 2022 (57%).

From October 2021 to April 2022, the trust's referral to treatment time (RTT) had generally improved (except for January where there was a slight decline). The figures for April 2022 showed 73.1% of this group of patients were treated within 18 weeks, which was similar to the England average of 74.0%.

Outpatients

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients could give feedback via the trust website and the service clearly displayed information about how to raise a concern in patient areas.

There was a policy and procedure for the management of complaints, concerns, comments and compliments. Staff understood the policy on complaints and knew how to handle them. Patients were kept informed about progress with the investigation of their complaint and received an outcome.

Leaders and the patient advice and liaison service (PALS) received formal complaints which were investigated by the leaders of the outpatient department and leaders told us learning was shared at the team meetings or with staff individually if required. Complaints were part of the agenda for team meetings where required and were part of senior leaders' meetings.

Complaints had been mainly about waiting times and car parking facilities. Staff could give examples of how they used patient feedback to improve daily practice. Managers shared feedback from complaints with staff and learning was used to improve the service.

Managers investigated complaints and identified themes. The trust had information boards on departments titled 'You say, we did'. These identified thematic feedback and reported improvements made as a result of this.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, staff told us that senior managers were less visible in the service.

Staff we spoke with were positive about local leadership within their teams and told us team leaders were supportive and available when required. However, the service was in a state of transition and moving to a new directorate structure, so this made staff unclear about who their divisional leaders were. Staff told us that they were able to talk to the senior leadership team but reported that the trust executive team were never seen around the departments.

Outpatient services had been previously managed under one directorate. Outpatient departments were now divided across three directorates. Diana Princess of Wales outpatient department in Grimsby was in the medicine directorate,

Outpatients

Scunthorpe General Hospital was in the surgical directorate and Goole Hospital sat within the community services directorate. This divisional restructure was in its infancy and under review. The divisional matrons across these areas would work together to ensure consistency across the outpatient teams. At the time of inspection, it was too early to say whether this had been successful or not.

There was a structure for the management of outpatients. There was a matron for outpatients covering each site and each outpatient department had an individual manager.

Senior managers we spoke with were aware there were challenges with waiting lists for outpatient appointments and issues with referral to treatment indicators.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

As part of the NHS Ten Year Plan, the trust pledged to make changes to outpatient services and detailed intentions in its Strategic Plan (2019-2024). This strategy included information on the trust strategic framework, the current outpatient position and the outpatient objectives and priorities over five years. In all areas that we visited, information was available for staff to read about the transformation aims.

The outpatient transformation programme 2022/2023 had aims, ambitions and outcomes. We saw that some of these aims had come into fruition and had been achieved. Some aims remained a work in progress.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff in departments told us there was good teamwork, openness and honesty within their teams. Overall staff were positive about working in their departments. Most staff told us they felt supported.

Staff told us morale was generally good, however, the recent reorganisation of directorates was causing some concern as outpatient staff aligned to their new leaders. The service was getting used to a restructure although this did not seem to impact on the day to day running of departments.

Staff told us that they were proud to work in the trust. We spoke to staff who told us ‘I love my job’. Another staff member told us they would not want to work anywhere else. Staff also told us they would be happy to have their own family treated at the trust

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Outpatients

Leaders described governance arrangements for the outpatient departments. Governance meetings and governance issues fed into quality and safety meetings which were held every week.

At this meeting incidents and complaints were discussed. This meeting was attended by senior staff who could then escalate governance issues through this meeting to the performance improvement meetings, trust management board and the clinical quality board.

There was a clinical utilisation group who supported the work around capacity and demand challenges in outpatients. A breach review meeting was held weekly as was a planning and delivery meeting.

One report was published for all these meetings which was the integrated performance report so that there was a 'single version of the truth'.

The trust had engaged with the Getting It Right the First Time (GIRFT) national programme and had a dedicated GIRFT team to support improvement. The trust had governance arrangements for oversight for the GIRFT program.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were risk registers that detailed issues pertinent to the service. Risks were rated and had actions associated with them. Staff were aware of top risks such as capacity for appointments, staffing, estates and facilities and information technology.

The outpatient services monitored performance through performance reports and regular meetings. Progress was monitored by the planning and performance function at weekly divisional and trust meetings. The executive team had monthly formal Performance and Improvement meetings (PRIMS), with the divisions. Any escalations or concerns were made to the Finance and Performance Committee which was a sub-committee of the board. Monthly integrated performance reports were also provided to the Finance and Performance Committee for oversight of performance, including key performance indicators relating to the backlog of waiting appointments.

There was a trust business continuity plan that detailed how the outpatient departments would continue to operate during an unplanned disruption in service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff could access the trust intranet for information and news about the trust. Policies and procedures were available on the trust systems to staff. Staff had access to an internal information technology team for support as required.

The service had performance reports, for example patient tracking list reports which enabled the service to monitor the waiting lists and understand where there were challenges.

Information systems were used across the departments to provide patient care. For example, there was access to electronic patient records and the trust had an electronic incident reporting system.

Outpatients

The service collected reliable data and analysed it. Senior staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. We were shown data bases used in different departments to gather information on performance and used for audit. The information systems were electronic and secure. Staff told us that these audits were shared with the trust management and submitted to external organisations as required. For example, compliance with the National Institute for Health and Care Excellence (NICE) standards in rheumatology.

Engagement

Leaders and staff actively and openly engaged with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The leadership team had discussed methods for helping staff to understand the new structure. They told us that they were in the process of spending time with staff to increase their visibility.

Staff were able to feedback using staff surveys. We were told that staff completed a trust staff survey every three months and a national staff survey each year. The results were fedback to the staff and actions that needed to be taken as a result were shared.

The Connected Health Network project meant that cardiologists worked actively with GP partners to help improve services for patients.

The trust commissioned an audit to review performance and systems to ensure that they were aligned to the outpatient transformation programme.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The Connected Health Network project was developed in partnership with another organisation. This was a new model of care in which GPs and hospitals worked together as one clinical network. It meant that GPs no longer needed to make a referral into a hospital. Instead, they worked directly with trust specialists to agree how to safely deliver your care. A shared admin team helped ensure a streamlined pathway for patients The project picked up an award in the early-stage pilot of the early adopter of the year category.

Diagnostic imaging

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Compliance for radiographers and sonographers (allied health professional (AHP staff)) was 98% which exceeded the Trust target of 85%. Compliance for the majority of e-learning courses was 100% with compliance for face to face courses in individual departments ranging from 40% for moving and handling for patients using a chair, to 84% for Mental Capacity Act training.

Medical staff training compliance exceeded the Trust target of 85% and staff achieved 100% for nine out of 18 courses. Compliance for the remainder ranged from 71% (five out of seven staff) for antimicrobial stewardship to 86% (six out of seven staff) for adult basic life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers and staff confirmed face to face courses were becoming more accessible and staff were rostered and booked to attend as soon as new courses became available.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding Adults and Children training compliance met the Trust target of 85%. Compliance for AHP staff was collated for Scunthorpe General Hospital and Goole General Hospital. Staff achieved 92% compliance for Adults Safeguarding Level 2 training and 99% had completed Children's Safeguarding Level 2. Medical staff compliance met the Trust target at 86%. Six out of seven radiologists had completed Adults and Children's Safeguarding training to Level 2.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Data provided by the trust showed, and staff confirmed, no staff had completed Children's Safeguarding to level 3, although the Trust Safeguarding Children's policy was comprehensive and included Trust safeguarding contacts and processes to follow and staff gave examples of how they had put this into practice. . Staff and managers used the Trust safeguarding team guidance to mitigate any risk.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Diagnostic imaging

Staff could access safeguarding advice via the Trust's lead nurse for safeguarding. Staff explained some vulnerable patients may come to the department with a signed consent form from the referrer if they were unable to give consent themselves. There were a small number of children referred to diagnostic imaging for suspected physical abuse checks. If these patients did not attend (DNA) staff would send a DNA report back to the referrer.

Staff followed safe procedures for children visiting the department. Images taken for babies and children when non-accidental injuries were suspected were reported by consultant radiologists and the Trust had a service level agreement for these images to be double-reported by radiologists at a neighbouring NHS Trust.

Staff attended paediatric multidisciplinary meetings to discuss referrals, images and reports relating to children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises clean in most areas.

Staff provided records to show cleanliness of equipment had been checked. All rooms and public areas were cleaned daily by hospital domestic staff, but cleaning checklists were not available to staff.

Clinical area cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed staff cleaned equipment after every patient contact. Ultrasound staff cleaned and checked all probes were disinfected before use. However, records for public areas were not available to staff and inspectors highlighted to staff some items in public areas were dusty. Staff explained domestic staff cleaned these areas and checklists were kept separately.

The latest PLACE assessment had been carried out in 2019 and the overall hospital scores showed Scunthorpe General Hospital was within the middle 50% of hospital sites for all six domains; above the median for (C) privacy, dignity & wellbeing, (E) dementia and (F) disability; below the median for (A) cleanliness,(B) food & hydration, ward food scores, and (D) condition, appearance & maintenance.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact. Staff disposed of ultrasound gels in bottles at the end of shifts or cleaned and kept them for one more session if still full. Sonographers cleaned and disinfected ultrasound probes before use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff and managers maintained appropriate records of checks of specialist equipment. Staff managed clinical waste well.

All clinical areas we inspected were clean and well-kept and patient areas were spacious and bright. However, we did find dusty items in the main patient waiting area which we highlighted to staff. Domestic cleaning records and checklists were not available to staff so they did not know what should have been cleaned or when. Treatment rooms and storerooms were well stocked, clear of clutter, tidy, and appeared clean. The layout of departments was suitable for following patient pathways. There was sufficient space and furniture in waiting areas.

Diagnostic imaging

The design of the environment followed national guidance. There was clear signage throughout the departments where ionising radiation or magnetic resonance imaging (MRI) equipment was used and there were controls to restrict access to patients and staff. Equipment used in MRI environments were suitable for use and labelled as MR safe. There was appropriate PPE available including lead aprons and coverings. We observed no obvious environmental hazards during our inspection.

Staff wore dosimeters (small badges to measure radiation) to ensure that they identified and accurately recorded any exposure to higher levels of radiation than was considered safe. Radiology staff collected dosimeters and sent them for testing. Results were all within the safe range.

The trust had a radiation safety policy, which met 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.

There were radiation protection supervisors for each modality to lead on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(ME)R. Staff demonstrated safe working methods to record patient doses for radiation.

We saw radiation protection supervisor reports showing reviews undertaken against IR(ME)R and learning shared with staff through team meetings and training.

Staff carried out daily safety checks of specialist equipment. Service and maintenance reports were easily available to staff and managers. They were completed with details of equipment condition and any work carried out. Staff provided servicing and maintenance documents for all equipment. They were completed with details of equipment condition and any work carried out. Staff were able to raise any immediate concerns to managers who took action to rectify faults quickly.

Staff completed quality assurance (QA) checks on all equipment. These were mandatory (must do) checks based on the Ionising Radiation Regulations 2017 and IR(ME)R 2017. These protect patients against unnecessary exposure to harmful radiation. All x-ray equipment had been measured by the regional medical physics advisor and had been found to be safe.

The service had suitable facilities to meet the needs of patients' families. There was sufficient space for carers to accompany patients if required and a small area for use by families and children with some toys and books which were kept clean and in good condition.

The service had enough suitable equipment to help them to safely care for patients.

The service had an equipment replacement schedule with a five-year plan and a central Trust equipment fund. Equipment service and maintenance contracts were in place and trust medical engineering supported the service for non-radiation checks and repairs. Resuscitation trolleys were well stocked, locked and tagged. Equipment was clean.

Staff told us protocols for ultrasound and x-ray equipment were available on the shared drive but these were not adapted solely for each piece of equipment, so staff were not aware of specific requirements of the equipment they were using.

Diagnostic imaging

There were temperature controls in areas where radiological contrast was stored. Inspectors found contrast stock was well managed and all packages of contrast were within date.

MRI safety was monitored and managed by a medical physics expert based at a local NHS trust and a specialist radiologist within the trust.

There were protocols and guidance for quality assurance and diagnostic reference levels (DRL) for equipment. DRLs were present in main x-ray rooms but both CT rooms displayed identical levels. Each piece of equipment should have separate and specific DRLs so the manager informed us they would contact their medical physics expert for advice.

In the x-ray department there was a nominated QA radiographer who had created and prepared a draft QA programme with draft paper copies available for all equipment. This project had begun in November 2021 but was not completed at the time of the inspection. A QA programme for fluoroscopy was under review and had not started.

All resuscitation trolleys were well stocked, locked and tagged. Equipment including suction and oxygen lines were clean. There were anaphylaxis and cardiac arrest kits kept with the trolleys. The checklists for resuscitation trolleys had no missing entries for the month of June 2022.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient's health. The trust had clear policies and guidance in place for managing medical emergencies. Staff received basic life support training as a minimum and there was an emergency crash team who could be called to assist.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a standard document for all examinations consistently across all sites. This document was uploaded to the patient record and there was a standardised process to check patient identification, contrast safety and World Health Organisation (WHO) safer steps to surgery checks.

Staff knew about and dealt with any specific risk issues. Radiology equipment had been risk-assessed and portable equipment tested to ensure the safety of staff and patients. Specific testing and reporting on equipment included radiographic tubes and generators, ultrasound, CT and image intensifiers.

Staff asked patients if they were or may be pregnant. If patients could not be sure, staff ensured a pregnancy test was completed before carrying out any examination involving exposure to radiation. This met with the radiation protection requirements and identified risks to an unborn foetus. Staff followed different procedures for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and staff completed checklists to record them.

Staff knew what actions to take if a patient's condition deteriorated while in each department. There were enough resuscitation trolleys across all departments. All staff had completed basic life support as a minimum.

Diagnostic imaging

Staff completed risk assessments including National Early Warning Score (NEWS), pre-assessment for interventional procedures. Staff recorded these in patient records and escalated any concerns to medical staff. There were emergency assistance call bells in patient areas in radiology, but we rarely saw patients unaccompanied or left for long periods in waiting areas. Staff confirmed that, when patients activated emergency call bells, they answered them immediately. There were emergency call buttons for staff use in all departments.

Staff followed the radiation protection policy and procedures in the diagnostic imaging department. Managers ensured that roles and responsibilities of all staff including clinical leads were clear and therefore managed and minimised risks to patients from exposure to harmful substances.

Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. The trust had named and certified radiation protection supervisors and liaised with the radiation protection advisor (RPA). There were three RPA's based at a local NHS trust, one of whom would attend patient safety meetings every two months. These were minuted and shared with staff including radiation protection supervisors (RPS) for each modality, for example general x-ray and CT, who provided advice when needed to ensure patient safety. Staff described a good relationship with the RPA's. Arrangements had been agreed via the RPA for reporting and assessment of radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Staff had written and agreed policies and processes to identify and deal with risks. This met with IR(ME)R 2017.

Diagnostic imaging and screening departments used adaptations of the WHO safer surgical checklist for all interventional procedures.

Staff shared key information to keep patients safe when handing over their care to others. Images and reports were made immediately available to all referrers and clinicians. Previous images and reports were also available to help staff check previous findings for clinical checks and comparison.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended a "huddle" every morning before the main shift began to exchange information on equipment, expected patients, any identified risks, and to prepare for the day ahead.

Staffing

Allied health professional (AHP) staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough AHP staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of AHP staff and healthcare assistants needed for each shift in accordance with national guidance. Reporting radiographers reported all plain film x-rays except for babies and head and neck images which were always reported by consultant radiologists.

The service had one vacancy due to staff development and opportunities for and moving into new modalities. Three staff had been recently recruited but had not yet started in post. Managers told us this meant there were always continuous vacancies in diagnostic imaging that could take several months to fill. Apart from this there was generally low turnover trust-wide and low sickness rates.

Diagnostic imaging

The service had low rates of bank staff. Some senior staff had left and returned as bank staff.

Managers made sure all bank staff had a full induction and understood the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience. However, managers reviewed the skill mix and were able to keep patients safe from avoidable harm and to provide the right care and treatment.

There were six consultant radiologists based between Scunthorpe General Hospital and Goole and District Hospital, but medical staff did not match the planned number. Although there was a shortage of radiologists, the service had enough medical staff to keep patients safe. Radiologists reported all CT and MRI studies and specialist x-rays including all head and neck images and examinations of babies. Reporting radiographers reported all other plain film x-rays.

All radiologists and some reporting radiographers were able to access images from home and report them remotely. Home reporting stations had been set up during Covid-19 restrictions so that staff could continue to work when they could not access the department. Two radiologists continued to work from home permanently and some on-call work was completed remotely.

The service used an external reporting company for out of hours reporting of CT and MRI examinations. This service also provided some support for CT and MRI reporting during daytime hours to meet increases in demand and to help meet reporting time targets. There was a service level agreement, quality assurance agreement, and contract written for this.

The service had high vacancy rates for medical staff. The trust had recently appointed three new radiologists but medical staff told us there was a 50% vacancy rate for radiologists in the Trust.

The service had low turnover and sickness rates for medical staff.

The service used no locum staff and there were no specialist radiology trainees.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient referrals, reports and images were stored electronically and all staff could access them easily at any time and from any location.

When patients transferred to a new team or department, there were no delays in staff accessing their records. The record system was accessible and reliable, and images could be viewed and reported on remotely by all registered clinicians.

Records were stored securely. Staff accessed records using their own login and password.

Diagnostic imaging

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were prescribed and administered by consultant radiologists, or specialist referring doctors. In nuclear medicine advanced practitioner nurses administered medicines under patient group directions. PGDs provide a legal framework that allows authorised registered health professionals to supply and/or administer specified medicines.

Staff stored and managed all medicines safely.

Staff followed national practice to check patients had the correct medicines.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. For MRI or interventional procedures, adult patients could be prescribed pain relief and sedation, and children could be prescribed general anaesthetics. These were managed by anaesthetists. Nurses, employed by the Outpatients department or specialties, helped to monitor pain management during interventional procedures.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff were confident to raise concerns and reported incidents and near misses in line with trust policy.

The service had no never events.

Staff reported all incidents of repeated or excessive radiation dose to the RPA who advised if any reached a notifiable dose and no incidents required Ionising Radiation (Medical) Regulation (IR(Me)R) notification.

Managers shared learning with their staff about incidents and never events that happened elsewhere. Staff attended Yorkshire network meetings and discussed learning from incidents across the region.

Staff reported serious incidents clearly and in line with trust policy. There had been four serious incidents classified for radiology throughout the trust, one of which had been downgraded following an internal investigation. Staff involved had completed investigations, action plans, and reflection exercises with learning identified for the future.

Following serious incidents, a lead individual was nominated to investigate, and a panel assigned. Diagnostic imaging staff met with specialty doctors to complete the investigation and write up the findings within agreed timeframes. An extension had been requested following the most recent incident due to its complexity and number of departments involved.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers and staff told us Duty of Candour had been followed for all serious incidents. Duty of candour for the telereporting incident had been completed by the specialty team.

Diagnostic imaging

There was evidence that changes had been made as a result of feedback. Following previous incidents where images had been taken of the wrong side of the body, staff had displayed posters in patient areas to encourage people to challenge staff if they felt the wrong area was being x-rayed.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Staff told us about an incident where a patient received the wrong examination using a mobile x-ray machine. The radiographer had gone to the ward to carry out the exam and learned afterwards there had been two inpatients who both required a mobile x-ray. Learning from this incident meant radiographers telephoned the department to check patient details before carrying out any mobile exams.

Radiologists and reporting radiographers attended monthly discrepancy meetings where findings were discussed, actions agreed, and learning was shared. Reporting radiographers liaised with staff regarding poor image quality, identified trends, and led workshops on making improvements.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Inspected but not rated

We do not rate effective in diagnostic imaging, however we found:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured updates to clinical practice.

The departments were adhering to local policies and procedures.

Staff were following procedures regarding National Institute for Health and Care Excellence guidance to prevent contrast induced acute kidney injury and completed evidence-based documentation before, during and after interventional procedures which included NEWS (national early warning system) assessments.

Diagnostic imaging

We saw reviews against IR(ME)R and learning shared to staff through team meetings and training. The trust had a radiation safety policy, which met 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.

Radiation protection supervisors for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(Me)R.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. The trust provided water fountains for patients' use and there was a shop and a hospital café where people could purchase drinks, snacks, and meals. Staff ensured patients requiring CT examination using contrast were sufficiently hydrated prior to their procedure.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain during interventional procedures and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it.

Referring staff prescribed pain relief, and nursing staff or medical staff administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. An audit radiographer carried out audits throughout the radiology department including primary markers, where radiographers attach a marker before an image is taken to show which side of the patient is left and right. All images had digital markers but results of the audit from January 2022 showed only 21% of images had primary markers. This was a poor result and was shared with all staff through team brief and emails. A second audit was planned for October 2022 to check compliance. However, results of a similar audit carried out more recently by staff at Goole had shown a marked improvement in compliance and results were shared with staff at all trust sites.

The Radiology department was part of all major pathways in the hospital. Examples included the stroke pathway, which staff developed through involvement of specialist staff. Staff audited WHO checklists for compliance and quality.

Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. Image quality audits were completed monthly and IR(Me)R procedures were audited bi-monthly with a yearly report and results were consistently good. However, CT image quality was not checked until radiologists reported findings, and staff had reported incidents where patients had to be rescanned because of poor quality images.

Diagnostic imaging

Managers and staff used the results to improve patients' outcomes. Audits included themes on interventional procedures including chest biopsies and fine needle aspiration. Recent learning from this audit reflected on some poor results and the department changed the type of biopsy needle used. Another audit resulted in the implementation of a coloured flag system for the picture archive communication system (PACS) where a draft policy had been compiled for all reporters. This policy was undergoing governance checks prior to full implementation. Staff reported this was part of learning identified through the patient pathway and would include checks to be carried out by all reporters and for all examinations.

Managers and staff carried out audits to check improvement over time. Consultant radiologists and reporting radiographers attended discrepancy meetings, undertook quality checks, and double reported (an independent report was carried out by a second member of the team) 20% of images in line with the departmental discrepancy policy. Staff also double reported 5% of outsourced images.

Staff carried out quality assurance of home equipment using light meters.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All new staff followed the trust competency framework where staff must perform a number of observed procedures to gain competency in that particular area. Designated supervisors approved and signed off the competency framework. Radiographers and sonographers told us the department supported them to complete competencies.

The service was committed to developing the skills, knowledge and competence of its students, staff and managers. Students enjoyed their placements and took up permanent posts once trained. All staff were able to make use of opportunities to learn, develop, and share good practice.

Managers gave all new staff a full induction tailored to their role before they started work.

Newly qualified staff and staff recruited from overseas all told us the department had offered them a good level of competency training and students described good opportunities to achieve the required learning for their placement.

The service was committed to develop its students, staff and managers through their skills, knowledge, and competence. Students enjoyed their placements and took up permanent posts once trained. All staff were able to make use of opportunities to learn, develop, and share good practice. Staff were recruited following completion of university courses as assistant practitioners and then, once qualified, they progressed to radiographer posts. Staff were also recruited from overseas and several staff said they were very happy to work at the Trust. Managers reported staff tended to stay with the Trust but moved to different modalities as part of their development.

Managers supported staff to develop through yearly, constructive appraisals of their work. The performance and development review compliance rate for the previous 12 months was calculated as a joint rate for Scunthorpe and Goole staff at 89%. The trust target was 95% and managers said those staff who had not yet had a PDR had one booked. The trust carried out medical revalidation for all consultants.

All staff had completed performance and development reviews. The trust carried out medical revalidation for all consultants.

Diagnostic imaging

The service provided specialist information and guidance in radiology on areas such as radiation protection and education for referrers. Radiation protection supervisors received training from the RPA. The interim manager for CT was undertaking RPS training as part of their development.

Radiographers followed the trust competency framework where staff must perform a number of observed procedures to gain competency in that particular area. Designated supervisors approved and signed off the competency framework. Radiographers told us the department supported them to complete competencies. Radiography students told us the department had offered them good opportunities to achieve the required learning for their placement. Qualified radiographers were completing postgraduate courses including forensic radiography.

Consultant radiologists had annual appraisals with a named appraiser.

The education lead supported the learning and development needs of staff and managers made sure staff received any specialist training for their role. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had a good relationship with Health Education England and had secured funding for professional development of AHP staff at £1000 every three years for each person. Managers encouraged staff to take advantage of this opportunity to undertake postgraduate training certificates, ultrasound scanning training, reporting radiographer training and to attend conferences and present any learning to peers.

Managers identified poor staff performance promptly and supported staff to improve. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The service had created some Band 6 posts to enable staff to progress and take on additional responsibilities.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There was a staff meeting once a month which was minuted and notes shared with all staff. Staff attended daily huddles prior to the main morning shift where they discussed plans for the day ahead and shared any concerns or incidents throughout the week. At the end of each week managers provided a summary via email to all staff and a printed version for staff noticeboards in each department.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Medical staff could contact a duty Radiologist any time to discuss issues and to provide support to other doctors and staff throughout the trust. Radiologists specialised in areas including interventional procedures such as nephrostomies and placing of stents and a recently recruited radiologist specialised in paediatric imaging. A radiologist from a local trust visited once a week to support specialist paediatric imaging.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Reporting radiographers attended specialty MDTs for chest and abdominal imaging as well as local trust MDTs.

Patients could see all the health professionals involved in their care at one-stop clinics.

Seven-day services

Key services were available seven days a week to support timely patient care.

Diagnostic imaging

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests.

The trust provided 24 hours a day, seven days a week service for emergency plain x-ray imaging, emergency CT, and out of hours portable images. Staff also provided radiology services to GP patients from Monday to Friday. The diagnostic imaging department provided general radiography, CT and ultrasound scanning, and fluoroscopy for all patients every day. Out of hours interventional radiology was carried out at a neighbouring NHS Trust.

Staff could find all patient information such as diagnostic imaging records and reports, other diagnostic tests, medical records and referral letters through electronic records. Diagnostic imaging departments used picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff used systems to check outstanding reports and staff could prioritise reporting and meet internal and regulator standards.

The diagnostic imaging department kept an electronic list of approved referrers and practitioners and senior staff vetted internal and external staff against the protocol for the type of requests they were authorised to make.

There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle such as for patients attending for gastrointestinal imaging.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent but did not always record it. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal consent from patients for care and treatment in line with legislation and guidance. Diagnostic imaging, and medical staff understood their roles and responsibilities and knew how to obtain consent from patients. They could describe to us the various ways they would do so. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain x-rays. In some general cases this was inferred consent. Specialty medical staff obtained consent for any interventional procedures in writing before attending departments and for biopsy procedures.

However, staff did not always adhere to the Trust Consent Policy. Staff did not always clearly record consent in the patients' records. Staff and managers told us consent was always taken, and documents managers had checked showed consent was recorded. However, we found two out of five ultrasound records we reviewed did not show consent was recorded even when intimate procedures were carried out. Trust policy stated: "For significant procedures, it is essential for health professionals to document clearly … in the patient's notes that they have given verbal consent." Staff recognised the need to audit this as they had not realised it was being done inconsistently.

Staff made sure patients consented to treatment based on all the information available. Patients told us that staff were good at explaining what was happening to them before asking for consent to carry out procedures or examinations.

Diagnostic imaging

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patients and relatives said the service had “good, kind staff” and staff were “caring and understanding”.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff interactions with patients in all areas we inspected were polite, courteous, and respectful. We heard staff introducing themselves when dealing with patients and relatives. Staff greeted patients in a kind and friendly manner. We spoke with five patients and their carers or relatives and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.

Reception staff respected patient privacy when they were checking personal details on arrival for their appointments, although glass screens to protect people from infection sometimes made this more difficult.

Staff respected patients’ privacy, dignity, and confidentiality at all times.

Staff organised imaging times to ensure patients did not have to wait unnecessarily and there were no queues of inpatients waiting for imaging or to return to the wards.

Staff collected patients from waiting areas and took them to private changing facilities and managers had invested in additional privacy screens for use during some procedures.

Diagnostic imaging

Patients told us, and we saw without exception, that staff treated them kindly and in a consistently caring and compassionate way.

Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

Staff at all levels helped and supported patients in all aspects of care. Staff reacted compassionately to, or pre-empted, patient discomfort or distress by using appropriate communication methods to suit individual needs. MRI staff involved patients, their carers, and families by discussing and planning their procedure.

Patients and their relatives told us staff had treated them with dignity and respect and overall, they were happy with the service provided. They also told us that the staff were, caring, and friendly but professional. Staff confirmed that patients would have a chaperone made available when intimate examinations were performed or at any time on their request.

Staff in all departments we inspected were caring and compassionate to patients. We watched positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.

Staff respected patients' privacy and dignity. Staff took patients to private changing facilities with a curtain or lockable door to ensure privacy and dignity. Staff knocked on doors before entering and closed doors when patients were in treatment areas. Patients and relatives told us staff had treated them with dignity and respect. Management had invested in additional portable screens to be pulled across the corridor when a patient required additional privacy during some procedures and while moving from a changing room to a scanning room and to return again. Staff in x-ray informed us that they spent the time necessary with patients to ensure they informed, supported, and reassured them about the procedure to be undertaken.

An action plan to improve communication with patients was created to address changes to practice across all sites at the Trust following a general patient satisfaction survey carried out in general radiology at Diana, Princess of Wales Hospital in December 2021. Results had shown 10% of patients said staff had not introduced themselves and about 8% said they were not told how they would receive their test results. All recommendations were met within the agreed timescale. Staff followed the "hello, my name is" campaign and were reminded of the importance of letting the patient know how they will be informed of their results.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff could support patients suffering from claustrophobia and anxiety.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff providing care before, during, and after procedures and showing consideration to patient's emotions, allowing them time to ask questions or comply with requests. Staff were aware some positioning could be uncomfortable and allowed patients to be independent or made adjustments where possible.

Diagnostic imaging

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Staff in x-ray informed us that they spent whatever time necessary to ensure that the patient understood and consented to the procedure. Staff also confirmed that should they have any concerns about a patient who did not fully understand what their care entailed then they could delay or cancel the procedure to suit the patient.

Staff made sure patients and those close to them understood their care and treatment. Staff made sure that people understood any information given to them before they left the departments.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff used a simple picture board so patients who were unable to communicate through speech could convey their feelings.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were patient suggestion boxes in waiting areas which staff checked regularly. Following patient feedback regarding some long waits for porters to return patients to wards after their examination staff and porters had established a “wait and return service”. Some porters could wait with a patient and return them to the ward. Staff explained this could not always happen, but hospital porters usually arrived promptly when called.

Patients gave positive feedback about the service. There was a blackboard in the patient changing area for patients to write comments on their care. We saw comments including: “A big thank you, such caring and understanding staff” and “thank you for being friendly and making me feel safe”.

Is the service responsive?

Good ↑↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

The departments were accessible for people with limited mobility and people who used a wheelchair.

Diagnostic imaging reporting and record keeping was electronic, and the department used paperless methods to reduce time and administration.

Managers monitored all targets and reported to the trust board through their overall performance reports.

Diagnostic imaging

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. There were some rapid access clinics for example prostate clinics in urology where patients attended clinics on Fridays, scanned over the weekend, and images were reported in time for review by the MDT on a Monday. The service supported “one stop” hysteroscopy and stroke clinics.

Facilities and premises were appropriate for the services being delivered.

There was out of hours cover for interventional radiology provided by a nearby trust with a service level agreement, a formal process, and protocols in place.

The service had systems to help care for patients in need of additional support or specialist intervention. There were sufficient facilities to meet the needs of inpatients with bays set away from the main waiting areas. These bays could accommodate trolleys and wheelchairs and staff often accompanied patients from wards.

Managers monitored and took action to minimise missed appointments. Staff respected inpatient mealtimes and organised inpatient imaging to avoid them.

Managers ensured that families of children or vulnerable patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. Reporting radiographers checked suspected fractures straight away and provided results back to the emergency department to ensure efficient patient care or discharge.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other departments, services and providers.

The main waiting area was large and airy. There was sufficient seating and a small area with children’s toys and books which were clean and well maintained. Sub waiting areas provided adequate seating arrangements. Patients attending departments had access to drinks and snack facilities, a café and a shop. All departments were well signposted and provided plentiful comfortable seating and areas for children. A younger children’s waiting area was provided and stocked with books and some toys.

Patient toilets (including disabled facilities and baby changing) were all easily accessible.

Staff told us a patient hoist was available at a nearby department should it be needed for any immobile patients. Staff had been trained to move and handle patients safely.

Wards were designed to meet the needs of patients living with dementia. Referrers informed departments in advance of patients with special needs attending for procedures and reception staff informed radiographers if patients attending had any additional needs. Staff could offer flexibility in terms of appointment times if a patient had a particular need, such as a learning difficulty or dementia, where waiting in a busy waiting area could be distressing. Staff confirmed that priority was generally given to people with additional needs.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The reception staff organised interpreter services for patients who did not speak or understand English. Staff told us they did not have trouble in booking interpreters.

The service had information leaflets available in languages spoken by the patients and local community. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Bookings staff provided leaflets to patients with their appointment information. If referrers provided information on the language required or any specific patient needs, leaflets would be printed accordingly.

Following feedback from a patient's family, staff had replaced two changing rooms with one large one. This was to enable a person with specific needs to have a carer with them and enable them to change safely and discreetly.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Referral to treatment (RTT) rates were measured against national targets for all patients on cancer pathways, two week waits, urgent and planned care, and routine images. Referral to imaging times were better than regional averages and continued to show an improving trend for patients waiting for a diagnostic test. The trust compliance rate for reporting times was 98.6% of all images reported on time in line with trust policy. This was better than regional and national standards. All referrals were triaged by radiographers and the service used monitoring, oversight and escalation processes with time-based triggers to identify and prevent delays. The service reported a deterioration in routine CT reporting times in the few weeks prior to the inspection. To address this, they had made changes to radiologists' job plans to allow more time for reporting and scheduled weekly calls with the reporting outsource company. They had agreed a three-month block of concentrated reporting of CT images out of hours and some daytime inpatient reporting to reduce the risk of delays.

Managers explained actions taken to reduce the number of non-urgent GP referred patients by extending sessions to weekday evenings. Managers reported the waiting time for GP patients at the time of the inspection had reduced to two weeks. Staff were taking positive action to address this before the KPI was breached.

Waiting times for non-urgent ultrasound scans had reduced from 12 weeks in March 2022 to 7 weeks at the time of the inspection,

All patients who attended from accident and emergency department or for urgent referrals from clinics had images completed the same day. If radiographers identified suspicious findings on chest x-rays they were able to share the image immediately with a reporting radiographer or radiologist to generate a report or make an instant referral for CT.

The trust could offer up to 50 patients a week a scan with a local independent healthcare provider for MRI and non-obstetric ultrasound.

The service liaised with another local trust who provided interventional radiology procedures during evenings and weekends. Referrals were triaged by trust staff then directed to the other trust for procedures out of hours. This meant patients would have to travel or be transported elsewhere but they could have their procedure carried out in a timely way.

Diagnostic imaging

There were some rapid access clinics for example in urology where patients attended for MRI on Fridays, scanned over the weekend, and images were reported in time for review by the MDT on a Monday.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Managers worked to keep the number of cancelled examinations to a minimum. When patients had their examinations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. A booking team worked with patients and referrers to ensure appointments met local and national timeframes. Appointments were managed according to priority such as unplanned or emergency care, urgent and routine.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff told us there were formal written complaints direct to the service in the 12 months prior to our inspection. However, staff contributed to complaint responses regarding specialty care for any parts that were relevant to diagnostic imaging. Staff had carried out a telephone conversation to better understand their needs and concerns regarding a long complaint where diagnostic imaging was a component of the patient journey. An appointment had to be changed to a week later than originally planned because the patient required a specialist treatment that involved additional staff. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Following a complaint about a patient's lost jewellery during a procedure, staff had discussed opportunities to prevent a recurrence and had initiated key reminder stickers to be used if a patient was required to remove jewellery. This prompted the radiographer to check and return any jewellery before the patient left the imaging room.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Diagnostic imaging

Leadership

Leaders had the skills and abilities to run the service. They understood and managed most of the priorities and issues the service faced. However, senior managers lacked clear oversight of consent processes. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There had been recent changes in divisional leadership and diagnostic imaging had recently been included within the division of surgery and critical care. Senior leaders were aware of and supported teams to improve regarding high-level performance of the departments including national targets.

There were new, interim managers in each department, whilst colleagues undertook secondment opportunities or other leave.

Staff described managers as being accessible and approachable. Although new divisional leaders were relatively new to the service, staff knew who they were and how to contact them should the need arise.

Interim managers performed well, provided clear leadership, and were highly valued by staff in CT and MRI. Staff raised concerns during the inspection that the opportunities for learning and sharing these experiences had gained could be lost at the end of the secondments.

However, managers for ultrasound were not aware that although verbal consent was gained it was not always recorded.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

A five-year trust radiology strategy had been launched in 2019 which was relevant to diagnostic and interventional radiology at all sites within the Trust. The strategy described patient centred care as being the bedrock with a system wide approach to service delivery and providing efficient care. There were clear objectives and priorities with benchmarking against national quality standards. Partnership working with other local providers was identified as an opportunity for future working.

Managers were aware of challenges and risks to providing an improved service and had identified and implemented changes to meet some priorities and planned outcomes early which included investment in additional equipment including MRI and CT scanners at Diana, Princess of Wales Hospital and Scunthorpe General Hospital.

Radiologists supported the strategy and, although the team was pressured and short of staff due to a shortage of radiologists, they had been able to make some recent appointments and make improvements to rotas to support emergency access to care, timely discharges, and significantly reduce reporting times.

The department reported good relationships with clinical commissioning groups (CCGs) who had allocated funding for provision of independent healthcare to support patient access and the reduction of waiting lists.

Diagnostic imaging

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were proud to work at the trust and within their departments. Staff, from students to senior staff were loyal to the trust and chose to develop and progress within the service and across modalities. Staff reported an improvement in culture between all levels and disciplines of staff since the last inspection. Staff told us that working relationships were professional and friendly. One member of staff said working within the department "often felt like being with friends and family rather than working with colleagues".

Staff supported each other and would often work extra hours to support colleagues and enable patients to receive the best service. All staff we spoke with said they felt able to raise any concerns to colleagues or managers and were aware of how to contact the Freedom to Speak up Guardian.

Managers described how they supported serious incident investigations with specialty colleagues and followed Duty of Candour where appropriate. We saw examples of letters provided to patients regarding incidents that included openness and honesty.

Staff explained managers and the Trust had supported them during difficulties and in particular during COVID-19 additional pressures.

Equality and diversity were clearly promoted to patients, students, and staff throughout the service. There were no barriers to progression or development and staff were proud of their diverse recruitment and development experiences. Qualified staff recruited from overseas were supported to complete competencies to enable them to work independently and progress or specialise throughout the service.

Radiology students told us the trust was their first choice in the local network for placements and recruitment.

Governance

Leaders operated effective governance processes for most requirements throughout the service and with partner organisations. However, there was a lack of oversight regarding quality and safety checks and the consent process. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At the time of the inspection diagnostic imaging was managed by a new directorate; surgery and critical care. However, staff explained governance was still managed via the directorate of clinical sciences.

Managers, heads of departments, and deputies attended monthly governance meetings and submitted monthly activity figures along with data on sickness, vacancies, training and development, finance and waiting times. The head of governance attended and the regular agenda included serious incidents, new policies and regular reviews, audits and opportunities for learning. Deputies shadowed department leads to review serious incidents and gain experience of root cause analysis (RCA) investigations.

Diagnostic imaging

Staff carried out governance responsibilities and completed effective audits to ensure they were carried out correctly and consistently. However, there was a lack of clear oversight regarding diagnostic reference levels (DRLs) for items of radiological equipment and protocols and managers in ultrasound did not have clear oversight to ensure quality assurance checks were being completed according to national guidelines.

There was no clear oversight of documentation reflecting the consent process. Staff did not always follow the Trust consent policy completely by documenting consent had been taken, but managers and senior managers were unaware this was happening. Records were not effectively audited to identify issues regarding documentation of consent.

Senior managers told us they would need to make changes to the agenda of the weekly management meeting to ensure crosschecking was carried out in future. They believed the business meetings and governance structure could also help pick up non-compliance.

There were radiation protection committee meetings attended by the RPA, RPS for each modality, senior managers, and the trust medical physics expert. Minutes from the meeting in March 2022 included equipment faults and checks, radiation incidents, none of which required IR(Me)R reporting, audit results and actions, new non-medical referrers, risk assessments and staff competency records.

Managers, heads of departments, and deputies attended monthly governance meetings and submitted monthly activity figures along with data on sickness, vacancies, training and development, finance and waiting times. The head of governance attended, and the regular agenda included serious incidents, new policies and regular reviews, audits and opportunities for learning.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk register identified risks which were categorised according to potential impact. These were mainly regarding staffing, ageing equipment, and capacity and demand. Risks from individual department managers were included in the directorate risk register. The register showed actions taken and any remaining gaps were identified with dates for review. There were plans in place for equipment failure.

Staff managed performance effectively and had achieved better than regional average referral to imaging times. There was an improving trend for patients waiting for diagnostic tests with a reduction of the waiting list for non-urgent ultrasound from12 weeks to 7 weeks over a period of two months. Staff monitored performance against key performance indicators (KPI) and took action to avoid breaches before they occurred such as provision of additional scanning sessions, an independent healthcare contract for CT imaging.

Staff described good IT support and no recent breakdowns or failures in the picture archiving and communications system (PACS). Images were available at all times to all relevant professionals.

Service leads and managers worked together to provide information to the executive performance meeting. They monitored performance and provided information to the directorate leads, along with identified risks and issues for escalation. Service leads reported a good level of support in planning for the future including finance and workforce planning.

Diagnostic imaging

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff could find all patient information such as diagnostic imaging records including previous images, and reports, medical records and referral letters through electronic records.

CT and MRI images were available securely via picture archive communication system (PACS) to external telereporting clinicians.

All staff had access to the trust intranet to gain information on policies, procedures, National Institute for Health and Care Excellence guidance, and e-learning.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust and its staff were part of the Yorkshire Imaging Collaborative, a partnership of nine local trusts who met monthly to benchmark performance and share learning and good practice.

Radiographer ambassador meetings had been established monthly via Teams calls and staff explained these enabled radiographers to have a voice regarding departmental matters. Staff said they could discuss their opinions on staffing, morale, and ideas for improvements to patient care. Staff reported this helped them feel they were listened to but also that changes often took a long time to action.

Staff satisfaction surveys and “innovation stations” had been implemented throughout diagnostic imaging departments and were in very early stages. However, staff were aware of them and had engaged positively with them. Staff said they used them to share ideas.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff explained suggestions for service improvements came from radiographers who see the needs of patients first-hand and who want to become better radiographers. Staff took ownership of projects and ideas for change and felt self-motivated and empowered to implement change within their service.

Staff felt proud of how they had worked throughout the COVID-19 pandemic when suddenly they were asked to perform increased interventional procedures such as a gallbladder drain instead of a patient undergoing surgery in theatre. Staff felt they were regularly asked to do more interventions than were really required and some referrals were inappropriate, but consultant radiologists held conversations with referrers to explore alternative tests or actions.

Diagnostic imaging

There had been a marked improvement in actions to address the backlogs for waiting times and reporting times. These had reduced significantly since the previous inspection and, at the time of the inspection, the trust performance was better than the regional average. The Trust consistently and continuously explored opportunities and initiatives to improve their reporting capacity. The trust had invested in new equipment including CT and MRI scanners, complemented by additional staff.

End of life care

Inadequate ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The end of life (EoL) team met the trust target for mandatory training in key skills and EoL core specific training. The mandatory training was comprehensive and met the needs of patients at EoL.

We reviewed the mandatory training compliance rates for all staff working within EoL. This also included the Macmillian and palliative healthcare teams. This showed an overall compliance rate of 97% for mandatory training and 88% for role specific EoL training which both met the trust target.

However, the mandatory training compliance rate for medical staff, within the EoL team, was 66% which did not meet the trust target of 90%.

Staff we spoke with said they had been given protected time to complete this training. All staff had completed equality and diversity, information governance and data security and moving and handling training.

All ward staff received an introduction to EoL care as part of their induction and completed online courses which were related to EoL and palliative care.

The EoL team delivered two EoL specific training courses face to face training in the form of workshops or ward visits to eligible staff.

- Syringe Driver and Symptom Management
- End of Life Planning

The EoL team monitored the compliance of EoL training modules for eligible staff and received updates from divisional highlight reports presented at the EoL implementation meeting. We heard that this training had been problematic throughout the pandemic with ongoing operational pressures. In addition, the EoL team told us approximately 40% of eligible staff had received their syringe driver refresher training. This did not meet the trust target of 85% and was a repeat issue from the last inspection.

The EoL planning training for registered nurses was comprehensive and included the five priorities of care for the dying person (2015) which were;

- recognising that someone was dying
- communicating sensitively with them and their family
- involving them in decisions

- supporting them and their family
- creating an individual plan of care that includes adequate nutrition and hydration.

Safeguarding

Staff understood how to protect patients from abuse however, they did not always have training on how to recognise and report abuse or how to apply it.

We reviewed the safeguarding mandatory training compliance rates for end of life (EoL) staff. This showed 60% of staff completed level 2 adult, 100% level 3 adult, and 78% level 2 children safeguarding training. This meant not all staff had met the trust target of 90% and this was a repeated issue from our previous inspection.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics. They knew how to identify adults and children at risk of, or suffering, significant harm, how to make a safeguarding referral and who to inform if they had concerns.

We heard of one example when a patient had disclosed information, and this was appropriately raised as a safeguarding concern.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

All areas where palliative and end of life (EoL) care were provided appeared clean, tidy and well maintained. We observed staff using PPE such as gloves and aprons, adhering to the 'bare arms below the elbow' infection prevention and control guidance.

We visited several areas in which EoL care were provided. This included hospital wards, the mortuary, the multifaith rooms and bereavement offices. All ward areas appeared clean, tidy and well maintained. We saw that personal protective equipment including gloves and aprons were readily available. There were appropriate handwashing and hand decontamination facilities in all areas.

Ward staff would always try to prioritise side rooms for EoL patients however, this was not always possible as some patients needed to be isolated for infection control issues.

We reviewed the mortuary area. It was clean, tidy and appropriate for relatives visiting the deceased patient. We reviewed cleaning records which were up to date and demonstrated that areas had been cleaned regularly. Staff identified what had been cleaned and signed their name once it was completed. However, we saw several areas accessible by staff within the mortuary which were unclean and untidy such as equipment storage areas. This meant there was an increased the risk of environmental infections.

Environment and equipment

The design and maintenance of the mortuary did not meet national standards. Not all staff were trained to use available equipment. Staff managed clinical waste well.

We visited the mortuary, chapel and bereavement room which were all suitable facilities to meet the needs of patients and their relatives. All were well signposted.

The mortuary was clean and odour free. All areas were covered by CCTV.

It had the storage capacity for 30 deceased patients, including three bariatric patients. There was a semi-permanent body storage unit in place which accommodated 12 deceased patients. However, the top or bottom spaces could not be accessed because staff had not been trained to use the available hoist. This continued to be an issue from the last inspection in 2020. There were three deep freezers suitable for longer term storage of bodies.

The mortuary had two viewing rooms, one for adults and children, and a second for babies. There was additional seating available for relatives.

We reviewed the Human Tissue Authority (HTA) audit which was completed in May 2022 for the mortuary environment. The results showed several shortfalls against HTA standards;

- The temporary storage units did not have a remote temperature monitoring system similar to the cold storage units. This meant if the temperature deviates from normal range out of hours there would be no one to hear the audible alarm.
- Insufficient storage capacity within the trust to meet high demand.
- Rusty mortuary trolleys (which we also saw on inspection).

In addition, to the findings of this report we noted that the storage areas were dirty and untidy.

Staff who delivered end of life (EoL) care said they had enough suitable equipment to help them to safely care for patients. The service used specialist syringe drivers for patients who required a continuous infusion of medication to help control their symptoms. These were readily available and obtained from a trust wide central equipment library however, staff informed us there were some delays of up to an hour to receive syringe drivers after the request was made on the computer system.

We found a box of mouth care sponges which had expired in 2019. We escalated this to staff, and it was immediately removed, and other boxes were checked.

In the mortuary we saw bariatric trolleys with suitable coverings.

Mortuary staff disposed of clinical and non-clinical waste safely.

Assessing and responding to patient risk

Ward staff provided care to patients requiring palliative and end of life (EoL) care. They completed risk assessments for patients who were deteriorating and in the last days or hours of their life.

They used a nationally recognised tool to identify deteriorating patients and would discuss them at daily safety huddles twice a day. Staff said they would escalate appropriately to medical staff.

Staff told us they always completed pain assessments and ensured patients basic health care needs were met such as mouth care and washing.

There were pathways and escalation processes for the identification of patients approaching EoL. However, some staff we spoke with confirmed these processes were not instigated in a timely manner and this was also observed on inspection. This meant there was a potential risk that patients approaching end of life were not reviewed appropriately or staff looking after them were given adequate support and guidance.

End of life care

Staffing

The end of life (EoL) service had enough staff with the right qualifications, skills, training and experience to provide the right care for patients who were at EoL.

All staff throughout the hospital delivered end of life and palliative care but were supported by a dedicated end of life care team and a specialist palliative care team.

At the last two inspections in 2018 and 2020 the service was told they must ensure that sufficient numbers of EoL staff were employed to provide care and treatment. At this inspection the service had increased the size of the EoL team across both sites to a matron, a lead nurse, a clinical practice educator and a bluebell roll out lead nurse.

The EoL team were responsible for providing support and guidance to all staff who delivered care and treatment to patients who had been identified as EoL and had been started on the EoL pathway. There was a matron who was responsible for the EoL team.

However, on the days of our inspection there were EoL staff absences at Scunthorpe hospital. We were informed that the EoL team worked in collaboration to deliver a seamless pathway of care to patients who were palliative and at EoL. However, there was no formalised process for this cover arrangement, and we did not see any cross site cover. We were informed the clinical nurse specialists based at Diana Princess of Wales Hospital who were employed by an external health care provider would cover absences however, this was not always possible due to their workload.

We reviewed the sickness, turnover and vacancy rates for the EoL service from June 2022 to May 2022. The average sickness rate over this time period was 0.2% and there was no turnover rate.

We heard there was one EoL community nurse vacancy.

There were mortuary, chaplaincy and bereavement staff who provided EoL care to patients and relatives.

The chaplaincy team were responsible for offering spiritual and religious support to patients, relatives and staff. There were four chaplaincy volunteers, and they were in the process of actively recruiting additional volunteers.

At the last inspection in 2020 there were vacancies within the chaplaincy team, and we found the same concerns at this inspection. There was not enough chaplaincy staff to cover the on-call system for nights and weekends and the lead chaplain was on call every evening until midnight.

Medical staffing

The service did not have enough end of life (EoL) consultants with the right qualifications, skills, training and experience to provide the right care for patients who were at EoL

At the last inspection in 2018 and 2020, the trust was told they must ensure that sufficient numbers of EoL consultant staff employed to provide care and treatment. At this inspection we found the same concerns which meant the service had not addressed this issue for four years.

The EoL team had one consultant employed by the trust. They were responsible for reviewing patients who had been identified as EoL and had been started on the EoL pathway. They were available for clinical advice and support and they provided support to patients, relatives and staff.

This meant there was minimal consultant cover across all trust sites during the day. It was unclear what the on call consultant provision was for evenings and weekends. The service did not employ locums or trainee doctors to cover absences such as sickness or annual leave. However, all staff we spoke with gave positive examples of the level of support provided by this consultant.

There was no sickness, turnover or vacancy rates for the EoL medical staff from June 2022 to May 2022.

Within the catchment area of North East Lincolnshire there was a specialist palliative care consultant who was employed by an external health care provider and whose services was commissioned by North East Lincolnshire CCG. They were responsible for reviewing any palliative care patients within the community. They completed two weekly ward rounds to review any palliative care patient who had been admitted into hospital from the community. They were not commissioned to review patients who were at EoL however, they were available for clinical advice and support.

In addition, there was a lack of oncology consultants at this trust.

Records

Patients who had been identified as end of life (EoL), and placed on the EoL pathway, did not always have their personalised needs and preferences recorded or documented in their medical records. Records were not always easily available and were not always securely stored.

At the last inspection in 2018 and 2020, the trust was told they must ensure that all patient records were to be completed consistently and appropriately. At this inspection we found similar concerns with patient medical records being incomplete which meant the service had not addressed these issues for four years.

We reviewed the “care in the last days of life” document which was supposed to be commenced by ward staff when a patient was identified as EoL and placed on the EoL pathway. It was a two part document consisting of a clinical review, and care plan which recorded personalised needs and preferences. We spoke with staff who said they were not clear who should complete each part of the document.

We reviewed five of these documents within patient records and found the majority had been completed appropriately. However, there were incomplete sections within the care plan to detail the patient’s preference for spiritual and/ or religious care, and any psychological and emotional needs.

The service acknowledged this document was not always started when the patient was started on the EoL pathway. From April 2021 to March 2022 only 27% of EoL patients had this document fully completed and this was worse than the previous year. Following the inspection, the trust provided additional information to clarity these EoL patients included unexpected deaths.

In response to this poor compliance the service implemented two task and finish groups. One group was assigned to amend this document so that it was easier to complete and avoided duplication of information. At the time of writing this report a new draft version of the “care in the last days of life” document had been developed and we were told that this would be shared at the next EoL implementation group meeting. The second group was assigned to discuss the most effective way of recording a patient’s spiritual and religious care.

End of life care

In 2020 the trust implemented the use of a recommended summary plan for emergency care and treatment (ReSPECT) form. This had been rolled out across all providers within the Northern Lincolnshire area to improve partnership working and shared care. This was an advanced care planning record which focussed on a patient's wishes for treatments in an emergency such as resuscitation.

We reviewed two patients ReSPECT forms and found the majority had been completed appropriately.

We reviewed the most recent audits related to record keeping. These results showed poor compliance with the completion of the patient's personal values and fears, and recording of future care discussions.

As part of the EoL improvement plan, the electronic palliative care coordination system (EPaCCS) was being implemented across all wards. This was used to record key details about a patient's care preferences within Northern Lincolnshire. This meant that health professionals such as GP's and community based staff would be able to access information from a single point rather than from multiple computer systems. We heard of plans for the ReSPECT form to be added to EPaCCS.

The mortuary staff showed us warning notices which were used to identify deceased patients with similar names or those who had a pacemaker or implantable defibrillator.

We found patient's medical records in unlocked filing cabinets across the wards we visited.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, however prescription charts were not always complete.

The trust provided medicines management training as part of mandatory training and staff induction. Nurses were required to complete additional training and competency assessment for intravenous administration.

The end of life (EoL) team had created a policy for anticipatory drug prescribing to guide staff when and how to prescribe medicines to EoL patients, even those not started on the EoL pathway, to provide symptom and pain relief.

We observed staff adhering to this policy when prescribing predetermined selection of anticipatory medicines. We reviewed electronic medicine charts which showed staff regularly reviewed, and prescribed, medications. However, the majority of the charts did not record that oxygen was being prescribed and this was already a known issue within the trust.

We observed delays in the prescribing of anticipatory medicines as not all staff were aware of a priority alerting system for the ordering of anticipatory medicines. We did not see any evidence of prescribing audits relating to EoL care. The trust used a dispensing for discharge model which means they are unable to audit discharge medications turnaround times.

We reviewed the results of the national audit of care at end of life (NACEL) from data collected from June 2021 to May 2022. This showed an average of 40% of patients had anticipatory medicines prescribed who had not been commenced on the EoL pathway. In addition, this showed an average of 100% of patients had anticipatory medicines prescribed who were commenced on the EoL pathway.

End of life care

Staff were aware of a recent medicine advisory that Morphine Sulphate was to be prescribed instead of Diamorphine. This information was also on the EoL May 2022 newsletter.

Incidents

The end of life (EoL) team recognised and reported incidents. They investigated incidents and shared lessons learned with the wider service.

The service had a comprehensive incident reporting policy. The EoL team, and staff delivering care to EoL patients, told us they understood their responsibilities regarding the reporting of incidents. They were encouraged to incident report when patient discharges were not activated or when patients did not achieve their preferred place of care.

The results of the most recent national audit of care at end of life (NACEL) confirmed that 49% of staff strongly agreed, and 42% of staff agreed, they felt able to raise a concern about EoL care.

Although ward staff knew how to report incidents, we heard of many examples when incidents were not always reported. For example, for when there were delays in identifying patients or delays to starting the pathway.

The EoL team could easily identify incidents related to EoL from the addition of a tick box added onto the electronic database. They regularly reviewed and investigated all incidents that were graded as moderate or above harm.

We reviewed the end of life analysis report published in May 2022. This showed that from October 2020 to March 2022 there were 183 reported incidents relating to EoL. This was less than the number from the previous 18 months.

This report identified emerging themes and trends across each division. These were mapped against the EoL improvement plan and continually monitored by the EoL team.

The most common themes included;

- Medicines prescribing process
- Admissions to inappropriate settings and discharge process
- Communication.

The medicine division continued to have the highest number of reported incidents for EoL patients. They had identified their main theme was administrative processes such as failure to initiate the EoL pathway at the earliest opportunity and poor documentation. This also prompted staff to complete the “care in the last days of life document”.

There had been a high number of serious incidents involving EoL care patients within the surgical and critical care division. These were due to late or no decisions being made for patients.

The biggest theme from mortality reviews was the lack of advanced care planning and the concern that some patients were being admitted to hospital unnecessarily.

We reviewed the community and therapy services clinical governance meeting minutes from March, April and May 2022 as the EoL team sat within this directorate. These demonstrated that incidents were discussed and learning from competed specific incidents were shared.

End of life care

The EoL team provided examples of how ward staff were supported after raising incidents and would provide further training for incidents relating to syringe drivers, communication or cultural awareness.

We were informed that the main themes following mortality reviews was related to a lack of advanced care planning, where a high proportion of patients ended up in hospital who could possibly have been managed within the community. In addition, there were cases where patients had been discharged from hospital and readmitted in close proximity to their death.

Is the service effective?

Inadequate 

Our rating of effective stayed the same. We rated it as inadequate.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

We reviewed audits which showed low compliance for the completion of the recommended summary plan for emergency care and treatment" (ReSPECT) document and 27% completion of the care in the last days of life" document.

We reviewed the results of the national audit of care at end of life (NACEL) from 2020/2021 which found the "care in the last days of life" document was not started early enough, and patient's personalised wishes and discussions were not recorded. This meant that staff were not always able to deliver care based on patient's individual needs or preferences because they had not been documented.

The trust scored in line with the national average for seven themes. They scored much higher than the national average for workforce, staff confidence and staff support. However, they scored lower for four themes which were linked to communication with patients, and relatives and individualised care plans. Following this audit, the EoL team identified 18 learning points and acknowledged that communication remained as the main theme for improvement.

The EoL team shared anticipatory medicine safety alert to ward staff using the EoL newsletter. For example, in May 2022 we saw that staff were reminded to prescribe Morphine Sulphate instead of Diamorphine.

Ward staff delivering end of life told us they were able to access policies on the trust intranet. We reviewed policies and they were reflective of national evidence based best practice and guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff explained that referrals could be made to the mental health liaison team and outlined support that were available when required.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

End of life care

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed records which confirmed they had used the malnutrition universal screening tool (MUST) appropriately to identify and score nutritional and hydration requirements.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs.

We saw evidence of mouth care for those patients unable to tolerate fluids and care plans for patient mouth care for patients who were unable to tolerate food or fluids.

We reviewed the February 2022 results of the most recent national audit of care at end of life (NACEL). This showed the trust scored worse than the national average for recording patient's hydration and nutrition requirements and any related discussions. However, it also confirmed that 39% of staff strongly agreed, and 50% of staff agreed, they were confident in their ability to discuss hydration options with patients.

Pain relief

Staff used the pain management tool to assess the pain levels in patients who were identified as end of life (EoL). However, they did not always reassess pain in a timely way.

At the last inspection in 2020 the trust were told they must ensure safe medicines management in all areas, specifically in relation to reviewing and monitoring of analgesia. At this inspection we found similar concerns which meant the service had not addressed these issues for two years.

The EoL team acknowledged there had not been a consistent approach to the monitoring of pain relief and the reassessment of pain.

We continued to see different pain assessment tools being used to assess pain across the wards we visited.

We saw ward staff using the pain assessment charts in both paper and electronic formats. We reviewed the medical records for two patients receiving pain relief however, the electronic pain assessments had not been completed.

We reviewed the February 2022 results of the national audit of care at end of life (NACEL). This confirmed that 43% of staff strongly agreed, and 39% of staff agreed, they were confident in their ability to assess and manage pain and physical symptoms.

We reviewed the results of the pain audits completed in 2020 and 2021 which provided limited assurance that all patients received adequate pain relief medication.

The pain audit completed in 2020 showed that staff did not always;

- complete pain assessments correctly
- prescribe appropriate pain relief medication
- reassess pain levels after the administration of pain relief medication
- document relevant discussions with the patient or relative about the use of the pain assessment charts.

End of life care

We reviewed the pain audits which had been completed in 2021 and 2022. The results demonstrated an increase in compliance with providing pain medication to patients from 78% to 95%. These audit results were below the trust target of 100%. In addition, 81% of patients in April and 87% of patients in May felt their pain was well managed whilst in hospital. However only 48% of patients who had received pain relief were followed up within the hour to record its effectiveness.

Following these audit results the EoL team added this to their improvement plan and the surgical division were developing a new policy on pain management.

The trust informed us they were working towards implementation of a trust-wide tool for use across both the acute and community settings. This was being done in collaboration with the EoL team who would provide the training and education. We heard that five wards had been piloting a quality improvement project on pain management to find out if the most effective way of assessing and recording pain scores was either online or on paper. In addition, the EoL team planned to monitor the effectiveness of these pain assessments using ward assurance tool results and audits.

Patient outcomes

The service monitored the effectiveness of care and treatment and knew where improvements needed to be made. However, they continued to achieve poor outcomes.

At the last inspections in 2018 and 2020 the service was told they must ensure that robust systems were in place to monitor the effectiveness of care and treatment delivered to achieve good outcomes for patients. At this inspection we found similar concerns which meant the service had not made sustainable or measurable progress in the last four years.

There was an annual program of end of life (EoL) audits which fed into the quality improvement plan. However, we did not see audits to measure referral times and the responsiveness of the EoL team.

We reviewed the draft results of a snap shot audit from December 2021 for the completion of the recommended summary plan for the emergency care and treatment (ReSPECT) document. The EoL team identified there was low compliance with staff documenting patient's values and fears and recording emergency contact names. The version of the audit document we reviewed did not include an associated clinical audit action plan. However, the EoL team were providing specific ReSPECT training sessions and presentations both within the trust and with other providers within Northern Lincolnshire. The EoL team told us they would repeat this audit to assess the impact of these educational interventions.

We reviewed the results of the deceased patient audit tool from June 2021 to May 2022. This showed that 65% of patients died with the audit tool completed against a trust target of 80%. Of these 31% had the "care in the last days of life" document completed, 30% had discussed their preferred place of death and 15% achieved their preferred place of death.

These audit results provided limited assurance that ward staff were fully completing the deceased patient audit tool, ReSPECT or the "care in the last days of life" documents.

We heard of ways the EoL team had used the audit results to improve their patient outcomes. For example, the new version of the "care in the last days of life" document was being created using the NACEL audit results and feedback from staff.

End of life care

The EoL team regularly monitored patient outcomes and safety performance data using the EoL specific dashboard which showed monthly results over a rolling 18 month period. The compliance levels were poor for the completion of the "care in the last days of life" document, prescribing anticipatory medications and recording of preferred place of death. These issues were addressed within the EoL improvement plan and there were appropriate action plans.

The EoL team had implemented the bluebell project across most wards. The word "bluebell" was an acronym used to ensure staff considered all aspects of patient's care such as B meant "be prepared and encouraged staff to display a blue bell symbol for patients receiving EoL care". The EoL team were going to start to measure the effectiveness of the audits relating to the bluebell project.

Competent staff

The end of life (EoL) team did not always make sure staff delivering care were competent for their roles. EoL leaders did not always provide clinical supervision to staff. However, they appraised staff's work performance to provide support and development.

At the last inspection in 2020 the EoL team did not make sure staff were competent for their roles. At this inspection we found similar concerns with low compliance rates for syringe driver training.

We were given an approximately figure that 40% of eligible staff had received their syringe driver refresher training and did not meet the trust target of 85%. This result was lower than expected because the frequency of syringe driver refresher training had been mistakenly set at five years by the corporate team instead of every two years according to manufacturing guidelines. This meant there were staff using syringe drivers who had not received refresher training for five years. This is a deteriorating position since our last inspection.

We reviewed the results of the second specific competency training module and found 78% of eligible staff had completed the care planning module.

We reviewed the most recent EoL meeting minutes from June 2022. The EoL team had initiated an education and training task and finish group in response to this syringe driver error.

In the future syringe driver training would be delivered face to face at induction, via e-learning at year two and face to face on year three.

The EoL team were keen to improve the attendance at training sessions as there were high rates of staff who did not attend, and they had started to deliver training on the wards.

At the time of our inspection there were 70 EoL champion volunteers. Before the pandemic these were known as link nurses, but the invitation was extended out to all members of staff. However, they had not received their competency training and had not met up as a group.

We reviewed the most recent results from the 2020/2021 NACEL audit which showed that 41% of eligible staff strongly agreed, and 41% of eligible staff agreed they had completed training specific to EoL care within the last three years.

For the last two years the recommended summary plan for emergency care and treatment (ReSPECT) awareness and authorship training was delivered face to face to medical staff by a dedicated specialist nurse. This was funded by a local

charity, but the funding had discontinued and there were no plans for a replacement. This meant that medical staff could only access this training course online via an external website. The compliance rates for the training was 48% and for awareness was 91%. In response to this the EoL team proposed the development of an online training package and training at clinical sessions.

We reviewed the outstanding actions from the improvement plan and there was recognition that more work needed to provide medical staff the skills and knowledge to recognise and identify those patients approaching EoL.

We read an ongoing action on the improvement plan that there were plans for primary care teams to make an electronic palliative care coordination system (EPaCCS) training video for all staff and an EPaCCS awareness video for patients.

All staff we spoke with gave excellent praise for the bluebell training which was delivered on the wards by the EoL team.

All of the EoL team we spoke with had regular appraisals and felt supported by their managers.

The chaplaincy team felt supported by their own faith leaders and had regular appraisals and support from their managers. They had completed relevant training courses and would provide training to their chaplaincy volunteers.

The mortuary team felt supported by their manager and had regular appraisals. They kept up to date with their mortuary specific skills training.

The bereavement team felt supported by their manager. They were keen to complete counselling courses because they had not received any formal training to deal with the emotional aspect of their role.

There was a new Northern Lincolnshire EoL care education and training platform which had been recently launched on NHS futures. This included EoL specific training modules and learning pathways for up to 10 separate job roles. The training task and finish group and the trust's training and development team were developing a strategy of how to access this training on Electronic Staff Record (ESR) and how to record compliance.

Multidisciplinary (MDT) working

Ward staff told us the end of life (EoL) team were visible on wards especially when delivering training such as the new bluebell project.

We heard many positive examples when the EoL team worked collaboratively with all staff including palliative and oncology nursing and medical staff. We observed good working relationships between staff who worked at different hospital sites such as the bereavement staff.

We saw excellent MDT working relationships between bereavement, chaplaincy and mortuary staff. In addition, we observed a patient discharge to the local hospice and saw coordinated and timely interactions between ward staff, patient discharge team members, portering staff and paramedics.

There was a good uptake of EoL champion volunteers from different healthcare roles and the bluebell initiative encouraged good working relationships between wards.

There was a monthly MDT EoL implementation group meeting. This was regularly attended by all staff, including the mortuary and chaplaincy staff. In addition, the palliative clinical nurse specialists and consultants, who worked for an external health care provider also attended. However, bereavement staff were not invited to this meeting.

End of life care

We reviewed effective and successful partnerships of the EoL team working across Northern Lincolnshire. There was a monthly MDT Northern Lincolnshire EoL steering group meeting. This was regularly attended by the EoL team and other partner organisations across Northern Lincolnshire.

The bereavement team worked well with the registry office where deaths were reported.

The EoL team attended weekly meetings with the local hospice along with the ambulance and discharge teams to facilitate patient transfers.

Seven-day services

The end of life (EoL) team were not available seven days a week to support ward staff caring for patients at EoL.

At the last inspection in 2018 and 2020, the EoL team were told they should develop a comprehensive seven-day service in line with national guidance. At this inspection we found the same concerns with no access to the EoL team at evenings or weekends. There were no formal cover arrangements offered by the clinical nurse specialists, consultant or other community staff who were employed by external health care providers.

We reviewed the seven day action plan which was developed following the last inspection. We read meeting minutes from the Northern Lincolnshire Steering group with relevant stakeholders. There was an ambition for the implementation of a robust seven day service across the Northern Lincolnshire area and not just for the EoL team at this trust. We heard that funding had recently been approved for the recruitment of consultants and clinical nurse specialists to provide this seven day service for both EoL and palliative care patients within the hospital, community, and hospice settings.

We heard there was a palliative support telephone line, also known as the “butterfly line” which was available for 24 hours seven days a week. This was managed by palliative care nurse specialists and was delivered from a local hospice.

The mortuary team did not routinely work at evenings or weekends. However, they would attend if assistance was needed for a transfer in or out of the mortuary.

The bereavement team officers worked 30 hours during the day Monday to Friday and these hours were aligned to the local registrar’s opening hours. There was no provision for out of hours or on call work. The trust covered their annual leave with existing staff who have been trained in the bereavement officer process.

The chaplaincy team were available during the day Monday to Friday and the lead chaplain was on call until midnight every evening. However, there was no available overnight or weekend cover. We heard that once the new chaplaincy volunteers had been recruited, they would review the on-call arrangement.

Portering staff were available to transport patients when needed at all times. This meant they were always available to support the transition of deceased patients from the wards to the mortuary. They had access to the mortuary out of hours and weekends.

Health promotion

Staff gave patients practical support to help them live well until they died.

End of life care

We saw relevant information promoting support on every ward. There were Macmillan support centres within the trust which were staffed by volunteers. They had leaflets and guidance on a range of subjects such as emotional, financial and therapy information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff followed national guidance to support patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

We reviewed training compliance data for EoL life staff which included the Macmillian and palliative healthcare teams. This showed 96% of staff had completed mandatory training on the Mental Capacity Act and 98% of staff had completed Deprivation of Liberty Safeguards training.

Ward staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005.

Staff had access to a mental health liaison nurse 24 hours seven days a week.

The EoL told us they were meeting with the mental health liaison team to incorporate mental health into the EoL training.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness. They respected their privacy and dignity, and took account of their care needs.

We spoke with all staff who provided nursing, palliative and medical care to patients who were approaching the end of their life (EoL). They would make sure patients were comfortable, washed, and hydrated.

We observed the EoL team taking the time to interact with patients and their relatives in a respectful and considerate way. They introduced themselves and were compassionate to those who were experiencing pain, discomfort or distress.

Patients receiving palliative and/ or EoL care would be nursed on side rooms to maintain their privacy and dignity. However, if this was not possible, they were nursed on a bay. We observed staff closing curtains around these patient's beds during patient reviews.

We observed a patient being transferred to the hospice for palliative care. This was done with the upmost dignity and respect. All staff involved in this transfer including the ward staff, porters and ambulance team spoke to the patient and relative in a very caring way.

End of life care

Ward staff described how they would care for deceased patients before their transfer to the mortuary. Portering staff described how they would close all the windows and doors along a ward corridor before transferring the patient from the ward to the mortuary. Bereavement and mortuary staff provided bereavement care and support to relatives following a patient's death.

Emotional support

All staff provided individualised emotional support to end of life (EoL) patients and relatives to minimise their distress. They understood patients' personal, cultural and religious needs.

We observed staff demonstrating sensitive and supportive care.

We heard of positive examples of when staff provided emotional support. For example, they arranged for relatives to receive parking permits and stay overnight when patients were cared for in side rooms, even if they had not been commenced on the EoL pathway. They would try and nurse the same patient to keep the continuity of care.

The EoL team created the bluebell initiative to provide a sensitive and emotional care to patients and their relatives.

As part of the new blue bell initiative we saw a range of items which had been donated from local charities. There were memory teddy bears which could be given to patients or relatives especially children to provide comfort. There were comfort packs containing self-care items such as toothbrush, toothbrush and washing items for relatives who were staying overnight. It also included lip moisturiser if relatives wished to provide lip care to their loved ones.

The EoL team reported the "feedback we have received since launching Bluebell has been extremely positive from both patients, relatives and staff". We heard that relatives had reported back saying "wow, this is amazing! What a simple, but truly marvellous idea. We love what Bluebell stands for. We also really like the teddy bear idea too. "

We spoke with staff on wards where the bluebell model had been implemented. They were so proud to be part of this and said it encouraged positive engagements with patients and their relatives. One staff member reported the "bluebell ensure(d) that all aspects of the care are met and is a really well thought out, educational way of delivering care to EoL patients".

They showed us the hessian bags which were used to store the deceased patient's belongings and small pouches which could be used for rings, jewellery or a lock of hair.

Staff understood and respected the personal, cultural, social, and religious needs of patients and their relatives. The bereavement team knew about the promptness of burials for different religions.

The chapel was always open to offer spiritual or religious comfort to patients, relatives and staff. We saw various ways which prayers or messages could be dedicated to loved ones. For example, we saw relatives had written names of loved ones on a leaf and hung it on a specially constructed tree.

The chaplaincy staff told us they delivered a "thought of the day" on the hospital radio and also did radio services on religious days.

We spoke with mortuary staff who provided positive examples of how they delivered emotional care to relatives of the deceased patient. They would spend time with relatives and gave them the time they needed. They encouraged relatives

to take away comfort teddy bears, smooth coloured stones or would offer other physical memory aids such as hand or footprint castings. The staff said they would always put a handknitted teddy bear into babies and children's baskets. We saw there were available parking spaces directly outside the mortuary for relatives which meant they did not have to walk through the hospital.

We saw complimentary letters written about the emotional care provided by the mortuary staff. The trust's chief executive shared a personal message to them thanking them for "the extraordinary impact they had on a terribly bereaved family through your compassion, kindness, imagination and generosity with your time" and said it was an honour to have them as a colleague.

The bereavement staff were able to give us positive examples when they delivered emotional care. They told us they were the main contact for relatives following the bereavement. They would request the deceased belongings from the ward so they could return these to the relatives to avoid relatives having to visit the ward.

We read a "good news story" within a senior nurse meeting minutes from March 2022 when a patient had passed away with their arms around their pet dog.

Understanding and involvement of patients and those close to them

Staff supported patients who were approaching end of life (EoL), and their relatives.

They made sure patients and relatives understood their care and treatment. We heard an example when relatives were told that the patient was unlikely to recover from their illness and had been started on the EoL pathway. They also explained how pain relief and other medications would be delivered from a syringe driver.

All staff talked with patients and relatives in a way they could understand. They allowed patients and relatives the time to take on board the information provided and were encouraged to ask any questions. Relatives we spoke with were very complimentary about these discussions and appreciated the honesty of this update. We observed EoL staff kneel down, so they were eye level with the patient and relatives to discuss decision making and advanced care plans.

We spoke with relatives of a patient before their transfer to the local hospice and were relieved they had met the patient's wishes not to die in the hospital. They accepted the risks of transfer and were invited to travel with the patient to the hospice.

The EoL team supported patients and relatives to be actively involved in making decisions about their care treatment and support. They had implemented the bluebell project on most wards. The blue bell principles were a simple way to highlight the importance of putting the patient and relatives at the heart of decision making when it comes to EoL care planning. The word "bluebell" was an acronym used to ensure staff considered all aspects of patient's care. For example, this included "B" for "be prepared and encouraged staff to display a bluebell symbol for patients receiving EoL care", "L" for learning from every family and treat each patient as an individual.

All staff were very proud to be part of this bluebell initiative. They were passionate about using it to deliver the best care possible. They gave teddy bears to anyone needing comfort especially younger relatives. There were story books for children to write their name inside to help them understand death and bereavement.

End of life care

The EoL team supported patients and relatives to express their views and thoughts about the care being given. In response to recent themes and trends emerging from divisions they had recently introduced the "family voices diary". This diary was placed on the patient's bedside and relatives were encouraged to complete it daily for the ward staff to review and address any concerns. It allowed relatives to choose answers for questions such as today my relative or friend;

- "seems to be in pain"
- "calm, relaxed and at ease"
- "breathing comfortably".

There was also a free text for relatives to report if they needed any help or support.

We reviewed the summary highlights from the most recent 2021 national inpatient survey which had not been published at the time of the writing the inspection report. It showed the trust had shown a marked improvement in eight of nine patient focussed agreed actions from the 2020 survey and positives included, "patients felt nurses answered questions clearly" and "patients felt that staff helped control pain".

We reviewed the national audit of care at end of life (NACEL) quality survey responses from April to August 2021. This was in the middle of the COVID pandemic. The results showed a mixture of positive reviews such as; "staff provided excellent care", care was "both professional and compassionate" and aftercare was "was one of the best (they) had experienced".

However, we also heard of very poor negative responses with a common theme of communication. These included relatives not being able to get through on ward telephone lines and also lack of available staff for support. The end of life team acknowledged there needed to be improved communication when listening and involving patients and relatives in personalised plans of care.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate.

Service delivery to meet the needs of local people

The end of life (EoL) team planned and provided care in a way that met the needs of local people within Northern Lincolnshire.

The EoL team had developed a strategy which addressed the needs of the Northern Lincolnshire population for both acute and community services.

This meant EoL care was delivered to patients in a system wide approach with the involvement of multidisciplinary teams. For example, A&E and oncology healthcare professionals within the trust and GP's, hospices, community staff, local councils and other private providers within Northern Lincolnshire. We heard how beneficial the electronic palliative care coordination system (EPaCCS) would be once fully embedded within Northern Lincolnshire to help with communication and continuity of care.

End of life care

Ward staff had access to a palliative care advise and support telephone line also known as butterfly line. This was which was available 24 hours seven days a week and support was delivered by specialist palliative care nurses from a local hospice.

The facilities and premises were appropriate for the services being delivered. We heard of positive examples when patients receiving EoL care were moved to side rooms on wards to ensure their privacy and dignity was maintained. Although these side rooms were limited, staff would always try and accommodate this for EoL patients.

We reviewed the EoL dashboard which showed from June 2021 to May 2022, 90% of patients, who had been commenced on the "care in the last days of life" document, had died in a side room.

Relatives were able to visit patients receiving EoL care at all times. There were arrangements were made for relatives who wished to stay overnight.

There were parking permits available for relatives which meant did not need to pay for car parking at the hospital. There were allocated car parking spaces reserved for relatives who were visiting the mortuary and these spaces were close to the mortuary entrance.

Staff said the EoL staff were very responsive and always available to help with symptom management and clinical support.

The chaplaincy staff were responsive to any request and would listen and support relatives or staff whether they had faith or not. We heard the trust would pay for a hospital funeral if a deceased patient or relatives had limited funds.

The bereavement team provided a service which we heard met the needs of relatives. They would ensure relatives received a bereavement pack. They also provided practical advice regarding visits to the chapel of rest, collecting personal belongings and administration procedures such as registering the death and collecting the death certificate.

The mortuary environment had been recently decorated and had reception and quiet areas as well as viewing rooms.

Meeting people's individual needs

The end of life (EoL) team delivered inclusive care to patients and coordinated care with other services and providers. However, ward staff did not take account of patients wishes and preferences as these were not comprehensively recorded.

Over the last few years the trust had implemented two new processes which were used to document individualised needs and preferences; the recommended summary plan for emergency care and treatment (ReSPECT) and the Electronic Palliative Care Co-ordination System (EPaCCS). Some staff we spoke with did not have access to the EpaCC's system and not all staff were trained to use the system.

The "care in the last days of life" document was used to record patient's preferences such as spiritual and religious wishes and patient's needs such as psychological and emotional needs. However, we reviewed recent audit results in April 2021 and March 2022 relating to this document which showed only 43% of patients on the EoL pathway died at their preferred place of death. This meant patient's wishes or needs were not always fulfilled.

We saw evidence staff were not always meeting individual needs. Patients who had been identified as started on the EoL pathway had an "EOL" icon next to their name on the electronic patient whiteboard. They would also have a bluebell

sticker placed on their side room door on the ward. Staff used a rose icon for patients who were not for resuscitation. However, we noted one patient who had been on the EoL pathway for over 24 hours but did not have an "EOL" icon displayed. This was raised at the time of the inspection and it was immediately rectified. We were informed this error had occurred because only certain members of staff have access or authority to start the EoL pathway.

There was a chapel and multifaith room which were open all the times and were well signposted within the hospital. These were accessible for the spiritual and religious needs of all patients, relatives and staff. We saw a diverse selection of religious books, information and posters available in languages spoken by the patients and local community.

The chapel was also used every Friday for Islamic prayer. We saw an appropriate area for ritual washing and a place to safely store shoes. We saw different religious items such as prayer mats and scarfs.

The chaplaincy team could access the hospital computer system to identify EoL patients. They also received referrals from staff via phone calls, however said most of these were last minute requests. They had a message box outside the chapel for anyone to request a visit or phone call. Chaplaincy staff would visit the patient, relatives, or staffing looking after patient, and offer spiritual and religious support.

They were able to offer Christian and Anglican support within the team and had access to other faith leaders in the community. The chaplaincy volunteers would visit wards regularly to speak with patients.

The bereavement staff explained how they delivered a seamless service to relatives and helped them organise paperwork, visits to the chapel of rest.

Staff made sure patients and relatives could get help from interpreters or signers when needed.

All staff we spoke with gave positive examples of how they were aware of religious and cultural differences when caring for a deceased patient. For example, we heard chaplaincy staff were going to perform a shared faith funeral with another faith leader.

The EoL team gave examples when they had visited patients with the lead nurse for learning disabilities and dementia to meet their needs.

Access and flow

Patients, and staff who cared for them did not consistently have access to the EoL team when they needed it. There was no standardised process for referrals to the EoL or chaplaincy teams. There was no available data to measure the responsiveness, or availability, of the EoL.

The EoL team encouraged ward staff to recognise patients who were at EoL as soon as possible. However, the responsibility for making this final decision was the named consultant and was normally done at routine medical or surgical ward rounds.

Staff reported patients were not always identified early enough to start on the EoL pathway which meant they were not able to start the relevant documentation. In some cases the patient had deteriorated quickly, or medical staff were waiting to see if medication had been successful.

Staff said it was unclear who had the responsibility, authority or access to update the computer records to document a patient had been started on the EoL pathway.

End of life care

The service did not have a formalised referral process to the EoL and some staff we spoke with said they didn't know how to contact them especially in the evenings or weekends. We heard examples when staff had attempted to contact the EoL team by telephone for advice and guidance but had not been successful.

We heard the EoL staff would access the computer system to identity patients who had been started on the EoL pathway by ward staff. They would aim to visit these patients the same day and ward staff confirmed they were very responsive.

At the time of our inspection there were absences within the EoL team at Diana Princess of Wales Hospital. We were not aware of any cross site cover from the EoL team based at Scunthorpe General Hospital (SGH). We were made aware of a patient who was receiving palliative care had been placed on the EoL pathway. When we tried to contact the EoL team at SGH there was no answering machine facility or message.

Following the inspection, the EoL team said they would implement a single point of access for all EoL and palliative care referrals.

We reviewed EoL dashboards which showed compliance against key performance indicators. This did not show data to measure the responsiveness, or the availability of the EoL team. In addition, there were no audits to measure the quality of the referrals.

The trust had a discharge policy to guide staff how to fast track the discharge of patents who required palliative care. The EoL team had daily meetings with the local hospice who accepted admissions seven days a week. They told us local nursing homes would also accept admissions.

We heard many positive examples of when the portering staff were very responsive when required to transfer a deceased patient from the ward to the mortuary.

The trust did not have a formalised referral process for the chaplaincy team, however, we observed a chaplain visiting an EoL patient and relatives within 30 minutes of a referral.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The end of life (EoL) team treated concerns and complaints seriously, and shared lessons learned with all staff. They included patients and relatives in the investigation of their complaint.

At the last CQC inspection in 2020 we heard that concerns and complaints relating to EoL were managed by each division. At this inspection the EoL team could now identify, and had oversight of EoL concerns and complaints.

From April 2021 to March 2022 there were 35 complaints out of 351 trust wide and 20 patients advise liaison (PAL)'s concerns out of 1,195 trust wide. As of May 2022 there were 7 ongoing complaint investigations.

The EoL team would prepare a monthly report which included the emerging themes from concerns and complaints. We saw the main themes were related to advanced care decisions, communication, attitude of staff, lost property and delays for equipment. We were told this report was discussed at the monthly EoL meetings. However, we reviewed the March, April and May 2022 minutes "summary of actions" from the Northern Lincolnshire EoL steering group and did not see any associated escalations or actions relating to concerns or complaints. It was not clear how these were monitored in this group or how actions were cascaded back to the EoL Implementation group.

End of life care

The EoL team confirmed they did share feedback and learning from complaints to ward staff. They told us there had been fewer reported concerns and complaints since the introduction of the bluebell model and family voice diaries. They also provided specific training with ward staff and worked collaboratively with partnership services such as hospices.

Ward staff gave positive examples of when performance had improved as a direct result from complaints. For example, the introduction of blue bell bags and jewellery pouches were developed because of a high number of complaints regarding lost property of deceased patient's belongings. Staff said they could pick up any immediate concerns from the patient's family voices diary.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had improved the skills and abilities to run the end of life (EoL) service. They understood and managed the priorities and issues the service faced.

The EoL team had an improved management and leadership structure following the previous inspection in 2020. The service had an executive lead, who was also the medical director, and they reported to the board. There was also a newly appointed associate chief nurse for the communities and therapy division.

Within the EoL team there was a transformation / service improvement manager who was responsible for managing the improvement plan, maintaining the pace of actions by key work streams and task and finish groups.

The EoL leaders had oversight of priorities and issues and were involved in the various meetings and task and finish projects.

Vision and Strategy

The service had a vision for what it wanted to achieve and a new five year strategy to turn it into action. This had been developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The end of life (EoL) group launched a systemwide EoL five year strategy in September 2021. We heard staff had been given the opportunity to share their views and ideas on the strategic principles in June 2019.

This strategy was based on the national ambitions and the priorities for EoL care were;

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and well being

End of life care

- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help.

These were aligned with the trust principles for example, “right care, right place, right time” and objectives for example, “to work more collaboratively”.

The strategy was linked to the improvement plan and demonstrated what they needed to do to

deliver these priorities and how they would measure the improvements.

Following the inspection the trust provided further information detailing the implementation of a strategy for all healthcare providers within Northern Lincolnshire. This was part of the Northern Lincolnshire EoL steering group.

Culture

The EoL staff felt respected, supported and valued. They were focused on the needs of staff who cared for EoL patients and their relatives.

We heard positive examples of how the culture had improved following the last inspection in 2020.

The EoL team spoke highly of the support they provided each other despite being a small number of staff. They were dedicated to their role. They reported the bluebell project had brought the team closer together and collectively they felt more confident in offering support to ward staff who cared for EoL patients.

They encouraged ward staff to share personal experiences during EoL training sessions so that other staff could listen to real experiences.

The EoL team hoped to start training the new EoL champions and would incorporate additional time for them to receive appropriate supervision and have debrief opportunities.

We saw quiet rooms known as “wobble rooms” within the hospital which were available for all staff.

The mortuary, bereavement and chaplaincy staff described a good working culture with each other and felt well supported in their role.

Governance

EoL leaders did not always operate effective governance processes. Not all staff involved in the delivery of EoL care were clear about their responsibilities and accountabilities and did not feel part of the EoL team. However, staff had regular opportunities to meet, discuss and learn from the performance of the service.

There were areas of the service which continued to be of concern and had been previously identified during our previous inspections.

We spoke to some staff who delivered end of life care to patients and relatives in a daily basis however, they did not know how they roles fitted within the EoL structure. This was due to a wide range of issues such as not being invited to meetings, being unaware of EoL issues and being managed by different leadership.

End of life care

There was no formalised referral or review process for patients once they had been identified to be started on the EoL pathway. In addition, we did not see cross site cover within the trust's EoL team.

Ward staff were not clear who had the responsibility, authority or access to update the computer records to document a patient had been started on the EoL pathway.

However, at this inspection the service had demonstrated that clear improvements had been made following the last inspection in 2020.

There was a now a formalised governance structure which showed escalation pathways from EoL team to board and also dissemination routes from board to EoL team onto ward staff. We reviewed various EoL meeting minutes which showed that learning had been shared with staff.

The EoL team now held a monthly EoL implementation group meeting which was attended by a range of staff who delivered EoL or palliative care across the trust, as well as lead staff from safeguarding, divisions, governance and mortuary. This meeting had standard agenda items which covered quality, safety and performance issues. On a rotational basis each division; surgery and critical care, medicine, family services and diagnostics presented their main risks and issues at this meeting using the EoL analysis report.

This group would monitor the progress and improvements made within each division over time using an EoL analysis report. This clearly showed how division were managing their main risks and issues, what learning had been identified and actions taken as a result. For example, the medicine division announced they would start discussing EoL decisions at ward rounds and improve handovers for EoL patients. The EoL consultant gave a presentation to all divisional leads on the recommended plan for emergency care or treatment (ReSPECT).

The EoL team had identified six main improvement themes from complaints, incidents, audits and mortality reviews across all divisions. These were;

- Recognition that a patient is entering into the EoL phase
- Proactive and advanced care planning in preparation for EoL
- Communication and listening to the patient and relative and involving them to develop personalised plans of care
- Assessment of patient needs at EOL including pain assessment
- Full completion use of the 'Care in the Last Days of Life' pathway document

The EoL team measured the compliance against these six key improvements and updated the improvement plan which also incorporated the CQC action plan from the previous inspections. However, we saw further work was needed to improve patient outcomes and audit results.

There were various work streams within divisions and task and finish groups which had been formed as a result of the EoL implementation plan. For example, there was a training and education task and finish group to implement system wide EoL competencies and learning outcomes across Northern Lincolnshire.

We saw examples of how top themes identified from each division were fed into this meeting and added to the EoL analysis report on a rotational basis. These included incidents, complaints, audits, risks and mortality reviews with associated learning or actions taken as a result. This information would then be updated in the EoL improvement plan.

There was a clear dual process of escalating concerns from this meeting to the trust management board. The first process was from the community and therapies clinical governance divisional meeting, and other performance meetings if necessary. The second process was from the Northern Lincolnshire EoL steering group who would discuss the report, agree and escalate any immediate or long term actions against themes or specific issues.

We saw evidence the EoL team were regular attendees at other divisional meetings and heard that work was underway to ensure that each divisional governance meetings had an agenda item dedicated to EoL.

The monthly EoL implementation group meeting minutes would be shared with all attendees who would then cascade within their own division.

Management of risk, issues, and performance

The end of life (EoL) team did not always use effective systems to improve the awareness of risks and issues and manage performance. However, they identified, and escalated relevant risks and issues and identified actions to reduce their impact but progress was slow.

At the last inspection the service was told they must ensure robust governance processes were in place to lead, manage, risk assess and sustain effective services. At this inspection we found similar concerns.

For example, there was only one consultant based at Scunthorpe Hospital covering three hospital sites. There were no audits to measure the responsiveness of the EoL team to measure performance. We saw there were continued low compliance with the quality of record keeping especially for documenting patient's wishes and preferences and refresher syringe driver training. In addition, the EoL team had not yet implemented a seven day onsite service which meant staff did not have access to inhouse specialised clinical advice and support 24 hours seven days a week.

We reviewed the EoL dashboards which were reviewed by EoL staff to monitor safety concerns and assess performance. However, the dashboard did not show any comparison data against national averages or with trusts of similar size. It was difficult to compare the information from previous dashboards with the current one and we were told this was due to a drop in compliance measurements during October 2021 when the incident reporting tool was replaced. In addition, we heard there were delays with enabling access to reliable data within 24 hours of referral or patient contact.

We reviewed the results of the Human Tissue Authority (HTA) audit which matched those identified on the mortuary risk register from 2019. We saw appropriate actions had been put in place in June 2022 to mitigate against these risks. The first risk was insufficient storage capacity which was mitigated with the local funeral directors providing temporary overflow storage if required. The second risk related to the lack of an automatic alert to switchboard if the temperatures of the temporary fridge storage deviated from normal range out of hours. Staff controlled this risk by completing twice daily recordings including weekends. However, the majority of these had not been completed within the target time frame. In addition, some parts of the mortuary were dirty, and equipment was rusty, but these were not visible to visiting relatives.

We reviewed the risk register for the community and therapies division. This showed one risk relating to the clinical capacity of the team to fully embed the EoL initiatives within each division. This risk was reviewed bimonthly. These risks were described in more detail on the EoL improvement plan. We saw how the EoL team planned to mitigate against these risks and measure the effectiveness of the initiatives.

End of life care

Despite these current challenges, the service had made a number of improvements following the last CQC inspection. There were clear plans with defined trajectories. These provided assurances of the sustainability of the EoL service. We recognised the ambition to deliver a seamless provision of EoL care within Northern Lincolnshire.

The service reported a significant reduction in the number of EoL patient harm related incidents in the last two years.

The EoL team had designed and rolled out the Bluebell principles onto ward areas and patients and relatives reported positive experiences. This was an example of an innovative approach to engage everyone in the principles of delivering good quality EoL care and had achieved national recognition. This roll out was due to be completed in November 2022 and the service plan had started to measure the success of the model.

The service had implemented the advanced care document (ReSPECT) which reflected nationally accepted best practice. This had been fundamental in changing the conversation from Do Not Resuscitate towards a more holistic approach.

The service had rolled out the electronic palliative care coordination system (EPaCCS) within the trust. This work was driven by the Northern Lincolnshire steering group and operationalised by a working group. It is now an embedded practice within the specialist teams and work was ongoing to raise awareness.

The trust were leading a quality improvement project which aimed to deliver a single pain assessment tool which will be used for all patients, including those who are at the end of their life. In addition, there was a pain specific question within the new family voice diary which can be acted upon immediately by staff.

The Northern Lincolnshire EoL steering group had been successful with implementing a performance dashboard to identify if the needs of the local population are being met.

Following the inspection the trust provided information to demonstrate they had taken immediate action with some of the issues raised at this inspection.

For example, in response to the poor audit compliance with the deceased audit tool the service added this tool onto the trust's computer system to make it more accessible to staff caring for EoL patients.

The service were planning to implement a single point of access for all EoL and palliative care

referrals by March 2023 to improve service delivery. This new system would ensure a formalised and streamlined approach to referrals and review process for patients who had been identified to be started on the EoL pathway. It would allow cross cover between each hospital site and remote cover if needed.

The service had hoped with the roll out of the advanced care planning (ReSPECT) across all wards, and regionally, would have helped staff with the early recognition and identification of patients approaching the end of life. We acknowledge there will be a period of time required to allow these to become embedded as part of the care delivery so that patient's wishes and preferences would be fulfilled. In response to the poor audit compliance of the ReSPECT document the service had delivered specialised training sessions over the last six months. The training was included at a locality wide EoL conference. They planned to provide further training sessions to senior clinicians and complete another audit to assess the impact of these educational interventions.

In addition, the Northern Lincolnshire EoL steering group had been successful with implementing a performance dashboard to identify if the needs of the local population are being met.

Following the inspection we were informed additional funding had been agreed to support a workforce to provide a seven day service within Northern Lincolnshire. This involved a review of the current workforce establishment, mapping of current EoL resources, recommendations from the last CQC report, national guidance, commissioning guidance and support from NHS England / Improvement. There were also several task and finish research and engagement groups. This work resulted in funding being made available for an increased establishment of medical staffing (1.7 whole time equivalent (WTE)) and nurse staffing.

Information Management

Staff did not always find the information they needed within patient records or computer systems. The EoL end of life (EoL) team did not always collect reliable data to understand performance, make decisions and improvements.

We observed ward staff spending time recording the same information within both paper and electronic formats of patient records.

We heard from staff that not everyone had the access, or authority, to update the computer records to show the patient had been started on EoL treatment. Staff told us it was challenging to access electronic systems to find EoL patients.

We found two ReSPECT paper documents for one patient and neither were dated. In addition, there were different versions of the ReSPECT form being used within Northern Lincolnshire. We heard that one local trust was still using an older version of the document. This meant patient's most up to date wishes and preferences may not always be granted.

We heard that the EoL dashboards used to measure key performance contained unreliable data which was difficult to analyse. We were unable to compare recent data with previous dashboard information.

However, we heard positive examples of how systems were being used to improve communication of a patient's individual preferences of their care. For example, all staff within Northern Lincolnshire were being trained to access the electronic palliative care co-ordination systems (EPaCCS) using different computer systems.

We also read there were several partners such as hospices and local trusts within Northern Lincolnshire had granted access rights for patient information stored within the trust computer system. The trust also has information shared agreements in place with local safeguarding and council teams and community pain services.

Engagement

The end of life (EoL) team actively and openly engaged with staff, patients and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Two members of the EoL team were responsible for creating the blue bell project and all EoL staff were involved with the roll out on wards. The EoL team were well known on all the wards we visited. Ward staff reported they always gave positive feedback on how the blue bell model had significantly helped them in their roles.

The chaplaincy team described how they asked staff of different faiths to help redecorate the multifaith room and chapel.

End of life care

We reviewed a special edition of the NLaG newsletter from May 2022 which focussed on EoL care as being a continued trust priority. It included recent achievements such as the bluebell initiative and family voices and information about the new EoL systemwide five year strategy. It provided details of how to contact the EoL team.

We heard of positive ways the EoL team successfully collaborated and met with patients and relatives to help plan and manage the services. They spoke with patients and relatives about the best ways to capture their preferences and needs and have used this information to redesign the "care in the last days of life" document. They produced a syringe driver information easy to read document for patients and relatives. Ward staff continued to encourage patients and relatives to complete the family voices diary.

The EoL team had planned to have awareness stalls at local town markets and garden centres.

We heard different ways the chaplaincy team reached out to engage with patients, and staff with their daily "thought of the day" and other services broadcasted on the hospital radio station and on social media platforms.

The EoL team collaborated and worked well with providers within Northern Lincolnshire. For example, they met with senior representatives from the local hospices, councils and other partners at the steering group meetings. The meeting minutes showed these representative attendees held delegated authority to deliver sustainable improvements in the system.

We heard positive examples of how the advanced care planning tools such as ReSPECT and EPaCCS were being rolled out within providers in the Northern Lincolnshire. The EoL team regularly met with the palliative care clinicians within the ICS patch and GPs with specialist interest in EoL community support. They were going to work with care homes to the quality of care and work to prevent unnecessary hospital admissions

The EoL team were due to present at a conference in September 2022 and attendees to this would include hospices, councils, domiciliary care and neighbouring trusts including ambulance services.

We reviewed examples of positive working with local healthcare partnerships and the local commissioning intentions. For example, to increase the quality of EoL care provided in the community.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Ward staff were keen to learn more about how to deliver the best end of life (EoL) care and they had embraced the new bluebell and family voices initiatives. On some wards ward staff had introduced further blue bell items such as crockery and catering baskets with drinks and snacks for relatives.

We heard there were various quality improvement projects which included EoL. For example, the pain assessment tool is being trialled in paper and electronic formats.

One of the EoL team members had been shortlisted for the nursing times award. In addition, the EoL team had been shortlisted for the EoL team of the year category.

The community and therapy division had previously been shortlisted for the community provider of the year from the health service journal (HSJ) in 2021 for their virtual EoL care training which was provided to care homes.

End of life care

Chaplaincy volunteers had been given “star” and “sparkle” awards.

Staff participated in a fundraising event for the local charity who supplied the items for the blue bell initiative items.

Urgent and emergency services

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

Although the service provided mandatory training in key skills to all staff to keep patients safe, training compliance rates for medical staff still remained below the trust target.

Managers monitored mandatory training and alerted staff when they needed to update their training. Since the last inspection in September 2019 there had been high levels of input from a clinical educator who had played a key role in addressing shortfalls in training and focusing upon staff training and development across the department which had been successful with the nursing staff.

The service ensured that staff providing support to children had relevant paediatric competencies to ensure delivery of safe care and treatment.

We saw examples of the content of training and information posters on display in the staffing areas which were comprehensive and promoted the needs of patients to keep them safe from harm.

Nursing staff received and kept up-to-date with their mandatory training. At the time of the inspection core training compliance matched the trust target of 85%.

However, medical staff still did not keep up-to-date with their mandatory training. At the time of the inspection we were advised that the overall compliance rate for medical staff mandatory training was 70% against the trust target of 85%.

Departmental compliance with Adult Immediate Life Support (AILS) resuscitation training for nursing staff was 66% and 58% for Paediatric Immediate Life Support (PILS) resuscitation training.

Medical staff compliance with basic life support training, 61.1% had completed adult basic life support training at level two and only 38.24% had completed the mandatory level two paediatric basic life support training.

Only 53% of medical staff had completed dementia awareness training at the time of the inspection.

Safeguarding

Although staff understood how to recognise and protect patients from abuse and the service worked well with other agencies to do so, overall safeguarding training compliance had only shown some signs of improvement since our previous inspection in September 2019.

Nursing staff received training specific for their role on how to recognise and report abuse. The trust provided us with a summary of safeguarding training compliance rates which highlighted 93% of nursing staff had completed safeguarding adults level two training and 87% had completed safeguarding at level three. Safeguarding Children level two compliance was 92% and 65% for safeguarding children level three.

Medical staff received training specific for their role on how to recognise and report abuse. However, only 67% of medical staff had completed safeguarding adults level two and at the time of the inspection the completion rate for safeguarding children level three training was 39%.

Despite ongoing inconsistencies with training compliance rates, staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff within both the adult department and paediatrics were able to explain the safeguarding reporting procedures and provided examples of safeguarding referrals they had made.

Patients with known safeguarding concerns were automatically flagged by the electronic record system. The registered sick children's nurse on-shift during the inspection informed us that safeguarding nurses screened all paediatric attendances in order to monitor potential safeguarding concerns.

Information and guidance on safeguarding awareness was clearly displayed and easily accessible for all staff.

Cleanliness, infection control and hygiene

During the inspection the service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. We saw the correct storage of cleaning materials and mop heads in-line with control of substances hazardous to health (COSHH) guidelines.

The service generally performed well for cleanliness. We saw official trust guidance and information on display highlighting the department's commitment to cleanliness, whilst promoting staff awareness.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

We inspected five treatment bays, all appeared visibly clean. Disposable labelled curtains were used and all mattresses were clean and free from breaks.

We saw evidence that staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

All sharps bins were dated, signed and less than three quarters full.

Patients with symptoms of COVID19 and other easily transmissible diseases had signs placed on their cubicles to ensure staff adhered to infection control policies. During the inspection we saw members of staff appropriately completing a deep-clean of one of the resuscitation bays which had been used to treat a COVID-positive patient.

We observed staff following infection control principles including the use of personal protective equipment (PPE). All staff were observed to be wearing appropriate PPE and were bare below the elbow.

Nursing staff compliance with infection prevention and control (IPC) training was 68% and 69% for medical staff, below the trust benchmark of 85%.

The most recent compliance audit indicated staff consistently donned and doffed the correct PPE during contact with patients.

There were numerous sinks in the department with hand gel and handwashing instructions on posters displayed near the sinks. Staff were observed washing their hands before and after patient contact.

Audit data for May 2022 indicated that a total of six hand hygiene audits had been completed during this period, below the trust-wide target of 10 per month. However, overall staff compliance with hand hygiene protocol within this period was 80%.

Environment and equipment

The design, maintenance and use of facilities and premises did not always keep people safe. However, staff ensured mitigation was in place to promote patient safety. Staff could readily access equipment and were trained to use them. Staff managed clinical waste well.

At the time of the inspection, the emergency department was in the process of a redesign and this included ongoing construction work. Access to the department was clearly signposted, along with trust guidance on the criteria for attending in order to promote appropriate use of the service by the public. Face coverings and hand sanitising stations were available for those attending department.

Although there was a designated waiting area in place for children attending the department, this did not follow national guidance, as this was not audio-visually separate to the rest of the waiting area. Furthermore, there was no separate paediatric resuscitation bay and children were not always treated in a separate area to adults due to the surge in attendances within the department.

The trust provided evidence that there was full oversight of paediatric patients on the department and best efforts were made to maintain a degree of segregation from adult patients by allocating a designated space for children to be treated. The new emergency department will have a separate waiting area and cubicles specifically allocated for paediatric patients.

Patients were able to share personal information with reception staff who sat behind protective screens away from the main waiting area. The reception desk was at a height enabling patients in wheelchairs to speak with staff members and there was also a hearing loop system in place. Overall visibility of the main waiting area for adults from reception was good and both reception staff and the streaming nurse had clear oversight of the waiting area.

Once checked-in, waiting times for the various pathways of care were displayed on an electronic screen.

Within the majors and minors areas of the department, patients could easily reach call bells and we saw multiple examples of staff responding proactively when called upon.

The trust now had a dedicated ligature-free room in accordance with the Psychiatric Liaison Accreditation Network (PLAN) standards which could be allocated to patients deemed to be at potential risk of harm as a result of mental health crisis. The room was minimally furnished and in close proximity to the nurses' station for monitoring purposes.

There was a dedicated relatives' rooms located within a quiet area which patients' relatives could access accordingly.

On inspection we checked multiple consumable items from storage areas at random, all were in date.

We saw evidence clinical waste was managed in a way that kept people safe. Arrangements were in place for the segregation, storage and disposal of waste.

We saw the resuscitation trolley was appropriately stored within the department and included all relevant equipment. There was a designated safety checklist in place and evidence the equipment had been checked each day and was fit for purpose.

We saw evidence of back-up generators receiving regular essential service and testing and the department fire risk assessment was in place.

Security support was available for the department 24 hours a day to promote the safety of staff and patients.

Due to the small size of the department and the high numbers of attendances, adjustments had been made to temporarily increase departmental capacity. Seats had been placed in one of the corridors to accommodate patients deemed 'fit to sit' and temporary dividing curtains had been placed in treatment bays to create additional room for either beds or chairs. Patients allocated to the corridor were regularly monitored by staff and during the inspection we saw evidence that these patients had made progress in their treatment pathway by either being allocated to a treatment bay or moving on from the department.

The service had enough equipment to help safely care for patients and staff carried out daily safety checks of specialist equipment such as hoists and oxygen cylinders which were appropriately stored within the department. However, some equipment had out of date PAT test labels. Senior managers advised us that equipment requiring a new PAT test had been logged with the estates team and although these items had been flagged, the trust remained within the set safety compliance rate.

Assessing and responding to patient risk

The department continued to not have a qualified paediatric nurse on-shift 24 hours a day. Compliance rates with training tailored to assist staff with specific risk issues were not always in-line with trust targets and department audit data was inconsistent. However, staff completed risk assessments for each patient swiftly and minimised risks. Staff identified and quickly acted upon patients at risk of deterioration to keep them safe.

Children were not always assessed and monitored by a Registered Sick Children's Nurse (RSCN). Staff we spoke with regarding paediatric nursing and medical cover advised that an RSCN was available on the department until 9pm. Following this, children were supported by the general nurses on-shift.

Although this had been a longstanding matter, we saw evidence that the trust had now taken steps to mitigate risks associated with the care of children attending the department, as highlighted in the Care Quality Commission Brief Guide: Staffing in Emergency Departments that treat children.

Medicine and Family Services had implemented the Paediatric Emergency Nursing Team across both hospital sites. A dedicated team of RSCNs were on site seven days a week providing flexible support to both the Emergency Department and Paediatric Assessment Units when required.

We received assurances from senior management that staff caring for children after 9pm had appropriate paediatric competencies to keep children safe. Managers confirmed that all Registered Nursing Staff in the department were working through the Royal College of Nursing Competencies Framework for Emergency Department Nursing which included care of the sick child. These particular competencies were assessed and signed off by the Paediatric Nursing Team to ensure oversight of learning and development in regards to caring for sick children.

We also saw evidence of embedded departmental processes which were followed to ensure children received relevant care and treatment when accessing the service. In the case of a child's condition deteriorating, the emergency physician in charge (EPIC) could speak directly with an on-call Paediatrician and trigger an escalation process to fast-track the child to one of the paediatric in-patient wards based on-site.

Although the steps taken by the trust do not specifically meet the recommendation of two RSCNs being present on the department at all times, as set out by the Royal College of Paediatrics and Child Health. Given the ongoing external factors impacting upon recruitment, the trust had now ensured that adequate cover was in place to treat sick children and keep them safe.

We saw relevant guidance and policies for managing falls and evidence in patient records that falls assessments had been appropriately completed for patients considered to be at risk of falling. However, despite there being no incidents evidencing patient harm, the most recent trust-wide emergency department audit data provided highlighted inconsistencies with the completion of falls risk assessments with 60% compliance recorded in the matron audit for the period 04 April 2022 until 27 June 2022.

Staff knew about specific patient risk issues and could explain the steps taken to identify these. We saw evidence of a robust standard operating procedure and guidance for monitoring patients at risk of venous thromboembolism (VTE). Nursing staff compliance with VTE training was 93.33% and 61.1% for medical staff.

Staff demonstrated an understanding of sepsis in patients and we saw multiple information posters on display in staffing areas to assist with education and awareness. Patient records evidenced appropriate use of the sepsis care bundle and we saw evidence of antibiotics being prescribed within the recommended timeframe of one hour. However, training compliance data obtained from the trust highlighted that only 55% of nursing staff and 28% of medical staff had completed the mandatory sepsis awareness training.

We reviewed the trust-wide sepsis screening performance data for the emergency department from April 2021 until June 2022, in which a random selection of patients were reviewed per month. Out of 270 patients with a NEWS score of five or more, 83.7% were screened for sepsis. Of the 156 patients requiring treatment for suspected sepsis, 139 (89.1%) received antibiotics within the recommended timeframe of one hour.

Upon arriving in the department, patients were triaged using the Manchester Triage System, a nationally recognised clinical risk management tool used to safely manage patient flow and help identify deteriorating patients.

We saw within three patient records, staff undertaking rapid assessments using the national early warning score (NEWS) tool in order to promptly identify the most appropriate care pathway for potentially deteriorating patients. Regular audits completed by the department matron evidenced that staff consistently followed the correct escalation process for patients when NEWS was triggered.

We reviewed 10 sets of patient records which highlighted that regular intentional rounding checks had been completed by staff. Additional checks were also in place due to the extended length of stays that patients allocated to treatment bays were experiencing.

Board rounds took place every two hours throughout the day in order to monitor patient risk and access and flow within the department.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health liaison and both nursing and medical staff described high levels of support were made available to them. Paediatric patients presenting with mental health problems were referred to children and adolescent mental health services (CAMHS) for appropriate care and support. However, staff described that overnight there could be difficulties accessing support in a timely manner.

Staff shared key information during shift changes and handovers to keep patients safe when handing over their care to others.

Nurse staffing

The service had enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. However, there was not 24-hour paediatric nursing cover within the department.

Due to ongoing external factors impacting upon recruitment, the department continued to not have Registered Sick Children's Nursing (RSCNs) cover available after 9:00pm. However, managers provided us with evidence that there were enough general nurses on-shift after 9:00pm with adequate paediatric training to keep children safe. We also saw evidence that there was an embedded Paediatric Support Pathway in place, ensuring clear lines of communication between the emergency department and paediatric in-patient wards to enable children to receive appropriate care and treatment in a timely manner to keep them safe.

The Royal College of Paediatrics and Child Health (RCPCH) also acknowledge the standards are recommendations rather than absolute, and that the challenges in recruiting the workforce needed to meet standards are ongoing.

Managers told us that staffing remained a constant challenge and whilst there was enough staff on-shift to keep patients safe, due to ongoing sickness and staff vacancies, the department continued to adopt flexible working patterns to ensure staffing remained appropriate.

On the day of the inspection the number of nurses and healthcare assistants matched the planned numbers.

We saw staffing rotas for the period 11 July 2022 up until the time of the inspection which highlighted that managers had calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance to keep patients safe.

Any potential shortfalls in staffing were initially monitored at a daily meeting with the medicine operational matron and departmental shift lead staff member. This meeting enabled staff to review staffing for the following 24 hours and helped to inform next steps to mitigate potential risks associated with staff shortages. Daily 'safe staffing' meeting and operations calls would also be held to complete a further review of the staffing situation trust wide. Action would then be taken to adjust staffing levels either internally or via access to bank and agency staff according to the needs of patients.

The trust-wide registered nursing vacancy target was 8%. However, the last recorded vacancy figure in May 2022 was 13.7%.

Trust-wide nursing staff turnover rates had remained between 11.06% and 11.96% over the previous 12 months.

There were no members of nursing staff off sick at the time of the inspection. The most recent overall sickness rate was 7.5%

Managers limited their use of bank and agency staff and requested staff familiar with the service. We saw evidence that the trust made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

On the day of the inspection the service had enough medical staff to keep patients safe and the medical staff matched the planned numbers on the day. Overall, the service had a good skill mix of medical staff on each shift and this was reviewed on a regular basis.

The department had nine consultants providing 16 hours of cover each day, seven days a week in-line with the 16 hours recommended by the Royal College of Emergency Medicine (RCEM). The department advised us that it planned to increase consultant cover up to 12 once approved by the trust. Five of the nine consultants currently in-post had obtained Certificate of Completion of Training (CTT) status or Certificate of Eligibility of Specialist Registration (CESR).

The service always planned 24-hour consultant cover with a consultant physically present on the department between 08:00am and midnight, seven days a week. Between midnight and 08:00am there was an on-call consultant available. The service always had a consultant on call during evenings and weekends.

Staff told us that weekends on the department could be challenging due to the volume of patients attending and reduced levels of staff availability. Medical staffing rotas provided by the trust showed, on average, a significant reduction in consultant and junior doctor cover during weekends.

The trust-wide vacancy rate for medical staff in May 2022 was 14.12% against an overall target of 15%.

Turnover rates for medical staff had reduced from 10.17% in June 2021 down to 9.38% in May 2022.

Trust-wide sickness rates for medical staff had increased from 1.56% in May 2021 up to 3.67% in April 2022.

The department managers informed us that medical staffing is planned two weeks in advance, with any potential gaps initially being addressed by adjusting the current staffing pool's scheduled hours. Any remaining shortfalls are then advertised for bank and agency staff to fulfil. We saw evidence that the trust actively monitored medical staffing and provided us with the standard operating procedure for the escalation process to executive-level, which included hourly staffing reviews, when staffing on the department was deemed to be potentially unsafe.

Urgent and emergency services

Records

Staff kept detailed records of patients' care and treatment. Records were clear, stored securely and easily available to all staff providing care.

We reviewed 12 patient records during the inspection. All hand-written notes were comprehensive in detail and appropriately stored.

When patients transferred to a new team, there were no delays in staff accessing their records due to use of the centralised recording system.

Staff told us that there were visible safeguarding alerts on the system for vulnerable patients which assisted in accurate information sharing and ensuring patient safety.

Patient information was also readily available electronically on various screens showing an overview of patient locations within the department and a summary of their presenting condition.

We were provided with the most recent records audit data from March 2022 which highlighted that the department generally performed well. However, within the random sample of 30 patient records which were reviewed, only 60% had vital signs documented at triage and 70% had recorded the patients' national early warning signs (NEWS) score. The audit also highlighted that only 36% of a total 175 entries made within the 30 patient files had been time stamped to enhance accuracy.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not always document a patient's prescribed medicines in their record following their initial assessment.

Staff followed systems and processes to prescribe and administer medicines safely and there was evidence of critical medication being prescribed and administered in a timely and appropriate manner.

We reviewed 10 patient records during the inspection which showed staff completed medicines records accurately and kept them up to date. However, in the most recent patient records audit, only 60% of the 30 patient records checked had current prescribed medications documented in their notes.

Staff stored and managed all medicines and prescribing documents safely and we saw evidence of patient allergies clearly documented during the prescribing process. The department also prescribed and administered oxygen to patients appropriately in-line with best practice guidelines and regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008.

We saw evidence displayed in the staff only areas that the department learned from safety alerts and incidents to improve its practice.

Staff compliance with medicines management awareness training met the trust target of 85%.

The service had an up to date restraint and sedation policy in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Urgent and emergency services

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff we spoke with knew what incidents to report, how to report them in-line with trust policy and provided recent examples to demonstrate their knowledge.

The department manager told us that the trust shared learning with their staff about serious incidents that happened elsewhere in the trust.

Staff understood the duty of candour principles and gave us examples of when the principles had been applied. They were open and transparent and gave patients and their families a full explanation if and when things went wrong.

Managers met monthly to discuss quality and safety and staff received feedback from investigation of incidents, both internal and external to the service and met to discuss potential improvements to patient care. There was evidence that changes had been made as a result of feedback and the department clearly displayed incident information and themes, as well as learning points resulting from previous risk factors. Staff also had the opportunity to attend weekly educational sessions to discuss learning from incidents in greater detail.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations and Managers debriefed and supported staff after any serious incident. We also saw examples of recent serious incidents which had been fully investigated by the trust and the lessons learned from each.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice and Managers checked to make sure staff followed guidance. Staff understood what was necessary to protect the rights of patients subject to the Mental Health Act 1983.

We found the service had completed internal audits to monitor progress against the Royal College of Emergency Medicine (RCEM) audit standards. We found some improvement, but this was not consistent across all the required standards.

However, staff understood the rights of patients subject to the Mental Health Act and followed the Code of Practice. The department received support from psychiatric liaison which could be accessed 24 hours a day.

Every patient attending the department had their mental health needs taken into consideration throughout the triage process with a further Management of Adults with Mental Health Presentations within the Emergency Department risk assessment being completed if any signs of mental health crisis were identified. Staff could complete additional care plan documentation for children experiencing mental health crisis within the department. Although this enabled staff to complete a further holistic assessment, it did not enable staff to categorise and rate presenting levels of risk.

Nutrition and hydration

Staff gave patients enough food and drink to meet their nutritional needs whilst accessing the department. However, the trust was unable to provide any additional nutrition and hydration audit data following the inspection.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and we saw some examples in patient records where staff had completed fluid and nutrition records where needed.

Although we saw evidence of staff promoting the nutritional needs of patients and their relatives/carers, managers informed us that there were no departmental nutrition and hydration audits completed in the last three months by the clinical audit department.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The most recent departmental audit score for use of the correct pain assessment tool was 100%.

It was identified during the last inspection of the department that the service should ensure patients are given pain relief medication appropriately. We saw evidence in patient records that staff prescribed, administered and recorded pain relief accurately. In the most recent pain scoring in adults audit which was completed in September 2021, out of a sample of 60 patients, 97% had their pain score recorded. This was a marked improvement on the previous audit result of 72% in February 2020.

However, as part of the same audit, a further 20 records were identified where patients had required analgesia following initial assessment. Only 12 out of the 20 patients identified had been provided with pain relief

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements in order to achieve good outcomes for patients.

For acute trusts, NHS England's operational pressures escalation levels (OPEL) had been nationally defined as being levels one to four, with four being the highest level of operational pressure. At the time of the inspection the hospital was running close to full capacity, causing delays in patient transfers and discharge. Despite the challenges, staff worked hard to achieve positive outcomes for patients.

The service advised it participated in relevant Royal College of Emergency Medicine (RCEM) audits and we saw examples of quality improvement projects for pain in children, infection control and most recently the neck of femur fractures audit for which the hospital site submitted 117 cases. All of which were measured against national standards. The department also participated in the UK Trauma Audit and Research Network (TARN).

We saw evidence that managers and staff carried out a programme of repeated audits to check improvement over time. Regular support was provided to the department by the Quality Team and Clinical Educators and the information gathered from audits was shared with staff and used to improve care and treatment.

From 01 July 2021 to 30 June 2002 the trust's overall unplanned re-attendance rate to urgent and emergency care within seven days was 7.94%, less than the national average of 8.7%.

Competent staff

The service made sure staff were competent for their roles. Managers reviewed staff's work performance and held supervision meetings with them to provide support and development. However, not all staff had up to date appraisals of their work.

At our last inspection, in September 2019, we advised the service that all nursing and medical staff needed an up to date appraisal of their work. Despite this, we found that 18 out of 40 Nursing and Midwifery registered members of staff still did not have an up to date appraisal. We requested but did not receive data from the trust showing appraisal rates for medical staff.

Service managers told us that there was ongoing focus upon training and development and with the support of the clinical educator, work to address shortfalls in both training compliance rates and appraisals was ongoing.

However, staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The trust provided a full induction tailored to their role before they started work which gave a good overview of the department.

Managers supported staff to develop through constructive clinical supervision of their work, identified any training needs their staff had and tried to give them the time and opportunity to develop their skills and knowledge.

We saw practice education and development displays in the staffing areas focussing on the basic nursing care needs as well as more specialised areas of learning unique to the local population. Staff told us that they had the opportunity to discuss training needs with their line manager and the recent input from the clinical educator had played a key role in supporting to develop their skills and knowledge.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw evidence of meeting minutes and news bulletins on display within the staff room which could be easily accessed.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients and they supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. During the inspection, we saw examples of multi-disciplinary working with occupational therapy to support patient discharge, as well as input from diagnostic services to help inform the most appropriate treatment pathway for patients.

Staff worked across health care disciplines and with other agencies such as social care, addictions and mental health services when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The department could refer patients to psychiatric liaison services 24 hours a day. Staff informed us that there is often a lack of beds for patients requiring psychiatric admission, as well as a lack of community-based resources for patients experiencing mental health difficulties to access when ready to leave the department.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. However, the department could experience delays accessing support from other services, both internal and external, due to the overwhelming demand being placed upon the hospital and wider integrated care system.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had a selection of information leaflets and posters promoting healthy lifestyles and support.

Within the department additional information on health conditions prevalent in the local community were also on display, such as diabetes management and promoting awareness of diabetic ketoacidosis.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Medical staff did not keep up to date with training on the Mental Capacity Act and Deprivation of Liberty Safeguards. However, staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, only 38.89% of medical staff had completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

However, all staff understood how and when to assess whether a patient had the capacity to make decisions about their care and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. We saw some examples within patient records where staff had assessed and documented patients' capacity prior to commencing treatment in their best interests.

Staff demonstrated an understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005. We saw examples in two patient records where staff had completed relevant MCA documentation and followed appropriate guidance. Information documented was accurate and legible.

Urgent and emergency services

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

In the department staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff introduce themselves and explain who they were and their role.

Patients told us staff treated them well and with kindness and that they were happy with the care and support provided despite their frustrations with the long waits to receive it.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients' needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw multiple positive interactions wherein staff ensured the emotional wellbeing of both patients and their relatives/carers when discussing plans for treatment.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them and undertook training on breaking bad news.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Due to ongoing COVID19 restrictions and the recent surge in attendances, only patients who required carer support were allowed into the department accompanied.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Within the department patient feedback and the actions taken by the trust to act upon concerns were clearly on display. Within the staff room we also saw examples of positive patient experiences and highlighted good areas of practice.

We requested an overview of patient feedback received regarding the emergency department. However, the trust only provided an overview of the National Inpatient Summary. Despite this, patients and relatives told us that staff took the time to make sure that they understood their care and treatment.

Urgent and emergency services

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

Due to the hospital running at full capacity and a lack of community-based resources there were delays in treatment and discharge from the service. However, the service worked with others in the wider system and local organisations to plan care.

Although we saw evidence that managers planned and organised services so they met the needs of the local population, for example, we saw was information displayed to ensure staff awareness of diabetic ketoacidosis due to the high prevalence of diabetes within the local population. The service still did not meet some of the relevant recommended standards set out in the RCPCH Facing the Future: Standards for children in emergency care settings guidance.

Due to the increasing numbers attending the department, patients could experience long stays and delays in treatment. Patients we spoke with told us that they had attended hospital as they knew they would receive support and treatment, despite the long waiting times.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. Staff spoke positively about the support of the psychiatric liaison team. However, the trust highlighted that there was a lack of suitable resources available within the community for patients experiencing mental health difficulties. We were told that patients experiencing mental health crisis would often present to the department to seek support and often there would be delays discharging patients due to difficulty accessing appropriate community-based services.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We saw positive interactions between staff and patients with complex needs to ensure they remained settled on the department.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from the trust interpreting service which could offer support with face-to-face interpreting and translation.

Access and flow

The trust faced ongoing challenges with access and flow which meant that they could not ensure people were able to access the department and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in-line with national standards.

Urgent and emergency services

Patients could not access the department in a timely way and the trust faced known challenges with access and flow. Managers and staff worked to make sure patients did not stay longer than they needed to. However, this was not always possible due to increasing numbers of patients attending the department, lack of available beds within the wider hospital and wider pressures within the integrated care system. Despite the ongoing issues with access and flow, staff ensured that patients were cared for with dignity and respect.

Trust-wide overall accident and emergency attendances had increased by 20% on the previous year, with a 58% increase in paediatric attendances recorded for the period March 2021 until February 2022. Staff told us that there were regularly multiple patients waiting for a bed to become available within the wider hospital at the start of the day-shift. At the time of the inspection 14 patients had been on the department for over 12 hours and two patients had been waiting for over 24 hours to be transferred off the department.

Initial assessment within the department was provided at reception by an Urgent Care Practitioner who determines the most appropriate care pathway for the patient. This is completed during Urgent Care Service hours (8am until 8pm, seven days a week). Outside of these hours a traditional triage model is put in place.

Managers told us that the introduction of the Urgent Care Service (UCS) had assisted in taking some of the pressure off the emergency department as patients with lower-level injuries and complaints could be redirected from the department to the UCS for treatment. However, at the time of the inspection, the UCS only operated from 8am until 8pm.

Due to the UCS operating hours at the time of the inspection, there was a transition between UCS closing and a traditional minors stream commencing after 8pm. This switch sees patients booked onto the Emergency Department electronic system to be seen as minors, as opposed to the system used for UCS. This process was in reverse in the morning for the commencement of UCS. To support this a different staffing model commences to provide a minors stream.

Following the inspection, the trust provided us with assurances that the operating hours for the UCS would be extended until midnight from 01 August 2022 which follows the division's plan to follow a 24/7 model.

A Same Day Emergency Care (SDEC) unit could also be accessed on-site for patients with minor ailments, deemed suitable for rapid assessment and same day discharge. This pathway could be accessed directly through the emergency department, via GP referral or via ambulance conveyance. During the inspection, the hours of operation for SDEC were 8am until 8pm and between 50 and 70 patients attended daily. Staff based on SDEC stated the referral process from the emergency department worked well, with clear exclusion criteria for new referrals in place. No safety incidents had been raised regarding inappropriate referrals and staff reported that patients rarely needed to return to the emergency department. Furthermore, there were no issues with SDEC operating beyond its scheduled hours.

For the period 01 June 2022 until 30 June 2022, 6592 patients attended the department, with an overall average waiting time of approximately four hours and 27 minutes.

The most recent data provided by the trust highlighted that only 13.87% of patients attending the department had achieved the Department of Health's standard for emergency departments four hour wait target. Of the same sample of patients obtained between 01 June 2022 and 30 June 2022, 45.2% waited between 4-12 hours from decision to admit to admission and the longest recorded wait for admission was over 34 hours.

Urgent and emergency services

Trust-wide data for July 2022 highlighted that 532 patients spent more than 12 hours on the emergency department across both hospital sites from decision to admit to admission.

Data provided by the trust for June 2022 showed 2.06% of patients left the department before an initial assessment and 0.94% of patients left after receiving an initial assessment, but before receiving treatment.

The department continued to experience delays with ambulance handovers as a result of ongoing access and flow issues trust wide. The average ambulance handover time for week commencing 18 July 2022 was 84 minutes, with 88 minutes recorded the previous week and 62 minutes recorded during week commencing 04 July 2022. Only 19% of ambulance handovers were completed within the national target of 15 minutes during the four weeks prior to the date of inspection on 26 July 2022. Data for the same period also highlighted that 38% of ambulance handovers had taken over 60 minutes.

Performance in terms of the percentage of ambulance attendances taking over 30 minutes to handover had fluctuated between 15% and 23% since January 2022, with the most recent figure of 19% recorded on 08 May 2022. This remained above the integrated care system average of 12%.

Due to the ongoing challenges faced with ambulance handovers, processes were in place for patients required to wait in ambulances until a bed became available within the department. Ambulance staff advised us that emergency department staff would regularly check on patients in ambulances when there was a long wait to access a bed within the department and we saw examples of this during the inspection.

Managers and staff started planning each patient's discharge as early as possible. However, due to a lack of community-based resources or limited bed availability within the wider hospital, it was not always possible to discharge or transfer patients in a timely manner. Although there were no patients presenting with mental health difficulties at the time of the inspection, staff described significant delays in discharge if a mental health act assessment or psychiatric hospital admission was required.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

From 29 June 2021 until 29 June 2022, approximately 50% of all of the complaints received at Scunthorpe General Hospital related to emergency care. Trust-wide only one complaint regarding the emergency department had been referred to the Parliamentary Health Service Ombudsman (PHSO) within the previous 12 months, which the PHSO chose not to investigate following review.

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in all patient areas. Staff understood the policy on complaints and knew the process on how to handle them.

Managers investigated complaints, identified themes and shared feedback with staff and learning was used to improve the service. Staff we spoke with could give examples of how they used patient feedback to improve daily practice and we saw examples clearly displayed in the staff room for ease of access. Staff knew how to acknowledge complaints and we saw examples on display where patients had received feedback after the investigation into their complaint.

Urgent and emergency services

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They had made progress in understanding and managing the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. The work undertaken by the clinical educator and lead nurses had supported staff to develop their skills.

We saw evidence the nurse management leaders had the relevant skills, knowledge, experience and integrity to run the service.

The trust acknowledged the current challenges with staffing, an issue which was actively being investigated to promote stability and sustainability, in-line with the new department opening.

Nurse managers we spoke with understood the challenges to quality and sustainability. We saw evidence of regular departmental audits and action plans with evidence of progress against some actions. Senior management were aware of any shortfalls in audit results and there was evidence that the department was committed to improving upon areas of development.

Local leadership on-site at Scunthorpe General Hospital has helped the Same Day Emergency Care unit work successfully due to consistent managerial oversight and implementation of processes.

Vision and Strategy

Due to a lack of resources in the wider integrated care system there had only been limited progress made by the service. Although the service had implemented various changes and improvements since the last CQC inspection, these were not always done in a proactive and timely manner. However, the service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

There was a clear vision in place, however, due to ongoing pressures within the wider integrated care system, the trust experienced difficulties putting their vision and strategy into practice.

Goals such as reducing ambulance handover times and improving overall departmental waiting times had not been achieved due to both internal and external factors effecting access and flow. We saw examples of a reactive approach to resolving issues rather than proactive, such as the decision to extend the operating hours of the urgent care service to ease pressures on the department after our inspection.

The trust had developed a clear vision and strategy which was directly linked to the upcoming opening of the new department. This was clearly displayed within the current department and highlighted targets for 2022 which included the development of care pathways within urgent and emergency care, continuous development of staff skills and service improvement targets such as improving ambulance handover times.

Urgent and emergency services

Each member of staff we spoke with was focused upon the move to the new department and optimistic for the future of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff had been resilient in their response to the ongoing COVID-19 pandemic. However, staff had found their situation challenging and described being tired.

There was a recognition that the wellbeing and morale of staff was impacted over the past year, however we found staff displayed resilience and hope despite these challenges. Senior leadership told us they recognised the pivotal role staff resilience had played in maintaining the urgent and emergency care system despite the tremendous pressure it was under.

Despite the difficult circumstances, staff were positive about working within the service and praised the teamwork and educational ethos. Staff felt there was good support from senior members of staff. There was also information on display for staff to ensure they cold access the Professional Nurse Advocacy service to discuss both professional and personal matters.

Governance

Leaders operated set governance processes, throughout the service. However, these required further embedding to ensure the highest possible standards were achieved within the department. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We saw evidence of the use of governance processes to monitor standards of performance at both departmental level and trust-wide and signs of improvement from the last inspection. However, outcomes of departmental and trust-wide audits were not always consistent and did not always meet the highest possible standards.

Training compliance rates remained below the trust target and not all staff had an up to date appraisal.

Staff we spoke with clearly understood their role within the wider team and took responsibility for their actions.

Management of risk, issues and performance

Not all must-do actions identified at the last inspection had been addressed by the trust. Further development of adopting a proactive approach to resolving risk and performance issues is still required. Despite this, leaders and teams understood the ongoing pressures faced with access and flow within the department. They used systems to monitor and manage performance and they identified and escalated relevant risks to potentially reduce their impact.

We only saw some with the must-do actions identified at the last inspection, with the designated mental health treatment room now complying with Psychiatric Liaison Accreditation Network standards. Medical staffing cover had also improved, with appropriate medical cover now in place and evidence of ongoing efforts to ensure consistency with medical staffing moving forward into the new department.

The trust had not ensured that mandatory training compliance rates were in-line with trust targets, as well as ensuring appraisals were up to date for all staff.

Although the service ensured paediatric patients were supported by nursing staff with adequate skills in caring for children when attending the department, the trust still did not meet relevant recommended standards in regards to ensuring enough registered sick children's nurses cover was available.

Patients accessing the department continued to experience extended waiting times in excess of the four-hour benchmark and ambulance handover times were frequently in excess of the national standards. However, patients told us that despite the long wait treatment, they were happy with the care provided to them and it was evident that staff worked hard to achieve the best possible outcomes for all patients.

Senior managers met on a monthly basis to discuss trust-wide quality and safety, as well potential improvements to patient care. There was evidence that changes had been made as a result of feedback and the department clearly displayed incident information and themes, as well as learning points.

The senior management team based within the department met on a weekly basis to discuss performance data and risk. We also saw evidence of regular quality audits completed across multiple areas within the department in order to identify shortfalls in performance and to mitigate potential risks to patient safety. The department highlighted that reducing ambulance wait times was a priority and work was ongoing to address this which would improve access and flow within the department and increase productivity in the wider integrated care system.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We saw evidence of effective data management both during the inspection and when receiving additional data from the trust post-inspection.

Information was stored securely at department-level and could only be accessed by staff using a unique log-in.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They had developed relationships with partner organisations to help improve services for patients. Engagement both internally and externally needs to be sustained to ensure delivery of key messages to both staff and patients accessing the service.

Regular meetings were held at trust-level with other external organisations such as the neighbouring local authorities to help improve patient experience.

The trust had implemented ongoing work as part of its Patient Experience Priorities, which was in place to improve the patient experience when accessing the service. This was based upon listening to patients and gathering feedback in order to align service delivery with the needs of the local population and to ensure the highest possible standards of care are being delivered.

Staff were invited to engage with the trust-wide staff survey which had an overall response rate of 38% with overall satisfaction in all question areas being below the national average.

Learning, continuous improvement and innovation

Shortfalls remained in overall compliance with trust-wide training targets. However, staff were committed to continually learning and improving services. They understood quality improvement methods and the skills to use them.

At the time of the inspection mandatory training compliance rates for medical staff remained below the trust target of 85%, with significant shortfalls in safeguarding training and immediate life support training. At the previous inspection, ensuring compliance with trust-wide standards for mandatory training was identified as a must-do action. However, there had only been limited progress in addressing this matter, with nursing staff now meeting the trust target.

There was evidence that the nurse managers, along with the clinical educator and matron, had taken steps to promote a learning culture which adhered to both Royal College of Emergency Medicine and NICE (The National Institute for Health and Care Excellence) guidelines.

We saw information and guidance on display in the staffing areas of the department to promote awareness of issues such as sepsis, use of antimicrobial prescribing, mental capacity and safeguarding guidelines.

We saw evidence that the departmental learning and development programme followed Royal College of Nursing standards to ensure staff had the relevant competencies in place to progress to a higher grade.

Diana Princess of Wales Hospital

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Description of this hospital

Diana Princess of Wales Hospital (DPoW) is one of the three hospital sites for Northern Lincolnshire and Goole NHS Foundation Trust. It is located in Grimsby and provides acute hospital services to the North East Lincolnshire area.

DPoW is the trust's largest hospital. It offers a range of inpatient and outpatient services including urgent and emergency care, medical care, surgery, critical care, maternity, end of life and outpatients and diagnostic services for children, young people and adults primarily in the North East Lincolnshire area.

Outpatients

Good ↑↑

Is the service safe?

Good ↑↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was provided as a mixture of e-learning and face to face learning. Staff felt supported to access mandatory training and were able to keep up to date with their training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Each department manager had oversight of mandatory training compliance. Management provided assurance that where any staff members were not up to date with training, they had been booked on to complete it.

Staff received and kept up to date with their mandatory training. The trust set a target of 85% for completion of core mandatory training. The trust monitored mandatory training for all staff across the three outpatient departments rather than by location.

Overall, the outpatient department met completion of core mandatory training with values ranging from 87% to 100 % in all core subjects.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

The chief nurse was the executive lead for safeguarding at trust board level. There was a trust-wide safeguarding team available to provide advice and support to staff.

There were safeguarding policies for both adults and children, which were accessible to staff on the trust intranet. The policies contained a flowchart for practitioners to follow if they had any concerns. Children attended some outpatient clinics. Some senior registered nurses were trained to level 3 in safeguarding adults and children. Staff requiring level 3 safeguarding for children had completed their training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could describe the safeguarding process and gave examples of safeguarding concerns that they had escalated.

Outpatients

Staff followed safe procedures for children visiting the department. Staff had an awareness and understanding of female genital mutilation, which was covered as part of their safeguarding training.

Staff gave an example of how they had used the safeguarding process to protect a patient whose first language was not English, from alleged domestic abuse. The patient had sought help from a staff member once in a consulting room away from family. The local safeguarding team had thanked those involved for making the referral and protecting the individual.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas visited were visibly clean and tidy. Clinical areas were clean and had suitable furnishings which were in good condition and well-maintained. The cleaning staff were all trust employees. Each area had a routine cleaning schedule to follow and managers audited how well the areas were cleaned. Results from these audits were positive.

The trust had a '15 step challenge' approach to cleanliness and infection control. Areas were award ratings based on how well they performed at these audits. All areas visited had received either a good or outstanding rating for level of cleanliness.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Disposable antimicrobial curtains were used in all outpatient clinics.

Staff adhered to 'bare arms below the elbow' protocol. Hand sanitiser was available for use throughout the department and there were hand washing sinks available in areas visited.

Hand hygiene audits were completed regularly, and trust data showed that compliance with this was also positive. Feedback was given to staff at team meetings and improvements needed were discussed.

There were designated waiting areas for patients with children which were clean and tidy. All toys and games available were easy to keep clean.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out daily safety checks of specialist equipment. Staff reported they had access to equipment for bariatric patients, for example, appropriate scales and seating. There was a range of seating provided including high back chairs and seating of appropriate heights for patients with orthopaedic conditions.

Resuscitation equipment was available on trolleys at various locations in the main outpatient areas and near other clinics. Daily checks were completed, and tamper proof tags were used to show if the contents had been accessed. Full checks of the trolleys were completed weekly. We examined checklists covering the previous three months and saw that appropriate stock was in place and this was regularly updated. Trolleys were clean and dust free.

We checked electrical equipment and found them to be within their service date and that they had been safety tested. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. Staff told us equipment was promptly repaired or replaced if required by the estates department.

We checked a range of items including dressings and syringes. All items were within their expiry date and staff confirmed processes were in place to check that stock was regularly rotated to ensure the use of short dated items.

Sharps bins were properly assembled, stored off the floor, not over full and signed and dated. There was waste disposal in the department for clinical and non-clinical waste.

There were self-check in desks in the outpatient department but these were not in use. They had been placed out of action during the Covid-19 pandemic and now needed a software upgrade before patients could use them.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

The trust had a clinical prioritisation system for patients overdue their appointment dates. The trust had a backlog of patients waiting to be seen. The backlog was in part incurred as a result of the cessation of services during the Covid-19 pandemic.

The trust had implemented risk stratification systems to help ensure patients were seen in order of clinical need and had strategies to reduce the waiting lists for each clinical speciality. However, there remained risk due to the volume of patients waiting and the service not meeting the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral for a suspected cancer diagnosis. There was an national shortage of oncologists that meant the trust did not have enough medical staff to treat cancer patients. However, the trust was working with another hospital trust to remedy the risk and were continually undertaking validation of the waiting lists.

Safety checklists were used in some areas such as ophthalmology prior to intravitreal injections. Ophthalmology was managed by the surgery division and therefore the surgery division managed the safety checklist audits. The trust provided WHO checklist audit results which showed compliance with WHO checklist procedures.

There was a clear trust-wide pathway and process for the assessment of both adults and children within outpatient clinics who became clinically unwell while in attendance. All staff we spoke with could describe the pathway, which involved contacting the trust resuscitation team or emergency service dependent on location.

Staff were aware of sepsis and could describe the signs and symptoms to be aware of. We saw posters on walls to raise awareness of sepsis and staff told us sepsis was included in mandatory training.

Clinical nurse specialists gave patients their contact details so they could escalate any change in their condition or seek advice when they needed to.

There was a policy for staff to follow if a child or young person did not attend their appointment. The policy described that the clinician must consider whether there was a safeguarding risk for any nonattendance in the case of children and young people and then act accordingly in following any concerns up, liaising with the referrer to assess the risk and consider further actions if appropriate. The policy directed clinicians to the trust policy for safeguarding children and young people for guidance.

Outpatients

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Nurse vacancy rates were low and staff turnover rate at 4.3% was low across all departments. Staff sickness ranged between 5.5% and 9% for the previous 12 months. This was a lower sickness rate than most other directorates within the trust.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance.

Managers could adjust staffing levels daily according to the needs of patients. When extra clinics were added, managers used their own bank staff to fill these shifts. Managers limited their use of bank and agency staff and if using agency workers, they requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the department.

The number of nurses and healthcare assistants matched the planned numbers and rotas were refreshed on a weekly basis. Managers held weekly clinical utilisation meetings and these meetings shaped where there would be either an increased need for staff or a reduction if a clinic was cancelled. Clinical nurse specialists were not managed by the individual outpatient departments but had rooms allocated to them when they held clinics.

There was no staffing data for medical staff in outpatients due to medical staff being assigned to their individual speciality rather than the outpatients department.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient records were paper based, however patient letters including referral letters and all diagnostic results were easily accessible via electronic systems.

Staff told us that there were rarely missing records and would contact medical records to locate patient notes if necessary. If records were not located before a clinic, the administration team would make up a temporary set of records, which would be merged with the original set when they were located.

Records were stored securely in locked areas and were not accessible to the public. We observed that covers for notes trolleys were used to maintain confidentiality when moving notes in trolleys within the department.

We looked at the medical records. We found that they contained up to date information about patients including referral letters, copies of letters to GPs and patients' medical and nursing notes. There was a plan of care documented for each patient. Records were always dated and signed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Medicines were stored in locked cupboards and refrigerators. We checked a range of medicines and found them to be in date and stored appropriately in locked cupboards.

No controlled drugs (CDs) were stored in the areas we inspected.

Staff monitored and recorded the temperature of the rooms where drugs were kept. We reviewed the temperature records in clinic rooms and saw that daily checks had been completed. We saw the temperatures were within acceptable limits. Staff we spoke with could explain the process to follow should temperatures fall outside the required range.

Clinicians used a mixture of electronic prescribing and FP10 prescriptions. The FP10 prescriptions were securely stored in a locked cupboard. Prescription records were kept securely and separately from prescription books.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff used the electronic incident reporting system to report incidents and near misses.

At the previous CQC inspection, it was noted patients had come to serious harm due to delays in receiving treatment. There were no such incidents noted at this inspection and the process for incident management had improved.

Staff gave us examples of how to report an incident. We were told of one incident where a sick patient that had attended their local outpatient department by default because an accompanying family member thought that the hospital had an emergency department. The outpatient department was near the hospital main entrance so the first staff on scene were from outpatients. This incident was reported and recorded. As a result of this, changes were made and lessons shared to ensure staff were ready to respond in the event of an unexpected patient attending in need of emergency care.

Staff understood the duty of candour. Some staff were aware of the concept and had not needed to act on it. Others understood the process but not the term. Staff told us they were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents or through team meetings, staff huddles or from information displayed in staff areas. The trust had introduced a patient safety bulletin and a learning lessons bulletin that shared incidents that had occurred, their root causes and their conclusions.

Managers debriefed and supported staff after any serious incident. Staff told us that they would be given the opportunity to discuss concerns following an incident.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Outpatients

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We saw staff taking time to interact with patients and those close to them in a respectful and considerate way. Staff greeted patients and introduced themselves. Staff cared about their patients and patients were pleased to see faces they recognised. We saw patient thank you cards which thanked staff for their care and compassion.

Staff were discreet and responsive when caring for patients. Patients said staff treated them well and with kindness. We read cards given to staff in clinics thanking them for their care and support. Patients told us that reception staff were welcoming and friendly

All patients we spoke with during the inspection told us that staff treated them with respect and maintained their dignity and privacy, for example, through ensuring clinic doors were closed during appointments and using curtains in treatment rooms.

Chaperones were available and provided as necessary across the outpatient department. There was a chaperone policy available for reference and to support staff.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

There was a quiet room available with seating for patients to use if they were anxious or worried when visiting the department and staff told us this room was available to patients as needed. Staff used this room for private discussion with patients and for patients who had received bad news to provide privacy if they were distressed.

Staff described being adaptable to the needs of patients, for example, providing separate waiting areas for distressed or anxious patients, and fast-tracking patients through outpatient clinics if they were anxious or phobic.

There were specialist nurses in some clinics who were able to provide care and support for patients. Patients were offered contact details so they could call specialist nurses if they had any questions or concerns.

There were leaflets available throughout clinic areas signposting other emotional support services for patients, for example, local support and listening groups.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients' told us that if there was a delay to a clinic they were informed by the staff or by messages on the display board.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw posters in clinics advertising the friends and family test.

Patients gave positive feedback about the service.

Outpatients

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The service had reacted to the challenges created by the Covid-19 pandemic by being inventive with ways to contact and treat people using technology and new pathways.

There were outpatient specialities which held clinic appointment slots for urgent appointments. There were speciality administration teams which booked and assisted in managing appointments for the specialties.

The clinic utilisation group and speciality administration teams were involved in managing the clinic bookings. Additional clinics were put on for specialities and extra staff would be scheduled to those clinics.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. There were virtual clinics which reduced the need for patients to attend departments unnecessarily by having a consultation over a video link or by telephone. The departments worked closely with GPs via the Connected Health Network project which meant that patients were seen promptly and treatments or investigations might happen closer to home.

The outpatient department could provide patients with a pager, so patients could leave the waiting room for a break and could be contacted when their appointment was imminent.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Some areas had dementia friendly environments, for example clocks and toilet signage. There was a trust wide dementia strategy. There was a trust wide senior nurse for vulnerable people who led on dementia and learning disabilities. There were dementia champions who could be contacted for advice and support and the department worked as needed with the trust learning disability and dementia matron. Electronic referrals could be made through the system to the clinical nurse specialist. Patients with learning disabilities could also be highlighted on the electronic systems.

Outpatients

The outpatient patient survey showed that 100% of respondents found the environment in the waiting room pleasant and comfortable.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to translation services via an interactive electronic tablet that was quick and easy to use. British sign language interpretation could be requested.

There was a quiet room available in the department which could be used for patients who may be anxious or where patients required a quieter room than the waiting room. Additional time could be provided in the clinic for patient's appointments if required. Appointment times varied depending on whether the appointment was a new appointment or a follow up appointment and depending on the speciality.

The service had information leaflets available in languages spoken by the patients and local community. There were a range of patient information leaflets available throughout the department.

There was a trust patient advice and liaison service (PALS) which provided advice and support regarding concerns.

Staff told us that they worked closely with the services that provided patient transport to clinics to help patients access transport to and from their appointment. They would contact transport services if there was a delay in collection or appointments. Staff always waited with patients until transport arrived to take them home.

Letters were sent to patients from the bookings and administration teams following appointments or before appointments.

Access and flow

People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. However, this was an improvement on the previous inspection in 2019.

Although the trust were struggling to meet the demand for outpatient appointments, they had strategies and mitigations in place to help remedy this. This was an improvement from their previous inspection and much work had been undertaken as part of the outpatient transformation programme.

From February 2021 to January 2022, the total number of appointments in outpatient services was 420,283.

Medical specialties had seen the largest increase in appointments (27%), compared to the previous 12 months. This was followed by dermatology (22%) and surgical specialties (21%).

Ophthalmology (6%) and oncology (6%) were the only specialties to see a decrease in the total number of appointments, compared to the previous 12 months.

A breakdown of specialties is shown below:

Specialty Number of appointments Proportion of appointments

Surgical specialties 160,299 38.1%

Outpatients

Medical specialties 96,246 22.9%

Other 92,697 22.1%

Ophthalmology 46,434 11.1%

Oncology 19,027 4.5%

Dermatology 5,580 1.3%

Total 420,283 **100.0%**

Managers monitored waiting times and although patients could not always access services when needed, there were systems in place to keep checks on this.

Managers were monitoring numbers of patients on all the waiting lists, waiting times, breaches and people who do not attend appointments (DNA's). There was also robust monitoring of the numbers of outpatients overdue their follow up appointment, which was a challenge for the trust.

Waiting lists were managed and patients were prioritised. The trust used risk stratification protocols to give all patients a risk prioritisation status. Patients were subsequently monitored continuously on waiting lists. Patients at most risk of potential clinical harm if not treated had enhanced monitoring and there were escalations procedures to follow.

Progress and performance for each clinical speciality was overseen at weekly performance and planning meetings.

Patient initiated follow-up (PIFU) had been introduced using readily available technology to give patients and their carers the flexibility to arrange their follow-up appointments as and when they needed them. This meant patients did not routinely sit on waiting lists but requested an appointment to befit their symptoms and needs.

The Connected Health Network project meant that cardiologists worked actively with GP partners to help improve services for patients. The patients involved in this project did not need to come into the hospital or wait on a list for treatment or advice but could access this locally.

The trust aimed to undertake 25% of its outpatient consultations virtually. Patients could receive advice and treatment via video call or telephone without the need to attend hospital.

However, there was a shortage of oncology doctors which impacted on the trust's ability to reduce the wait time for cancer treatment appointments. The trust was also providing mutual aid to this speciality for another NHS trust which affected their data and wait times.

In March 2022, the percentage of patients receiving Cancer treatment within 62 days at Northern Lincolnshire and Goole NHS Foundation Trust was 64%, compared to the National average of 67%. When comparing this trust to its peer group (based on activity), it had the second worst performance rate (out of 30 trusts). However, performance had improved by 7% since January 2022 (57%).

Outpatients

From October 2021 to April 2022, the trust's referral to treatment time (RTT) had generally improved (except for January where there was a slight decline). The figures for April 2022 showed 73.1% of this group of patients were treated within 18 weeks, which was similar to the England average of 74.0%.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients could give feedback via the trust website and the service clearly displayed information about how to raise a concern in patient areas.

There was a policy and procedure for the management of complaints, concerns, comments and compliments. Staff understood the policy on complaints and knew how to handle them. Patients were kept informed about progress with the investigation of their complaint and received an outcome.

Leaders and the patient advice and liaison service (PALS) received formal complaints which were investigated by the leaders of the outpatient department and leaders told us learning was shared at the team meetings or with staff individually if required. Complaints were part of the agenda for team meetings where required and were part of senior leaders' meetings.

Complaints had been mainly about waiting times and car parking facilities. Staff could give examples of how they used patient feedback to improve daily practice. Managers shared feedback from complaints with staff and learning was used to improve the service.

Managers investigated complaints and identified themes. The trust had information boards on departments titled 'You say, we did'. These identified thematic feedback and reported improvements made as a result of this.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, staff told us that senior managers were less visible in the service.

Staff we spoke with were positive about local leadership within their teams and told us team leaders were supportive and available when required. However, the service was in a state of transition and moving to a new directorate structure, so this made staff unclear about who their divisional leaders were. Staff told us that they were able to talk to the senior leadership team but reported that the trust executive team were never seen around the departments.

Outpatients

Outpatient services had been previously managed under one directorate. Outpatient departments were now divided across three directorates. Diana Princess of Wales outpatient department in Grimsby was in the medicine directorate, Scunthorpe General Hospital was in the surgical directorate and Goole Hospital sat within the community services directorate. This divisional restructure was in its infancy and under review. The divisional matrons across these areas would work together to ensure consistency across the outpatient teams. At the time of inspection, it was too early to say whether this had been successful or not.

There was a structure for the management of outpatients. There was a matron for outpatients covering each site and each outpatient department had an individual manager.

Senior managers we spoke with were aware there were challenges with waiting lists for outpatient appointments and issues with referral to treatment indicators.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

As part of the NHS Ten Year Plan, the trust pledged to make changes to outpatient services and detailed intentions in its Strategic Plan (2019-2024). This strategy included information on the trust strategic framework, the current outpatient position and the outpatient objectives and priorities over five years. In all areas that we visited, information was available for staff to read about the transformation aims.

The outpatient transformation programme 2022/2023 had aims, ambitions and outcomes. We saw that some of these aims had come into fruition and had been achieved. Some aims remained a work in progress.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff in departments told us there was good teamwork, openness and honesty within their teams. Overall staff were positive about working in their departments. Most staff told us they felt supported.

Staff told us morale was generally good, however, the recent reorganisation of directorates was causing some concern as outpatient staff aligned to their new leaders. The service was getting used to a restructure although this did not seem to impact on the day to day running of departments.

Staff told us that they were proud to work in the trust. We spoke to staff who told us ‘I love my job’. Another staff member told us they would not want to work anywhere else. Staff also told us they would be happy to have their own family treated at the trust

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Outpatients

Leaders described governance arrangements for the outpatient departments. Governance meetings and governance issues fed into quality and safety meetings which were held every week.

At this meeting incidents and complaints were discussed. This meeting was attended by senior staff who could then escalate governance issues through this meeting to the performance improvement meetings, trust management board and the clinical quality board.

There was a clinical utilisation group who supported the work around capacity and demand challenges in outpatients. A breach review meeting was held weekly as was a planning and delivery meeting.

One report was published for all these meetings which was the integrated performance report so that there was a 'single version of the truth'.

The trust had engaged with the Getting It Right the First Time (GIRFT) national programme and had a dedicated GIRFT team to support improvement. The trust had governance arrangements for oversight for the GIRFT program.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were risk registers that detailed issues pertinent to the service. Risks were rated and had actions associated with them. Staff were aware of top risks such as capacity for appointments, staffing, estates and facilities and information technology.

The outpatient services monitored performance through performance reports and regular meetings. Progress was monitored by the planning and performance function at weekly divisional and trust meetings. The executive team had monthly formal Performance and Improvement meetings (PRIMS), with the divisions. Any escalations or concerns were made to the Finance and Performance Committee which was a sub-committee of the board. Monthly integrated performance reports were also provided to the Finance and Performance Committee for oversight of performance, including key performance indicators relating to the backlog of waiting appointments.

There was a trust business continuity plan that detailed how the outpatient departments would continue to operate during an unplanned disruption in service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff could access the trust intranet for information and news about the trust. Policies and procedures were available on the trust systems to staff. Staff had access to an internal information technology team for support as required.

The service had performance reports, for example patient tracking list reports which enabled the service to monitor the waiting lists and understand where there were challenges.

Outpatients

Information systems were used across the departments to provide patient care. For example, there was access to electronic patient records and the trust had an electronic incident reporting system.

The service collected reliable data and analysed it. Senior staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. We were shown data bases used in different departments to gather information on performance and used for audit. The information systems were electronic and secure. Staff told us that these audits were shared with the trust management and submitted to external organisations as required. For example, compliance with the National Institute for Health and Care Excellence (NICE) standards in rheumatology.

Engagement

Leaders and staff actively and openly engaged with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The leadership team had discussed methods for helping staff to understand the new structure. They told us that they were in the process of spending time with staff to increase their visibility.

Staff were able to feedback using staff surveys. We were told that staff completed a trust staff survey every three months and a national staff survey each year. The results were fedback to the staff and actions that needed to be taken as a result were shared.

The Connected Health Network project meant that cardiologists worked actively with GP partners to help improve services for patients.

The trust commissioned an audit to review performance and systems to ensure that they were aligned to the outpatient transformation programme.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The Connected Health Network project was developed in partnership with another organisation. This was a new model of care in which GPs and hospitals worked together as one clinical network. It meant that GPs no longer needed to make a referral into a hospital. Instead, they worked directly with trust specialists to agree how to safely deliver your care. A shared admin team helped ensure a streamlined pathway for patients The project picked up an award in the early-stage pilot of the early adopter of the year category.

Diagnostic imaging

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Compliance for radiographers and sonographers (allied health professional (AHP staff)) was 90% which exceeded the Trust target of 85%. Compliance for the majority of e-learning courses was 100%, with compliance for face to face courses in individual departments ranging from 40% for moving and handling for patients using a chair, to 83% for Level 2 Adult Basic life support.

Medical staff training compliance exceeded the Trust target of 85% and staff achieved 100% for nine out of 18 courses. Compliance for the remainder ranged from 60% (three out of five staff) for antimicrobial stewardship to 80% (four out of five staff) for infection prevention and control training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers and staff confirmed face to face courses were becoming more accessible and staff were rostered and booked to attend as soon as new courses became available.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding Adults and Children training compliance met the Trust target of 85%. Of 23 AHP staff in general radiology and 32 staff in MRI, 90% had completed Adults Safeguarding Level 2 training and 100% had completed Children's Safeguarding Level 2. All medical staff had completed Adults and Children's Safeguarding training to Level 2.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Data provided by the trust showed one nurse allocated to the radiology outpatients service had completed Children's Safeguarding training to level 3 but no medical staff, radiographers or sonographers, including safeguarding leads, had completed Children's Safeguarding to level 3, and it was not a mandatory course. However, the Trust Safeguarding Children's policy was comprehensive and included Trust safeguarding contacts and processes to follow and staff gave examples of how they had put this into practice. Staff and managers used the Trust safeguarding team guidance to mitigate any risk.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff could access safeguarding advice via the Trust's lead nurse for safeguarding.

Staff followed safe procedures for children visiting the department. Images taken for babies and children when non-accidental injuries were suspected were reported by consultant radiologists and the Trust had a service level agreement for these images to be double-reported by radiologists at a neighbouring NHS Trust.

Staff attended paediatric multidisciplinary meetings to discuss referrals, images and reports relating to children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff provided records to show cleanliness of equipment had been checked. All rooms and public areas were cleaned daily and healthcare assistants kept cleaning records up to date.

All clinical areas appeared clean and had suitable furnishings which appeared to be clean and well-maintained. We observed staff cleaned equipment after every patient contact. Ultrasound staff cleaned and checked all probes were disinfected before use.

The latest PLACE assessment had been carried out in 2019 and the overall hospital scores showed Diana, Princess of Wales Hospital was within the middle 50% of hospital sites for five out of six domains and within the bottom 25% of hospital sites for food & hydration. However, there was no data available specific to diagnostic imaging departments.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact. Staff disposed of ultrasound gels in bottles at the end of shifts or cleaned and kept them for one more session if still full. Sonographers cleaned and disinfected ultrasound probes before use.

Environment and equipment

Staff and managers did not always maintain appropriate records of checks of specialist equipment. The design, maintenance and use of facilities, premises and other equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff and managers in CT/MRI did not always carry out daily safety checks
of specialist equipment and did not maintain appropriate records of checks of specialist equipment including x-ray equipment and resuscitation equipment to support staff to respond to an emergency. This meant the service could not evidence that staff conducted appropriate checks including daily checks of equipment to ensure it was safe. However, quality assurance checks were completed in the other modalities and departments.

There were missing equipment safety and quality assurance (QA) checklists in general radiology and staff were unable to confirm quality assurance (QA) checks had been carried out on x-ray equipment. Staff were unable to provide these during the inspection, however, some examples were provided to us following the inspection. These were mandatory (must do) checks based on the Ionising Radiation Regulations 2017 and IR(ME)R 2017. These protect patients against

unnecessary exposure to harmful radiation. Protocols stated if any equipment failed a check it should be repeated and recorded but on two occasions no repeat test was recorded for a CT machine following QA "FAIL". There was a reliance on deputies to complete quality and safety checks but there was no clear management oversight, and on some occasions, documentation was not available, and staff told us checks had not been carried out.

The checklist for the resuscitation trolley in Coastal CT had 20 missing entries out of 28 for the month of June 2022. had 20 missing entries out of 28 for the month of June 2022. However, all resuscitation trolleys were well stocked, locked and tagged. Equipment including suction and oxygen lines were clean. There were anaphylaxis and cardiac arrest kits kept with the trolleys.

There were no temperature controls in areas where radiological contrast was stored. This meant staff could not be sure manufacturers' guidelines were followed. Inspectors found contrast stock was not well managed and two packages of contrast had gone out of date in April 2021 and September 2021.

There were protocols and guidance for quality assurance and diagnostic reference levels (DRL) for equipment available on the intranet but these had not been adapted for individual machines so staff could not follow all processes correctly. Not all DRLs were present in main x-ray rooms and some exposure charts, although still suitable for use, should have been revised in 2021.

However, all areas we inspected appeared clean, were well kept and patient areas were spacious and bright. Treatment rooms and store rooms were clear of clutter, tidy and well stocked and appeared clean. The layout of departments was suitable for following patient pathways. There was sufficient space and furniture in waiting areas.

The design of the environment followed national guidance. There was clear signage throughout the departments where ionising radiation or magnetic resonance imaging (MRI) equipment was used and there were controls to restrict access to patients and staff. Equipment used in MRI environments were suitable for use and labelled as MR safe.

There was appropriate PPE available for prevention of infection. However, some lead aprons were not clean and ready for use. When we pointed this out to staff, they cleaned them immediately. Some lead aprons and body coverings (used to protect the body from exposure to radiation) in the main department and in theatre were missing from checklists and audit so staff were not aware of the condition and integrity of all protective equipment.

We observed no obvious environmental hazards during our inspection.

Staff wore dosimeters (small badges to measure radiation) to ensure that they identified and accurately recorded any exposure to higher levels of radiation than was considered safe. Radiology staff collected dosimeters and sent them for testing. Results were all within the safe range. The department policy was to replace dosimeters every two months and all those we checked were within date.

The trust had a radiation safety policy, which met 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.

There were radiation protection supervisors for each modality to lead on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(ME)R. Staff demonstrated safe working methods to record patient doses for radiation.

Diagnostic imaging

We saw radiation protection supervisor reports showing reviews undertaken against IR(ME)R and learning shared with staff through team meetings and training.

MRI safety was monitored and managed by a medical physics expert based at a local NHS trust and a specialist radiologist was on site.

Staff told us protocols for ultrasound and x-ray equipment were available on the shared drive, but these were not adapted solely for each piece of equipment, so staff were not aware of specific requirements of the equipment they were using.

In all other departments we inspected quality assurance checks were completed, and documentation was provided in to meet IR(ME)R requirements. Staff working from home carried out quality assurance of their equipment using light meters. All staff were able to raise any immediate concerns to managers who took action to rectify faults quickly.

The service had suitable facilities to meet the needs of patients' families. There was sufficient space for carers to accompany patients if required and a small area for use by families and children with some toys and books which were kept clean and in good condition.

The service had enough suitable equipment to help them to safely care for patients.

The service had an equipment replacement schedule with a five-year plan and a central Trust equipment fund. Equipment service and maintenance contracts were in place and trust medical engineering supported the service for non-radiation checks and repairs. Examples of engineer reports were provided following the inspection.

The service displayed “Pause and Check” prompts for radiographers in all X-ray rooms and CT scanners. We observed staff carrying out checks on patients, doses, and image quality throughout the inspection.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff responded promptly to any sudden deterioration in a patient’s health. The trust had clear policies and guidance in place for managing medical emergencies. Staff received basic life support training as a minimum and there was an emergency crash team who could be called to assist.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff used a standard document for all examinations consistently across all sites. This document was uploaded to the patient record and there was a standardised process to check patient identification, contrast safety and World Health Organisation (WHO) safer steps to surgery checks.

Staff knew about and dealt with any specific risk issues. Radiology equipment had been risk-assessed and portable equipment tested to ensure the safety of staff and patients. Specific testing and reporting on equipment included radiographic tubes and generators, ultrasound, CT and image intensifiers.

Diagnostic imaging

Staff asked patients if they were or may be pregnant. If patients could not be sure, staff ensured a pregnancy test was completed before carrying out any examination involving exposure to radiation. This met with the radiation protection requirements and identified risks to an unborn foetus. Staff followed different procedures for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and staff completed checklists to record them.

Staff knew what actions to take if a patient's condition deteriorated while in each department. There were enough resuscitation trolleys across all departments. All staff had completed basic life support as a minimum.

Staff completed risk assessments including National Early Warning Score (NEWS), pre-assessment for interventional procedures. Staff recorded these in patient records and escalated any concerns to medical staff. There were emergency assistance call bells in patient areas in radiology, but patients were not left for long periods in waiting areas. Staff confirmed that, when patients activated emergency call bells, they answered them immediately. There were emergency call buttons for staff use in all departments.

Staff followed the radiation protection policy and procedures in the diagnostic imaging department. Managers ensured that roles and responsibilities of all staff including clinical leads were clear and therefore managed and minimised risks to patients from exposure to harmful substances.

Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. The trust had named and certified radiation protection supervisors and liaised with the radiation protection advisor (RPA). There were three RPA's based at a local NHS trust, one of whom would attend patient safety meetings every two months. These were minuted and shared with staff including radiation protection supervisors (RPS) for each modality, for example general x-ray and CT, who provided advice when needed to ensure patient safety. Staff described a good relationship with the RPA's. Arrangements had been agreed via the RPA for reporting and assessment of radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Staff had written and agreed policies and processes to identify and deal with risks. This met with IR(ME)R 2017.

Diagnostic imaging and screening departments used adaptations of the WHO safer surgical checklist for all interventional procedures.

Staff shared key information to keep patients safe when handing over their care to others. Images and reports were made immediately available to all referrers and clinicians. Previous images and reports were also available to help staff check previous findings for clinical checks and comparison.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended a "huddle" every morning before the main shift began to exchange information on equipment, expected patients, any identified risks, and to prepare for the day ahead.

Staffing

Allied health professional (AHP) staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction.

Diagnostic imaging

The service had enough AHP staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of AHP staff and healthcare assistants needed for each shift in accordance with national guidance. Reporting radiographers reported all plain film x-rays except for babies and head and neck images which were always reported by consultant radiologists. A consultant radiographer reported breast images, carried out ultrasound scans and biopsies.

The service had three vacancies due to staff development and opportunities for moving into new modalities. A further four staff had been recruited but not yet started. Staff told us there were continuous vacancies in general x-ray that took several months to fill. However, there was generally low turnover trust-wide and low sickness rates.

The service had low rates of bank and agency staff. Some senior staff had retired and returned as bank staff.

Managers made sure all bank staff had a full induction and understood the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience. However, managers reviewed the skill mix and were able to keep patients safe from avoidable harm and to provide the right care and treatment.

There were six consultant radiologists based at Diana Princess of Wales Hospital, including two who worked from home, but medical staff did not match the planned number. Although there was a shortage of radiologists, the service had enough medical staff to keep patients safe. Radiologists reported all CT and MRI studies and specialist x-rays including all head and neck images and examinations of babies. Reporting radiographers reported all other plain film x-rays.

All radiologists and some reporting radiographers were able to access images from home and report them remotely. Home reporting stations had been set up during Covid-19 restrictions so that staff could continue to work when they could not access the department. Two radiologists continued to work from home permanently and some on-call work was completed remotely.

The service used an external reporting company for out of hours reporting of CT and MRI examinations. This service also provided some support during daytime hours to meet increases in demand and to help meet reporting time targets although staff told us this still could not meet demand, in particular for CT reporting. There was a service level agreement, quality assurance agreement, and contract written for this.

The service had high vacancy rates for medical staff. The trust had recently appointed three new radiologists and a specialist radiologist for breast screening, but medical staff told us there was a 50% vacancy rate for radiologists in the Trust.

The service had low turnover and sickness rates for medical staff.

The service used no locum staff and there were no specialist radiology trainees.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends.

Diagnostic imaging

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely, and easily available to all staff providing care.

Patient referrals, reports and images were stored electronically, and all staff could access them easily at any time and from any location.

When patients transferred to a new team or department, there were no delays in staff accessing their records. The record system was accessible and reliable, and images could be viewed and reported on remotely by all registered clinicians.

Records were stored securely. Staff accessed records using their own login and password.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were prescribed and administered by consultant radiologists, or specialist referring doctors. In nuclear medicine advanced practitioner nurses administered medicines under patient group directions. PGDs provide a legal framework that allows authorised registered health professionals to supply and/or administer specified medicines.

Staff did not always store and manage medicines safely. There were no temperature controls or checks in areas where resuscitation medicines were stored so staff would not know if storage environments exceeded manufacturer's guidance on safe temperature levels for medicines use or efficiency.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. For MRI or interventional procedures, adult patients could be prescribed pain relief and sedation, and children could be prescribed general anaesthetics. These were managed by anaesthetists. Nurses, employed by the Outpatients department or specialties, helped to monitor pain management during interventional procedures.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff were confident to raise concerns and reported incidents and near misses in line with trust policy.

The service had no never events.

Staff reported all incidents of repeated or excessive radiation dose to the RPA who advised if any reached a notifiable dose and no incidents required Ionising Radiation (Medical) Regulation (IR(Me)R)) notification.

Managers shared learning with their staff about incidents and never events that happened elsewhere. Staff attended Yorkshire network meetings and discussed learning from incidents across the region.

Diagnostic imaging

Staff reported serious incidents clearly and in line with trust policy. There had been four serious incidents classified for radiology throughout the trust, one of which had been downgraded following an internal investigation. Staff involved had completed investigations, action plans, and reflection exercises with learning identified for the future.

There had been one missed diagnosis by the outsourced telereporting company. The company carried out their own QA processes and shared these with the Trust which are reviewed at the Joint Radiologists meeting monthly.

Following serious incidents, a lead individual was nominated to investigate, and a panel assigned. Diagnostic imaging staff met with specialty doctors to complete the investigation and write up the findings within agreed timeframes. An extension had been requested following the most recent incident due to its complexity and number of departments involved.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Managers and staff told us Duty of Candour had been followed for all serious incidents. Duty of candour for the telereporting incident had been completed by the specialty team.

There was evidence that changes had been made as a result of feedback. Following previous incidents where images had been taken of the wrong side of the body, staff had displayed posters in patient areas to encourage people to challenge staff if they felt the wrong area was being x-rayed.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. Radiologists and reporting radiographers attended monthly discrepancy meetings where findings were discussed, actions agreed, and learning was shared. Reporting radiographers liaised with staff regarding poor image quality, identified trends, and led workshops on making improvements.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Inspected but not rated

We do not rate effective in diagnostic imaging, however we found:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured updates to clinical practice.

Diagnostic imaging

The departments were adhering to local policies and procedures.

Staff were following procedures regarding National Institute for Health and Care Excellence guidance to prevent contrast induced acute kidney injury and completed evidence-based documentation before, during and after interventional procedures which included NEWS (national early warning system) assessments.

We saw reviews against IR(ME)R and learning shared to staff through team meetings and training. The trust had a radiation safety policy, which met 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.

Radiation protection supervisors for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with IR(Me(R.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. The trust provided water fountains for patients' use and there was a shop and a hospital café where people could purchase drinks, snacks, and meals. Staff ensured patients requiring CT examination using contrast were sufficiently hydrated prior to their procedure.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain during interventional procedures and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it.

Referring staff prescribed pain relief, and nursing staff or medical staff administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements to outcomes for patients.

The service participated in relevant national clinical audits. Staff carried out audits throughout the radiology department. Audits included themes on trauma response times, kidney function checks prior to CT or MRI using contrast, stroke treatment times, and patient identification checks. Staff audited WHO checklists for compliance and quality.

Staff provided a '15 steps' improvement plan (an NHS Innovation and Improvement initiative that captures data from the perspective of the patient to see what good quality care looks, sounds and feels like). following a visit to the service

in May 2022. Some actions had already been met immediately including locking of storeroom doors and using “I am clean” tape on equipment. Other actions tabled for completion by July 2022 required support from other services such as removing limescale deposits from the water cooler and a uniform poster had been requested to include local information.

Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. Image quality audits were completed monthly and IR(Me)R procedures were audited bi-monthly with a yearly report and results were consistently good. However, CT image quality was not checked until radiologists reported findings, and staff had reported incidents where patients had to be rescanned because of poor quality images.

Some audits had provided poor results such as the trauma response times audit which was completed in January 2022. However, staff had developed an action plan to make positive changes and continue monitoring to check improvement.

Managers and staff used the results to improve patients' outcomes. Staff carried out bone density (DEXA) scans to check overall bone mineral density and following hip replacement surgery to check bone growth around the operation site. Referrers could then act on the results and make changes to patient care and treatment.

Managers and staff carried out audits to check improvement over time. Consultant radiologists and reporting radiographers attended discrepancy meetings, undertook quality checks, and double reported (an independent report was carried out by a second member of the team) 20% of images in line with the departmental discrepancy policy. Staff also double reported 5% of outsourced images.

Staff carried out quality assurance of home equipment using light meters.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All new staff followed the trust competency framework where staff must perform a number of observed procedures to gain competency in that particular area. Designated supervisors approved and signed off the competency framework. Radiographers and sonographers told us the department supported them to complete competencies.

The service was committed to developing the skills, knowledge and competence of its students, staff and managers. Students enjoyed their placements and took up permanent posts once trained. All staff were able to make use of opportunities to learn, develop, and share good practice.

Managers gave all new staff a full induction tailored to their role before they started work.

Newly qualified staff and staff recruited from overseas all told us the department had offered them a good level of competency training and students described good opportunities to achieve the required learning for their placement.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff were recruited following completion of university courses as assistant practitioners and then, once qualified, they progressed to radiographer posts. Staff were also recruited from overseas and several staff said they were very happy to work at the Trust. All staff had completed performance and development reviews. Managers reported staff tended to stay with the Trust but

moved to different modalities as part of their development. There was a consultant radiographer and three advanced practitioners in the breast service, and two advanced practitioners in general radiology. Managers identified poor staff performance promptly and supported staff to improve through action planning, competency-based learning, and reflection.

Consultant radiologists had annual appraisals with a named appraiser and the trust carried out medical revalidation for all consultants.

The service provided specialist information and guidance in radiology on areas such as radiation protection and education for referrers. Radiation protection supervisors received training, but some staff had not received updates for several years.

The education lead supported the learning and development needs of staff and managers made sure staff received any specialist training for their role. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had a good relationship with Health Education England and had secured funding for professional development of AHP staff at £1000 every three years for each person. Managers encouraged staff to take advantage of this opportunity to undertake postgraduate training certificates, ultrasound scanning training, reporting radiographer training and to attend conferences and present any learning to peers.

Managers identified poor staff performance promptly and supported staff to improve. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The service had created some Band 6 posts to enable staff to progress and take on additional responsibilities.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There was a staff meeting once a month which was minuted and notes shared with all staff. Staff attended daily huddles prior to the main morning shift where they discussed plans for the day ahead and shared any concerns or incidents throughout the week. At the end of each week managers provided a summary via email to all staff and a printed version for staff noticeboards in each department.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Medical staff could contact a duty Radiologist any time to discuss issues and to provide support to other doctors and staff throughout the trust. Radiologists specialised in areas including interventional procedures such as nephrostomies and placing of stents, chest imaging and head and neck imaging. They led multidisciplinary team meetings (MDTs) on a range of studies.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Reporting radiographers attended specialty MDTs for chest and abdominal imaging as well as local trust MDTs.

Patients could see all the health professionals involved in their care at one-stop clinics.

Seven-day services

Key services were available seven days a week to support timely patient care.

Diagnostic imaging

Staff could call for support from doctors and other disciplines, including diagnostic tests.

The trust provided a service 24 hours a day, seven days a week for emergency plain x-ray imaging, emergency CT, and out of hours portable images. Staff also provided radiology services to GP patients from Monday to Friday. The diagnostic imaging department provided general radiography, CT and ultrasound scanning, fluoroscopy and mammography for all patients every day. Out of hours interventional radiology was carried out at a neighbouring NHS Trust.

Staff could find all patient information such as diagnostic imaging records and reports, other diagnostic tests, medical records and referral letters through electronic records. Diagnostic imaging departments used picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff used systems to check outstanding reports and staff could prioritise reporting and meet internal and regulator standards.

The diagnostic imaging department kept an electronic list of approved referrers and practitioners and senior staff vetted internal and external staff against the protocol for the type of requests they were authorised to make.

There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in patient areas.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle such as for patients attending for gastrointestinal imaging.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent but did not always record it. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained verbal consent from patients for care and treatment in line with legislation and guidance. Diagnostic imaging, and medical staff understood their roles and responsibilities and knew how to obtain consent from patients. They could describe to us the various ways they would do so. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain x-rays. In some general cases this was inferred consent. Specialty medical staff obtained consent for any interventional procedures in writing before attending departments and for biopsy procedures.

However, staff did not always adhere to the Trust Consent Policy. Staff did not always clearly record consent in the patients' records. Staff and managers told us consent was always taken, and documents managers had checked showed consent was recorded. However, we found ultrasound records did not always show consent was recorded even when intimate procedures were carried out. Trust policy stated: "For significant procedures, it is essential for health professionals to document clearly … in the patient's notes that they have given verbal consent."

When patients could not give consent, referrers made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Diagnostic imaging

Staff made sure patients consented to treatment based on all the information available. Patients told us that staff were good at explaining what was happening to them before asking for consent to carry out procedures or examinations. Staff described an x-ray to a child's parent and if they chose to stay with their child the radiographer explained the content and reason for consent with a "comforters and carers" form. This was fully completed before imaging went ahead.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patients and relatives said "we couldn't praise staff enough" and awarded them "10/10 for the experience".

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff interactions with patients in all areas we inspected were polite, courteous, and respectful. We heard staff introducing themselves when dealing with patients and relatives. Staff greeted patients in a kind and friendly manner. We spoke with four patients and their carers or relatives and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.

Reception staff respected patient privacy when they were checking personal details on arrival for their appointments, although glass screens to protect people from infection sometimes made this more difficult.

Staff respected patients' privacy, dignity, and confidentiality at all times.

Diagnostic imaging

Staff organised imaging times to ensure patients did not have to wait unnecessarily and there were no queues of inpatients waiting for imaging or to return to the wards. Some porters could wait with a patient and return them to the ward. Staff explained this could not always happen, but hospital porters usually arrived promptly when called.

Staff collected patients from waiting areas and took them to private changing facilities and managers had invested in additional privacy screens for use during some procedures.

Patients told us, and we saw without exception, that staff treated them kindly and in a consistently caring and compassionate way.

Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

Staff at all levels helped and supported patients in all aspects of care. Staff reacted compassionately to, or pre-empted, patient discomfort or distress by using appropriate communication methods to suit individual needs. MRI staff involved patients, their carers, and families by discussing and planning their procedure.

Patients and their relatives told us staff had treated them with dignity and respect and overall, they were happy with the service provided. They also told us that the staff were friendly, and professional. Staff confirmed that patients would have a chaperone made available when intimate examinations were performed or at any time on their request.

Staff in all departments we inspected were caring and compassionate to patients. We watched positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.

Staff respected patients' privacy and dignity. Staff took patients to private changing facilities with a lockable door to ensure privacy and dignity. Staff knocked on doors before entering and closed doors when patients were in treatment areas. Patients and relatives told us staff had treated them with dignity and respect. Management had invested in additional portable screens to be pulled across the corridor when a patient required additional privacy during some procedures and while moving from a changing room to a scanning room and to return again. Staff in x-ray informed us that they spent the time necessary with patients to ensure they informed, supported, and reassured them about the procedure to be undertaken.

The general x-radiology department had recently carried out a paediatric patient satisfaction survey and had collected 36 responses from children who had used the service. All responses were positive and, although not yet collated, they were shared with the inspection team. Some patients wrote about how previous anxieties had been allayed by friendly and professional staff who made them feel at ease and had struck up an immediate rapport with a child. Results of a general patient satisfaction survey carried out in December 2021 in general x-ray showed 100% of patients rated their experience as good or excellent and all patients said staff treated them with dignity and respect. However, staff identified a lack of communication with patients on some issues and about 10% of patients said staff had not introduced themselves and about 8% said they were not told how they would receive their test results. An action plan was created to address changes to practice and all recommendations were met within the agreed timescale. Staff followed the "hello, my name is" campaign and were reminded of the importance of letting the patient know how they will be informed of their results.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Diagnostic imaging

Staff gave patients and those close to them help, emotional support and advice when they needed it. MRI staff could support patients suffering from claustrophobia and anxiety and one MRI room was equipped with calming equipment such as ambient lighting and ceiling images.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff providing care before, during, and after procedures and showing consideration to patient's emotions, allowing them time to ask questions or comply with requests. Staff were aware some positioning could be uncomfortable and allowed patients to be independent or made adjustments where possible.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff in x-ray informed us that they spent whatever time necessary to ensure that the patient understood and consented to the procedure. Staff also confirmed that should they have any concerns about a patient who did not fully understand what their care entailed then they could delay or cancel the procedure to suit the patient.

Staff made sure patients and those close to them understood their care and treatment. Staff made sure that people understood any information given to them before they left the departments.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff used a simple picture board so patients who were unable to communicate through speech could convey their feelings. Staff in CT used face masks with a transparent mouth area to enable patients to lip read and had received good feedback from patients regarding their use.

Staff supported patients to make informed decisions about their care. Patients gave positive feedback about the service. Patients told us staff explained all things to them including safety, clinical information and how they would carry out a procedure such as cannulation, patient expectations, aftercare following their procedure and what would happen next on their care pathway.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were patient suggestion boxes in waiting areas which staff checked regularly.
The CT and MRI departments had patient feedback blackboards where patients could write comments for staff. We saw comments including "Good service" and "Thank you very much for friendly service".

Is the service responsive?

Good ↑↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Diagnostic imaging

Managers planned and organised services so they met the changing needs of the local population.

The departments were accessible for people with limited mobility and people who used a wheelchair.

Diagnostic imaging reporting and record keeping was electronic, and the department used paperless methods to reduce time and administration.

Managers monitored all targets and reported to the trust board through their overall performance reports.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. There were some rapid access clinics for example prostate clinics in urology where patients attended clinics on Fridays, scanned over the weekend, and images were reported in time for review by the MDT on a Monday. The service supported “one stop” hysteroscopy and stroke clinics.

Facilities and premises were appropriate for the services being delivered.

There was out of hours cover for interventional radiology provided by a nearby trust with a service level agreement, a formal process, and protocols in place.

The service had systems to help care for patients in need of additional support or specialist intervention. There were sufficient facilities to meet the needs of inpatients with bays set away from the main waiting areas. These bays could accommodate trolleys and wheelchairs and staff often accompanied patients from wards.

Managers monitored and took action to minimise missed appointments. Staff respected inpatient mealtimes and organised inpatient imaging to avoid them.

Managers ensured that families of children or vulnerable patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. Reporting radiographers checked suspected fractures straight away and provided results back to the emergency department to ensure efficient patient care or discharge.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services.

The main waiting area was large and airy. There was sufficient seating and a small area with children’s toys and books which were clean and well maintained. Sub waiting areas provided adequate seating arrangements. Patients attending departments had access to drinks and snack facilities, a café and a shop. All departments were well signposted and provided plentiful comfortable seating and areas for children. A younger children’s waiting area was provided and stocked with books and some toys.

Patient toilets (including disabled facilities and baby changing) were all easily accessible.

Diagnostic imaging

Wards were designed to meet the needs of patients living with dementia. Referrers informed departments in advance of patients with special needs attending for procedures and reception staff informed radiographers if patients attending had any additional needs. Staff could offer an appointment at a quiet time if a patient had a particular need, such as a learning difficulty or dementia, where waiting in a busy waiting area could be distressing. Staff confirmed that priority was generally given to people with additional needs.

The service had information leaflets available in languages spoken by the patients and local community. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Bookings staff provided leaflets to patients with their appointment information. If referrers provided information on the language required or any specific patient needs, leaflets would be printed accordingly.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The reception staff organised interpreter services for patients who did not speak or understand English. Staff told us they did not have trouble in booking interpreters.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Referral to treatment (RTT) rates were measured against national targets for all patients on cancer pathways, two week waits, urgent and planned care, and routine images. Referral to imaging times were better than regional averages and continued to show an improving trend for patients waiting for a diagnostic test. The trust compliance rate for reporting times was 98.6% of all images reported on time in line with trust policy. This was better than regional and national standards. All referrals were triaged by radiographers and the service used monitoring, oversight and escalation processes with time-based triggers to identify and prevent delays. The service reported a deterioration in routine CT reporting times in the few weeks prior to the inspection. To address this, they had made changes to radiologists' job plans to allow more time for reporting and scheduled weekly calls with the reporting outsource company. They had agreed a three-month block of concentrated reporting of CT images out of hours and some daytime inpatient reporting to reduce the risk of delays.

Managers explained actions taken to reduce the number of non-urgent GP referred patients by asking for staff to volunteer for an extra weekend session. The waiting time was at 38 days against a key performance indicator (KPI) that required all patients to be seen within 42 days. Staff were taking positive action to address this before the KPI was breached.

Waiting times for non-urgent ultrasound scans had reduced from 12 weeks in March 2022 to 7 weeks at the time of the inspection,

All patients who attended from accident and emergency department or for urgent referrals from clinics had images completed the same day. If radiographers identified suspicious findings on chest x-rays they were able to share the image immediately with a reporting radiographer or radiologist to generate a report or make an instant referral for CT.

Diagnostic imaging

The trust could offer up to 50 patients a week a scan with a local independent healthcare provider for MRI and non-obstetric ultrasound. This was through an additional contract fully funded by the CCG to reduce waiting lists. Managers described a good relationship with CCGs.

The service liaised with another local trust who provided interventional radiology procedures during evenings and weekends. All referrals for imaging were triaged by trust staff then directed to the other trust for procedures out of hours. This meant patients would have to travel or be transported elsewhere but they could have their procedure carried out in a timely way.

Managers worked to keep the number of cancelled examinations to a minimum. When patients had their examinations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. A booking team worked with patients and referrers to ensure appointments met local and national timeframes. Appointments were managed according to priority such as unplanned or emergency care, urgent and routine.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

There had been no formal written complaints direct to the service in the 12 months prior to our inspection. However, staff contributed to complaint responses regarding specialty care for any parts that were relevant to diagnostic imaging. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers had a process for sharing learning from complaints with staff and ensuring learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Diagnostic imaging

Leadership

Leaders had the skills and abilities to run the service but were not always aware of all safety risks the service faced. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There had been recent changes in divisional leadership and diagnostic imaging had recently been included within the division of surgery and critical care. Senior leaders were aware of and supported teams to improve regarding high-level performance of the departments including national targets.

There were managers in each department, all of which were longstanding, experienced managers. Managers in general radiology and ultrasound were not aware that consent was not always recorded, safety checks were not always carried out, and some safety controls were not in place.

Staff described managers as being accessible and approachable. Although new divisional leaders were relatively new to the service, staff knew who they were and how to contact them should the need arise.

Staff raised concerns during the inspection that the opportunities for learning and sharing these experiences had gained could be lost at the end of the secondments.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

A five-year trust radiology strategy had been launched in 2019 which was relevant to diagnostic and interventional radiology at all sites within the Trust. The strategy described patient centred care as being the bedrock with a system wide approach to service delivery and providing efficient care. There were clear objectives and priorities with benchmarking against national quality standards. Partnership working with other local providers was identified as an opportunity for future working.

Managers were aware of challenges and risks to providing an improved service and had identified and implemented changes to meet some priorities and planned outcomes early which included investment in additional equipment including MRI and CT scanners at Diana, Princess of Wales Hospital and Scunthorpe General Hospital.

Radiologists supported the strategy and, although the team was pressured and short of staff due to a shortage of radiologists, they had been able to make some recent appointments and make improvements to rotas to support emergency access to care, timely discharges, and significantly reduce reporting times.

The department reported good relationships with clinical commissioning groups (CCGs) who had allocated funding for provision of independent healthcare to support patient access and the reduction of waiting lists.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Diagnostic imaging

Staff were proud to work at the trust and within their departments. Staff, from students to senior staff were loyal to the trust and chose to develop and progress within the service and across modalities. Staff reported an improvement in culture between all levels and disciplines of staff since the last inspection. Staff supported each other and would often work extra hours to support colleagues and enable patients to receive the best service. All staff we spoke with said they felt able to raise any concerns to colleagues or managers and were aware of how to contact the Freedom to Speak up Guardian.

Managers described how they supported serious incident investigations with specialty colleagues and followed Duty of Candour where appropriate. We saw examples of letters provided to patients regarding incidents that included openness and honesty.

Staff explained managers and the Trust had supported them during difficulties and in particular during COVID-19 additional pressures.

Equality and diversity was clearly promoted to patients, students, and staff throughout the service. There were no barriers to progression or development and staff were proud of their diverse recruitment and development experiences. Qualified staff recruited from overseas were supported to complete competencies to enable them to work independently and progress or specialise throughout the service.

Radiology students told us the trust was their first choice in the local network for placements and recruitment.

Governance

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but did not always fulfil them. They had regular opportunities to meet, discuss and learn from the performance of the service.

At the time of the inspection diagnostic imaging was managed by a new directorate; surgery and critical care. However, staff explained governance was still managed via the directorate of clinical sciences.

Managers and leaders relied on systems, and deputies to carry out some governance processes, but did not effectively audit or check these to ensure they were carried out correctly or consistently.

In general radiology there was no clear oversight of safety checks or if processes were being carried out effectively for; cleanliness, condition of lead aprons and body coverings kept within the department and elsewhere in the hospital such as in theatres; temperature controls or checks in areas of the department where contrast or resuscitation medicines were stored; diagnostic reference levels (DRLs) for items of radiological equipment; or resuscitation trolley checks.

Managers in ultrasound did not have clear oversight to ensure quality assurance checks were being completed according to national guidelines.

There was no clear oversight of documentation reflecting the consent process. Staff did not always follow the Trust consent policy completely by documenting consent had been taken, but managers and senior managers were unaware this was happening. Records were not effectively audited to identify issues regarding documentation of consent.

Senior managers told us they would need to make changes to the agenda of the weekly management meeting to ensure crosschecking was carried out in future. They believed the business meetings and governance structure could also help pick up non-compliance.

Diagnostic imaging

Staff relied on the Radiation protection advisors (RPAs) from another local trust to fulfil their duties but there had been no update to the formal agreement of what they would provide since 2019. The RPA was responsible for radiation protection supervisor training and updates, but some staff had not completed updates for several years. Senior leaders told us the RPA service level agreement would need to be renewed but there was no clear oversight of what was expected of the RPAs.

There had been a serious incident where the telereporting (outsource) service had missed a diagnosis and the patient had come to harm. Although both services carried out quality assurance checks, the teleradiology service declined to provide its investigation report into the incident. Senior managers had not identified any need to check or review the service level agreement regarding quality assurance and information sharing. The trust managers had not attempted to investigate this further in order to satisfy themselves there had been sufficient learning from the incident.

There were radiation protection committee meetings attended by the RPA, RPS for each modality, senior managers, and the trust medical physics expert. Minutes from the meeting in March 2022 included equipment faults and checks, radiation incidents, none of which required IR(Me)R reporting, audit results and actions, new non-medical referrers, risk assessments and staff competency records.

Managers, heads of departments, and deputies attended monthly governance meetings and submitted monthly activity figures along with data on sickness, vacancies, training and development, finance and waiting times. The head of governance attended, and the regular agenda included serious incidents, new policies and regular reviews, audits and opportunities for learning.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk register identified risks which were categorised according to potential impact. These were mainly regarding staffing, ageing equipment, and capacity and demand. Risks from individual department managers were included in the directorate risk register. The register showed actions taken and any remaining gaps were identified with dates for review. There were plans in place for equipment failure.

Staff managed performance effectively and had achieved better than regional average referral to imaging times. There was an improving trend for patients waiting for diagnostic tests with a reduction of the waiting list for non-urgent ultrasound from12 weeks to 7 weeks over a period of two months. Staff monitored performance against key performance indicators (KPI) and took action to avoid breaches before they occurred such as provision of additional scanning sessions, an independent healthcare contract for CT imaging.

Staff described good IT support and no recent breakdowns or failures in the picture archiving and communications system (PACS). Images were available at all times to all relevant professionals.

Service leads and managers worked together to provide information to the executive performance meeting. They monitored performance and provided information to the directorate leads, along with identified risks and issues for escalation. Service leads reported a good level of support in planning for the future including finance and workforce planning.

Diagnostic imaging

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff could find all patient information such as diagnostic imaging records including previous images, and reports, medical records and referral letters through electronic records.

CT and MRI images were available securely via picture archive communication system (PACS) to external telereporting clinicians.

All staff had access to the trust intranet to gain information on policies, procedures, National Institute for Health and Care Excellence guidance, and e-learning.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust and its staff were part of the Yorkshire Imaging Collaborative, a partnership of nine local trusts who met monthly to benchmark performance and share learning and good practice.

Staff in general radiology had undertaken a survey with paediatric patients to find out how the service met children's needs. Responses had been collated but results had not been processed at the time of the inspection. However, we viewed the responses, and all were positive.

Staff satisfaction surveys and "innovation stations" had been implemented throughout diagnostic imaging departments and were in very early stages. However, staff were aware of them and had engaged positively with them. Staff said they used them to share ideas.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Staff met regularly with colleagues at other Trust sites within the Yorkshire Imaging Collaborative to share learning and provide peer support.

The Blue Sky Imaging Suite which incorporated the new CT and MRI departments had received very positive results in their "15 Steps Challenge" and had been commended for cleanliness and maintenance, patient experiences and information, staff interactions and knowledge.

There had been a marked improvement in actions to address the backlogs for waiting times and reporting times. These had reduced significantly since the previous inspection and, at the time of the inspection, the trust performance was better than the regional average. The Trust consistently and continuously explored opportunities and initiatives to improve their reporting capacity. The trust had invested in new equipment including two new CT scanners and two new MRI scanners, complemented by additional staff.

Diagnostic imaging

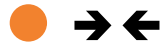
There was ongoing work with a local trust to align protocols to improve the service for stroke patients. The service had also implemented a 1-stop pathway for prostate patients and a streamlined pathway for colorectal patients.

CT and MRI staff had implemented the use of transparent face masks to enable patients to lipread whilst maintaining infection control.

End of life care

Inadequate 

Is the service safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The end of life (EoL) team met the trust target for mandatory training in key skills and EoL core specific training. The mandatory training was comprehensive and met the needs of patients at EoL.

We reviewed the mandatory training compliance rates for all staff working within EoL. This also included the Macmillan and palliative healthcare teams. This showed an overall compliance rate of 97% for mandatory training and 88% for role specific EoL training which both met the trust target.

Staff we spoke with said they had been given protected time to complete this training. All staff had completed equality and diversity, information governance and data security and moving and handling training.

All ward staff received an introduction to EoL care as part of their induction and completed online courses which were related to EoL and palliative care.

The EoL team delivered two EoL specific training courses face to face training in the form of workshops or ward visits to eligible staff.

- Syringe Driver and Symptom Management
- End of Life Planning

The EoL team monitored the compliance of EoL training modules for eligible staff and received updates from divisional highlight reports presented at the EoL implementation meeting.

We heard that this training had been problematic throughout the pandemic with ongoing operational pressures. In addition, the EoL team told us approximately 40% of eligible staff had received their syringe driver refresher training. This did not meet the trust target of 85% and was a repeat issue from the last inspection.

The EoL planning training for registered nurses was comprehensive and included the five priorities of care for the dying person (2015) which were;

- recognising that someone was dying
- communicating sensitively with them and their family
- involving them in decisions
- supporting them and their family
- creating an individual plan of care that includes adequate nutrition and hydration.

End of life care

Safeguarding

Staff understood how to protect patients from abuse however they did not always have training on how to recognise and report abuse or how to apply it.

We reviewed the safeguarding mandatory training compliance rates for end of life (EoL) staff. This showed 67% of staff completed level 3 adult and 83% children level 2 safeguarding training. This meant not all staff had met the trust target of 90% and this was a repeated issue from our previous inspection.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics. They knew how to identify adults and children at risk of, or suffering, significant harm, how to make a safeguarding referral and who to inform if they had concerns.

We heard of one example when a patient had disclosed information, and this was appropriately raised as a safeguarding concern.

Cleanliness, infection control and hygiene

Not all staff followed infection control principles. However, they used infection control measures when visiting patients on wards and transporting patients after death.

All areas where palliative and end of life (EoL) care were provided appeared clean, tidy and well maintained.

We observed staff using PPE such as gloves and aprons. However not all staff adhered to the 'bare arms below the elbow' infection prevention and control guidance.

We visited several areas in which EoL care were provided. This included hospital wards, the mortuary, the multifaith rooms and bereavement offices. All ward areas appeared clean, tidy and well maintained. We saw that personal protective equipment including gloves and aprons were readily available. There were appropriate handwashing and hand decontamination facilities in all areas.

Ward staff would always try to prioritise side rooms for EoL patients however, this was not always possible as some patients needed to be isolated for infection control issues.

We reviewed the mortuary area. It was clean, tidy and appropriate for relatives visiting the deceased patient. We reviewed cleaning records which were up to date and demonstrated that areas had been cleaned regularly. Staff identified what had been cleaned and signed their name once it was completed. However, we saw several areas accessible by staff within the mortuary which were unclean and untidy such as equipment storage areas. This meant there was an increased the risk of environmental infections.

Environment and equipment

The design and maintenance of the mortuary did not meet national standards. Staff did not manage clinical waste well.

We visited the mortuary, chapel, multifaith room, and bereavement room which were all suitable facilities to meet the needs of patients and their relatives. All were well signposted.

The mortuary was clean and odour free. All areas were covered by CCTV.

It had the storage capacity for 60 deceased patients, including four bariatric patients. There was a semi-permanent body storage unit in place. However, the top or bottom spaces could not be accessed because they did not have any hoists or lifts. This continued to be an issue from the last inspection in 2020. There were five deep freezers suitable for longer term storage of bodies, however these were not suitable for bariatric patients.

The mortuary had two viewing rooms, one for adults and children, and a second for babies. There was additional seating available for relatives.

We reviewed the Human Tissue Authority (HTA) audit which was completed in May 2022 for the mortuary environment. The results showed several shortfalls against HTA standards;

- The post-mortem floor tiles had porous grouting and the metal drainage pipes were corroded. This meant they could not be fully cleaned.
- Insufficient storage capacity within the trust to meet high demand.
- Rusty mortuary trolleys (which we also saw on inspection).

In addition to the findings of this report we noted that damage to a wall and door and cleaning equipment had become rusty however, a replacement was provided on the day of our inspection.

The female changing rooms were blocked by two trolleys; one was full of old medical records and the other stored bags of waste.

In addition to the findings of this report we noted that the storage areas were dirty and untidy.

Staff who delivered end of life (EoL) care said they had enough suitable equipment to help them to safely care for patients. The service used specialist syringe drivers for patients who required a continuous infusion of medication to help control their symptoms. These were readily available and obtained from a trust wide central equipment library.

We found a box of mouth care sponges which had expired in 2019. We escalated this to staff, and it was immediately removed, and other boxes were checked.

In the mortuary we saw bariatric trolleys with suitable coverings.

Mortuary staff disposed of clinical and non-clinical waste safely, apart from the waste bags found on the trolley in the mortuary.

Assessing and responding to patient risk

Ward staff provided care to patients requiring palliative and end of life (EoL) care. They completed risk assessments for patients who were deteriorating and in the last days or hours of their life.

They used a nationally recognised tool to identify deteriorating patients and would discuss them at daily safety huddles twice a day. Staff said they would escalate appropriately to medical staff.

Staff told us they always completed pain assessments and ensured patients basic health care needs were met such as mouth care and washing.

End of life care

There were pathways and escalation processes for the identification of patients approaching EoL. However, some staff we spoke with confirmed these processes were not instigated in a timely manner and this was also observed on inspection. This meant there was a potential risk that patients approaching end of life were not reviewed appropriately or staff looking after them were given adequate support and guidance.

Staffing

The end of life (EoL) service had enough staff with the right qualifications, skills, training and experience to provide the right care for patients who were at EoL.

All staff throughout the hospital delivered end of life and palliative care but were supported by a dedicated end of life care team and a specialist palliative care team.

At the last two inspections in 2018 and 2020 the service was told they must ensure that sufficient numbers of EoL staff were employed to provide care and treatment. At this inspection the service had increased the size of the EoL team across both sites to a matron, a lead nurse, a clinical practice educator and a bluebell roll out lead nurse.

The EoL team were responsible for providing support and guidance to all staff who delivered care and treatment to patients who had been identified as EoL and had been started on the EoL pathway.

Within the catchment area of North East Lincolnshire there were two palliative care nurse specialists who were employed by an external health care provider and their services were commissioned by North East Lincolnshire CCG. They were responsible for supporting staff to deliver palliative care to patients in hospital and in the community. They would also helped plan patient discharges into the community, home or hospice.

There was a matron who was responsible for the EoL team.

However, on the days of our inspection there were EoL staff absences. We were informed that the EoL team and the specialist palliative care team worked in collaboration to deliver a seamless pathway of care to patients who were palliative and at EoL. However, there was no formalised process for this cover arrangement, and we did not see any cross site cover. We were informed the clinical nurse specialists who were employed by an external health care provider would cover absences however, this was not always possible due to their workload.

We reviewed the sickness, turnover and vacancy rates for the EoL service from June 2022 to May 2022.

The average sickness rate over this time period was 5%, with the highest sickness of 15% in March 2022. The turnover rate of staff was 15%.

We heard there was one EoL community nurse vacancy.

There were mortuary, chaplaincy and bereavement staff who provided EoL care to patients and relatives.

The chaplaincy team were responsible for offering spiritual and religious support to patients, relatives and staff. There were four chaplaincy volunteers, and they were in the process of actively recruiting additional volunteers.

At the last inspection in 2020 there were vacancies within the chaplaincy team, and we found the same concerns at this inspection. There was not enough chaplaincy staff to cover the on-call system for nights and weekends and the lead chaplain was on call every evening until midnight.

End of life care

Medical staffing

The service did not have enough end of life (EoL) consultants with the right qualifications, skills, training and experience to provide the right care for patients who were at EoL

At the last inspection in 2018 and 2020, the trust was told they must ensure that sufficient numbers of EoL consultant staff employed to provide care and treatment. At this inspection we found the same concerns which meant the service had not addressed this issue for four years.

The EoL team had one consultant employed by the trust. They were based at Scunthorpe Hospital and were responsible for reviewing patients who had been identified as EoL and had been started on the EoL pathway. They were available for clinical advice and support and they provided support to patients, relatives and staff.

This meant there was minimal consultant cover across all trust sites during the day. It was unclear what the on call consultant provision was for evenings and weekends. The service did not employ locums or trainee doctors to cover absences such as sickness or annual leave. However, all staff we spoke with gave positive examples of the level of support provided by this consultant.

There was no sickness, turnover or vacancy rates for the EoL medical staff from June 2022 to May 2022.

Within the catchment area of North East Lincolnshire there was a specialist palliative care consultant who was employed by an external health care provider and whose services was commissioned by North East Lincolnshire CCG. They were responsible for reviewing any palliative care patients within the community. They completed two weekly ward rounds to review any palliative care patient who had been admitted from the community. They were not commissioned to review patients who were at EoL however, they were available for clinical advice and support.

In addition, there was a lack of oncology consultants at this trust.

Records

Patients who had been identified as end of life (EoL), and placed on the EoL pathway, did not always have their personalised needs and preferences recorded or documented in their medical records. Records were not always easily available and were not always securely stored.

At the last inspection in 2018 and 2020, the trust was told they must ensure that all patient records were to be completed consistently and appropriately. At this inspection we found similar concerns with patient medical records being incomplete which meant the service had not addressed these issues for four years.

We reviewed the “care in the last days of life” document which was supposed to be commenced by ward staff when a patient was identified as EoL and placed on the EoL pathway. It was a two part document consisting of a clinical review, and care plan which recorded personalised needs and preferences. We spoke with staff who said they were not clear who should complete each part of the document.

We reviewed five of these documents within patient records and found the majority had been completed appropriately. However, there were incomplete sections within the care plan to detail the patient’s preference for spiritual and/ or religious care, and any psychological and emotional needs.

End of life care

The service acknowledged this document was not always started when the patient was started on the EoL pathway. From April 2021 to March 2022 only 30% of EoL patients had this document fully completed and this was worse than the previous year. Following the inspection, the trust provided additional information to clarity these EoL patients included all unexpected deaths.

In response to this poor compliance the service implemented two task and finish groups. One group was assigned to amend this document so that it was easier to complete and avoided duplication of information. At the time of writing this report a new draft version of the "care in the last days of life" document had been developed and we were told that this would be shared at the next EoL implementation group meeting. The second group was assigned to discuss the most effective way of recording a patient's spiritual and religious care.

In 2020 the trust implemented the use of a recommended summary plan for emergency care and treatment (ReSPECT) form. This had been rolled out across all providers within the Northern Lincolnshire area to improve partnership working and shared care. This was an advanced care planning record which focussed on a patient's wishes for treatments in an emergency such as resuscitation.

We reviewed five patients ReSPECT forms and found the majority had been completed appropriately. However, we found there were no evidence that patients and relatives were routinely involved in advance planned decisions. We found two undated ReSPECT forms in one set of notes. We found only three out of six forms were stored appropriately in plastic folders at the front of the notes and the other three were hard to find.

We reviewed the most recent audits related to record keeping. These results showed poor compliance with the completion of the patient's personal values and fears, and recording of future care discussions.

As part of the EoL improvement plan, the electronic palliative care coordination system (EPaCCS) was being implemented across all wards. This was used to record key details about a patient's care preferences within Northern Lincolnshire. This meant that health professionals such as GP's and community based staff would be able to access information from a single point rather than from multiple computer systems. We heard of plans for the ReSPECT form to be added to EPaCCS.

We reviewed nine "do not attempt cardiopulmonary resuscitation" DNACPR patient records and found the majority had been completed appropriately. However, nothing had been recorded for the patient's individual needs. In addition, they were not always stored at the front of the patient's notes for easy access.

The mortuary staff showed us warning notices which were used to identify deceased patients with similar names or those who had a pacemaker or implantable defibrillator.

We found patient's medical records in unlocked filing cabinets across the wards we visited.

We visited the mortuary and found a large trolley containing medical records dating back to 1930's which were waiting to be archived. This trolley was blocking access to the female changing rooms which meant they were not securely stored and were a fire risk.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, however prescription charts were not always complete.

The trust provided medicines management training as part of mandatory training and staff induction. Nurses were required to complete additional training and competency assessment for intravenous administration.

The end of life (EoL) team had created a policy for anticipatory drug prescribing to guide staff when and how to prescribe medicines to EoL patients, even those not started on the EoL pathway, to provide symptom and pain relief.

We observed staff adhering to this policy when prescribing predetermined selection of anticipatory medicines. We reviewed electronic medicine charts which showed staff regularly reviewed, and prescribed, medications. However, the majority of the charts did not record that oxygen was being prescribed and this was already a known issue within the trust.

We observed delays in the prescribing of anticipatory medicines as not all staff were aware of a priority alerting system for the ordering of anticipatory medicines. We did not see any evidence of prescribing audits relating to EoL care. The trust used a dispensing for discharge model which means they are unable to audit discharge medications turnaround times.

We reviewed the results of the national audit of care at end of life (NACEL) from data collected from June 2021 to May 2022. This showed an average of 64% of patients had anticipatory medicines prescribed who had not been commenced on the EoL pathway. In addition, this showed an average of 98% of patients had anticipatory medicines prescribed who were commenced on the EoL pathway.

Staff were aware of a recent medicine advisory that Morphine Sulphate was to be prescribed instead of Diamorphine. This information was also on the EoL May 2022 newsletter.

Incidents

The end of life (EoL) team recognised and reported incidents. They investigated incidents and shared lessons learned with the wider service.

The service had a comprehensive incident reporting policy. The EoL team, and staff delivering care to EoL patients, told us they understood their responsibilities regarding the reporting of incidents. They were encouraged to incident report when patient discharges were not activated or when patients did not achieve their preferred place of care.

The results of the most recent national audit of care at end of life (NACEL) confirmed that 49% of staff strongly agreed, and 42% of staff agreed, they felt able to raise a concern about EoL care.

Although ward staff knew how to report incidents, we heard of many examples when incidents were not always reported. For example, for when there were delays in identifying patients or delays to starting the pathway.

The EoL team could easily identify incidents related to EoL from the addition of a tick box added onto the electronic database. They regularly reviewed and investigated all incidents that were graded as moderate or above harm.

We reviewed the end of life analysis report published in May 2022. This showed that from October 2020 to March 2022 there were 183 reported incidents relating to EoL. This was less than the number from the previous 18 months.

This report identified emerging themes and trends across each division. These were mapped against the EoL improvement plan and continually monitored by the EoL team.

End of life care

The most common themes included;

- Medicines prescribing process
- Admissions to inappropriate settings and discharge process
- Communication.

The medicine division continued to have the highest number of reported incidents for EoL patients. They had identified their main theme was administrative processes such as failure to initiate the EoL pathway at the earliest opportunity and poor documentation. This also prompted staff to complete the “care in the last days of life document”.

There had been a high number of serious incidents involving EoL care patients within the surgical and critical care division. These were due to late or no decisions being made for patients.

The biggest theme from mortality reviews was the lack of advanced care planning and the concern that some patients were being admitted to hospital unnecessarily.

We reviewed the community and therapy services clinical governance meeting minutes from March, April and May 2022 as the EoL team sat within this directorate. These demonstrated that incidents were discussed and learning from competed specific incidents were shared.

The EoL team provided examples of how ward staff were supported after raising incidents and would provide further training for incidents relating to syringe drivers, communication or cultural awareness.

We were informed that the main themes following mortality reviews was related to a lack of advanced care planning, where a high proportion of patients ended up in hospital who could possibly have been managed within the community. In addition, there were cases where patients had been discharged from hospital and readmitted in close proximity to their death.

Is the service effective?

Inadequate 

Our rating of effective stayed the same. We rated it as inadequate.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

We reviewed audits which showed low compliance for the completion of the recommended summary plan for emergency care and treatment” (ReSPECT) document and 30% completion of the care in the last days of life” document.

We reviewed the results of the national audit of care at end of life (NACEL) from 2020/2021 which found the “care in the last days of life” document was not started early enough, and patient’s personalised wishes and discussions were not recorded. This meant that staff were not always able to deliver care based on patient’s individual needs or preferences because they had not been documented.

End of life care

The trust scored higher than the national average for two themes of involvement in decision making and governance. However, they scored lower for nine themes linked to communication with patients, and relatives and individualised care plans. Following this audit, the EoL team identified 25 learning points and acknowledged that communication remained as the main theme for improvement.

The EoL team shared anticipatory medicine safety alert to ward staff using the EoL newsletter. For example, in May 2022 we saw that staff were reminded to prescribe Morphine Sulphate instead of Diamorphine.

Ward staff delivering end of life told us they were able to access policies on the trust intranet. We reviewed policies and they were reflective of national evidence based best practice and guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff explained that referrals could be made to the mental health liaison team and outlined support that were available when required.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed records which confirmed they had used the malnutrition universal screening tool (MUST) appropriately to identify and score nutritional and hydration requirements.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs.

We saw evidence of mouth care for those patients unable to tolerate fluids and care plans for patient mouth care for patients who were unable to tolerate food or fluids.

We reviewed the February 2022 results of the most recent national audit of care at end of life (NACEL). This showed the trust scored worse than the national average for recording patient's hydration and nutrition requirements and any related discussions. However, it also confirmed that 39% of staff strongly agreed, and 50% of staff agreed, they were confident in their ability to discuss hydration options with patients.

Pain relief

Staff used the pain management tool to assess the pain levels in patients who were identified as end of life (EoL). However, they did not always reassess pain in a timely way.

At the last inspection in 2020 the trust were told they must ensure safe medicines management in all areas, specifically in relation to reviewing and monitoring of analgesia. At this inspection we found similar concerns which meant the service had not addressed these issues for two years.

The EoL team acknowledged there had not been a consistent approach to the monitoring of pain relief and the reassessment of pain.

We continued to see different pain assessment tools being used to assess pain across the wards we visited. The clinical nurse specialists, employed by the external health care provider, used five different prescribing conversion charts for medication and did not use the trust prescribing guidelines.

We saw ward staff using the pain assessment charts in both paper and electronic formats.

We reviewed the February 2022 results of the national audit of care at end of life (NACEL). This confirmed that 43% of staff strongly agreed, and 39% of staff agreed, they were confident in their ability to assess and manage pain and physical symptoms.

We reviewed the results of the pain audits completed in 2020 and 2021 which provided limited assurance that all patients received adequate pain relief medication.

The pain audit completed in 2020 showed that staff did not always;

- complete pain assessments correctly
- prescribe appropriate pain relief medication
- reassess pain levels after the administration of pain relief medication
- document relevant discussions with the patient or relative about the use of the pain assessment charts.

We reviewed the pain audits which had been completed in 2021 and 2022. The results demonstrated an increase in compliance with providing pain medication to patients from 78% to 95%. These audit results were below the trust target of 100%. In addition, 81% of patients in April and 87% of patients in May felt their pain was well managed whilst in hospital. However only 48% of patients who had received pain relief were followed up within the hour to record its effectiveness.

Following these audit results the EoL team added this to their improvement plan and the surgical division were developing a new policy on pain management.

The trust informed us they were working towards implementation of a trust-wide tool for use across both the acute and community settings. This was being done in collaboration with the EoL team who would provide the training and education. We heard that five wards had been piloting a quality improvement project on pain management to find out if the most effective way of assessing and recording pain scores was either online or on paper. In addition, the EoL team planned to monitor the effectiveness of these pain assessments using ward assurance tool results and audits.

Patient outcomes

The service monitored the effectiveness of care and treatment and knew where improvements needed to be made. However, they continued to achieve poor outcomes.

At the last inspections in 2018 and 2020 the service was told they must ensure that robust systems were in place to monitor the effectiveness of care and treatment delivered to achieve good outcomes for patients. At this inspection we found similar concerns which meant the service had not made sustainable or measurable progress in the last four years.

There was an annual program of end of life (EoL) audits which fed into the quality improvement plan. However, we did not see audits to measure referral times and the responsiveness of the EoL team.

We reviewed the draft results of a snapshot audit from December 2021 for the completion of the recommended summary plan for the emergency care and treatment (ReSPECT) document. The EoL team identified there was low compliance with staff documenting patient's values and fears and recording emergency contact names. The version of

the audit document we reviewed did not include an associated clinical audit action plan. However, the EoL team were providing specific ReSPECT training sessions and presentations both within the trust and with other providers within Northern Lincolnshire. The EoL team told us they would repeat this audit to assess the impact of these educational interventions.

We reviewed the results of the deceased patient audit tool from June 2021 to May 2022. This showed that 65% of patients died with the audit tool completed against a trust target of 80%. Of these 31% had the "care in the last days of life" document completed, 30% had discussed their preferred place of death and 15% achieved their preferred place of death.

These audit results provided limited assurance that ward staff were fully completing the deceased patient audit tool, ReSPECT or the "care in the last days of life" documents.

We heard of ways the EoL team had used the audit results to improve their patient outcomes. For example, the new version of the "care in the last days of life" document was being created using the NACEL audit results and feedback from staff.

The EoL team regularly monitored patient outcomes and safety performance data using the EoL specific dashboard which showed monthly results over a rolling 18 month period. The compliance levels were poor for the completion of the "care in the last days of life" document, prescribing anticipatory medications and recording of preferred place of death. These issues were addressed within the EoL improvement plan and there were appropriate action plans.

The EoL team had implemented the bluebell project across most wards. The word "bluebell" was an acronym used to ensure staff considered all aspects of patient's care such as B meant "be prepared and encouraged staff to display a blue bell symbol for patients receiving EoL care". The EoL team were going to start to measure the effectiveness of the audits relating to the bluebell project.

Competent staff

The end of life (EoL) team did not always make sure staff delivering care were competent for their roles. EoL leaders did not always provide clinical supervision to staff. However, they appraised staff's work performance to provide support and development.

At the last inspection in 2020 the EoL team did not make sure staff were competent for their roles. At this inspection we found similar concerns with low compliance rates for syringe driver training.

We were given an approximately figure that 40% of eligible staff had received their syringe driver refresher training and did not meet the trust target of 85%. This result was lower than expected because the frequency of syringe driver refresher training had been mistakenly set at five years by the corporate team instead of every two years according to manufacturing guidelines. This meant there were staff using syringe drivers who had not received refresher training for five years. This is a deteriorating position since our last inspection.

We reviewed the results of the second specific competency training module and found 78% of eligible staff had completed the care planning module.

We reviewed the most recent EoL meeting minutes from June 2022. The EoL team had initiated an education and training task and finish group in response to this syringe driver error.

End of life care

In the future syringe driver training would be delivered face to face at induction, via e-learning at year two and face to face on year three.

The EoL team were keen to improve the attendance at training sessions as there were high rates of staff who did not attend, and they had started to deliver training on the wards.

At the time of our inspection there were 70 EoL champion volunteers. Before the pandemic these were known as link nurses, but the invitation was extended out to all members of staff. However, they had not received their competency training and had not met up as a group.

We reviewed the most recent results from the 2020/2021 NACEL audit which showed that 41% of eligible staff strongly agreed, and 41% of eligible staff agreed they had completed training specific to EoL care within the last three years.

For the last two years the recommended summary plan for emergency care and treatment (ReSPECT) awareness and authorship training was delivered face to face to medical staff by a dedicated specialist nurse. This was funded by a local charity, but the funding had discontinued and there were no plans for a replacement. This meant that medical staff could only access this training course online via an external website. The compliance rates for the training was 48% and for awareness was 91%. In response to this the EoL team proposed the development of an online training package and training at clinical sessions.

We reviewed the outstanding actions from the improvement plan and there was recognition that more work needed to provide medical staff the skills and knowledge to recognise and identify those patients approaching EoL.

The consultant, employed by the external health care provider, provided lunchtime training sessions to medical staff who based at the hospital and in the community.

We read an ongoing action on the improvement plan that there were plans for primary care teams to make an electronic palliative care coordination system (EPaCCS) training video for all staff and an EPaCCS awareness video for patients.

All staff we spoke with gave excellent praise for the bluebell training which was delivered on the wards by the EoL team.

All of the EoL team we spoke with had regular appraisals and felt supported by their managers. However not all staff had received constructive clinical supervision of their work.

The chaplaincy team felt supported by their own faith leaders and had regular appraisals and support from their managers. They had completed relevant training courses and would provide training to their chaplaincy volunteers.

The mortuary team felt supported by their manager and had regular appraisals. They kept up to date with their mortuary specific skills training.

The bereavement team felt supported by their manager. They were keen to complete counselling courses because they had not received any formal training to deal with the emotional aspect of their role.

There was a new Northern Lincolnshire EoL care education and training platform which had been recently launched on NHS futures. This included EoL specific training modules and learning pathways for up to 10 separate job roles. The training task and finish group and the trust's training and development team were developing a strategy of how to access this training on Electronic Staff Record (ESR) and how to record compliance.

End of life care

Multidisciplinary (MDT) working

Ward staff told us the end of life (EoL) team were visible on wards especially when delivering training such as the new bluebell project.

We heard many positive examples when the EoL team worked collaboratively with all staff including palliative and oncology nursing and medical staff. We observed good working relationships between staff who worked at different hospital sites such as the bereavement staff.

We saw excellent MDT working relationships between bereavement, chaplaincy and mortuary staff. In addition, we observed a patient discharge to the local hospice and saw coordinated and timely interactions between ward staff, patient discharge team members, portering staff and paramedics.

There was a good uptake of EoL champion volunteers from different healthcare roles and the bluebell initiative encouraged good working relationships between wards.

There was a monthly MDT EoL implementation group meeting. This was regularly attended by all staff, including the mortuary and chaplaincy staff. In addition, the palliative clinical nurse specialists and consultants, who worked for an external health care provider also attended. However, bereavement staff were not invited to this meeting.

We reviewed effective and successful partnerships of the EoL team working across Northern Lincolnshire. There was a monthly MDT Northern Lincolnshire EoL steering group meeting. This was regularly attended by the EoL team and other partner organisations across Northern Lincolnshire.

The bereavement team worked well with the registry office where deaths were reported.

The EoL team attended weekly meetings with the local hospice along with the ambulance and discharge teams to facilitate patient transfers.

Seven-day services

The end of life (EoL) team were not available seven days a week to support ward staff caring for patients at EoL.

At the last inspection in 2018 and 2020, the EoL team were told they should develop a comprehensive seven-day service in line with national guidance. At this inspection we found the same concerns with no access to the EoL team at evenings or weekends. There were no formal cover arrangements offered by the clinical nurse specialists, consultant or other community staff who were employed by external health care providers.

We reviewed the seven day action plan which was developed following the last inspection. We read meeting minutes from the Northern Lincolnshire Steering group with relevant stakeholders. There was an ambition for the implementation of a robust seven-day service across the Northern Lincolnshire area and not just for the EoL team at this trust. We heard that funding had recently been approved for the recruitment of consultants and clinical nurse specialists to provide this seven-day service for both EoL and palliative care patients within the hospital, community, and hospice settings.

We heard there was a palliative support telephone line, also known as the “butterfly line” which was available for 24 hours seven days a week. This was managed by palliative care nurse specialists and was delivered from a local hospice.

End of life care

The mortuary team did not routinely work at evenings or weekends. However, they would attend if assistance was needed for a transfer in or out of the mortuary.

The bereavement team officers worked 30 hours during the day Monday to Friday and these hours were aligned to the local registrar's opening hours. There was no provision for out of hours or on call work. The trust covered their annual leave with existing staff who have been trained in the bereavement officer process.

The chaplaincy team were available during the day Monday to Friday and the lead chaplain was on call until midnight every evening. However, there was no available overnight or weekend cover. We heard that once the new chaplaincy volunteers had been recruited, they would review the on-call arrangement.

Portering staff were available to transport patients when needed at all times. This meant they were always available to support the transition of deceased patients from the wards to the mortuary. They had access to the mortuary out of hours and weekends.

Health promotion

Staff gave patients practical support to help them live well until they died.

We saw relevant information promoting support on every ward. There were Macmillan support centres within the trust which were staffed by volunteers. They had leaflets and guidance on a range of subjects such as emotional, financial and therapy information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff followed national guidance to support patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

We reviewed training compliance data for EoL life staff which included the Macmillan and palliative healthcare teams. This showed 96% of staff had completed mandatory training on the Mental Capacity Act and 98% of staff had completed Deprivation of Liberty Safeguards training.

Ward staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005.

We reviewed nine "do not attempt cardiopulmonary resuscitation" DNACPR patient records and found the majority had been completed appropriately.

Staff had access to a mental health liaison nurse 24 hours seven days a week.

The EoL told us they were meeting with the mental health liaison team to incorporate mental health into the EoL training.

Is the service caring?

Good ↑

End of life care

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness. They respected their privacy and dignity and took account of their care needs.

We spoke with all staff who provided nursing, palliative and medical care to patients who were approaching the end of their life (EoL). They would make sure patients were comfortable, washed, and hydrated.

We observed the EoL team taking the time to interact with patients and their relatives in a respectful and considerate way. They introduced themselves and were compassionate to those who were experiencing pain, discomfort or distress.

Patients receiving palliative and/ or EoL care would be nursed on side rooms to maintain their privacy and dignity. However, if this was not possible, they were nursed on a bay. We observed staff closing curtains around these patient's beds during patient reviews.

Ward staff described how they would care for deceased patients before their transfer to the mortuary. Portering staff described how they would close all the windows and doors along a ward corridor before transferring the patient from the ward to the mortuary. Bereavement and mortuary staff provided bereavement care and support to relatives following a patient's death.

Emotional support

All staff provided individualised emotional support to end of life (EoL) patients and relatives to minimise their distress. They understood patients' personal, cultural and religious needs.

We observed staff demonstrating sensitive and supportive care.

We heard of positive examples of when staff provided emotional support. For example, they arranged for relatives to receive parking permits and stay overnight when patients were cared for in side rooms, even if they had not been commenced on the EoL pathway. They would try and nurse the same patient to keep the continuity of care. They arranged a marriage for a patient with terminal cancer and visits by patient's pets.

The EoL team created the bluebell initiative to provide a sensitive and emotional care to patients and their relatives.

As part of the new blue bell initiative we saw a range of items which had been donated from local charities. There were memory teddy bears which could be given to patients or relatives especially children to provide comfort. There were comfort packs containing self-care items such as toothbrush, toothbrush and washing items for relatives who were staying overnight. It also included lip moisturiser if relatives wished to provide lip care to their loved ones.

The EoL team reported the "feedback we have received since launching Bluebell has been extremely positive from both patients, relatives and staff". We heard that relatives had reported back saying "wow, this is amazing! What a simple, but truly marvellous idea. We love what Bluebell stands for. We also really like the teddy bear idea too."

We spoke with staff on wards where the bluebell model had been implemented. They were so proud to be part of this and said it encouraged positive engagements with patients and their relatives. One staff member reported the "bluebell ensure(d) that all aspects of the care are met and is a really well thought out, educational way of delivering care to EoL patients".

They showed us the hessian bags which were used to store the deceased patient's belongings and small pouches which could be used for rings, jewellery or a lock of hair.

Staff understood and respected the personal, cultural, social, and religious needs of patients and their relatives. The bereavement team knew about the promptness of burials for different religions.

The chapel was always open to offer spiritual or religious comfort to patients, relatives and staff. We saw various ways which prayers or messages could be dedicated to loved ones. For example, we saw relatives had written names of loved ones on a leaf and hung it on a specially constructed tree. We saw a poster displaying messages which had been written on colourful cut out butterfly shapes. There was a display cabinet showing an open prayer book displaying names of deceased children.

The chaplaincy staff told us they delivered a "thought of the day" on the hospital radio and also did radio services on religious days.

We spoke with mortuary staff who provided positive examples of how they delivered emotional care to relatives of the deceased patient. They would spend time with relatives and gave them the time they needed. They encouraged relatives to take away comfort teddy bears, smooth coloured stones or would offer other physical memory aids such as hand or footprint castings. The staff said they would always put a handknitted teddy bear into babies and children's baskets. We saw there were available parking spaces directly outside the mortuary for relatives which meant they did not have to walk through the hospital.

The bereavement staff were able to give us positive examples when they delivered emotional care. They told us they were the main contact for relatives following the bereavement. They said they would always call the deceased patient a "patient" when speaking with relatives. They would request the deceased belongings from the ward so they could return these to the relatives to avoid relatives having to visit the ward.

We read a "good news story" within a senior nurse meeting minutes from March 2022 when a patient had passed away with their arms around their pet dog.

Understanding and involvement of patients and those close to them

Staff supported patients who were approaching end of life (EoL), and their relatives.

They made sure patients and relatives understood their care and treatment.

All staff talked with patients and relatives in a way they could understand. They allowed patients and relatives the time to take on board the information provided and were encouraged to ask any questions. We heard from one relative who said the end of life consultant "took the time to personally explain in language that they understood".

The EoL team supported patients and relatives to be actively involved in making decisions about their care treatment and support. They had implemented the bluebell project on most wards. The blue bell principles were a simple way to highlight the importance of putting the patient and relatives at the heart of decision making when it comes to EoL care planning. The word "bluebell" was an acronym used to ensure staff considered all aspects of patient's care. For example, this included "B" for "be prepared and encouraged staff to display a bluebell symbol for patients receiving EoL care", "L" for learning from every family and treat each patient as an individual.

End of life care

All staff were very proud to be part of this bluebell initiative. They were passionate about using it to deliver the best care possible. They gave teddy bears to anyone needing comfort especially younger relatives. There were story books for children to write their name inside to help them understand death and bereavement.

The EoL team supported patients and relatives to express their views and thoughts about the care being given. In response to recent themes and trends emerging from divisions they had recently introduced the "family voices diary". This diary was placed on the patient's bedside and relatives were encouraged to complete it daily for the ward staff to review and address any concerns. It allowed relatives to choose answers for questions such as today my relative or friend;

- "seems to be in pain"
- "calm, relaxed and at ease"
- "breathing comfortably".

There was also a free text for relatives to report if they needed any help or support.

We reviewed the summary highlights from the most recent 2021 national inpatient survey which had not been published at the time of the writing the inspection report. It showed the trust had shown a marked improvement in eight of nine patient focussed agreed actions from the 2020 survey and positives included, "patients felt nurses answered questions clearly" and "patients felt that staff helped control pain".

We reviewed the national audit of care at end of life (NACEL) quality survey responses from April to August 2021. This was in the middle of the COVID pandemic. The results showed a mixture of positive reviews such as; "staff provided excellent care" and "staff deserve a medal".

However, we also heard of very poor negative responses with a common theme of communication. These included relatives not being able to get through on ward telephone lines and also lack of available staff for support. The end of life team acknowledged there needed to be improved communication when listening and involving patients and relatives in personalised plans of care.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate.

Service delivery to meet the needs of local people

The end of life (EoL) team planned and provided care in a way that met the needs of local people within Northern Lincolnshire.

The EoL team had developed a strategy which addressed the needs of the Northern Lincolnshire population for both acute and community services.

End of life care

This meant EoL care was delivered to patients in a system wide approach with the involvement of multidisciplinary teams. For example, A&E and oncology healthcare professionals within the trust and GP's, hospices, community staff, local councils and other private providers within Northern Lincolnshire. We heard how beneficial the electronic palliative care coordination system (EPaCCS) would be once fully embedded within Northern Lincolnshire to help with communication and continuity of care.

Ward staff had access to a palliative care advise and support telephone line also known as butterfly line. This was which was available 24 hours seven days a week and support was delivered by specialist palliative care nurses from a local hospice.

The facilities and premises were appropriate for the services being delivered. We heard of positive examples when patients receiving EoL care were moved to side rooms on wards to ensure their privacy and dignity was maintained. Although these side rooms were limited, staff would always try and accommodate this for EoL patients.

We reviewed the EoL dashboard which showed from June 2021 to May 2022, 88% of patients, who had been commenced on the "care in the last days of life" document, had died in a side room.

Relatives were able to visit patients receiving EoL care at all times. There were arrangements were made for relatives who wished to stay overnight.

There were parking permits available for relatives which meant did not need to pay for car parking at the hospital. There were allocated car parking spaces reserved for relatives who were visiting the mortuary and these spaces were close to the mortuary entrance.

The chaplaincy staff were responsive to any request and would listen and support relatives or staff whether they had faith or not. We heard the trust would pay for a hospital funeral if a deceased patient or relatives had limited funds.

The bereavement team provided a service which we heard met the needs of relatives. They would ensure relatives received a bereavement pack. They also provided practical advice regarding visits to the chapel of rest, collecting personal belongings and administration procedures such as registering the death and collecting the death certificate.

The mortuary environment had been recently decorated and had reception and quiet areas as well as viewing rooms.

Meeting people's individual needs

The end of life (EoL) team delivered inclusive care to patients and coordinated care with other services and providers. However, ward staff did not take account of patients wishes and preferences as these were not comprehensively recorded.

Over the last few years, the trust had implemented two new processes which were used to document individualised needs and preferences; the recommended summary plan for emergency care and treatment (ReSPECT) and the Electronic Palliative Care Co-ordination System (EPaCCS). Some staff we spoke with did not have access to the EpaCC's system and not all were trained to use this system.

The "care in the last days of life" document was used to record patient's preferences such as spiritual and religious wishes and patient's needs such as psychological and emotional needs. However, we reviewed recent audit results in April 2021 and March 2022 relating to this document which showed only 16% of patients on the EoL pathway died at their preferred place of death. This meant patient's wishes or needs were not always fulfilled.

End of life care

We saw evidence staff were not always meeting individual needs. Patients who had been identified as started on the EoL pathway had an "EOL" icon next to their name on the electronic patient whiteboard. They would also have a bluebell sticker placed on their side room door on the ward. Staff used a rose icon for patients who were not for resuscitation. However, we noted one patient who had been on the EoL pathway for over 24 hours but did not have an "EOL" icon displayed. This was raised at the time of the inspection and it was immediately rectified. We were informed this error had occurred because only certain members of staff have access or authority to start the EoL pathway.

There was a chapel and multifaith room which were open all the times and were well signposted within the hospital. These were accessible for the spiritual and religious needs of all patients, relatives and staff. We saw a diverse selection of religious books, information and posters available in languages spoken by the patients and local community.

We saw several posters which displayed a welcome greeting in all languages, a multifaith calendar of religious events and chaplaincy contact numbers. We saw there was a submission box for messages requesting chaplaincy support or prayers.

There was a quiet room which was neutrally decorated which was used by visitors from other faiths or with no faith for prayer or contemplation.

We saw there were prayers and leaflets that could be taken away.

We spoke with a medical doctor who said they attended the chapel every Friday for Islamic prayer. He reported that the chapel was full every week. We saw an appropriate area for ritual washing and a place to safely store shoes. We saw different religious items such as prayer mats and scarfs.

The chaplaincy team could access the hospital computer system to identify EoL patients. They also received referrals from staff via phone calls. They had a message box outside the chapel for anyone to request a visit or phone call. Chaplaincy staff would visit the patient, relatives, or staffing looking after patient, and offer spiritual and religious support.

They were able to offer Christian and Anglican support within the team and had access to other faith leaders in the community. The chaplaincy volunteers would visit wards regularly to speak with patients.

The bereavement staff explained how they delivered a seamless service to relatives and helped them organise paperwork, visits to the chapel of rest.

Staff made sure patients and relatives could get help from interpreters or signers when needed.

All staff we spoke with gave positive examples of how they were aware of religious and cultural differences when caring for a deceased patient. For example, we heard staff helped with the religious washing and cleansing of deceased patients and had also arranged for a Buddhist faith leader to visit a patient.

The EoL team gave examples when they had visited patients with the lead nurse for learning disabilities and dementia to meet their needs.

We reviewed the human tissue authority (HTA) audit which was completed in May 2022. This report showed that the procedure for the long term storage of bodies had not been followed and did not meet the HTA standard.

End of life care

Access and flow

Patients and staff who cared for them, did not consistently have access to the EoL team when they needed it. There was no standardised process for referrals to the EoL or chaplaincy teams. There was no available data to measure the responsiveness, or availability, of the EoL.

The EoL team encouraged ward staff to recognise patients who were at EoL as soon as possible. However, the responsibility for making this final decision was the named consultant and was normally done at routine medical or surgical ward rounds.

Staff reported patients were not always identified early enough to start on the EoL pathway which meant they were not able to start the relevant documentation. In some cases, the patient had deteriorated quickly, or medical staff were waiting to see if medication had been successful.

Staff said it was unclear who had the responsibility, authority or access to update the computer records to document a patient had been started on the EoL pathway.

The service did not have a formalised referral process to the EoL and some staff we spoke with said they didn't know how to contact them especially in the evenings or weekends. We heard examples when staff had attempted to contact the EoL team by telephone for advice and guidance but had not been successful. In addition, staff were confused who the best team to refer the patients to. This was because some patients were receiving palliative care and some patients (who were also receiving palliative care) had been identified as approaching end of life. They did not know whether to refer the patients to the EoL team or the palliative care team employed by the external healthcare company.

We heard the EoL staff would access the computer system to identity patients who had been started on the EoL pathway by ward staff. They would aim to visit these patients the same day and ward staff confirmed they were very responsive.

At the time of our inspection there were absences within the EoL team at Diana Princess of Wales Hospital. We were not aware of any cross site cover from the EoL team based at Scunthorpe General Hospital (SGH). We were made aware of a patient who was receiving palliative care had been placed on the EoL pathway. When we tried to contact the EoL team at SGH there was no answering machine facility or message.

Following the inspection, the EoL team said they would implement a single point of access for all EoL and palliative care referrals.

We reviewed EoL dashboards which showed compliance against key performance indicators. This did not show data to measure the responsiveness, or the availability of the EoL team. In addition, there were no audits to measure the quality of the referrals.

We spoke to clinical nurse specialists who were employed by an external health care provider. They were only commissioned to provide palliative support to patients in hospital, hospice or the community. In the absence of the EoL team we were told the clinical nurse specialists would review EoL patients, but only if they had capacity. However, we observed an example when this was not possible because one clinical nurse specialist had nine palliative patients to review and there were a further six patients identified as EoL.

The trust had a discharge policy to guide staff how to fast track the discharge of patents who required palliative care. The EoL team had daily meetings with the local hospice who accepted admissions seven days a week. They told us local nursing homes would also accept admissions.

End of life care

We heard many positive examples of when the portering staff were very responsive when required to transfer a deceased patient from the ward to the mortuary.

The trust did not have a formalised referral process for the chaplaincy team,

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The end of life (EoL) team treated concerns and complaints seriously, and shared lessons learned with all staff. They included patients and relatives in the investigation of their complaint.

At the last CQC inspection in 2020 we heard that concerns and complaints relating to EoL were managed by each division. At this inspection the EoL team could now identify and had oversight of EoL concerns and complaints.

From April 2021 to March 2022 there were 35 complaints out of 351 trust wide and 20 patients advise liaison (PAL)'s concerns out of 1,195 trust wide. As of May 2022, there were 7 ongoing complaint investigations.

The EoL team would prepare a monthly report which included the emerging themes from concerns and complaints. We saw the main themes were related to advanced care decisions, communication, attitude of staff, lost property and delays for equipment. We were told this report was discussed at the monthly EoL meetings. However, we reviewed the March, April and May 2022 minutes "summary of actions" from the Northern Lincolnshire EoL steering group and did not see any associated escalations or actions relating to concerns or complaints. It was not clear how these were monitored in this group or how actions were cascaded back to the EoL Implementation group.

The EoL team confirmed they did share feedback and learning from complaints to ward staff. They told us there had been fewer reported concerns and complaints since the introduction of the bluebell model and family voice diaries. They also provided specific training with ward staff and worked collaboratively with partnership services such as hospices.

Ward staff gave positive examples of when performance had improved as a direct result from complaints. For example, the introduction of blue bell bags and jewellery pouches were developed because of a high number of complaints regarding lost property of deceased patient's belongings. Staff said they could pick up any immediate concerns from the patient's family voices diary.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had improved the skills and abilities to run the end of life (EoL) service. They understood and managed the priorities and issues the service faced.

End of life care

The EoL team had an improved management and leadership structure following the previous inspection in 2020. The service had an executive lead, who was also the medical director, and they reported to the board. There was also a newly appointed associate chief nurse for the communities and therapy division.

Within the EoL team there was a transformation / service improvement manager who was responsible for managing the improvement plan, maintaining the pace of actions by key work streams and task and finish groups.

The EoL leaders had oversight of priorities and issues and were involved in the various meetings and task and finish projects.

Vision and Strategy

The service had a vision for what it wanted to achieve and a new five year strategy to turn it into action. This had been developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The end of life (EoL) group launched a systemwide EoL five year strategy in September 2021. We heard staff had been given the opportunity to share their views and ideas on the strategic principles in June 2019.

This strategy was based on the national ambitions and the priorities for EoL care were;

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and well being
- Care is coordinated
- All staff are prepared to care
- Each community is prepared to help.

These were aligned with the trust principles for example, “right care, right place, right time” and objectives for example, “to work more collaboratively”.

The strategy was linked to the improvement plan and demonstrated what they needed to do

to deliver these priorities and how they would measure the improvements.

Following the inspection, the trust provided further information detailing the implementation of a strategy for all healthcare providers within Northern Lincolnshire. This was part of the Northern Lincolnshire EoL steering group.

Culture

The EoL staff felt respected, supported and valued. They were focused on the needs of staff who cared for EoL patients and their relatives.

We heard positive examples of how the culture had improved following the last inspection in 2020.

End of life care

The EoL team spoke highly of the support they provided each other despite being a small number of staff. They were dedicated to their role. They reported the bluebell project had brought the team closer together and collectively they felt more confident in offering support to ward staff who cared for EoL patients.

They encouraged ward staff to share personal experiences during EoL training sessions so that other staff could listen to real experiences.

The EoL team hoped to start training the new EoL champions and would incorporate additional time for them to receive appropriate supervision and have debrief opportunities.

We saw quiet rooms known as “wobble rooms” within the hospital which were available for all staff.

The mortuary, bereavement and chaplaincy staff described a good working culture with each other and felt well supported in their role.

Governance

EoL leaders did not always operate effective governance processes. Not all staff involved in the delivery of EoL care were clear about their responsibilities and accountabilities and did not feel part of the EoL team. However, staff had regular opportunities to meet, discuss and learn from the performance of the service.

There were areas of the service which continued to be of concern and had been previously identified during our previous inspections.

We spoke to some staff who delivered end of life care to patients and relatives in a daily basis however they did not know how they roles fitted within the EoL structure. This was due to a wide range of issues such as not being invited to meetings, being unaware of EoL issues and being managed by different leadership.

We also observed there to be an operational disconnect between the EoL team and palliative care team who were employed by the external healthcare provider.

There were no formalised processes with regard to referrals or patient reviews. In addition, we did not see cross site cover within the trust’s EoL team.

Ward staff were not clear who had the responsibility, authority or access to update the computer records to document a patient had been started on the EoL pathway.

However, at this inspection the service had demonstrated that clear improvements had been made following the last inspection in 2020.

There was now a formalised governance structure which showed escalation pathways from EoL team to board and also dissemination routes from board to EoL team onto ward staff. We reviewed various EoL meeting minutes which showed that learning had been shared with staff.

End of life care

The EoL team now hold a monthly EoL implementation group meeting which was attended by a range of staff who delivered EoL care across the trust, as well as lead staff from safeguarding, divisions, governance and mortuary. This meeting had standard agenda items which covered quality, safety and performance issues. On a rotational basis each division; surgery and critical care, medicine, family services and diagnostics presented their main risks and issues at this meeting using the EoL analysis report.

This group would monitor the progress and improvements made within each division over time using an EoL analysis report. This clearly showed how division were managing their main risks and issues, what learning had been identified and actions taken as a result. For example, the medicine division announced they would start discussing EoL decisions at ward rounds and improve handovers for EoL patients. The EoL consultant gave a presentation to all divisional leads on the recommended plan for emergency care or treatment (ReSPECT).

The EoL team had identified six main improvement themes from complaints, incidents, audits and mortality reviews across all divisions. These were;

- Recognition that a patient is entering into the EoL phase
- Proactive and advanced care planning in preparation for EoL
- Communication and listening to the patient and relative and involving them to develop personalised plans of care
- Assessment of patient needs at EOL including pain assessment
- Full completion use of the 'Care in the Last Days of Life' pathway document

The EoL team measured the compliance against these six key improvements and updated the improvement plan which also incorporated the CQC action plan from the previous inspections. However, we saw further work was needed to improve patient outcomes and audit results.

There were various work streams within divisions and task and finish groups which had been formed as a result of the EoL implementation plan. For example, there was a training and education task and finish group to implement system wide EoL competencies and learning outcomes across Northern Lincolnshire.

We saw examples of how top themes identified from each division were fed into this meeting and added to the EoL analysis report on a rotational basis. These included incidents, complaints, audits, risks and mortality reviews with associated learning or actions taken as a result. This information would then be updated in the EoL improvement plan.

There was a clear dual process of escalating concerns from this meeting to the trust management board. The first process was from the community and therapies clinical governance divisional meeting, and other performance meetings if necessary. The second process was from the Northern Lincolnshire EoL steering group who would discuss the report, agree and escalate any immediate or long term actions against themes or specific issues.

We saw evidence the EoL team were regular attendees at other divisional meetings and heard that work was underway to ensure that each divisional governance meetings had an agenda item dedicated to EoL.

The monthly EoL implementation group meeting minutes would be shared with all attendees who would then cascade within their own division.

End of life care

Management of risk, issues, and performance

The end of life (EoL) team did not always use effective systems to improve the awareness of risks and issues and manage performance. However, they identified, and escalated relevant risks and issues and identified actions to reduce their impact, but progress was slow.

At the last inspection the service was told they must ensure robust governance processes were in place to lead, manage, risk assess and sustain effective services. At this inspection we found similar concerns.

For example, there was only one consultant based at Scunthorpe Hospital covering three hospital sites. There were no audits to measure the responsiveness of the EoL team to measure performance. We saw there were continued low compliance with the quality of record keeping especially for documenting patient's wishes and preferences and refresher syringe driver training. In addition, the EoL team had not yet implemented a seven day onsite service which meant staff did not have access to inhouse specialised clinical advice and support 24 hours seven days a week.

We reviewed the EoL dashboards which were reviewed by EoL staff to monitor safety concerns and assess performance. However, the dashboard did not show any comparison data against national averages or with trusts of similar size. It was difficult to compare the information from previous dashboards with the current one and we were told this was due to a drop in compliance measurements during October 2021 when the incident reporting tool was replaced. In addition, we heard there were delays with enabling access to reliable data within 24 hours of referral or patient contact.

We reviewed the results of the Human Tissue Authority (HTA) audit which matched those identified on the mortuary risk register from 2019. We saw appropriate actions had been put in place in June 2022 to mitigate against these risks. The first risk was insufficient storage capacity which was mitigated with the local funeral directors providing temporary overflow storage if required. The second risk related to the lack of an automatic alert to switchboard if the temperatures of the temporary fridge storage deviated from normal range out of hours. Staff controlled this risk by completing twice daily recordings including weekends. However, the majority of these had not been completed within the target time frame. In addition, some parts of the mortuary were dirty, and equipment was rusty, but these were not visible to visiting relatives.

We reviewed the risk register for the community and therapies division. This showed one risk relating to the clinical capacity of the team to fully embed the EoL initiatives within each division. This risk was reviewed bimonthly. These risks were described in more detail on the EoL improvement plan. We saw how the EoL team planned to mitigate against these risks and measure the effectiveness of the initiatives.

Despite these current challenges, the service had made a number of improvements following the last CQC inspection. There were clear plans with defined trajectories. These provided assurances of the sustainability of the EoL service. We recognised the ambition to deliver a seamless provision of EoL care within Northern Lincolnshire.

The service reported a significant reduction in the number of EoL patient harm related incidents in the last two years.

The EoL team had designed and rolled out the Bluebell principles onto ward areas and patients and relatives reported positive experiences. This was an example of an innovative approach to engage everyone in the principles of delivering good quality EoL care and had achieved national recognition. This roll out was due to be completed in November 2022 and the service plan had started to measure the success of the model.

End of life care

The service had implemented the advanced care document (ReSPECT) which reflected nationally accepted best practice. This had been fundamental in changing the conversation from Do Not Resuscitate towards a more holistic approach.

The service had rolled out the electronic palliative care coordination system (EPaCCS) within the trust. This work was driven by the Northern Lincolnshire steering group and operationalised by a working group. It is now an embedded practice within the specialist teams and work was ongoing to raise awareness.

The trust were leading a quality improvement project which aimed to deliver a single pain assessment tool which will be used for all patients, including those who are at the end of their life. In addition, there was a pain specific question within the new family voice diary which can be acted upon immediately by staff.

The Northern Lincolnshire EoL steering group had been successful with implementing a performance dashboard to identify if the needs of the local population are being met.

Following the inspection, the trust provided information to demonstrate they had taken immediate action with some of the issues raised at this inspection.

For example, in response to the poor audit compliance with the deceased audit tool the service added this tool onto the trust's computer system to make it more accessible to staff caring for EoL patients.

The service were planning to implement a single point of access for all EoL and palliative care

referrals by March 2023 to improve service delivery. This new system would ensure a formalised and streamlined approach to referrals and review process for patients who had been identified to be started on the EoL pathway. It would allow cross cover between each hospital site and remote cover if needed.

The service had hoped with the roll out of the advanced care planning (ReSPECT) across all wards, and regionally, would have helped staff with the early recognition and identification of patients approaching the end of life. We acknowledge there will be a period of time required to allow these to become embedded as part of the care delivery so that patient's wishes and preferences would be fulfilled. In response to the poor audit compliance of the ReSPECT document the service had delivered specialised training sessions over the last six months. The training was included at a locality wide EoL conference. They planned to provide further training sessions to senior clinicians and complete another audit to assess the impact of these educational interventions.

Following the inspection, we were informed additional funding had been agreed to support a workforce to provide a seven day service within Northern Lincolnshire. This involved a review of the current workforce establishment, mapping of current EoL resources, recommendations from the last CQC report, national guidance, commissioning guidance and support from NHS England / Improvement. There were also several task and finish research and engagement groups. This work resulted in funding being made available for an increased establishment of medical staffing (1.7 whole time equivalent (WTE)) and nurse staffing.

Information Management

Staff did not always find the information they needed within patient records or computer systems. The EoL end of life (EoL) team did not always collect reliable data to understand performance, make decisions and improvements.

End of life care

We observed ward staff spending time recording the same information within both paper and electronic formats of patient records. In addition, we observed the palliative clinical nurse specialists record patient information into different computer systems.

We heard from staff that not everyone had the access, or authority, to update the computer records to show the patient had been started on EoL treatment. Staff told us it was challenging to access electronic systems to find EoL patients.

We found two ReSPECT paper documents for one patient, and neither were dated. In addition, there were different versions of the ReSPECT form being used within Northern Lincolnshire. We heard that one local trust was still using an older version of the document. This meant patient's most up to date wishes and preferences may not always be granted.

We heard that the EoL dashboards used to measure key performance contained unreliable data which was difficult to analyse. We were unable to compare recent data with previous dashboard information.

However, we heard positive examples of how systems were being used to improve communication of a patient's individual preferences of their care. For example, all staff within Northern Lincolnshire were being trained to access the electronic palliative care co-ordination systems (EPaCCS) using different computer systems.

We also read there were several partners such as hospices and local trusts within Northern Lincolnshire had granted access rights for patient information stored within the trust computer system. The trust also has information shared agreements in place with local safeguarding and council teams and community pain services.

Engagement

The end of life (EoL) team actively and openly engaged with staff, patients and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Two members of the EoL team were responsible for creating the blue bell project and all EoL staff were involved with the roll out on wards. The EoL team were well known on all the wards we visited. Ward staff reported they always gave positive feedback on how the blue bell model had significantly helped them in their roles.

We reviewed a special edition of the NLaG newsletter from May 2022 which focussed on EoL care as being a continued trust priority. It included recent achievements such as the bluebell initiative and family voices and information about the new EoL systemwide five year strategy. It provided details of how to contact the EoL team. However, some staff told us they did not know the difference between the end of life and the palliative care team and didn't know the best team to contact.

We heard of positive ways the EoL team successfully collaborated and met with patients and relatives to help plan and manage the services. They spoke with patients and relatives about the best ways to capture their preferences and needs and have used this information to redesign the "care in the last days of life" document. They produced a syringe driver information easy to read document for patients and relatives. Ward staff continued to encourage patients and relatives to complete the family voices diary.

The EoL team had planned to have awareness stalls at local town markets and garden centres.

We heard different ways the chaplaincy team reached out to engage with patients, and staff with their daily "thought of the day" and other services broadcasted on the hospital radio station and on social media platforms.

End of life care

The EoL team collaborated and worked well with providers within Northern Lincolnshire. For example, they met with senior representatives from the local hospices, councils and other partners at the steering group meetings. The meeting minutes showed these representative attendees held delegated authority to deliver sustainable improvements in the system.

We heard positive examples of how the advanced care planning tools such as ReSPECT and EPaCCS were being rolled out within providers in the Northern Lincolnshire. The EoL team regularly met with the palliative care clinicians within the ICS patch and GPs with specialist interest in EoL community support. They were going to work with care homes to the quality of care and work to prevent unnecessary hospital admissions

The EoL team were due to present at a conference in September 2022 and attendees to this would include hospices, councils, domiciliary care and neighbouring trusts including ambulance services.

We reviewed examples of positive working with local healthcare partnerships and the local commissioning intentions. For example, to increase the quality of EoL care provided in the community.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Ward staff were keen to learn more about how to deliver the best end of life (EoL) care and they had embraced the new bluebell and family voices initiatives. On some wards ward staff had introduced further blue bell items such as crockery and catering baskets with drinks and snacks for relatives.

We heard there were various quality improvement projects which included EoL. For example, the pain assessment tool is being trialled in paper and electronic formats.

One of the EoL team members had been shortlisted for the nursing times award. In addition, the EoL team had been shortlisted for the EoL team of the year category.

The community and therapy division had previously been shortlisted for the community provider of the year from the health service journal (HSJ) in 2021 for their virtual EoL care training which was provided to care homes.

Chaplaincy volunteers had been given “star” and “sparkle” awards.

Staff participated in a fundraising event for the local charity who supplied the items for the blue bell initiative items.

Urgent and emergency services

Requires Improvement ● →←

Is the service safe?

Requires Improvement ● ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

Although the service provided mandatory training in key skills to all staff, training compliance rates for nursing and medical staff did not meet the trust target.

Managers monitored mandatory training and could alert staff when they needed to update their training. Since the last inspection, in September 2019, there had been high levels of input from a clinical educator who had played a key role in addressing shortfalls in training and focusing upon staff training and development across the department which had some success with the nursing staff.

We saw evidence that the service ensured staff providing support to children had relevant paediatric competencies to ensure delivery of safe care and treatment.

We saw examples of the content of training and information posters on display in the staffing areas which were comprehensive and promoted the needs of patients.

However, we still found that not all nursing staff kept up-to-date with their mandatory training, with an overall 78% compliance rate against the trust target of 85%. At the time of the inspection we were advised that the overall compliance rate for medical staff mandatory training was 62%.

There were ongoing concerns with overall departmental compliance for Adult Immediate Life Support (AILS) resuscitation training. Compliance for nursing staff was 72% and 67% for Paediatric Immediate Life Support (PILS) resuscitation training. Medical staff compliance with level two adult basic life support training was 63% and only 27% had completed the mandatory level two paediatric basic life support training.

Nursing staff compliance with dementia awareness training was 87% and only 57% for medical staff.

Safeguarding

Although staff understood how to recognise and protect patients from abuse and the service worked well with other agencies to do so, overall safeguarding training compliance had only shown some signs of improvement since our previous inspection in September 2019.

Although nursing staff had achieved 100% compliance for safeguarding adults level two, level three training was only 59%. The compliance rate for safeguarding children training was 53%.

Medical staff compliance with safeguarding adults level two training was 67% and only 33% for safeguarding children level three training, well below the trust target of 85%. Information provided by the trust indicated that middle-grade doctors had not yet received safeguarding training.

However, staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff within both the adult department and paediatrics were able to explain the safeguarding reporting procedures and provided examples of safeguarding referrals they had made.

Patients with known safeguarding concerns were automatically flagged by the electronic record system. The registered sick children's nurse on-shift during the inspection informed us that safeguarding nurses screened all paediatric attendances in order to monitor potential safeguarding concerns.

Information and guidance on safeguarding awareness was clearly displayed and easily accessible for all staff within the department.

Cleanliness, infection control and hygiene

During the inspection the service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. We saw the correct storage of cleaning materials and mop heads in-line with control of substances hazardous to health (COSHH) guidelines.

The service generally performed well for cleanliness. We saw official trust guidance and information on display highlighting the department's commitment to cleanliness, whilst promoting staff awareness. The department clearly displayed cleanliness ratings which were graded at three out of five stars at the time of the inspection.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

We inspected six treatment bays, all appeared visibly clean. Disposable labelled curtains were used and all mattresses were clean and free from breaks.

We saw evidence that staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

All sharps bins were dated, signed and less than ¾ full.

Patients with symptoms of COVID19 and other easily transmissible diseases were allocated to cubicles with doors within the department to reduce the risk of cross-infection. Signs were also placed on the cubicle doors to ensure staff adhered to infection control policies.

We observed staff following infection control principles including the use of personal protective equipment (PPE). All nursing staff were observed to be wearing appropriate PPE and were bare below the elbow. However, we saw medical staff with sleeves below their elbows interacting with patients.

The most recent compliance audit indicated staff consistently donned and doffed the correct PPE during contact with patients.

There were numerous sinks in the department with hand gel and handwashing instructions on posters displayed near the sinks. Staff were observed washing their hands before and after patient contact.

However, nursing staff compliance with infection prevention and control (IPC) training was 70% and 57% for medical staff, below the trust benchmark of 85%.

Audit data for May 2022 indicated that a total of 11 hand hygiene audits had been completed during this period out of a trust-wide target of 10 per month. However, overall staff compliance with hand hygiene protocol within this period was only 69%.

Environment and equipment

The design, maintenance and use of facilities and premises did not always keep people safe. However, staff ensured mitigation was in place to promote patient safety. Staff could readily access equipment to promote patient safety and were trained to use them. Staff managed clinical waste well.

At the time of the inspection, the emergency department was in the process of a redesign and this included ongoing construction work. Access to the department was clearly signposted, along with trust guidance on the criteria for attending in order to promote appropriate use of the service by the public. Face coverings and hand sanitising stations were available for those attending department.

During busy periods, the reception area quickly became overcrowded which was not conducive to social distancing protocol. We also observed patients queuing outside of the department to check-in, which was monitored by reception staff.

Overall visibility of the main waiting area for adults from reception was poor, particularly during busy periods. Although there was a staff presence on the front desk at all times, patients and relatives who were not in direct view of staff were not always monitored.

The design of the environment did not always follow national guidance. There was no separate waiting area or space for children attending the department. Ensuring children were treated in a separate area was also problematic for the department. We saw adult patients being allocated cubicles usually designated to children due to the surge in attendances within the department. The trust provided assurances that there was full oversight of paediatric patients on the department and best efforts were made to maintain a degree of segregation from adult patients by allocating a designated space for children to be treated. The new emergency department will have a separate waiting area and four cubicles specifically allocated for paediatric patients.

The paediatric resuscitation cubicle was located within the main four-bed resuscitation area which would often be rearranged to accommodate up to eight patients during busy times. Best efforts were made by staff to ensure that any children in the resuscitation area were separated from adult patients.

Due to the ongoing construction work on-site, patients transported by ambulance arrived at the department via the front entrance. Department staff were able to raise a temporary screen in front of the waiting area to promote a degree of privacy for those patients being supported into the department by ambulance crews.

The ambulance triage area consisted of four bays. However, we were told that during busy periods up to eight patients could be placed in this area to ensure access and flow was maintained within the entire department. At the time of the inspection we saw six adult patients and an infant patient waiting in this area due to the high number of attendees.

Within the majors and minors areas of the department, not all patients could easily reach call bells. Two patients within the majors department were unable to reach their call bells. However, we saw multiple examples of staff responding

proactively when called upon.

Patients were able to share personal information with reception staff who sat behind protective screens away from the main waiting area. The reception desk was at a height enabling patients in wheelchairs to speak to staff members and there was also a hearing loop system in place.

Once checked-in, waiting times for the various pathways of care were displayed on an electronic screen.

The trust now had a dedicated ligature-free room in accordance with the Psychiatric Liaison Accreditation Network (PLAN) standards which could be allocated to patients deemed to be at potential risk of harm as a result of mental health crisis. The room was minimally furnished and in close proximity to the nurses' station for monitoring purposes.

There was a dedicated relatives' rooms located within a quiet area which patients' relatives could access accordingly.

The service had enough suitable equipment to help them to safely care for patients and staff carried out daily safety checks of specialist equipment such as hoists and oxygen cylinders which were appropriately stored within the department.

We saw the resuscitation trolley was appropriately stored within the department and included all relevant equipment. There was a designated safety checklist in place and evidence the equipment had been checked each day and was fit for purpose.

On inspection we checked multiple consumable items from storage areas at random, all were in date.

We saw evidence clinical waste was managed in a way that kept people safe. Arrangements were in place for the segregation, storage and disposal of waste.

We saw evidence of back-up generators receiving regular essential service and testing and the department fire risk assessment was in place.

Security support was available for the department 24 hours a day to promote the safety of staff and patients.

Assessing and responding to patient risk

The department continued to not have a qualified paediatric nurse on-shift 24 hours a day. Compliance rates with training tailored to assist staff with specific risk issues were not always in-line with trust targets and department audit data was inconsistent. However, staff completed risk assessments for each patient swiftly and minimised risks. Staff identified and quickly acted upon patients at risk of deterioration to keep them safe.

Children were not always assessed and monitored by a Registered Sick Children's Nurse (RSCN). Staff we spoke with regarding paediatric nursing and medical cover advised that an RSCN was available on the department until 9pm. Following this, children were supported by the general nurses on-shift.

Although this had been a longstanding matter, we saw evidence that the trust had now taken steps to mitigate risks associated with the care of children attending the department, as highlighted in the Care Quality Commission Brief Guide: Staffing in Emergency Departments that treat children.

Urgent and emergency services

Medicine and Family Services had implemented the Paediatric Emergency Nursing Team across both hospital sites. A dedicated team of RSCNs were on site seven days a week providing flexible support to both the Emergency Department and Paediatric Assessment Units when required.

We received assurances from senior management that staff caring for children after 9pm had appropriate paediatric competencies to keep children safe. Managers confirmed that all Registered Nursing Staff in the department were working through the Royal College of Nursing Competencies Framework for Emergency Department Nursing which included care of the sick child. These particular competencies were assessed and signed off by the Paediatric Nursing Team to ensure oversight of learning and development in regards to caring for sick children.

We also saw evidence of embedded departmental processes which were followed to ensure children received relevant care and treatment when accessing the service. In the case of a child's condition deteriorating, the emergency physician in charge (EPIC) could speak directly with an on-call Paediatrician and trigger an escalation process to fast-track the child to one of the paediatric in-patient wards based on-site.

Although the steps taken by the trust do not specifically meet the recommendation of two RSCNs being present on the department at all times, as set out by the Royal College of Paediatrics and Child Health. Given the ongoing external factors impacting upon recruitment, the trust had now ensured that adequate cover was in place to treat sick children and keep them safe.

We saw relevant guidance and policies for managing falls and evidence in patient records that falls assessments had been appropriately completed for patients considered to be at risk of falling. However, despite there being no incidents evidencing patient harm, the most recent audit data provided by the trust highlighted inconsistencies with the completion of falls risk assessments with 60% compliance recorded in the matron audit for the period 04 April 2022 until 27 June 2022.

Staff knew about specific patient risk issues and could explain the steps taken to identify these. We saw evidence of a robust standard operating procedure and guidance for monitoring patients at risk of venous thromboembolism (VTE). Nursing staff compliance with VTE training was 90.74% and 60% for medical staff.

Staff demonstrated an understanding of sepsis in patients and we saw multiple information posters on display in staffing areas to assist with education and awareness. Patient records evidenced appropriate use of the sepsis care bundle and we saw evidence of antibiotics being prescribed within the recommended timeframe of one hour. However, training compliance data obtained from the trust highlighted that only 53.85% of nursing staff and 37% of medical staff had completed the mandatory sepsis awareness and deteriorating patient training.

We reviewed the trust-wide sepsis screening performance data for the emergency department from April 2021 until June 2022, in which a random selection of patients were reviewed per month. Out of 270 patients with a NEWS score of five or more, 83.7% were screened for sepsis. Of the 156 patients requiring treatment for suspected sepsis, 139 (89.1%) received antibiotics within the recommended timeframe of one hour.

In a trust-wide sample of 260 paediatric patients attending the department with suspected child sepsis, 95% had their observations recorded on a paediatric early warning signs (PEWS) chart.

Upon arriving in the department, patients were triaged using the Manchester Triage System, a nationally recognised clinical risk management tool used to safely manage patient flow and help identify deteriorating patients.

Urgent and emergency services

We saw examples within patient records of staff undertaking rapid assessments using the national early warning score (NEWS) tool in order to promptly identify the most appropriate care pathway for potentially deteriorating patients. Regular audits completed by the department matron evidenced that staff consistently followed the correct escalation process for patients when NEWS was triggered.

We reviewed a sample of 11 patient records which highlighted that regular intentional rounding checks had been completed by staff. Hourly checks were also in place due to the extended length of stays that patients allocated to treatment bays were experiencing.

Regular board rounds took place at two-hourly intervals throughout the day in order to monitor patient risk and access and flow within the department.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health liaison and both nursing and medical staff described high levels of support were made available to them. Paediatric patients presenting with mental health problems were referred to children and adolescent mental health services (CAMHS) for appropriate care and support. However, staff described that overnight there could be difficulties accessing support.

Staff shared key information during shift changes and handovers to keep patients safe when handing over their care to others.

Nurse staffing

The service had enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. However, there was not 24-hour paediatric nursing cover within the department.

Due to ongoing external factors impacting upon recruitment, the department continued to not have Registered Sick Children's Nursing (RSCNs) cover available after 9:00pm. However, managers provided us with evidence that there were enough general nurses on-shift after 9:00pm with adequate paediatric training to keep children safe. We also saw evidence that there was an embedded Paediatric Support Pathway in place, ensuring clear lines of communication between the emergency department and paediatric in-patient wards to enable children to receive appropriate care and treatment in a timely manner to keep them safe.

The Royal College of Paediatrics and Child Health (RCPCH) also acknowledge the standards are recommendations rather than absolute, and that the challenges in recruiting the workforce needed to meet standards are ongoing.

Managers told us that staffing remained a constant challenge and whilst there was enough staff on-shift to keep patients safe, due to ongoing sickness and staff vacancies, the department continued to adopt flexible working patterns to ensure staffing remained appropriate.

At the time of the inspection the service had enough nursing and support staff on-shift to keep patients safe. On the day of the inspection the number of nurses and healthcare assistants matched the planned numbers.

We saw staffing rotas for the period 11 July 2022 up until the time of the inspection which highlighted that managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance to keep patients safe.

Any potential shortfalls in staffing were initially monitored at a daily meeting with the medicine operational matron and departmental shift lead staff member. This meeting enabled staff to review staffing for the following 24 hours and helped to inform next steps to mitigate potential risks associated with staff shortages. In addition to this, a daily 'safe staffing' meeting and operations calls would also be held to complete a further review of the staffing situation trust-wide. Action would then be taken to adjust staffing levels either internally or via access to bank and agency staff according to the needs of patients.

The trust-wide registered nursing vacancy target was 8%. However, the last recorded vacancy figure in May 2022 was 13.7%.

Trust-wide nursing staff turnover rates had remained between 11.06% and 11.96% since June 2021.

The service had increasing sickness rates, with trust-wide data highlighting an increase in nursing staff sickness rates from 5.73% in May 2022 up to 7.97% in April 2022.

Managers tried to limit their use of bank and agency staff and requested staff familiar with the service. We saw evidence that the trust made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right skills, training and experience on-shift to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction. However, there were some shortfalls in middle-grade and junior level medical staffing at weekends and ongoing substantial use of locums.

The service had enough medical staff to keep patients safe and the medical staff matched the planned numbers on the day. Overall, the service had a good skill mix of medical staff on each shift and this was reviewed on a regular basis.

However, staff told us that weekends on the department could be challenging due to the volume of patients attending and reduced levels of staff availability. Medical staffing rotas provided by the trust showed, on average, a 50% reduction in consultant and junior doctor cover during weekends. However, consultant cover still met the required 16 hours of on-site cover and there was junior doctor presence 24 hours a day to keep patients safe.

Staffing rotas provided by the trust highlighted some shortfalls in middle-grade level and junior doctor staffing numbers over the previous two months. Staff told us that the medical staff rotas were planned for 14 middle-grade doctors, but, only 10 were in post. Whereas, gaps in junior doctor numbers were due to absence.

The department provided over 16 hours of consultant cover each day, seven days a week in-line with the 16 hours recommended by the Royal College of Emergency Medicine (RCEM). The service always planned 24-hour consultant cover with a consultant physically present on the department between 8am and midnight, seven days a week. Between midnight and 8 am there was an on-call consultant available. The service always had a consultant on call during evenings and weekends.

At the time of the inspection only one consultant with a Certificate of Eligibility of Specialist Registration (CESR) remained on a fixed term contract within the department. The trust told us they were both actively in the process of advertising four specialist consultant roles across both emergency department sites, as well as discussing plans for the current locums to move onto permanent contracts.

Urgent and emergency services

The trust-wide vacancy rate for medical staff in May 2022 was 14.12% against an overall target of 15%.

The trust-wide turnover rate for medical staff had reduced from 10.17% in June 2021 down to 9.38% in May 2022.

Trust-wide sickness rates for medical staff had increased from 1.56% in May 2021 up to 3.67% in April 2022.

The department managers informed us that medical staffing is planned two weeks in advance, with any potential gaps initially being addressed by adjusting the current staffing pool's scheduled hours. Any remaining shortfalls are then advertised for bank and agency staff to fulfil. We saw evidence that the trust actively monitored medical staffing and provided us with the standard operating procedure for the escalation process to executive-level, which included hourly staffing reviews, when staffing on the department was deemed to be potentially unsafe.

Records

Staff kept detailed records of patients' care and treatment. Most records were clear, up-to-date, stored securely and easily available to all staff providing care.

We reviewed 10 patient records during the inspection. All hand-written notes were detailed and appropriately stored.

We were provided with the most recent records audit data from March 2022 which highlighted that the department performed well. However, within the random sample of 30 patient records which were reviewed, only 67% had vital signs documented at triage and 77% had recorded the patients' national early warning signs (NEWS) score. The audit also highlighted that only 48% of a total 124 entries made within the 30 patient files had been time stamped to enhance accuracy.

Patient information was also readily available electronically on various screens showing an overview of patient locations within the department and a summary of their presenting condition.

When patients transferred to a new team, there were no delays in staff accessing their records due to use of the centralised recording system.

Staff told us that there were visible safeguarding alerts on the system for vulnerable patients which assisted in accurate information sharing and ensuring patient safety.

Medicines

The service used systems and processes to safely prescribe, administer and store medicines. However, staff did not always document a patient's prescribed medicines in their record following their initial assessment.

Upon receiving treatment within the department staff followed systems and processes to prescribe and administer medicines safely and there was evidence of critical medication being prescribed and administered in a timely and appropriate manner.

We reviewed 10 patient records during the inspection which showed staff completed medicines records accurately and kept them up-to-date. However, the most recent patient records audit highlighted only 37% of the 30 patient records checked had current prescribed medications documented in their notes.

Urgent and emergency services

Staff stored and managed all medicines and prescribing documents safely and we saw evidence of patient allergies clearly documented during the prescribing process. The department now prescribed and administered oxygen to patients appropriately in-line with best practice guidelines and regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008.

We saw evidence displayed in the staff only areas that the department learned from safety alerts and incidents to improve its practice.

Nursing staff compliance with medicines management awareness training was 88.46% and 81.48% for medical staff.

The service had an up to date restraint and sedation policy in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff we spoke with knew what incidents to report, how to report them in-line with trust policy and provided recent examples to demonstrate their knowledge.

The department manager told us that the trust shared learning with their staff about serious incidents that happened elsewhere in the trust.

Staff understood the duty of candour and gave us examples of when the principles had been applied. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers met monthly to discuss quality and safety and staff received feedback from investigation of incidents, both internal and external to the service and met to discuss potential improvements to patient care. There was evidence that changes had been made as a result of feedback and the department clearly displayed incident information and themes, as well as learning points resulting from previous risk factors. Staff also had the opportunity to attend weekly educational sessions to discuss learning from incidents in greater detail.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations and Managers debriefed and supported staff after any serious incident. We also saw two examples of recent serious incidents which had been fully investigated by the trust and the lessons learned from each.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Urgent and emergency services

Evidence-based care and treatment

Whilst the service provided care and treatment based on national guidance and evidence-based practice, we were not assured the service consistently used the findings to make improvements to achieve good outcomes for patients. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The service did not consistently assure all staff had completed mandatory training to ensure they were competent for their roles. Managers did not always appraise staff's work performance.

The service was not meeting the trust target for mental capacity act and deprivation of liberty training for medical staff.

However, the department followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) Guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The department received support from psychiatric liaison which could be accessed 24 hours a day.

Every patient attending the department had their mental health needs taken into consideration throughout the triage process with a further Management of Adults with Mental Health Presentations within the Emergency Department risk assessment being completed if any signs of mental health crisis were identified. Staff could complete additional care plan documentation for children experiencing mental health crisis within the department. Although this enabled staff to complete a further holistic assessment, it did not enable staff to categorise and rate presenting levels of risk.

Nutrition and hydration

Staff gave patients enough food and drink to meet their nutritional needs whilst accessing the department. However, the trust were unable to provide any additional audit data following the inspection.

During the inspection we saw multiple examples where patients had been provided with food and drink from staff after accessing the department.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and we saw some examples in patient records where staff had completed fluid and nutrition records where needed.

Although we saw evidence of staff promoting the nutritional needs of patients and their relatives/carers, the service informed us that no departmental nutrition and hydration audits had been completed in the last three months by the clinical audit department.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw evidence in records that patients received pain relief soon after it was identified they needed it or they requested it. The most recent departmental audit score for use of the correct pain assessment tool was 100%.

Patient records indicated that staff prescribed, administered and recorded pain relief accurately. In the most recent pain scoring in adults audit which was completed in September 2021, out of a sample of 60 patients, 93% had their pain score recorded. As part of the same audit, a further 20 records were identified where patients had required analgesia following initial assessment. Sixteen out of the 20 patients identified had been provided with pain relief.

Information and guidance was clearly displayed within the staffing areas to promote staff awareness of ensuring a consistent approach to pain management within the department across both hospital sites.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and worked hard to achieve the best possible outcomes for patients.

For acute trusts, NHS England's operational pressures escalation levels (OPEL) had been nationally defined as being levels one to four, with four being the highest level of operational pressure. At the time of the inspection the hospital was running close to full capacity, causing delays in patient transfers and discharge. Despite the challenges, staff worked hard to achieve positive outcomes for patients.

The service advised that there were no national clinical audits that the emergency department was eligible for. However, it participated in relevant Royal College of Emergency Medicine (RCEM) audits and we saw examples of quality improvement projects for pain in children, infection control and most recently the neck of femur fractures audit for which the hospital site submitted 102 cases. All of which were measured against national standards. The department also participated in the UK Trauma Audit and Research Network (TARN).

We saw evidence that managers and staff carried out a programme of repeated audits to check improvement over time. Regular support was provided to the department by the Quality Team and Clinical Educators and the information gathered from audits was shared with staff and used to improve care and treatment.

From 01 July 2021 to 30 June 2002 the trust's unplanned re-attendance rate to urgent and emergency care within seven days was 8.7% and similar to the national average .

Competent staff

The service made sure staff were competent for their roles. Managers reviewed staff's work performance and held supervision meetings with them to provide support and development. However, not all staff had up to date appraisals of their work.

Managers supported staff to develop through constructive clinical supervision of their work, identified any training needs their staff had and tried to give them the time and opportunity to develop their skills and knowledge. However, at the time of the inspection 26 out of 55 Nursing and Midwifery registered members of staff did not have an up to date appraisal.

We requested but did not receive data from the trust showing appraisal rates for medical staff.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The trust provided a full induction tailored to their role before they started work which gave a good overview of the department.

Urgent and emergency services

We saw practice education and development displays in the staffing areas focusing on the basic nursing care needs as well as more specialised areas of learning unique to the local population. Staff told us that they had the opportunity to discuss training needs with their line manager and the recent input from the clinical educator had played a key role in supporting to develop their skills and knowledge.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw evidence of meeting minutes and news bulletins on display within the staff room which could be easily accessed.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. During the inspection, we saw examples of multi-disciplinary working with occupational therapy to support patient discharge, as well as input from diagnostic services to help inform the most appropriate treatment pathway for patients.

Staff worked across health care disciplines and with other agencies such as social care, addictions services and mental health services when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. The department could refer patients to psychiatric liaison services 24 hours a day. During the inspection, we did not see any patients attending the department requiring support with their mental health needs. However, staff informed us that there is often a lack of beds for patients requiring psychiatric admission, as well as a lack of community-based resources for patients experiencing mental health difficulties to access when ready to leave the department.

Seven-day services

Key services were available seven days a week to support patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. However, the department could experience delays accessing support due to the overwhelming demand being placed upon the hospital and wider integrated care system.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support. We saw a small selection of leaflets within the waiting area which patients could access. Within the department additional information on health conditions prevalent in the local community were also on display, such as diabetes management and promoting awareness of diabetic ketoacidosis.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Medical staff did not keep up to date with training on the Mental Capacity Act and Deprivation of Liberty Safeguards. However, staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Urgent and emergency services

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, only 50% of medical staff had completed relevant training.

However, staff understood how and when to assess whether a patient had the capacity to make decisions about their care and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. We saw some examples within patient records where staff had assessed and documented patients' capacity prior to commencing treatment in their best interests.

Staff gained consent from patients for their care and treatment during triage in line with legislation and guidance.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw two examples where staff had completed relevant MCA documentation and followed appropriate guidance. Information documented was accurate and legible.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

In the department staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff introduce themselves and explain who they were and their role. They spoke quietly to patients to try and ensure they maintained a level of patient confidentiality.

Patients told us staff treated them well and with kindness and that they were happy with the care and support provided despite their frustrations with the long waits to receive it.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients' needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Urgent and emergency services

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw multiple positive interactions wherein staff were ensuring the emotional wellbeing of both patients and their relatives/carers

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them and undertook training on breaking bad news.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Due to ongoing COVID19 restrictions and the recent surge in attendances, only patients who required carer support were allowed into the department accompanied.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Within the department patient feedback and the actions taken by the trust to act upon concerns were clearly on display. Within the staff room we also saw examples of positive patient experiences and highlighted good areas of practice.

We requested an overview of feedback received from the Emergency department patient survey. However, the trust only provided an overview of the National Inpatient Summary. Despite this, patients and relatives told us that staff took the time to make sure that they understood their care and treatment.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

Due to the hospital running at full capacity and a lack of community-based resources there were delays in treatment and discharge from the service. However, the service worked with others in the wider system and local organisations to plan care.

Although we saw evidence that managers planned and organised services so they met the needs of the local population, for example, we saw was information displayed to ensure staff awareness of diabetic ketoacidosis due to the high prevalence of diabetes within the local population. The service still did not meet some of the relevant recommended standards set out in the RCPCH Facing the Future: Standards for children in emergency care settings guidance.

Due to the increasing numbers attending the department, patients could experience long stays and delays in treatment. Patients we spoke with told us they had attended hospital as they could not get an appointment with their GP surgery and despite the long wait, knew they would be seen in the emergency department.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. Staff spoke positively about the support of psychiatric liaison. However,

the trust highlighted that there was a lack of suitable resources available within the community for patients experiencing mental health difficulties. We were told that patients experiencing mental health crisis would present to the department to seek support and often there would be delays discharging patients due to difficulty accessing appropriate community-based services.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We saw positive interactions between staff and patients with complex needs to ensure they remained settled on the department.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

During the inspection we saw patients whose first language was not English, receiving support from multi-lingual members of staff and through the use of a portable translator to ensure their needs were clearly communicated. However, despite the diverse local demographic, there were no additional patient information leaflets or signage within the department provided in other languages. However, they were available if requested.

Managers made sure staff, and patients, loved ones and carers could get help from the trust interpreting service which could offer support with face-to-face interpreting and translation.

Access and flow

The trust faced ongoing challenges with access and flow which meant that they could not ensure people were able to access the department and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in-line with national standards.

Patients could not access the department in a timely way and the trust faced known challenges with access and flow. Managers and staff worked to make sure patients did not stay longer than they needed to. However, this was not always possible due to increasing numbers of patients attending the department, lack of available beds within the wider hospital and wider pressures within the integrated care system. Trust-wide overall accident and emergency attendances had increased by 20% on the previous year, with a 58% increase in paediatric attendances recorded for the period March 2021 until February 2022.

Staff told us that there were regularly 20-25 patients waiting for a bed at the start of the day-shift and at the time of the inspection 15 patients had been on the department for over 12 hours and three patients had been waiting for over 24 hours, with the longest wait recorded as one day and 14 hours due to the lack of an available bed within the wider hospital.

The initial assessment is provided at reception by an Urgent Care Practitioner as patient arrives who determines the most appropriate care pathway for the patient. This is completed during the hours of 8am and 8pm, seven days per week. Outside of these hours a traditional triage model is put in place.

Patients had their physical observations taken in a side room adjacent to the main desk, with an additional side room being made available during particularly busy times. Triage was then completed within the department. During the inspection we saw patients waiting in excess of two hours to be triaged.

Outside of these hours reception staff had been provided with a list of red flags relating to specific conditions which should be escalated to the triage nurse. Examples included vaginal bleeding, shortness of breath, severe nose bleed, head injuries, eye injuries, chest pain, burns and allergic reactions and severe abdominal pain.

Due to the UCS operating hours at the time of the inspection, there was a transition between UCS closing and a traditional minors stream commencing after 8pm. This switch sees patients booked onto the Emergency Department electronic system to be seen as minors, as opposed to the system used for UCS. This process was in reverse in the morning for the commencement of UCS. To support this a different staffing model commences to provide a minors stream.

Similarly, a Same Day Emergency Care (SDEC) unit had been created on-site for patients with minor ailments, deemed suitable for rapid assessment and same day discharge. This pathway could be accessed directly through the emergency department, via GP referral or via ambulance conveyance. At the time of the inspection we were told the operating hours were 8am until 8pm – We completed a night time visit at 7.45pm and the staff on-shift reaffirmed this point. However, staff told us that patients could experience long stays on SDEC due to issues with patient flow and patients regularly remained on the unit after the scheduled closing time. We saw an example of one patient experiencing an extended stay on SDEC due to there being no available surgeon, which we escalated to senior management. Staff told us that accessing the support of senior clinicians from medical and surgical wards to facilitate treatment and discharge had been an ongoing challenge, despite following the escalation process.

We also witnessed an agency doctor being redeployed from the emergency department to SDEC to ensure there was clinical oversight to facilitate patient discharge or admission. This took place at what should have been the scheduled closing time for SDEC.

Staff allocated to SDEC also advised that there were ongoing issues with patients being inappropriately referred to the unit for treatment and staff were unable to describe to us the set criteria for attendance. For example, the Standard Operating Procedure (SOP) for the department indicated that patients experiencing symptoms of stroke would be excluded from attending SDEC. However, staff informed us of occasions where patients showing signs of stroke had been referred into the department for treatment.

Trust-wide data for direct ambulance referrals for the period September 2021 up until May 2022 indicated that approximately one third of referrals had been deemed as inappropriate. For example, out of the 219 person-sample, 22 patients could have been treated in the community and a further 19 patients could have been accommodated via alternative treatment pathways within the hospital. We were told that patients would be regularly transferred back to the emergency department, creating additional access and flow pressures.

Following the inspection, the trust provided us with assurances that the operating hours for both UCS and SDEC would be extended until midnight from 01 August 2022 with the deadline for new patients accessing SDEC to be two hours prior to closure. This change followed the division's plan to follow a 24/7 model.

Ongoing assessment of patient risk within SDEC would be completed in-line with the emergency department's two-hourly board rounds which would assist in identifying patient risk and ensuring appropriate use of resources. The trust also provided evidence that there would be increased oversight from senior management and a more robust escalation process for staff to follow to ensure appropriate use of these care pathways, which would help to relieve pressures placed upon the emergency department.

For the period 01 June 2022 until 30 June 2022, 6307 patients attended the emergency department, with an overall average waiting time recorded as approximately five hours and 30 minutes.

The most recent data provided by the trust highlighted that only 16% of patients attending the department had achieved the Department of Health's standard for emergency departments four hour wait target. Of the same sample of patients obtained between 01 June 2022 and 30 June 2022, 42% waited between four and 12 hours from decision to admit to admission and the longest recorded wait for admission was over 58 hours.

Data for July 2022 highlighted that 532 patients spent more than 12 hours on the department from decision to admit to admission.

Data provided by the trust for June 2022 showed 1.38% of patients left the department before an initial assessment and 0.86% of patients left after receiving an initial assessment, but before receiving treatment.

The department continued to experience delays with ambulance handovers as a result of ongoing access and flow issues trust-wide. The average ambulance handover time for week commencing 18 July 2022 was 77 minutes, with 58 minutes recorded the previous week and 22 minutes recorded during week commencing 04 July 2022. Only 24% of ambulance handovers were completed within the national target of 15 minutes during the four weeks prior to the date of inspection on 26 July 2022. Data for the same period also highlighted that 23% of ambulance handovers had taken over 60 minutes.

There had been a steady increase in the percentage of ambulance attendances taking over 30 minutes to handover from March 2022, with performance seeing an improvement at the end of April 2022 to 12%, falling in line with the integrated care system average.

Due to the ongoing challenges faced with ambulance handovers, processes had been put in place for patients required to wait in ambulances until a bed became available within the department. The Hospital Ambulance Liaison Officer (HALO) advised us that emergency department staff would regularly check on patients in ambulances when there was a long wait. In the case of a pre-alert for sepsis, space would be found on the department to facilitate treatment.

Managers and staff started planning each patient's discharge as early as possible. However, due to a lack of community-based resources or limited bed availability, it was not always possible to discharge or transfer patients in a timely manner, particularly for those with complex mental health and social care needs. Although there were no patients presenting with a mental health problem at the time of the inspection, staff described prompt initial assessment from mental health services. However, there could be delays in discharge if a mental health act assessment or psychiatric hospital admission was required.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Urgent and emergency services

Patients, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in all patient areas. Staff understood the policy on complaints and knew the process on how to handle them.

From 29 June 2021 until 29 June 2022, approximately 45% of all of the complaints received at Diana Princess of Wales Hospital related to emergency care. Trust-wide only one complaint regarding the emergency department had been referred to the Parliamentary Health Service Ombudsman (PHSO) within the previous 12 months, which the PHSO chose not to investigate following review.

Managers investigated complaints, identified themes and shared feedback with staff and learning was used to improve the service. Staff we spoke with could give examples of how they used patient feedback to improve daily practice and we saw examples clearly displayed in the staff room for ease of access. Staff knew how to acknowledge complaints and we saw examples on display where patients had received feedback after the investigation into their complaint.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However, there was a lack of consistent senior management oversight of the Same Day Emergency Care (SDEC) unit which was having a significant impact upon access and flow within the emergency department.

We saw evidence the nurse management leaders had the relevant skills, knowledge, experience and integrity to run the service.

The trust acknowledged the current challenges with staffing, an issue which was actively being investigated to promote stability and sustainability.

Nurse managers we spoke with understood the challenges to quality and sustainability. We saw evidence of regular departmental audits and action plans with evidence of progress against most of the actions. Senior management were aware of any shortfalls in audit results and there was evidence of accountability for this.

Although we saw evidence of consistent leadership and management oversight on the emergency department, a lack of robust local managerial oversight within the Same Day Emergency Care (SDEC) unit was having a direct impact upon service delivery within the emergency department.

Urgent and emergency services

Vision and Strategy

Due to a lack of resources in the wider integrated care system there had only been limited progress made by the service. Although the service had implemented various changes and improvements since the last CQC inspection, these were not always done in a proactive and timely manner. However, the service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

There was a clear vision in place, however, due to ongoing pressures within the wider integrated care system, the trust experienced difficulties putting their vision and strategy into practice.

Goals such as reducing ambulance handover times and improving overall departmental waiting times had not been achieved due to both internal and external factors effecting access and flow. We saw examples of a reactive approach to resolving issues rather than proactive, such as the decision to extend the operating hours of the urgent care service and same day emergency care unit to ease pressures on the department after our inspection.

The vision and strategy was directly linked to the upcoming opening of the new department. This was clearly displayed within the current department and highlighted targets for 2022 which included the development of care pathways within urgent and emergency care, continuous development of staff skills and service improvement targets such as improving ambulance handover times.

Each member of staff we spoke with was focused upon the move to the new department and optimistic for the future of the service.

Culture

Staff on the department felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff had been resilient in their response to the ongoing COVID-19 pandemic. However, staff had found their situation challenging and described being tired.

There was a recognition that the wellbeing and morale of staff was impacted over the past year. Senior leadership told us they recognised the pivotal role staff resilience had played in maintaining the urgent and emergency care system despite the tremendous pressure it was under.

Despite the challenging circumstances, staff were positive about working within the service and praised the teamwork and educational ethos. Staff felt there was good support from senior members of staff. There was also information on display for staff to ensure they cold access the Professional Nurse Advocacy service to discuss both professional and personal matters.

Governance

Leaders operated governance processes throughout the service. However, these required further embedding. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Urgent and emergency services

We saw evidence of the use of governance processes to monitor standards of performance at both departmental level and trust-wide, and signs of improvement from the last inspection. However, outcomes of departmental and trust-wide audits did not always meet the highest possible standards, training compliance rates were below the trust target and not all staff had an up to date appraisal.

In regards to the issues identified with SDEC, we were not assured that all relevant mechanisms were in place to ensure the effective management of the unit. Embedding of policies and procedures was poor and need to be consistent and sustained to ensure overall improvement.

Staff we spoke with clearly understood their role within the wider team and took responsibility for their actions.

Management of risk, issues and performance

Not all must-do actions identified at the last inspection had been addressed by the trust. Further development of adopting a proactive approach to resolving risk and performance issues is still required. Despite this, leaders and teams understood the ongoing pressures within the department. They used systems to monitor and manage performance and they identified and escalated relevant risks to reduce impact.

The service had failed to ensure that mandatory training compliance rates were in-line with trust targets, as well as ensuring appraisals were up to date for all staff.

Although the service ensured paediatric patients were supported by nursing staff with adequate skills in caring for children when attending the department, the trust still did not meet relevant recommended standards in regards to ensuring enough registered sick children's nurses cover was available.

Service leads also acknowledged they needed to address medical staffing within the department, with a large proportion of staff remaining in-post as locums. The trust provided assurances that steps were being taken to address this issue in order to ensure a consistent and stable workforce could be put in place within the new department.

Patients accessing the department continued to experience extended waiting times in excess of the four hour benchmark and ambulance handover times were frequently in excess of the national standards. However, patients told us that despite the long wait treatment, they were happy with the care provided to them and it was evident that staff worked hard to achieve the best possible outcomes for all patients.

Senior managers met on a monthly basis to discuss trust-wide quality and safety, as well potential improvements to patient care. There was evidence that changes had been made as a result of feedback and the department clearly displayed incident information and themes, as well as learning points.

The senior management team based within the department met on a weekly basis to discuss performance data and risk. We also saw evidence of regular quality audits completed across multiple areas within the department in order to identify shortfalls in performance and to mitigate potential risks to patient safety. However, ongoing work was required to improve consistency.

We saw some progress against must-do actions identified in the last inspection report, with oxygen now being prescribed and monitored in-line with relevant guidelines, as well as the designated mental health treatment room complying with Psychiatric Liaison Accreditation Network standards.

Urgent and emergency services

Information Management

The service collected reliable data. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We saw evidence of effective data management both during the inspection and when receiving additional data from the trust post-inspection.

Information was stored securely at department-level and could only be accessed by staff using a unique log-in.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They had developed relationships with partner organisations to help improve services for patients.

Regular meetings were held at trust-level with other external organisations such as the neighbouring local authorities to help improve patient experience.

The trust had implemented ongoing work as part of its Patient Experience Priorities, which was in place to improve the patient experience when accessing the service. This was based upon listening to patients and gathering feedback in order to align service delivery with the needs of the local population and to ensure the highest possible standards of care are being delivered.

Staff were invited to engage with the trust-wide staff survey which had an overall response rate of 38% with overall satisfaction in all question areas being below the national average.

Learning, continuous improvement and innovation

Shortfalls remained in overall compliance with trust-wide training targets. However, staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Although nursing and medical mandatory training compliance rates were not in-line with the trust target of 85%, there was evidence that the nurse managers, along with the clinical educator and matron, had taken steps to promote a learning culture which adhered to both Royal College of Emergency Medicine and NICE (The National Institute for Health and Care Excellence) guidelines.

We saw information and guidance on display in the staffing areas of the department to promote awareness of issues such as sepsis, use of antimicrobial prescribing, mental capacity and safeguarding guidelines.

We saw evidence that the departmental learning and development programme followed Royal College of Nursing standards to ensure staff had the relevant competencies in place to progress to a higher grade.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff; however not all staff had completed it in line with trust guidance.

The trust set a target of 85% for completion of core mandatory training.

Not all nursing and medical staff had completed their mandatory training. The trust sent evidence to support training compliance within the medicine division for nursing and medical staff training. Mandatory training for nursing staff showed a compliance rate of 76.73%. Mandatory training for medical staff showed a compliance rate of 64.77%.

At the last inspection we told the trust they must ensure mandatory training compliance met the trust target. Both nursing and medical staff did not meet the trust target range.

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. We reviewed the trust action plan to address concerns raised following the last inspection regarding training compliance. A number of training modules had been transferred to online learning to allow greater access for staff. Training was monitored divisionally and discussed at monthly divisional performance review meetings.

Workforce development plans were being developed for each speciality within medicine supported by senior leaders from human resource business partners (HRBP) down to clinical leads to ensure a clear downward message to achieve engagement and compliance.

Managers told us difficulties that had impacted on compliance included, high patient acuity, staff sickness, staff isolation due to COVID 19 and operational pressures. The trust had reported several episodes of Operations Pressure Escalation Levels (Opel) level four where the trust had increased operational demand due to pressures. This impacted on staff training which had to be cancelled. Opel level is a method used by the National Health Service to measure the stress, demand and pressure a hospital is under, with Opel 4 representing a high escalation level. Opel 4 is declared when a hospital is “unable to deliver comprehensive care” and patient safety is at risk.

Mandatory training was on the risk register, the division had developed a task team. The human resource business partner was working closely with the head of nursing to improve staff compliance. The division had plans in place to provide trainee doctors access to the training platform in advance to commencing employment with the trust. Rotation of doctors had impacted on the data.

Managers were focused on training which carried the most risk, where compliance was below target range. Senior leaders met weekly to review training compliance with a rotating agenda.

Train the trainer models had commenced for moving and handling and resuscitation training to address low compliance.

Due to staffing pressures, staff across wards could have time allocated (one day) on the rota to complete online training outside of their clinical shifts. This was included in their working hours and supported flexible learning.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it; however not all staff had completed the training in line with trust guidance.

Nursing and medical staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

At the last inspection we told the trust they must ensure safeguard training compliance met the trust target of 85%. Staff received training specific for their role on how to recognise and report abuse.

The trust provided training data which evidenced both nursing and medical staff did not meet the trust target of 85% for some safeguard training modules. Safeguarding adults level two training showed a compliance rate 81.34% which did not meet the trust target. However safeguarding children level two showed a compliance rate of 85.50% which did meet trust target range. There were plans in place to improve compliance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff discussed safeguarding risks during patient handovers and staff huddles.

Staff demonstrated awareness and understanding of safeguarding. They knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Medical care (including older people's care)

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness.

The patient led audit of the care environment (PLACE) audit had not re-started since the suspension because of the COVID 19 pandemic. The formal PLACE audit was planned to re commence in 2023.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning staff were able to articulate the differing cleaning solutions used in line with guidance.

There were adequate supplies of hand gel and PPE in all areas we visited but we did not see prompts at some ward entrances to remind or encourage staff and visitors of hand hygiene. This put staff and patients at risk of potential harm from cross infection.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We observed differing staff at all levels not wearing face masks correctly in clinical areas in line with trust and national guidance. All clinical staff were bare below the elbow to enable effective cleaning of their hands.

Patients deemed to be a high risk due to exposure of infectious disease or potential to infectious transmission were isolated (barrier nursed) appropriately.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw a number of examples where domestic staff and nursing staff had cleaned equipment and clinical areas.

There were designated isolation side rooms for patients with COVID-19 symptoms or who were known to be COVID-19 positive. Staff knew which side rooms were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy.

Wards we visited reported low or no cases of clostridium difficile (C. diff) and methicillin resistant staphylococcus aureus (MRSA). Staff described how they worked with the trust's infection prevention control team on a programme of quality improvement at ward level.

We reviewed the trusts infection rates from June 2021 to May 2022. The trust provided trust wide figures within this timeframe which evidenced reported infection rates as MRSA bacteraemia (0) and clostridium difficile (0).

We asked the trust to provide hand hygiene audit results where they had checked the compliance score of hand hygiene completion. We reviewed the trusts hand hygiene audit data May 2022 which evidenced a trust wide compliance rate of 95%. The results were a cross section of 939 staff observations.

The trust undertook audit for sepsis screening in line with the National Institute for Health and Care Excellence (NICE). NICE guidance for sepsis stipulates that patients presenting with one or more high risk criteria should receive antibiotics within an hour of it being identified.

Sepsis is a common condition where the body's immune system goes into overdrive in response to an infection. Septic shock is a subset of sepsis, which describes circulatory, cellular, and metabolic abnormalities which are associated with a greater risk of mortality than sepsis alone.

The most common sites of infection leading to sepsis are the respiratory, gastrointestinal, renal, and genitourinary tracts.

Mandatory training on sepsis had been introduced. Sepsis formed part of the acute life-threatening events recognition and treatment (ALERT) course training for nursing staff. This had changed in February 2018 and incorporated a formal competency assessment with staff having to achieve a certain level to pass the course. The trust provided evidence of staff compliance at site level which evidenced nursing and medical staff compliance of 39.37% against a trust target of 85% for deteriorating patient training. Senior leaders told us face to face training had been impacted due to the COVID pandemic. Additional courses had been planned for 2023.

We reviewed the trusts training compliance figures for sepsis training (May 2022) which evidenced trust wide training compliance of 71% for nurse and medical staffing against a target rate of 85%. The compliance rate at site level demonstrated a compliance rate of 56%. Senior leaders told us operational system and staffing pressures impacted on the low compliance rate. The division was sighted on the need to improve training compliance.

Registered nurses and clinicians undertook sepsis training as an E-learning package. The training was mandatory, and renewal is required every four years. Healthcare assistants/ care navigators completed sepsis awareness using a work booklet.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well; however, did not always adhere to trust policy.

We observed a number of oxygen cylinders (CD, 460 litres) stored on the floor on ward C3 and the discharge lounge. This was a risk to staff, patient's and visitors as the oxygen was not fixed to the wall. The storage of oxygen was not in line with trust guidance.

The door entrance to the acute medical unit was not secure and was left open. The unit cared for frail elderly patients who could be confused and disorientated. This was a security and patient safety risk. We observed fire doors on the stroke unit which were in the open position. This was a fire risk to patient/staff and relatives. We noted that the ward clerk's office door was left open, the office contained patient medical notes. This was a security/patient confidentiality risk as the ward was open to patient visiting twice daily.

Staff did not always dispose of clinical waste safely. At ward entrances face masks and hand gel were readily available; however, we observed bins for face mask disposal had domestic waste bin liners and not clinical waste bin liners in line with trust guidance.

Wards we visited had boards to display public information about the staff on the ward, visiting times, who was in charge, and other useful information, such as mandatory training compliance.

All equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers.

Managers assured us repairs were made promptly if a piece of equipment developed a fault. Medical devices we looked at were mostly labelled to indicate when they were last serviced or checked for electrical safety, and to identify next test dates.

Patients could reach call bells; however, some call bells were not answered immediately due to staffing and operational pressures.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. Emergency resuscitation equipment on each ward had daily and weekly checks completed in line with policy. We checked the resuscitation policy which had a named author, version control and review date in place. We saw that daily checks were recorded as being completed. We checked consumable items, such as medicines, gloves, oxygen masks and suction equipment.

Staff on most wards told us that they had enough equipment to support them to safely care for patients, for example for use when moving and handling or caring for bariatric patients. This included pressure-relieving aids.

Staff in endoscopy received training for specialist equipment from the manufacturers who came into the hospital when necessary. The endoscopy unit had Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards.

Sharps bins were properly assembled, stored off the floor, not over full and signed and dated. Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients' families. The oncology and haematology ward had pull out beds available for patient relatives if they required to stay overnight.

Assessing and responding to patient risk

Staff did not consistently assess and manage risks to patients. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients (NEWS2). This helped staff to identify and escalate deterioration in a patient's condition. The NEWS2 alert system was embedded into practice with individual electronic ward boards providing oversight of the clinical area.

This helped staff to identify and escalate deterioration in a patient's condition. The NEWS2 alert system was embedded into practice with individual electronic ward boards providing oversight of the clinical area.

Patient risk assessments were completed on admission, where appropriate, for falls, nutrition and hydration, pressure area care, dementia and moving and handling. We saw evidence that these risk assessments were used to plan individualised care for each patient and relevant pathways were initiated when required.

The avoiding falls level of observation assessment tool (AFLOAT) included regular observations, physiotherapy assessment and physiological tests such as lying and standing blood pressure monitoring. Staff assessed how often a patient needed to be observed to avoid potential falls during their stay in hospital. The tool has four 'levels' of varying degrees of intensity: two hourly (least intense), hourly, line of sight and arms reach (most intense). An icon on the electronic patient system was used to identify patients at risk of falls.

Other falls prevention measures included low level beds, pressure pads, sensor clips, identification on boards in bays using coloured magnets, non-slip socks and coloured wristbands for patients. Availability of some items varied between areas and staff told us they often applied to a charity for funding for new equipment for example sensor alarms and clips. Some patients required one to one observation but, due to staffing pressures, this was not always possible. Staff told us they would try to cohort patients at risk in the same bay.

The service had a dedicated discharge lounge. The unit had 12 chairs & two bed spaces and was staffed by two registered nurses and two healthcare assistants. We noted there was no dedicated resuscitation trolley within this area. Staff told us they would use resuscitation equipment from AMU or ward C2 (either side of the unit). We did not consider this to be easily obtainable in an emergency situation. The doors at either end of the discharge lounge were fire doors which were closed. Staff told us the emergency alarm could not easily be heard. We requested to see the risk assessment for this area regarding the use of resuscitation equipment. The trust provided assurance that the risk was mitigated. The trusts lead resuscitation officer had reviewed the area and deemed access to the defibrillators on wards either side of the discharge lounge as suitable.

The trust undertook audit for sepsis screening in line with the National Institute for Health and Care Excellence (NICE). NICE guidance for sepsis stipulates that patients presenting with one or more high risk criteria should receive antibiotics within an hour of it being identified.

Mandatory training on sepsis had been introduced. Sepsis formed part of the acute life-threatening events recognition and treatment (ALERT) course training for nursing staff. This had changed in February 2018 and incorporated a formal competency assessment with staff having to achieve a certain level to pass the course. The trust provided evidence of staff compliance at trust level for deteriorating patient training which demonstrated a compliance rate of 52%. Site level training compliance evidenced nursing and medical staff compliance of 39.37% against a trust target of 85%. Senior leaders told us face to face training had been impacted due to the COVID pandemic. Additional courses had been planned for 2023.

We reviewed the trust wide training compliance figures for sepsis training (May 2022) which evidenced trust wide training compliance of 71% for nursing and medical staffing against a target rate of 85%. The compliance rate at site level demonstrated a compliance rate of 56%. Senior leaders told us operational system and staffing pressures impacted on the low compliance rate. The division was sighted on the need to improve training compliance.

Registered nurses and clinicians undertook sepsis training as an E-learning package. The training was mandatory, and renewal is required every four years. Healthcare assistants/ care navigators completed sepsis awareness using a work booklet.

Staff knew about and dealt with any specific risk issues.

The trust provided data to evidence the number of patient falls and pressure ulcers reported from June 2020 to May 2022. In May 2022 the division reported 18 hospital acquired pressure ulcers (grade 2) with an additional three hospital acquired pressure ulcers (unstageable) The division had reported 32 patient falls with no harm and 13 with minor harm in May 2022.

Recording of physiological observations was audited and reported as part of the nursing audit dashboard. Site data for April 2022 demonstrated a compliance rate of 88.6%. The trust target rate was 85%.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff could make referral requests on the IT platform and or request over the telephone.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. We reviewed the hand over sheets on all wards we inspected. We observed that key risks were discussed, and information disseminated to reduce risks. Staff told us that individual wards instigated safety huddles as part of the daily handover process where patient risks were discussed including: staffing, number of patients, risk of falls, enhanced care patients, high NEWS, end of life, cannula care, pressure ulcers, infections, infection control and COVID 19 swab status and do not attempt cardiopulmonary resuscitation orders.

Staffing

Nurse staffing

It was recognised by senior management that the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift. However, this did not always provide established safe levels of staffing.

Due to national shortages of nursing and support staff and high levels of staff absence the service did not always have enough nursing and support staff to keep patients safe.

There were continuous advertisements for nursing and healthcare assistant vacancies. Managers of the service told us they had increased nurse staffing establishment to allow for absences and vacancies so they could provide continual safe care as much as possible. However, staff in the areas we inspected told us they were often short of qualified nursing staff. The trust undertakes yearly staffing reviews, 2021 review had received a number of challenges with regard funding; however, leaders told us funding had been approved and recruitment was underway. All wards inspected had completed establishment review data collection in May 2022.

During inspection six out of the nine wards we visited did not meet planned verses actual staffing numbers which included registered nurses and healthcare assistants. Ward leaders were not always supernumerary due to low staffing numbers. Ward managers told us they were allocated dedicated managerial hours; however, these hours were often used to work clinically due to staffing shortages and patients requiring enhanced care due to frailty.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior leaders told us they used the electronic staff record (ESR) when redeploying clinical staff to other wards to assess skill and competency. Discussions with ward managers/matrons/bleep holders and risk assessments are completed, based on ward requirements and the staff competency and skill set. Leaders looked across the whole division and moved staff across site when needed based on skills available.

The ward manager could adjust staffing levels daily according to the needs of patients.

Medical care (including older people's care)

SafeCare live was used to support the deployment of staff on a daily basis to keep wards safe and mitigate or reduce risks, it takes into account acuity and dependency of patients and available staff.

SafeCare live is a unique daily staffing software tool matching nursing staffing levels to patient acuity, in real time, allowing informed decision making on staffing levels across the hospital. It enabled visibility and tracking of staff attendance, recording of red flags and professional judgement. Staffing shortfalls were reported and escalated through a red flag report using the SafeCare electronic system.

A short-term nurse staffing standard operating procedure (SOP) was in place to support decision making requirements and responsibilities in and out of hours and actions to be taken when considering opening escalation beds. This included a risk assessment which required senior management approval.

A supportive care policy was in place to support identification of patients requiring a heightened level of support and care to ensure safety was maintained and to ensure staffing resources were appropriately allocated through a robust assessment and escalation process.

Divisional morning 'huddles' were instigated with the matron of the day attended by the ward shift leads to highlight concerns they may have in relation to dependency, acuity and staffing levels. This enabled an early response and support to be planned by the divisional senior nursing team.

Matrons ensured acuity and dependency levels had been updated on Safecare live and added mitigation, their professional judgement, and changed the risk/colour appropriately to reflect the staffing risk level following the actions taken.

SafeCare data was reviewed at the trust wide safe staffing meeting (attended by matrons and chaired by deputy or associate chief nurse) where deployment of staff and mutual aid across divisions was agreed. The meetings were also attended by a representative from the temporary staffing office to support timely actioning of requests and issues.

An overview of staffing risks and any potential operational implications that may require additional mutual support or system support was also shared at trust operational meetings held three times a day. Matrons and site duty managers (out of hours) liaised across divisions and sites to ensure all possible mitigating actions were taken.

The Safecare model was used by all wards and reviewed as part of staffing meetings. The trust had a clear escalation process for making staff moves and recorded this on the rostra to ensure oversight of staff moves.

The number of nurses and healthcare assistants did not always match the planned numbers.

The division had a matron of the day role within medicine with responsibility for nurse staffing allocated on both sites across the trust.

We observed a bed meeting where matrons and senior staff discussed staffing and acuity across the wards on both hospital sites.

The trust provided vacancy, sickness and turnover rates at trust level from June 2021 to May 2022 for registered nurse.

Nursing staff vacancies in May 2022 showed a vacancy rate of 13.70% against a target rate of 8.00%.

Medical care (including older people's care)

Nursing staff turnover in May 2022 showed a turnover rate of 11.96%

Nursing staff sickness in April 2022 showed a sickness rate of 3.67%. In the last eight reporting months (August 2021 to March 2022), trust wide sickness rates for nursing and midwifery staff ranged between 6.5% and 6.8%, which was statistically similar to the sector averages.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe.

Medical staffing did not match the planned numbers; we found issues when talking to medical staff about day and out of hours cover, particularly overnight. At our last inspection we said the trust must ensure safe medical staffing levels were maintained and every effort should be made to recruit to vacancies.

At this inspection junior doctors at both sites said that there were vacant posts with no appointment and when on call especially at night and weekends there was always gaps in rotas. Junior doctors told us they received emails daily from the medical rota co coordinator asking juniors to agree to extra shifts. For example, on the first day of inspection at DPoW the ED department were two registrars down on the night shift. All junior doctors were emailed requesting additional shifts to cover the gap.

The trust provided site level data to evidence the numbers of rota gaps in the medical rota from July 2021 to June 2022. Rota gaps were impacted due to vacancies, COVID, Isolation and other sickness. The data for June 2022 highlighted 310 rota gaps were covered by agency staff and 137 gaps were covered by internal bank staff.

Leaders told us short notice gaps are immediately added to the locum management system (LMS) and emailed out to all local clinicians to try and fill rota gaps. Gaps are also shared with the clinical lead and medical director at the daily rota meeting and escalated throughout the day until shifts are covered. This was reflective of what we saw on inspection.

Senior leaders told us there were consultant vacancy gaps in the gastroenterology service due to recent staff turnover. The division had advertised the posts and had covered the gaps with locums.

The division had recruited advanced clinical practitioners (ACP), two had been appointed at SGH. A business case was ongoing to cover funding to recruit 13 additional ACP’s to work across site. The curriculum was linked to the university of Sheffield and Hull.

The guardian of safe working (GoSW) at the trust was managed by a consultant doctor. The guardian of safe working hours ensures issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.

We reviewed the guardian of safe working report (April 2022) which evidenced (January 2022 to March 2022) there had been a total of 89 exception reports submitted through the allocate exception report system. Exception reporting is a

contractual mechanism which doctors in training can use to report patient safety, rostering and training concerns. This showed an increase of five exception reports from the last quarter (October 2021 to December 2021). Of the 89 exception reports submitted, 77 of these were linked to hours. This showed a decrease of 11 reports from the previous quarter. The exception reports relating to hours had been agreed by the GoSW for either payment or time off in lieu (TOIL).

From January 2022 to March 2022 there were two exception reports submitted where doctors raised an immediate safety concern in addition to either a concern around working hours or clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern.

Any exception report which flagged immediate safety concerns was investigated by the GoSW administration and progressed appropriately. The two safety concerns related to staffing. Both were from the same department. One concerned a lack of staffing at a junior level, and one concerned a lack of consultant cover. Both of these issues had been addressed and the situations resolved by the GoSW.

The trust provided vacancy, sickness and turnover rates at trust level from June 2021 to May 2022 for medical staff; however, this was not site specific

Medical staff vacancies in May 2022 showed a vacancy rate of 14.12% against a target rate of 15.00%.

Medical staff turnover in May 2022 showed a turnover rate of 9.38%.

Trust wide sickness rates for medical and dental staff have been consistently similar to the sector averages for the past 12 months. In the latest month, March 2022, sickness rates were 2.6%, compared to 1.7% sector average. Sickness rates for medical staff in April 2022 showed a sickness rate of 3.67%.

The division had dedicated rota coordinators in post to support medical staffing.

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Records

Staff did not always keep detailed records of patient's care and treatment. Not all records were completed in line with trust policy or stored securely, however they were easily available to all staff providing care.

Staff used an electronic patient record supported by paper records for each patient. The trust had implemented a medical assessment document which was available on the IT platform. The trust had plans in place to trial a paperless record system. Senior leaders told us the urgent care service was now paperless at the DPoW site.

Patient notes were mostly comprehensive, and staff could access them easily. We reviewed 10 full sets of patient notes and sections of patients records when looking at examples of care we had observed across the medical wards inspected.

We saw some gaps in the recording of fluid balance, intentional rounding charts, bed rails assessments and ReSPECT forms. We saw some patient records had been completed in retrospect on ward 16. Staff had recorded activity on the ward and ward pressures had impacted on this. This was a risk to patients ongoing care to evidence complete ongoing assessment with a view to possible deterioration of frail elderly sick patients.

We reviewed the divisions WAT audit data (March to May 2022) which evidenced an average compliance rate of 61.7% for the accurate completion of patient food charts. The results of the WAT are discussed at ward managers/matron governance meetings with the head/deputy head of nursing to address low compliance.

We reviewed the trust wide audit of adult nursing documentation 2020/21. The audit highlighted areas of compliance on individual wards. Areas of low compliance were reviewed on the trust's records audit clinical action plan. Audit findings were reflective of what we found during inspection.

Information governance training for both nursing and medical staff showed a compliance rate of 82.83% which did not meet the trust target of 85%.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. On all wards we visited notes trollies were mostly left unlocked and unattended with patient notes stored underneath trollies, easily accessible to visitors. Individual patient paper records were stored in folders outside of each bay, or in folders not stored securely in the bay. We also saw a number of computers left unlocked allowing easy access into confidential patient records. This was in breach of trust policy and General Data Protection Regulation (GDPR). This was a must do action highlighted at last inspection.

During inspection we observed that several version control documents had passed the revision date; however, these records were still in use on all ward areas. For example, bed rails assessment (review date September 2021), endoscopy referral request form (review date February 2021) and intravenous cannulation record (review date August 2021). This was highlighted as a should do action at the last inspection.

During inspection of all medical wards we observed confidential waste was stored in paper bags which were unsecured and within easy reach of patients and visitors. We observed confidential ward and patient hand over documents for three consecutive days listing patient names, dates of birth, medical history and treatment plans on the HASU unit. This was highlighted as a concern at the last inspection.

Electronic whiteboards were used on all wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed some systems and processes to prescribe and administer medicines safely. Electronic prescriptions reviewed on inspection all had allergy status records completed.

A patient on one ward was encouraged to self-administer their medicines through an open discussion on their use. Staff completed appropriate patient assessment documents.

However, we found oxygen not prescribed to five patients when it was being administered. Four of these were found to be following admission to the short stay unit. One was after rapid deterioration of a patient overnight but had not been added following the morning multi disciplinary review meeting.

Staff reviewed some patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacists provided a targeted review of those patients on critical medicines as a priority; however, they were not always able to provide a review of each patient due to time constraints.

Staff completed medicines records accurately and kept most of them up to date. Electronic prescriptions reviewed on inspection all had administration records completed.

Registers for medicines that required extra checks were completed and stock audited regularly.

Staff stored and managed some medicines and prescribing documents safely.

Fridge temperatures were monitored centrally, and the system sent the ward personnel deviation warnings for them to action. Medicines requiring specific secure storage were managed appropriately and records of their administration maintained.

Emergency medicines were stored on resuscitation trolleys in accessible areas with regular checks on content and expiry dates an all wards inspected. On the acute assessment unit, one medicine (glucagen) stored on the resuscitation trolley required a new expiry date on removal from the fridge. This had not been amended. Staff checking the trolleys were not aware of the change in expiry date. Also, amendment of some of the liquid preparations after opening was not completed. This would be where manufacturers required specific change in expiry date after opening. This included furosemide, gabapentin and haloperidol.

Staff told us they followed national practice to check some patients had the correct medicines when they were admitted, or they moved between services.

Pharmacy technicians and pharmacists told us they provided the medicine reconciliation service for patients. Pharmacist additionally, completing targeted reconciliation of specific patients.

We reviewed the trusts medicine reconciliation policy (December 2020) which evidenced medicine reconciliation requires an audit to be performed and reviewed by the trust's safer medication group. National Institute for Health and Care Excellence, Quality Statement 120 (NICE QS) recommends checks to be completed within 24 hours of admission.

We received trust wide reconciliation audit data (Quarter 1 2022-2023) which evidenced in June 2022 medicines reconciliation compliance was 70%.

Senior leaders told us the trust target was to undertake medicines reconciliation within 24 hours of admission. This was not always possible. Medicines reconciliation was completed at the earliest opportunity when the pharmacy team reviewed the patient.

Medical care (including older people's care)

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they felt incidents were dealt with appropriately and that learning was taken from them.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Ward leaders could give some examples of recent incidents that had resulted in shared learning for the ward. Feedback and learning from incidents were cascaded to staff both individually and via team meetings. Staff could request to receive feedback via an email linked to the electronic reporting system.

Staff reported serious incidents clearly and in line with trust policy. From 01 May 2021 to 30 April 2022, in accordance with the Serious Incident Framework 2015, the trust reported 54 serious incidents (SIs) in medical care which met the reporting criteria set by NHS England. 72% of these were 'pressure ulcers' (39), 13% were 'slips, trips and falls' (seven) and 6% were 'treatment delay' (three).

Serious incidents were discussed at the weekly SI panel meeting. The governance team received incidents from the division and triangulated within 24 hours for incidents that are not reported as moderate/severe harm. Anything above are reviewed by the panel for transparency.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Incident learning was shared on individual ward boards for openness and transparency.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Ward managers and most of the staff we spoke to knew of the Duty of Candour (DoC) requirements. They understood that this involved being open and honest with patients and had been involved in investigations and responding to patients and families.

Managers debriefed and supported staff after any serious incident.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Medical care (including older people's care)

Patient saftey data was displayed on wards for staff and patients to see. The service continually monitored safety performance. All wards inspected had information to evidence the number of patient falls, pressure ulcers, NEWS audit compliance and hand hygiene audit results.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust's intranet, guidelines, policies, and procedures relevant to their role.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible evidence and in line with national guidance, for example, the acute ischaemic stroke thrombolysis integrated care pathway.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. Teams had access to a psychiatric liaison team on site.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary; however, fluid and food charts were not consistently completed. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff did not always fully and accurately complete patient's fluid and nutrition charts where needed. We observed several fluid balance charts which were incomplete or had no information recorded. Ward managers and matrons completed monthly ward assurance audits (WAT) covering four aspects of care: quality, safety, environment, and patient experience. Audit results were reviewed, and action plans instigated on individual ward areas to address low compliance.

We requested the divisions site level WAT audit data to evidence compliance rates. The trust provided site level compliance from March 2022 to May 2022 which evidenced low compliance rates of 61.7% for the key question surrounding 'have fluid balance charts commenced as per patients' needs and completed accurately'.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The malnutrition universal screening tool (MUST) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition

(undernutrition), or obese. The tool was not always completed fully or in a timely way and weights were not regularly recorded. We requested the divisions site level WAT audit data to evidence compliance rates. Site level compliance from March 2022 to May 2022 evidenced low compliance rates of 88.3% for the key question surrounding is the ward undertaking appropriate MUST screening in accordance with trust policy.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and patients requiring this were frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff used a pain-scoring tool, from one to 10, to assess a patient's level of pain. All staff we spoke with knew about pain assessments and how to score patients level of pain.

Staff prescribed and administered pain relief. Pain relief was prescribed, and staff would request additional pain relief from medical staff, if required. Some staff told us that some pain medications were often given late due to medic requests for prescribing being delayed due to system pressures.

Patients we spoke with told us staff managed their pain in a timely way.

We asked the trust to provide pain management audits where they had checked the compliance score of pain management. We reviewed the trusts ward assurance tool data for May 2022. The trust provided site level compliance from March 2022 to May 2022 which evidenced % compliance for the key question surrounding pain management.

The trust had instigated an acute and end of life pain assessment audit in January 2022. The results evidenced pain assessment charts had been commenced for 92% of patients across the trust demonstrating an increase from 86% in the previous audit in 2021.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant local and national audits and managers and staff used the results to monitor and improve care and treatment. We saw audit information displayed in ward areas and ward managers discussed results with staff.

The trust provided venous thromboembolism (VTE) risk assessment audit data at individual care group level. Data referred to the number of patients who had received a VTE risk assessment within 24 hours of admission. The compliance result (May 2022) demonstrated 97% compliance. The trust standard was 95%. Medical staff completed VTE assessment, information was uploaded onto the trust electronic platform. We saw evidence of this on inspection.

The national Institute of Clinical Excellence (NICE) state 'all patients should receive a VTE risk assessment as soon as possible after admission to hospital or by the time of first consult review by a medic.

Medical care (including older people's care)

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Ward managers and matrons completed monthly ward assurance audits (WAT) covering four aspects of care: quality, safety, environment, and patient experience. The results of the WAT are discussed at ward managers/matron governance meetings with the head/deputy head of nursing. Work was ongoing to make the electronic pull of the WAT data timelier as at the time of writing this report nurses reviewed the latest paper copies during their discussions.

The service had systems and processes in place to monitor patient outcomes including both trust-wide initiatives and ward-based actions, including reducing falls and pressure ulcers. On all wards visited we observed the 'future five'; an initiative introduced by the chief nurse in 2019. Staff told us that aspects of the future five plan included pressure area care and falls, and each ward team was requested to use the programme to develop ideas for improvement around the key points.

We observed different initiatives including implementation of additional training, purchasing of falls equipment and developing a more robust approach to delivering effective pressure area care.

In March 2022, there was a 17% increase in the number of patients seen by a specialist following an urgent GP referral, compared to February 2021 (which was similar to the increase in the North East overall). Total number of patients seen in March 2022 was 1,463, compared to 1,254 in February and around 400 patients less than in March 2019 (pre-Covid-19 pandemic).

The trust was in the middle 50% nationally for the proportion of patients seen by a specialist within two weeks of an urgent GP referral (94%) meeting the national standard.

At the trust 65% of patients seen by a specialist within two weeks following a GP referral for exhibited breast symptoms (cancer not initially suspected), in March 2022, compared to the national average 60%. The trust saw a similar number of patients in March 2022 (69), compared to the previous month (63), but 20% less than in March 2019 (86).

Over the past three months (January to March 2022), the percentage of patients being treated within 62 days of an urgent GP referral improved by 7%. With 64% in March 2022, the trust is in the middle 50% nationally, but below the regional (69%) and England (67%) averages.*(Source: NHS England)*

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. There were medical patients outlying on non-medical wards on the day of inspection.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The trust shared trust wide appraisal data with us for the medicine division which evidenced nursing appraisal compliance as 75.11%, this did not meet the trust target of 90%. The trust did not provide medical staff appraisal data at the time of writing this report. Post inspection senior leaders told us the trust wide compliance rate for staff appraisal for the medicine division was 72% which included both nursing and medical staff. High volumes of sickness due to COVID 19 and staff self-isolation had impacted on appraisal compliance.

Medical care (including older people's care)

Leaders were sighted on the need to prioritise clinical work and training, rather than undertake professional development reviews. Work was ongoing to address low compliance. On all wards inspected ward managers had plans in place to complete appraisals. Managers told us that organisational challenges continued to affect the ability of staff to undertake appraisal due to both availability of appraiser and appraisee, with clinical staff having to work clinically.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The trust provided newly qualified nurses with preceptorship for a period of four weeks. International nurses are provided with preceptorship up to six one year.

Managers supported staff to develop through yearly, constructive appraisals of their work. On all wards inspected ward managers had plans in place to complete appraisals. Managers told us that organisational challenges continued to affect the ability of staff to undertake appraisal due to both availability of appraiser and appraisee, with clinical staff having to work clinically.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. (use this statement if data is divided into medical staff). The division was focused on performance appraisal and development reviews (PADR) for junior doctors looking to provide additional supportive measures to increase compliance in training overall.

The clinical educators supported the learning and development needs of staff. All wards were supported by the trusts clinical practice educators. Clinical areas had substantive band 6 clinical sisters to support the delivery of clinical skills training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Medical care (including older people's care)

We saw there were daily multidisciplinary team (MDT) meetings on each of the wards, attended by a range of nursing and medical staff, clinical support workers, pharmacy staff, occupational therapists and physiotherapists. These meetings included discussions about patients' conditions and needs, clinical care and discharge planning. We observed an MDT meeting and saw that all staff had an input into care and contributions were valued

Staff worked across health care disciplines and with other agencies when required to care for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We observed an example of a referral during inspection, staff told us the psychiatric liaison team were efficient in streaming referrals to ensure patients were seen and reviewed quickly.

Patients had their care pathway reviewed by relevant consultants

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on acute wards, including weekends. Patients were reviewed by consultants depending on the care pathway. We reviewed the notes of 10 patients and found they all had a clinical assessment undertaken by a consultant as required within 12 hours of admission. Staff could call for support from doctors and other clinical professionals, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Funding had recently been approved by the division to implement an alcohol liaison team at DPoW site with the potential for a future role out at SGH.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients are screened on admission for smoking and alcohol intake as part of the admission pathway and offered advice on cessation.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. However, training compliance did not meet the trust target range.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We noted examples in nursing notes of staff formally assessing patient's capacity and taking appropriate actions to ensure safe care and treatment. Patient care records reflected day to day decision making in respect to patient care and documentation of capacity for example receiving personal care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There were examples in patient notes where consent had been sought appropriately to enable safe care and treatment.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Nursing staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards; however, staff compliance did not meet the trust target of rate of 85%. Trust wide data evidenced a compliance rate of 80.49% for nursing and medical staff. This training was part of the mandatory core training. This was highlighted at the last inspection in 2019 as a must do action to ensure training compliance meets the trust target. Senior leaders were sighted on the data results and met quarterly to review and discuss compliance rates within the division.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw three examples where staff had completed relevant MCA documentation and followed appropriate guidance to request a Mental Health Act assessment for a patient. Information documented was appropriate and legible.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Medical care (including older people's care)

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff understood and respected the individual needs of each patient, including personal, cultural, social and religious needs, and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Patients said staff treated them well and with kindness.

We observed many interactions between staff, patients and others (for example carers and relatives) during our inspection. We found all staff to be polite, respectful, professional and non-judgmental in their approach. Staff of all grades introduced themselves to patients, and asked what patients preferred to be called. We observed staff responding to patients' needs in a compassionate and timely manner; the patients we spoke with all had call bells available and those that had asked for assistance said they had not waited long before a member of staff attended. Staff conducted regular comfort rounds to assess patients' needs, such as if they required assistance to the toilet, if they were comfortable and if they would like anything to eat or drink.

Staff followed policy to keep patient care and treatment confidential. Patients bed curtains were drawn when providing care and treatment and nursing and medical staff spoke with patients in private to maintain confidentiality.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.Patients we spoke with said staff treated them well and with kindness.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We saw that patients were well supported emotionally, and staff were caring and empathetic. There was a room available on the wards we visited for the use of patients and families and for staff to hold discussions with patients if they were distressed.

The division had commenced a pilot surrounding the bluebell model. The model was for patients at end of life or living with dementia. staff had a good understanding of this and we saw good examples of patient centred care. Individual wards across the division had canvas bags available for patient property. The bags contained a teddy bear, a pouch for patient valuables and a remembrance book.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Posters were displayed advertising John's campaign for patients who were living with dementia to allow a carer to stay with the patient. (John's campaign is a national movement to promote the rights and choices of people living with dementia).

The division used the 'my life' document that assists health and social care professionals gain an insight and understanding of who the patient is. It included patient likes and dislikes and their care needs, which can help them deliver care that is person-specific and is tailored to their needs. Staff ensured the document was completed by someone who knows the person best, either before the patient's hospital visit or as soon as possible thereafter.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care. A new process had been introduced in September 2021 to give residents across Northern Lincolnshire more say about what happened to them if they needed emergency care or treatment. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is a nationally developed process led by the Resuscitation Council (UK). ReSPECT creates personalised recommendations for a person's clinical care in a future emergency, where they may be unable to make or express choices.

It was designed to allow patients greater influence on what happens to them, and that their wishes are carried out appropriately, should they ever find themselves in an emergency situation where they are not able to express their wants and/or needs. We reviewed ten ReSPECT care records which had been recorded effectively.

The trust provided training data to support the role out of the respect model. Training was provided on 'the purpose of the document' and on 'how to complete the document' through face-to-face training by the ReSPECT facilitator and online, utilising resources provided by the Resuscitation council. The data evidenced 74% of staff had completed ReSPECT awareness training to date.

Medical care (including older people's care)

ReSPECT authorship training became mandatory for doctors in 2020/21. To date 59% of doctors had completed authorship training.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Requires Improvement  

Our rating of responsive stayed the same. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. From 1 December 2010, the collection of monthly Mixed-Sex Accommodation (MSA) breaches was introduced. NHS organisations were required to submit data on the number of occurrences of unjustified mixing in relation to sleeping accommodation.

The NHS Operating Framework for 2012-2013 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient.

All Trusts were asked to resume data submission on the number of unjustified mixing from October 2021 following a period of suspension due to Covid-19 and the need to release capacity across the NHS. The division have had no breaches in medicine. Breaches are discussed in the morning operations meeting and are reported monthly in nursing assurance report.

Facilities and premises were appropriate for the services being delivered. Capital investments to develop new infrastructure was agreed and approved. Work had commenced on new build accident and emergency, integrated assessment unit and same day emergency care units at both SGH and DPoW.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. However, due to staffing shortages, additional one to one or specialised care was not always fulfilled.

The division were working to improve the cancer pathway and had a cancer improvement plan with action plans in place to address cancer appointment waiting times. The division has a dedicated lung cancer nurse lead. The division had funding and plans in place to recruit a lung cancer consultant. The trust worked collaboratively with a joint multidisciplinary team across the Humber network. The gastroenterology service was on the risk register due to consultant gaps. To mitigate rota gaps locum doctors had been appointed short term.

Managers monitored and took action to minimise missed appointments. Detailed capacity and demand modelling had been completed with elective activity recovery plans in place for all medical specialities.

Managers ensured that patients who did not attend appointments were contacted. The trust offered some outpatient clinics as virtual appointments. Patients are screened by administrative staff to ensure that virtual appointments are convenient and accessible. Traditional outpatient clinics were still operational; however, capacity was limited due to social distancing.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Wards were designed to meet the needs of patients living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The trust had a dementia strategy (July 2021) and worked closely with the carer's association to support carers of people with dementia; an information leaflet had been developed for carers. The trust had appointed two full time dementia clinical nurse specialists based at DPoW and SGH. The service celebrated dementia awareness week each year, undertaking promotional activities.

The service had introduced a flag system within the digital platform and a bedside magnet to enable staff to identify patients with dementia. During inspection we noted that dementia champions were visible on both clinical and non-clinical departments.

The trusts had introduced a safeguarding and vulnerability strategy (2022/2024). The strategy was developed to embed the safeguarding and vulnerabilities agenda across the trust.

The acute frailty care team were based on the same day emergency care unit where elderly patients were assessed and treated by a multidisciplinary team. This team had established links with acute and community services to initiate speedy treatment and care packages in the patient's home to be able to prevent inappropriate admissions and provide more appropriate care. The patients could return to the ward for day care treatments or further tests as necessary. Staff could admit patients via the site manager if needed.

Medical care (including older people's care)

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed a meal service during inspection and saw examples of differing food options available.

Staff had access to communication aids to help patients become partners in their care and treatment.

The trust continued to use software called reminiscence interactive therapy activities (RITA) which helped patients with dementia to recall memories and relax in the hospital environment. It encouraged conversation and interaction between patients, their families and staff, by running reminiscence sessions, creating life stories, playing interactive games, listening to music or watching movies. We saw patients enjoying using the software on the stroke unit.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Patients were being moved sometimes multiple times in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment.

We inspected the pathway of medicine patients from admission in accident and emergency/GP referral to point of discharge. Patients were assessed on admission to determine what treatment pathway was required. There were differing pathway options available within the medicine speciality.

The hospital had significant capacity problems due to the high number of patients who had the right to reside and there was no care package immediately available for discharge to be carried out safely. The situation was made worse by the complexities of COVID 19 pathways and keeping some patients isolated. Staff were required to monitor the number of delayed discharges and look at how to manage these effectively.

We noted a large number of patients on the medicine wards we inspected with the right to reside who had been in hospital over a period of several weeks. ‘Right to reside' means you have the right to live in the United Kingdom. On the day of inspection, the hospital site had 35 patients with the right to reside who were medically optimised patients fit for discharge.

Patients were waiting for a package of care, a discharge to assess bed in the community or continuing healthcare assessments to progress their discharge. There were many patients waiting for community hospital beds for rehabilitation after an acute illness and these patients had complex needs with most wanting to return to their own home.

Medical care (including older people's care)

Due to complexities in assessing patients who needed onward care, and the lack of care packages available to be purchased or arranged by social services, there were long delays in discharging patient's home. The staffing shortages in adult social care providers had a detrimental effect on the whole system of access and flow for medical care. Significant pressures on partner organisations for home care & domiciliary care, resulted in significant discharge delays.

Working closely with system partners the trust had implemented a discharge to assess (D2A) model. The trust created two hubs one at the Scunthorpe hospital and one at the Diana Princess of Wales hospital. The hubs received electronic D2A requests internally and facilitated the discharges by linking with community/social care.

Daily twelve noon D2A escalation meetings were chaired by clinical commissioning group (CCG) leads Monday to Friday and led by clinical matrons at weekends working with system partners to ensure clear action planning for delayed discharges.

Leaders of the service told us that continued IT system & reporting improvements were required to ensure all data was captured and reported accurately by the trust IT systems.

The trust reported significant system capacity issues across Northern Lincolnshire resulting in delayed discharges for patients on a discharge to assess pathway.

A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available.

Barriers to timely discharge included transport delays, completion of an electronic discharge summary, awaiting medication and implementation of care packages.

From December 2021 to April 2022, the percentage of delayed discharges increased from 75% to 82% but had since reduced to 79% (as of May 2022) which was similar to both the regional and national averages of 75%.

At the trust, the top reason for patients continuing to reside for over 14 days was 'pathway 2: awaiting availability of rehabilitation bed in community hospital or other bedded setting' (36%), which was a 10% increase from the previous month and 13% higher nationally. This was followed by 'pathway 3: awaiting availability of resource for assessment and start of care at home' (20%). This was similar to the regional and national levels. A similar picture can be seen for patients continuing to reside over 21 days.

At our last inspection we said the trust must continue to monitor referral to treatment times and the average length of patient stay for elective and non-elective specialties against the England average. The data evidenced from February 2021 to January 2022, the average length of stay for medical elective patients at the trust was 5.1 days, compared to 5.5 days for the preceding 12-month period.

The trust instigated effective meetings to address long length of stay and discharges. A daily patient list was populated identifying all patients in beds identifying length of stay, right to reside and if patients were on the D2A pathway. Final work was underway to ensure there was a live electronically generated list of all patient positions on all wards seven days per week.

In April 2022, the trust treated 71% of patients within 18 weeks (admitted and not admitted) compared with 76% regionally and 71% nationally.

Medical care (including older people's care)

The total number of patients treated has steadily increased since April 2021. In April 2022, 8.3% more patients were treated compared to April 2021, which was over a third less than the increases seen regionally (31.2%) and nationally (32.9%).

At the trust, 1.9% of patients had been waiting more than 52+ weeks for treatment (as of April 2022), which was amongst the lowest in the region and lower than the regional average of 3% and national average of 5%.

Senior leaders were aware of the pressures within the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. During these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the two.

Community and the therapies division were developing six workstreams to support discharge and admission avoidance.

The division had a discharge lounge improvement group to improve quality and utilisation of discharge lounges.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to do this. In March 2022, the trust treated 71% of patients within 18 weeks (admitted and not admitted) compared with 76% regionally and 71% nationally.

The total number of patients treated has steadily increased since April 2021. In March 2021, 15% more patients were treated compared to February 2021, which was similar to increases seen regionally (16%) and nationally (13%).

At the trust, less than 1% of patients had been waiting more than 52+ weeks for treatment (as of March 2022), which was amongst the lowest in the region and lower than regional (3%) and national averages (5%).

The service moved patients only when there was a clear medical reason or in their best interest. It was recognised as adding stress and anxiety for patients if they were moved. Staff tried not to move patients between wards at night. Patients were allocated beds throughout the night with planned moves to take place the following morning. However, staff told us this was not always possible due to the high demand on beds and sometimes patients were moved between wards at night.

The trust provided data which evidenced the number of bed moves undertaken in a 24 hour period in July 2022 for all specialities. The data evidenced 29 patients had been moved within this timeframe, three patients had been transferred throughout the night from midnight up to 08.00am. Senior managers were aware that additional work was required to ensure that patients were not moved out of hours.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

The trust employed care navigators who were responsible for the discharge process surrounding patients who had the right to reside. All wards we visited had full time care navigators in post. We spoke with a member of staff from the team who explained that part of their role was to assist in arranging the transfer of patients to other wards and to facilitate discharge for medically fit patients. We were told that timely and safe discharges were a priority. To achieve this, care navigators liaised with patients' families, social care teams, community nursing teams and care homes. If necessary, they were able to arrange home support and equipment.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number of delays and took action to prevent them. Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. During the inspection there was one medical outlier at DPoW hospital We were told that outliers were managed by using a 'buddy system' which ensured they were seen by a doctor every day and that tests were initiated, and results were reviewed. We tracked the outlying patient which evidenced daily medical review with discharge plans in place.

Ward managers cohorted where possible any medical outlying patients on specific wards using as few locations as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. Complaint leaflets were available on all wards inspected.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

The trust shared with us data for complaints and compliments received between April 2021 and March 2022. 45% of all complaints the trust received were related to the division of medicine and 28% of compliments received related to the medicine division.

Information sent from the trust showed that complaints were investigated, and themes were identified. The main themes of complaints were around inappropriate discharge, coordination of medical treatment, lack of explanation of care, poor nursing care and staff attitude.

The service displayed information about how to raise a concern in patient areas in all the wards we visited.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared with us examples of complaints that they had received and investigations and outcomes that came from them.

Medical care (including older people's care)

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had oversight of the service as a whole; however, we were not always assured that leaders understood the priorities and risks the service faced at ward level. Staff told us they were not always visible and approachable in the service for patients and staff. However, they supported staff to develop their skills and take on more senior roles.

The division of medicine was led by two divisional medical directors, associate chief nurse, head of nursing, associate chief operating officer (COO) and a general manager.

We saw examples of leadership at site level with regard communication with matrons and ward managers. Specific medicine wards had differing leadership from onsite matrons. Staff told us they felt supported by matrons and senior nurses.

Leaders we spoke with felt that they were visible. However, staff on the wards did not feel that there was leadership visibility aside from ward managers and matrons at local level.

The trust had instigated a nursing, midwifery and allied health professional future 5 and beyond strategy 2021-2024. The strategy builds on feedback sought through engagement events including conversations with the chief nursing team, the trusts 15 steps programme, speaking with external partners, surveys and walk arounds in clinical areas discussing key priorities with individual teams.

The 15 steps challenge focused on ward walk-arounds where the team considered their first impressions of the area from the perspective of a service user. The roll out was part of the future 5 nursing and midwifery priorities for 2019 and 2020 which had been developed by the chief nursing team. The 15 steps programme was one of a number of initiatives implemented to provide feedback about the challenges staff face on wards, as well as the experience patients receive.

The future 5 and beyond aligns with the trusts strategic vision and quality priorities supporting the organisation on its continuous journey of improvement. The strategy aimed to develop practice of continuous learning and development, develop a valued and respected workforce, use resources effectively, continue to embed and raise professional standards and provide high quality innovative care.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Medical care (including older people's care)

The medicine division business plan for 2021-2022 (year three of the five year strategy), set out how the trust implement an integrated plan to deliver urgent and emergency care, specialty services, cancer care, and elective and out-patient care at levels commensurate with the Care Quality Commission (CQC) 'Improving together' plan. The divisional strategy was published and shared across all staff groups in 2021.

The Trust agreed six priorities, set out in the Strategic Plan 2019 - 2024:

1. Integrated urgent and emergency care
2. Transformed outpatient services
3. Improved partnerships with community, primary and social care networks
4. Enhanced in patient services
5. Reconfigured specialties onto one site where appropriate
6. Restructured cancer services
7. Establish a workforce to support sustainable service models in line with CQC recommendations and transformation plans, including non-clinical structures and functions.

The trusts ambition was to deliver safe high quality patient centred services in line with the trust's key priorities with and in delivering this achieve a rating of 'good' across all CQC domains with a focus of creating and maintaining confidence in our services.

The division strives to transform its services to improve the acute patient pathway and elective care services and improve the performance against constitutional targets for standards in A&E waiting times, cancer, referral to treatment times (RTT) and zero overdue follow up appointments.

Senior leaders had an annual workforce plan (2021/2022) and were sighted with regard overall recruitment of staff from nursing, medical and non clinical staff. The division had highlighted speciality hotspots and the impact this would have on the service.

Culture

Not all staff felt respected, supported, and valued. However, they were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us there was an open culture and they felt confident to raise concerns with their managers.

Staff members that we spoke with expressed their frustrations at the ward moves their team encountered due to short staffing across the division. Staff told us that staff shortages often impacted on patient care as gaps in staffing were not always filled.

Overall, we found staff morale to be low. However, staff spoke proudly of their colleagues and the hard work they encountered during the pandemic, they said they felt valued by their peers but felt there was a disconnect between clinical and executive staff.

Staff survey results were shared as they were received into the division and individual areas had the opportunity to review and discuss their specialty results.

The division reviewed the most recent staff survey and identified the key areas surrounding, visibility and engagement, safety and governance and speciality specific actions

The trust provided evidence to support staff health and wellbeing. For example, senior nurse huddles, wellbeing conversations and supporting ward managers.

In the North East region, Northern Lincolnshire and Goole NHS Foundation Trust had the lowest overall score in the NHS Staff Survey 2021 (53.3). The National average was 56.3. The trust scored significantly below average in all areas and there was significant deterioration for two themes, morale and staff engagement.

The division reviewed the most recent staff survey and identified the key areas surrounding staff culture and moral. The division commenced monthly staff engagement events from May 2022 and committed to continue these during July, August and September 2022 to focus on both areas.

The division worked closely with human resources, occupational health, organisational development, and the freedom to speak up guardian to ensure staff have every opportunity to share feedback and were signposted to appropriate support where necessary.

Metrics for the culture transformation programme were being defined to include; workforce committee metrics, health and wellbeing, inclusion and attraction.

Governance

Leaders operated governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities, however we found examples where processes were not undertaken in line with guidance. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

We found a number of examples on inspection where processes were not undertaken in line with trust and national guidance which had been highlighted as concerns at the previous inspection. For example, mandatory, safeguarding and Mental Capacity Act and Deprivation of Liberty Safeguards training did not always meet the trust target. This was highlighted at the last inspection as a must do action. At this inspection some training compliance for nursing and medical staff was below the trust target range.

Oxygen was not routinely prescribed. This was highlighted at the last inspection as a must do action. At this inspection standard prescribing for oxygen was not undertaken in line with trust policy or best practice guidance.

Not all version-controlled documents were not reviewed in line with trust policy and national guidance. This was highlighted at the last inspection as a should do action. At this inspection we found a number of documents which had expired and were not version controlled.

Confidential waste was collected in waste bags, stored under ward reception desks which contained confidential patient information. This was highlighted at the last inspection as a must do action. At this inspection we found confidential waste stored in paper bags on all wards we inspected which was not stored securely.

Medical care (including older people's care)

Medical notes trollies were not locked on most wards inspected, records were stored underneath and on IT trollies. This was highlighted at the last inspection as a must do action. At this inspection patient records were not stored securely.

Nursing and medical staff appraisal rates did not meet the trust target. This was highlighted at the last inspection as a must do action. At this inspection appraisal rate compliance did not reach the trust target rate.

We were not assured that leaders had addressed all the key concerns highlighted at the last inspection. This was reflective of what we found during this inspection.

We reviewed the integrated governance report June 2022. The report included formal complaints, serious incidents, NICE guidance, risk register, mortality update and document control. At trust level the division of medicine had reported 10 serious incidents (seven at SGH). Common trends and themes were highlighted with associated actions assigned.

The department had a series of reports feeding into key meetings within the division, demonstrating the use of performance information to allow oversight and governance of improvement work. The reporting process was reviewed and discussed at a number of forums including medicine board, medicine governance, ward managers meetings and performance review and improvement meeting (PRIM).

We reviewed the minutes of the divisional clinical governance meeting for May 2022. items were aligned to the integrated performance report so that local leaders and the board were aware of the same issues and risks. We noted discussion such as mandatory training, IPC, risk, appraisals, complaints, incidents, and performance were considered at the meetings.

Management of risk, issues and performance

Leaders and teams mostly used systems to manage performance effectively. They did not always identify and escalate relevant risks and issues to identify actions to reduce impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

During inspection we noted there was no room temperature monitoring in clinical treatment rooms. This had not been highlighted as a risk or managed in accordance with individual manufacturer guidance.

The trust gave assurance of their intention to develop a room temperature policy and to implement daily readings of maximum/minimum room temperatures in clinical treatment rooms. Following approval of the policy the trust intended to roll out the process to include escalation should temperatures fall outside of range. The trust intended to audit this practice using the safe and secure medicine audit.

The trust Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) had commenced. We saw examples of ReSPECT forms in differing patient notes. The ReSPECT form has been in place for approximately 15 months across the Trust. Training was provided on ‘the purpose of the document’ and on ‘how to complete the document’ through face-to-face training by the ReSPECT facilitator and online, utilising resources provided by the Resuscitation Council. 74% of staff have completed ReSPECT awareness training at trust level.

ReSPECT authorship training became mandatory for doctors in 2020/21. To date 59% of doctors have completed authorship training, this is a 4% increase on the reported position (February 2022).

The ReSPECT model process created a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

We reviewed the medicine risk register. All the risks had action owners, updates on progress, mitigation, and review dates. There was 67 risks on the medicine risk register in total. Ten risks were rated as high, 53 moderate, four as low.

The leadership team were aware of their main risks and could explain the actions in place to mitigate their risks. Risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk and were regularly reviewed.

We saw governance boards on individual wards which displayed monthly governance information updates. The information included individual wards top three incident themes, falls and pressure ulcer statistics, three things that had gone well and learning from incidents. The boards also included messages for sharing, patient feedback, three things individual wards wanted to improve upon, staff achievements, mandatory training and staff appraisal compliance data.

Individual wards also displayed weekly team huddle information. The information included highlights surrounding star of the week, wellbeing at work, team messages, what's new, hot topics, achievements and performance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure; however, staff did not always adhere to trust policy with regard data security. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on all wards inspected. For example, notes trollies were left unlocked on all the wards we visited. Some computers with personal information were left unlocked and accessible.

Staff could access information technology (IT) systems to record and view information such as test and x-ray results and patient records. Patient records were mostly electronic, and many assessments were integrated into the trust's electronic patient record system. However, staff spoke about the difficulties in using both paper and electronic records with many complaining of the system being too slow and difficulties sometimes having access to IT equipment.

Staff we spoke with demonstrated they could locate and access relevant information and records to enable them to carry out their day-to-day roles. This was sometimes slowed down by connection issues with the software system that was in use.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training, and appraisals.

The service managed and used information appropriately to support its activities. The website contained detailed information about the differing wards, site maps, innovation and how to book an appointment.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The division provided patient feedback initiatives which had commenced following feedback, some examples include the purchase of additional wheelchairs and ramps, bluebell pilot model launched for patients at end of life, a pain collaborative quality improvement project is now underway and responsive visiting reviews under way.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The trust participated in the Friends and Family Test (FFT)

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged quality improvement.

The trust has established routes and continues to innovate by establishing learning networks and groups with representatives from each division. Staff are encouraged to identify quality improvement projects and undergo mentorship through to completion.

We saw evidence to support how new systems and processes were evaluated, implemented and embedded. Recent examples included implementation of the integrated assessment units across site, discharge to assess and the frailty pilot.

The division had launched the medicine and quality safety forum, a bi monthly learning and educational event which was managed across both sites. Staff are encouraged to submit topics for discussion.

Divisional staff meetings were held at all levels. Staff were encouraged to attend meetings in order to share ideas and concerns.

Surgery

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, managers did not make sure everyone completed it.

At the time of our inspection the division's role specific training compliance for nursing staff was 80.34%. This did not meet the trust target of 85%.

At the time of our inspection the hospital's overall mandatory training compliance for nursing and medical staff was 87.72%. This did not meet the trust target of 90%.

We reviewed mandatory training figures by module for all divisional staff. Hospital staff compliance varied between 100% for the preventing radicalisation and prevent awareness (3 years) module and the safeguarding children level 3 module with 66.67%. Staff achieved the trust target of 90% compliance in eight of their 18 modules.

The service had a continued focus on improving mandatory training compliance, especially in safeguarding and PREVENT (anti-terrorism and anti-radicalism of vulnerable people) modules. However, we heard theatre staff had no ringfenced or protected time to complete mandatory training.

On our last inspection in September 2019 we told the service it did not have effective systems and processes to ensure mandatory training was completed. We found mandatory training compliance was particularly poor for medical staff.

On this inspection we found limited improvement. The division's overall mandatory training compliance for medical staff was 70.68%. This did not meet the trust target of 90%. We heard completion rates were lower within certain specialties such as urology.

We heard work was progressing across all specialties to improve medical staff's mandatory training compliance. The division made all mandatory training modules available on work booklets or online.

However, as of 8 February 2022 the division only achieved 42% mandatory training compliance for the deteriorating patients module. This was similar to the previous six months. Divisional leads recognised deteriorating patients training attendance was quite poor.

The division's latest sepsis mandatory training data for March 2022 achieved 82% compliance for sepsis awareness and 69% for sepsis training. The division achieved 84% mandatory training compliance for sepsis in January 2022. Sepsis training compliance had decreased by 2% from January to March 2022. This still fell below trust target and needed improvement.

Surgery

The mandatory training was comprehensive and met the needs of patients and staff. Divisional managers were asked to always review mandatory training as part of any staff appraisal and update job plans accordingly. Service managers and secretaries supported consultants by giving them booklets. Service leads cascaded trainers to help their staff complete harder to access courses such as manual handling.

Leads told us their governance lead was undertaking a quality improvement (QI) course on mandatory training to support each specialty to sustain progress.

Managers monitored mandatory training and alerted staff when they needed to update their training. Leads explained some face to face mandatory training availability was reduced during COVID–19, but dates were sent to wards for specific core sessions. Leads were trying to organise face to face divisional sessions by consultant specialty; for example, so all the urologists could complete resuscitation training as compliance was low.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and knew how to apply it. However, they did not always complete the training.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. However, this was not always completed. On our last inspection in September 2019 we found medical staff's safeguarding training compliance was below the trust target.

On this inspection we still found medical staff did not always complete their safeguarding training. The surgical clinical director acknowledged safeguarding training compliance was still poor amongst medical staff. They confirmed this was significantly below trust target and could offer no solutions for how to improve compliance.

All theatre and recovery staff who worked with children were safeguarding level 3 trained. However, only two-thirds (66.67%) of all staff had completed this mandatory training module overall.

Staff we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We observed four children seen in theatres, two of which had learning disabilities (LD). Staff understood how to safeguard these patients by responding to their needs and involved their families.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We reviewed safeguarding adult concerns raised by surgical ward staff from September 2021 to June 2022. The most common concern category was community-acquired pressure ulcers.

Staff contacted or requested reviews by the hospital safeguarding team to understand the origins of any injury or harm from external sources. Since July 2021 this could be done through a trust database.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff kept equipment and the premises visibly clean. However, they did not always use equipment and control measures to protect patients, themselves and others from infection.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Domestic staff in theatres told us they were responsible for managing clinical waste. Staff told us their deep cleaning team were responsive.

We saw 'our commitment to cleanliness' noticeboards on all wards. These detailed a cleaning summary and gave wards a rating out of five stars. All wards were up to date and had achieved four or five stars. This met the trust standard for cleanliness.

We saw monthly hand hygiene audits took place on SDEC for the first six months of 2022. We reviewed the division's hand hygiene dashboard for audit completion up to 31 May 2022. All the hospital's surgical wards had at least ten areas audited during the month. However, the main theatres only had one audit in May 2022.

Divisional hand hygiene audit compliance was high across all areas from 1 March to 31 May 2022. 12 out of 18 wards achieved the trust target of 95% or above compliance. Five of these 12 wards achieved 100% compliance.

Staff identified how well the service prevented infections. However, they did not always prevent their potential spread. We found barrier nursing side room doors on wards were not always kept closed for potentially infectious patients. We were told this was so staff could monitor patients at higher risk of falls but no other mitigating actions had been put in place.

Not all staff we spoke with were aware of procedures to follow when managing patients with infectious diseases.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We saw B7 ward staff members not wearing their facemasks correctly

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw cleaning staff on most wards we visited who used 'I am clean' stickers and cleaned commodes well.

Staff worked effectively to prevent, identify and treat surgical site infections. The trust submitted data on their elective hip and knee operations and infections to the surgical site infection (SSI) surveillance service at Public Health England (PHE). We reviewed the high impact intervention (HII) dashboard summary breakdown by site. The hospital's number of SSIs from total knee and hip replacements had stayed at zero for the three years before our inspection; since quarter 1 2019/20.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We saw patient beds on all ward areas had buzzers and red cords patients and their families could pull for emergency help.

On our last inspection in September 2019 we told the service they must ensure patients on the hospital's pre-assessment ward have access to an emergency call system.

In response the service had taken action by requesting an emergency patient call system in the waiting room and the main waiting area. Managers had undertaken a clinical area review to identify any gaps. Emergency buzzers were tested weekly using a safety checklist. The unmanned patient waiting area had a call system that could be left with the patient. All staff we asked knew where the emergency call system buzzers were.

The service had no incidents in the six months up to March 2022 related to their department's patient call bell system or emergency buzzers. However, there was still not an emergency buzzer in the main waiting room.

Surgery

The design of the environment followed national guidance. On our last inspection in September 2019 we told the service it must continue to monitor and take action to reduce mixed sex accommodation breaches at the hospital

On this inspection we found the service had made some improvement in their number of and response to breaches. However, this was still an ongoing trustwide issue.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff told us they followed protocol, completed and signed all necessary paperwork for any breaches. Managers and ward staff on high observation bays (HOBs) were looking to anticipate any breaches to respond and resolve them faster, but this was not always possible

We found environmental issues in theatres which posed a potential risk to patient safety. The children's theatre had no adaptations to soften the environment and make it more child friendly. The hospital had outdated and confusing signage, as some wards had changed surgical specialities or departments since COVID-19 and signage had not been updated.

We found two control of substances hazardous to health (COSHH) cupboards were unlocked in theatres. We also found two cupboards unlocked with hazardous lotions which should have been in the COSHH cupboard. We asked staff why these were not locked, and they said new starters did not have a key. This meant there could be accidental contamination or unauthorised use or removal of these substances.

Staff carried out daily safety checks of specialist equipment. We reviewed staff's daily equipment checks for the ward or unit adult.

The resuscitation trolley between wards B3 and B4 had no signature or date on Saturday 11 June to indicate it had been checked. The rest of June 2022 was completed. Ward staff completed weekly battery checks on defibrillators.

Staff told us there was only one hoist available at the hospital to weigh patients unable to leave their beds. At the time of our inspection this was unavailable as it had been broken long-term and was being repaired. This caused ward staff to estimate patient's weights using old data. This meant there was a risk staff made clinical decisions based on less accurate observations. Accurate weights would be needed for prescribing some medicines such as paracetamol and those used in prophylaxis of deep vein thrombosis.

The service did not always have enough suitable equipment to help them to safely care for patients. We found defibrillator pads for children in their theatre had expired in May 2022. Staff told us they had tried to contact the resuscitation department or procurement to replace these urgently. Equipment failing or being unavailable was the fifth most common reason for hospital non-clinical cancellations from 1 June 2021 to 28 June 2022. 43 cancellations occurred for this reason.

Staff told us there were shortages of computers on wheels on some wards, as digital devices to help staff record and monitor patient observations went missing. We saw several staff at nursing stations sharing desktop computers.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified patients at risk of deterioration. However, they did not always quickly act upon escalating these patients appropriately.

Surgery

Staff used a nationally recognised tool to identify deteriorating patients. Staff followed the national early warning score (NEWS2) pathway. The service had pathways and processes in place to escalate deteriorating patients. These were overseen by the associate chief nurse.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service completed risk assessments for all patients identified as 'at risk' using a combination of the trust's clinical software system and paper assessments. Patients were escalated through matron huddles, nutrition and monitoring such as NEWS.

All wards we visited had daily team huddles attended by all nursing staff. They discussed any staffing shortages, issues or concerns, patient acuity, patients of concern, definite or possible discharges that day and any patients who needed social care input before updating safe care accordingly. Latest topics and issues discussed at huddles were written on team huddle boards under categories such as performance, achievements, team messages and wellbeing at work.

The service completed risk stratification against national criteria for all their inpatients on the waiting list. Service leads followed up and risk stratified all overdue patients who had waited over 52 weeks. Staff then appointed and manually tracked high risk patients within four weeks of their risk stratification. The service had a dedicated staff member to track overdue patients in ophthalmology due to a high number of patients on the waiting list.

Staff did not consistently understand when and how to escalate deteriorating patients. For example, medical and nursing staff we asked on one ward lacked clarity or awareness of any documented NEWS escalation processes. These staff reported there were no scores or triggers, they just called the resuscitation team. This was different to a ward manager who told us any patients with a NEWS of 5 or 6 were escalated to junior doctors. However, the manager added if patients NEWS reached 7 or above ward staff immediately rang the registrar medic on call. This meant there was a potential risk staff working on or moved between different wards may not escalate deteriorating patients appropriately.

As of 11 March 2022, the division achieved 92.5% overall compliance for staff completing NEWS observations within 30 minutes. This met the trust target of 90%. At the time of our inspection the trust was reviewing an electronic solution for rapid escalation of patients with a raised NEWS with plans for implementation.

The trust audited their deteriorating patient and sepsis screening as part of their priority audit programme. Eight hospital cases were reviewed with a NEWS2 score of 5 or 6 during February 2022 being identified whilst admitted. Three of these cases had evidence escalation not appropriate for the patient. We saw the risk of deteriorating patients not being escalated appropriately was on the trustwide risk register This risk was added in July 2018 with many controls in place to mitigate the risk.

On previous inspections since and including November 2016 we found the trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) surgical checklist. The checklist is a simple tool designed to improve communication and teamwork by bringing together the surgeons, anaesthesia providers and nurses involved in care to confirm that critical safety measures are performed before, during and after an operation. However, from a review of records and observations of procedures, it was apparent this was not an embedded consistent process.

On this inspection we were still not reassured staff's WHO checklist compliance was completely embedded within theatres.

Surgery

We observed staff were non-compliant with the WHO checklist's '5 steps to safer surgery' policy. This was not always documented as staff were not always aware this needed to be completed. Staff completed checklists on paper rather than on the trust's new clinical software system. The system had the facility to complete these electronically which would have raised documentation gaps and errors early on. We asked theatre staff why they completed checklists manually and they said the system was not always accessible and sometimes crashed.

We observed the WHO checklist's blank pre-operative patient marking verification was not subject to any staff (surgeon or ward) signing for at least six cases we reviewed. Marks on patients were physically present but staff did not sign these as having been checked.

For ophthalmic patients needing an injection area, the form had just one tickbox to indicate staff's WHO checklist compliance. As the WHO checklist works by staff reading each prompt aloud and confirming details for each, the absence of a written checklist in this service meant there was no governance/evidence staff completed each step. As ophthalmology is a high-risk specialty this meant there was a greater risk of staff oversight, omission or error as checklist elements were easier to forget or ignore.

We found theatre staff were not completing the theatre register during procedures which was a legally required document but not part of the WHO checklist guidelines. This meant these oversights would not be audited as part of staff's checklist compliance. None of the theatres we visited had registers completed by staff as per national policy. We asked staff where they completed the theatre register and some stated the procedures were entered into the trust's clinical software system. However, many staff were unaware the theatre register had to be completed and did not complete hard copies. Staff told us the surgeon had to complete the theatre register and they did not complete these due to problems accessing their clinical software system.

We reviewed the theatre live observations of team briefs and WHO time outs from 31 March, 27 May and 11 June 2022 for theatre six. March's live observation showed all staff were not present for the team brief as it lacked two staff members. It also noted one staff member entered the scrub room intending to start scrubbing for the procedure as the 'time out' started.

The division audited the WHO checklist and team brief which covered the '5 steps to compliance'. These were documented as completed and discussed at the confirm and challenge meetings.

We reviewed theatre WHO audits for the hospital which took place at least monthly. From 29 June 2021 to 25 June 2022 the audits were scored as achieving 100% compliance as all boxes were answered 'yes'. The audit's results were not indicative of what we found on inspection. This meant divisional leads were unaware of the risks of theatre staff omitting or not documenting vital stages of the WHO checklist.

Ward staff knew about and dealt with any specific risk issues. Nursing staff we asked understood and knew how to respond to symptoms of sepsis. Ward staff followed the sepsis 6 pathway and used red and amber flags to alert them to patients at higher risk of sepsis.

Staff used a power business intelligence (BI) dashboard to monitor the deteriorating patient and sepsis. The trust had implemented a sepsis ICON to provide staff with a visual compliance aid. The division and medicine had appointed a joint lead clinician for DP and sepsis.

Surgery

We reviewed the trust's sepsis and deteriorating patient meeting minutes which monitored NEWS compliance by exception. As of 8 February 2022, the division had achieved 89.6% sepsis compliance. We also reviewed a detailed sepsis report showing data from May 2022. It showed ward B6 was the only divisional ward to complete 100% of their KPI sepsis screenings.

However, leads acknowledged further improvements were needed around sepsis such as electronic recording within ED for screening and non-completion of the sepsis six tool's KPI of antibiotics prescribed within one hour. Designated divisional wards were progressing a digital solution for direct transfer of observations to the trust's clinical software system.

Integrated acute assessment unit (IAAU) staff used a falls multifactorial assessment to determine if a patient was a high falls risk. The assessment considered the patient's age, history, risks and environment. If the assessment had any 'yes' responses staff updated their clinical system risk and completed a falls care plan and avoiding falls level of observation assessment tool (AFLOAT). If all responses were 'no' then staff reassessed the patient on transfer, post fall, if their condition changed or weekly.

We reviewed three care plans for patients following an inpatient fall on the short stay ward. Staff considered their AFLOAT risk level, visibility by putting the patient in a cohort bay and took lying and standing blood pressure readings. They considered therapy reviews and updated patient relatives when necessary.

Staff also completed intentional rounding on wards we visited. We reviewed a completed form for a patient on B7 ward which included the four P's (pain, personal, position, possessions), falls risk, skin checks and a daily turning frequency chart.

We saw pressure ulcer incidents were high on ward 29 during June and July 2022. In response managers implemented refresher teaching and teamwork from the senior nursing and tissue viability nursing teams to improve pressure area assessments and documentation.

Pressure ulcers accounted for 56% of the division's STEIS incidents since May 2021. We followed up with staff how they were working to reduce these. We saw evidence staff completed SSKIN bundles, made timely referrals to the tissue viability nursing (TVN) team and sourced any specialist equipment such as airflow mattresses. SSKIN is a five-step model for pressure ulcer prevention.

However, staff did not always share key information to keep patients safe when handing over their care to others. For example, we saw three patients were transferred without wristbands or any paperwork from A&E to theatres.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. We reviewed the safe staffing dashboard for the four months before our inspection between February and May 2022.

However, the service's workforce was challenged across some services. The hospital's overall fill rate on surgical wards met the trust target of 95% in February 2022 with 95.2% but fell below target for March, April and May 2022. Ward B3 did not meet the overall target for any month during this period.

The total fill rate for care staff from February to May 2022 declined and missed the target every month, from 90.2% in February to 86% by May 2022. The total fill rate for registered nurses exceeded the trust target for three of these four months, except April 2022 with 92.6%. The hospital's nursing staff fill rate mitigated the gaps for their care staff.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. All the service's wards and departments used E-rostering with matron oversight and approval. The service had implemented a nationally recognised tool to ensure safe staffing.

Senior lead nurses held daily nurse staffing meetings to allocate staff and minimise risk.

The service was working through their skill mix and using the safer nursing care tool. Matrons rotated staffing to ensure all areas were clinically safe daily.

The ward manager could adjust staffing levels daily according to the needs of patients. Divisional workforce and recruitment meetings took place monthly. Service leads conducted annual establishment reviews.

The chief nurse reviewed skill mix by undertaking periodic nursing establishment reviews in the surgical division, not including theatres.

The service had mostly reducing vacancy rates overall, including for inpatient and day ward nursing staff up to band 7. The service's March 2022 self-assessment stated their nursing vacancies had improved over the last few months. Divisional leads told us the HOBs had increased their vacancy rates as these areas needed higher numbers of protected nursing staff.

We reviewed the divisional nursing staff vacancy rates trustwide for 10 months of 2021-22 and the first two months of 2022-23 and found some improvement. However, this was still more than twice above the 8% trust target vacancy rate. The division's medical staff vacancy rate easily met trust target of 15%. This showed the division had higher vacancy rates for nursing staff than medical staff.

Medical staffing

The service had enough medical staff with the right qualifications, skills, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

On our last inspection in September 2019 we told the service it did not always have enough medical staff to care for patients and keep them safe.

On this inspection we found the service filled any medical staffing gaps with suitable locum or agency workers once their CV had been agreed and signed off by the clinical lead to ensure the adequate skill mix and knowledge.

The medical staff matched the planned number. We reviewed general surgery rotas and found they were well organised with minimal gaps. The division's number of consultant surgeons (WTE) had reduced by 1% from April 2021 to April 2022. This was in line with the NHS national average.

The theatre manager told us they would like to rescope theatres to reduce and streamline staff.

The service had low and/or reducing rates of bank and locum staff. In their March 2022 self-assessment, the service were working with teams to ensure long-term locums could cover high-risk assessed team members to ensure emergency and elective activity was delivered.

This included plans to ensure the long-term sustainable viability of the rota. The rota was agreed with teams and then followed a robust process at the surgery and critical care (S&CC) board, trust management board, clinical commissioning groups (CCGs) and scrutiny panel.

Managers could access locums when they needed additional medical staff. Divisional leads admitted their locum spend was a little high. At the time of our inspection they planned to fill two urology locum applications.

From July 2022 the trust's criteria for COVID-19 risk assessments was being phased out. As a result, leads hoped their approval of doctors would increase so the locum spend could reduce. They explained the DO5 standard meant they must spend more on weekend doctors. NHS England's DO5 referred to adult critical care clinical reference group's recruitment standards of medical staff. The division were in their recruitment plan's final phase. Locums helped to cover the gaps and extra sessions as their business case had a significant uplift around obstetrics and intensivists.

Managers made sure locums had a full induction to the service before they started work. The service used locums familiar with the trust and their systems and processes who had completed foundation training to undertake specialist work.

The service had a good skill mix of medical staff on each shift and clinical leads reviewed this regularly. At the time of our inspection theatres were allocated by available consultants.

The division had significant vacancies in theatres of operating department practitioners (ODPs). Theatre leads held planning meetings at end of each week to agree cover for any shortfall.

Where divisional leads felt some surgical specialities needed more theatre lists,they p transferred ODPs from specialties with no waiting lists to those with a significant 52-week position.

There were plans in place to implement a healthcare assistant (HCA) to ODP pathway

Surgeon, theatre staff or anaesthetist unavailability was the reason for 100 hospital non-clinical cancellations between 1 June 2021 and 28 June 2022.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not always clear, up-to-date, or stored securely however records were easily available to all staff providing care.

Patient notes were not always comprehensive. However, all staff could access them easily. On our last inspection in September 2019 we found the service's records were poorly organised, not always completed and version control was poor.

On this inspection we found limited improvement as records were not always completed and parts of the patient pathway were lacking. We found no pre-operative notes for six patients whose medical records we reviewed, including one patient with no gynaecological records. This meant there was a risk the surgeon or theatre team would miss important information about the patient's background, allergies, medical history or clinical conditions.

Surgery

The trust had electronic patient records (EPRs) available on their clinical software system and the electronic prescribing and medicines administration system (ePMA) systems. Handovers were consistent with allocated space to record notes. Service staff utilised the clinical system template across all specialities.

Records were not always stored securely. We saw unlocked trolleys containing medical records on ward B7 despite reminder notices to staff to keep them locked. We saw the 15 steps challenge assurance tool reminded staff on one ward to always keep patient notes secure and safe. The code to access medical records trolleys was not secure. This code was issued by the supplier and not changed to improve security.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed some systems and processes when safely prescribing, administering, recording and storing medicines. On inspection we reviewed patient's electronic prescriptions. We found staff had completed all the allergy status records.

However, we found one patient on the orthopaedic ward did not have an electronic prescription chart. Staff were still using the paper prescription written on admission to the hospital.

We also found patient's weights were not always recorded on their electronic prescription charts. Additional records were available on the patient records system. However, some of these were completed by measuring mid upper arm circumference (MUAC). This meant staff recording of patient weights could be less accurate and potentially lead to medication prescribing errors.

All wards we visited had centralised fridge temperature monitoring. Ward and deputy ward managers along with the sister in charge received automated emails of these temperatures. We checked five items in the ward B2 fridge and found all were in date. Wards we visited had no room temperature monitoring for medicines. However, all wards had air conditioning to control these temperatures if they fell out of suitable storage range.

Controlled drugs (CDs) registers had patient's own medicines and stock records. However, we checked the CD book in four theatres and noted some of the books were not completed with signatures in line with national policies. Signatures were absent relating to the amount of drugs used or disposed of. Theatre 3's CD book showed discrepancies for chemical compounds oxycodone and remifentanil. This meant there was no accurate record of or accountability for some CDs which may potentially have been stolen or misused.

Ward staff segregated and checked intravenous (IV) fluids. Ward staff checked fridge temperatures daily. This was also as part of their monthly ward checklist.

The B2 ward's clinic room green bin was used to collect medicines to be returned to pharmacy. During our inspection time on the ward this bin was overflowing.

Blue box contents were not maintained by pharmacy. The ward staff were replacing the contents after use and if stock had expired.

After our chief pharmacist and medication safety officer interview during inspection, we received the medicines reconciliation audit data retrospectively. The trust policy on medicine reconciliation required an audit to be performed and reviewed by the trust's safer medication group.

Technicians and clinical pharmacist staff completed medicine reconciliation on charts examined during inspection as a joint effort. Medicine reconciliation completion rates were not audited at the time of the inspection.

The service had divisional representation in the form of Head of Nursing leads at the safer medication group.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Two surgical wards at the hospital were supported by the quality improvement (QI) team to help to improve their safe and secure storage of medicines processes in March 2022. B2 and B3 wards were re-audited and both showed positive steps towards improvement.

Staff stored and managed most medicines and prescribing documents safely. Medicines requiring specific secure storage were managed appropriately and records of their administration maintained.

Emergency medicines were stored on resuscitation trolleys in accessible areas with regular checks on content and expiry dates. However, one medicine on the resus trolley required a new expiry date on removal from fridge. This had not been altered. Staff checking the trolleys were not aware of the required change in expiry date.

We found paper prescription charts were used on admission through accident and emergency (A&E). Staff then transferred inpatients onto electronic prescription records.

We saw staff were administering oxygen to one ward B2 assessment unit patient which was prescribed.

A pharmacy coordinator covered all the hospital but targeted wards B6 and B7 to facilitate patient's timely discharge. Pharmacy support staff told us patient's TTOs were delayed causing a delay in discharge for short periods.

Service leads and pharmacists reviewed medication policies and procedures against NICE guidance and these reviews were approved through the appropriate governance committee.

Divisional leads told us staff reported any errors related to medicines reconciliation onto their incident system. The pharmacy staff involved investigated and followed up all incidents.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The service had governance oversight of medication incidents via summary reports. Medicines alerts were emailed to ward and deputy ward managers.

Incidents

Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.Managers investigated incidents. However, the service did not always manage patient safety incidents well. Lessons learned were not always shared with the whole team and the wider service.

Staff knew what incidents to report and how to report them. On our last inspection in September 2019 we found the service did always respond to safety incidents well or in a timely way. We told the service it must improve the quality and timeliness of response to incidents and oversight of incident themes and trends to improve the quality of patient care.

Surgery

On this inspection staff raised concerns and reported incidents and near misses in line with trust/provider policy. For example;

The service had two never events on their wards from August 2021 to July 2022. This had reduced from four during the same period the year prior. Never events were immediately cascaded to the areas where the incident occurred. Managers cascaded never event information to all staff via various channels such as all staff emails, notice boards, monitor screens, business meetings, ward meetings and via media groups. The medical director chaired a meeting within three days of the never event to review what happened and determine any immediate actions needed. These were followed up through the serious incident panel. Leads said they had been unable to identify thematic links from the recent never events. They did not emerge from one specialty, one site or one person easier but were across a multitude of specialties and sites.

Managers shared learning about never events with their staff and across the trust. The last few year's succession of never events were discussed at quality and safety meetings, departmental meetings and directly with staffing groups. Leads compiled a presentation to share and discuss with theatre staff. Completed never event SI investigations were shared with all business meetings. A4 learning the lessons paper copies were placed in the learning the lessons folders in ward areas and speciality areas for all staff to read. Leads were also planning to take over a quality and safety (Q&S) day to look at never events.

However, the division reviewed their current process of cascading and learning from incidents and investigations. They found the division did not have a robust method for evidencing how they shared all information.

The division's never event investigation root causes and recommendations were not always detailed enough. For example, a never event in ophthalmology from June 2021 found the theatre team failed to complete the necessary pre-operative checks to ensure they injected the correct eye. This never event's contributory factors were found to mostly relate to the WHO checklist and the stop and block. Recommendations from the report included all nursing and medical staff using the WHO checklist for every patient until the treatment room intravitreal injections procedure care plan was embedded.

At the time of our inspection one year after this never event, we found the WHO checklist was still not embedded in theatres and pre-operative patient marking verification sheets were blank.

We reviewed the division's quality and safety committee minutes from 22 March 2022. Attendees discussed and followed up learning from never events. For example, we saw in the minutes the division's four never events were caused by people not following process or feeling they were able to speak up if others were not doing likewise. They felt this culture needed to change.

After the service's never events in theatres since June 2021 an ergonomist was invited to attend their operating theatres to work with staff to identify solutions. They would then carry out a review and make recommendations based on what they had observed. The ergonomist was brought in to re-evaluate how one of the processes worked when factoring in human behaviour and culture. We reviewed this ergonomist report into never events which included findings/ recommendations around adhering to the WHO surgical checklist. For example, all theatre staff should be identified with a label or name on their hat and whiteboards should be replaced with a national design to add bits.

Staff reported serious incidents clearly and in line with trust policy. Staff we asked said they could access and used the trustwide incident reporting system.

Surgery

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The division adhered to duty of candour for all incidents graded a moderate or above level of harm. All divisional report templates had a section for duty of candour information around discussions with patients and if needed their families. The service appointed family liaison officers (FLOs) to contact any patients involved in incidents.

We reviewed an SI investigation report for delayed treatment within ophthalmology from April 2021. The division adhered to the duty of candour fully by sending the patient a follow up letter of apology on 14 May 2021. Staff sent reports copies to the patient and offered them a meeting to discuss the report's contents.

However, we reviewed the trust's SI panel meeting notes from 12 May 2022. This showed of their 12 outstanding, the division had nine overdue duty of candour letters to be cleared.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Divisional leads assured us they widely shared incident learning. However, theatre and ward staff we asked on inspection could not give any recent examples.

The service shared lessons learnt from incident investigations with the surgery and critical care (S&CC) division through newsletters and business meetings. For example, we reviewed an SI investigation report for delayed treatment within ophthalmology from April 2021. The investigation's key learning and findings were shared at the ophthalmology business meeting.

Staff met to discuss the feedback and look at improvements to patient care. We reviewed the trust's serious incident (SI) panel meeting notes for the three months before our inspection. At the 9 June 2022 meeting attendees escalated one divisional incident for urgent clinical review. Leads requested the incident learning and concise investigation was shared with GPs as they agreed there was value to sharing the learning with the GP practice.

There was evidence that changes had been made as a result of feedback. We saw managers shared themes from divisional incidents. For example, the lessons learnt newsletter from March 2022 contained four such themes with reminders of actions staff should take in response. Staff were reminded of the need for timely escalation to outreach of a deteriorating patient and recognition of sepsis and timely initiation of the appropriate treatment.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We heard the service had improved incident reporting and investigation in conjunction with specialist services such as safeguarding, mental health and other stakeholders.

The service had devised a divisional summary which brought together all monthly data around serious incidents and never events for discussion at the governance meetings where it was a standing item. Data was then fed back through the 6:1 and 'confirm and challenge' meetings to nursing staff.

However, we reviewed the trust's SI panel meeting notes for the three months before our inspection. The 19 May 2022 notes showed there was no ophthalmology clinician representation to present the two incidents due to clinical commitments, so discussions were delayed by one week.

Safety thermometer

The service improved safety. Staff collected safety information and shared it with staff, patients and visitors. However, the service did not always monitor results well.

Surgery

The service continually monitored and displayed safety performance on wards for staff and patients to see. Our time to shine monthly noticeboard on all wards were up to date with useful high-level themes. These outlined the top three incident reported themes, messages for sharing, number of harm free days, patient feedback, the patient advice and liaison service (PALS), complaints and compliments, three things that have gone well, three things staff would like to improve, learning from incidents, staff achievements, core mandatory training, role specific and personal development reviews (PADR) compliance and sickness.

On our last inspection in September 2019 we told the service they should improve systems for recording venous thromboembolism (VTE) assessments.

On this inspection we found the service had made limited improvement on completing VTE assessments. We found the service still did not always maintain current VTE guidelines, risk assessments and clinically accurate and timely VTE risk assessments. For example, ward B6 staff had not completed VTE risk assessments for two out of five patients. The VTE tick box for consultant review was not ticked as staff said they struggled to get orthopaedic consultants to approve daltiparin medications.

Staff risk assessed patients for VTE on admission to the hospital and at regular intervals. We found this was observed in patient's records on the assessment unit.

Staff used the safety performance data to further improve services. The service planned actions to adapt joint trust guideline on VTE and risk assessments with a neighbouring trust, carry out a gap analysis against the national institute for health and care excellence (NICE) guidance, junior doctors in medicine and surgery would carry out audit on % completed and quality of completion retrospectively; the service undertook various audits to assess the quality of VTE assessment against guidance.

The service had developed clinical software system risk assessments. VTE assessments were now mandated on the electronic prescribing and medicines administration system (ePMA) system. ePMA was live trustwide for all inpatients on medical and surgical wards.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The division had sustained improvement of compliance with NICE guidance in June 2022 and were maintaining an average of around 95% compliance. The service held quality and safety audit afternoons reinstated from cross-speciality learning and development.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs. However, patients fluid and nutrition intake was not always accurately recorded.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. On our last inspection in September 2019 we told the service they must improve the compliance of documenting fluid balance intake accurately (regulation 12).

On this inspection we found some improvement in hourly fluid chart monitoring. Many wards we visited had noticeboard displays on the importance of staff correctly completing fluid balance and weighing body mass index (BMI) for patients.

We also found staff on ward B6 did not record patient weights on the electronic prescribing and medicines administration (ePMA) system (only their clinical software system). For example, one patient had a weight recorded on their electronic prescription chart from 24 September 2021. Instead staff used either a mid-upper arm circumference (MUAC) assessment tool or had patient reported weight. For example, one patient had a weight recorded from 29/06/22 completed using MUAC. Staff told us they could not weight bedridden patients, so these patients reported their weights to staff themselves. This meant staff could potentially prescribe patients the wrong dosage of medicines and were basing clinical care and treatment decision making on less accurate baseline observations.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Nursing staff carried out malnutrition universal screening tool (MUST) assessments on patients. These were repeated weekly or sooner if the patient's condition changed. Ward B7 staff completed nutritional risk assessment screens for all patients within 24 hours of admission to the hospital.

All wards observed protected mealtimes for midday and evening meals. This meant during this hour visitors were not allowed unless they helped with feeding patients.

However, we saw no staff helping patients with their food. No wards we visited used red trays to help staff identify which patients needed extra attention when eating, or needed foods which had a modified texture such as being mashed or pureed.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Patients with complex feeding needs were referred to the nutritional support nurses or dietitian for assessment and advice.

Surgery

Patients waiting to have surgery were not left nil by mouth for long periods. We saw staff gave patients sandwiches to eat after fasting for long periods pre-surgery.

The number of on the day elective cancellations from June 2021 to June 2022 due to the patient eating/drinking prior to surgery was 12. The division had plans in place to complete further pre-operative fasting audits.

Pain relief

Staff gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Staff monitored patients to see if they were in pain. However, staff did not always document their assessment of pain for patients.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients received pain relief soon after requesting it. Patients we asked said they never had to wait more than a few minutes for staff to help them administer painkillers.

Staff prescribed, administered and recorded pain relief accurately. We saw ward staff used the ePMA. We saw an agency staff nurse checking patient's wristband before administering paracetamol. Ward and theatre staff could access a specialist pain team onsite. For example, if patients had epidurals or morphine for pain relief.

We reviewed an acute and end of life pain assessment audit where the division was the lead operational group from January 2022. A summary of key findings showed staff started pain assessment charts for 92% of patients trustwide. This was an increase from 86% in the previous audit.

However, staff's completion of the assessment chart showed areas of low compliance. For example, only 58% of patients had a follow up within one hour to record the effect of analgesia. Also, only 33% patients were referred to the acute pain specialists where pain was uncontrolled or persistent. Ward B7 staff completed none out of five pain assessment charts, the lowest of any ward audited. The audit determined results provided 'limited assurance'.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. However, the service did not always achieve good outcomes for patients.

The service participated in relevant national clinical audits. The trust participated in 48 or 100% of the national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The trust performed well in these audits and generally results were above national averages or within the expected range in all except the national oesophago-gastric cancer audit (NOGCA) 2021 report.

We reviewed the trust's national hip fracture database (NHFD) 2021 annual report. This gave an assurance level of moderate for the hospital. This was an improvement for the hospital which had previously been graded 'significant' in 2020. Most patients met best practice and these results were much higher than the national average (53.8%), yet the hospital's performance had reduced from 85.2% (2020) to 75.8%. Results were within the top quartile and well above the national average (65.3%).

Surgery

We reviewed the trust's national bowel cancer audit (NBOCA) 2021 report. The audit's aim was to measure the quality of care and outcomes for these patients. The trust's outlier from their previous year's NBOCA audit 2020 had improved to within the expected range. They planned actions to share and present the audit results at the general surgery audit meeting by 30 September 2022.

However, we reviewed the trust's national oesophago-gastric cancer audit (NOGCA) 2021 report. This covered the quality of care given to these patients. The audit found the trust performed badly for the sixth consecutive year with a result of 21.6% which was a 0.2% increase compared to last year and significantly higher than the national average of 12.6%. The length of time from referral to start of curative treatment was longer at the trust than nationally. The audit's only recommendation where the trust and clinical lead felt action was needed was to share learning and distribute results virtually by 30 August 2022. These actions had not had any impact on this audit's performance in the last six years.

The division's latest Patient Reported Outcome Measures (PROMs) paper showed the trust had maintained the good scores for knee replacements. The PROMs are a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The service performed within the expected range (between highest and lowest) for both primary hip replacement surgery and knee replacement surgery from April 2020 to March 2021.

Patient-reported outcomes after primary hip replacement surgery (published in February 2022) showed a statistical difference to national rates where the trust had fallen slightly outside the 95% control limit. The alert prompted the trust to investigate processes surrounding primary hip replacement surgery. Patient-reported outcomes following primary knee replacement surgery remained within the statistically calculated confidence intervals, demonstrating no significantly different performance compared to the UK.

However, outcomes had deteriorated for hip replacements and the team was starting a deep dive into the data in July 2022 to ascertain the underlying cause. Divisional leads had checked their staff had the opportunity to complete the surveys.

Managers and staff used the results to improve patients' outcomes. We read about service changes and summaries of some actions taken from clinical audits. For example, leads had amended their new NFHD hip fracture pathway at the first opportunity, to allow any nerve block given in A&E or on the ward to be easily documented.

The service monitored their expected risk of readmission for elective and non-elective care. We reviewed the division's total emergency readmissions within 30 days from June 2021 to May 2022. Across all metrics the specialty with the highest rate of readmissions within three and 30 days was general surgery.

However, the division did not separate elective and non-elective figures. The trust's data also did not compare or benchmark to the latest national average or clarify which readmissions were categorised as potentially preventable.

Managers used information from the audits to improve care and treatment. Leads undertook data validation for the NJR audit via a webtool data review system on an ongoing basis, rather than prior to the end of the deadline period. Leads also undertook a review of fracture liaison service database evidence as case ascertainment estimations were hugely overestimated using the hip fracture methodology and fed this back to the audit supplier.

Improvement was checked and monitored. We heard the division had started a joined getting it right first time (GIRFT) for retinal pathway patients with a neighbouring trust. GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

Surgery

Competent staff

Not all staff in the service were competent for their roles. Managers held supervision meetings with staff to provide support and development. However, managers did not always appraise staff's work performance.

Staff were experienced and qualified. For example, nursing staff were highly trained in the high observation bays (HOBs) and would update their competencies as needed.

However, not all theatre staff had the right skills and knowledge to meet the needs of patients. Staff we spoke with had concerns about the treatment of level 3 patients who transferred from ED for stabilisation. They were aware of their limitations and the outreach team also supported these patients.

Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. On our last inspection in September 2019 we found the service's appraisal rates did not meet the trust target.

On this inspection we found limited improvement. We reviewed the quality and safety committee minutes from April 2022. It showed surgery appraisals at 74% as one of only three red actions from our CQC update report. This did not meet the trust target of 80%.

We saw SDEC's personal appraisal development reviews (PADR) compliance was only 36% for June 2022 as this was displayed on the unit. The trust's board papers in June 2022 stated staffing challenges linked to the pandemic impacted upon personal appraisal development reviews (PADRs).

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, the service had developed a directorial video for junior doctors to help identify what further venous thromboembolism (VTE) training was required and if any additional resource was required to start embedding change.

However, the division continued to have a high number of staff not attending ALERT courses. This module was not included in mandatory training compliance figures. ALERT trained staff in recognising patient deterioration and acting appropriately in treating the acutely unwell. At the time of our inspection managers were reviewing this course to support e-learning and consider staff completing this 50% face-to-face and 50% virtually. They had contacted staff to find out why compliance was low, and work was ongoing to resolve this issue.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Divisional leads told us the trust's critical care outreach team (CCOT) trained over 800 of their staff with basic critical care skills to support patients within theatres. This was part of the trustwide mutual support during COVID-19 when many staff were redeployed. We heard many divisional staff were also upskilled at an independent hospital.

Managers made sure staff received any specialist training for their role. We saw theatre staff had completed simulation training events. For example, they undertook a paediatric massive haemorrhage simulation which followed the massive haemorrhage in children guideline DCG288 from which what went well, lessons learnt, and final thoughts were shared with further reading links.

However, many theatre staff we asked were unaware they had to complete theatre registers as part of WHO checklist requirements.

Surgery

Managers identified poor staff performance promptly and supported staff to improve. We heard the anaesthetic consultant's competencies had been questioned by operating department practitioner (ODPs) staff. The ODPs escalated these concerns to the theatre team leader who at the time of our inspection was on long-term sick leave.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed a medical handover which was delayed. Medical staff reviewed all patients in-depth and covered everything relevant. They gave appropriate attention to both end of life care (EOLC) involvement and patient flow discharge options as the hospital was on OPEL 4 status. We saw input from a colorectal surgeon and two advanced care practitioners (ACPs).

Seven-day services

Key services were available seven days a week to support timely patient care. However, staff could not always call for support from doctors and other disciplines 24 hours a day, seven days a week

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. We found generally patients of all surgical specialities were reviewed daily. However, some ward staff, for example those on B1/SDEC, told us they had to chase up surgical reviews for their post-theatre patients.

The service had revised and raised awareness of their clinical referral pathways and signposting support for both patients and their staff.

Staff could not always call for support from doctors and other disciplines 24 hours a day, seven days a week. As the hospital was not the division's main urology site their single site on-call structure meant no urologist staff were available out of hours (OOH) onsite. The division had no OOH interventional radiology or vascular support on either site. Staff had to blue light patients to a neighbouring trust. This arrangement was ad-hoc with no formal service-level agreement in place. This structure meant there was potential risk to patients who needed urgent/emergency urology clinical review or follow up.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. On our last inspection in September 2019 we found consent documentation was not always completed in line with national guidance to gain patients' consent. Patients were not always re-consented on the day of surgery and patient consent forms were not always shared with them in line with the trust policy.

On this inspection we reviewed written consent forms for ten patients undergoing surgical procedures. All these were completed and confirmed by the appropriate professional.

However, we found consent forms were still a key learning point to be shared within immediate teams and the wider organisation from never event investigation reports. For example, a never event in ophthalmology from June 2021 shared the importance of staff cross-referencing the consent form, patient notes and theatre list after the patient was not asked to confirm their identity or which eye was to be injected.

We reviewed the divisional documentation audit of medical record keeping approved by governance on 9 November 2021. This showed consent for anaesthetic was good.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We reviewed best interest decision for an orthopaedic patient with a do not attempt cardiopulmonary resuscitation (DNACPR) order in place. Ward staff had completed all the necessary paperwork involving and supported by the family.

Staff clearly recorded consent in the patients' records. We found this was clearly documented in all the records we reviewed.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLs) and made sure staff knew how to complete them. Staff implemented DoLs in line with approved documentation. We reviewed two patient's DoLs/MCA documentation onsite. Staff completed and reviewed these within the set seven-day timeframe. Staff also completed special consent forms for patients who lacked capacity. For example, the trauma and orthopaedics ward B6 had lots of these patients.

The trust monitored their DoLs data in detail including at monthly site-specific and ward-level along with local authority referrals. We reviewed divisional DoLs data from April to June 2022.

However, ward managers were not always aware which of their patients had DoLs in place. We could not locate three patients who we were told had DoLs in place on the IAAU B2 ward. This ward was a mix of medical and surgical patients. Senior staff later informed us four of their five patients with a DoLS in place during this period were discharged before our inspection.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We reviewed a site-specific qualitative audit of ward staff's reasons for undertaking capacity assessments between 9 December 2021 and 7 March 2022. Key findings were the MCA/DoLS and vulnerabilities teams had developed and implemented an electronic two-stage capacity assessment tool. Learning points and an action plan were made from the audit. They planned a continued approach to MCA audits to ensure changes and training were useful and could be embedded.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Surgery

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. A patient we asked said they were happy with the care provided by both nurses and medical staff. Staff we observed interacting with patients were friendly, approachable and talkative.

Patients said staff treated them well and with kindness. Patients we spoke to told us nursing staff went above and beyond to care and support them with an attentive bedside manner. We heard the example of a patient undergoing surgery who lacked full capacity. Staff arranged day release for them to go home and see his wife who was terminally ill

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. In theatres we observed a urological consultant developing an engaging and familiar rapport with the patient during their operation. We also overheard a B2 ward nurse offering emotional support to a patient relative on the phone for ten minutes despite being under pressure.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Where possible offices or meeting rooms were used for personal discussions, and bed curtains were drawn in shared bays to protect patient’s privacy.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff allowed a child patient with possible mild learning disabilities to be accompanied by their parent into the anaesthetic room.

Visiting times on wards were staggered between 2-4pm and 6-8pm seven days a week so as not to be too interruptive to patient care.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Surgery

Managers planned and organised services so they met the needs of the local population. The division had service-level agreements (SLAs) with neighbouring trusts to avoid significant losses in surgical clinical sessions to meet local patient demand. For example, they had priority sessions for cancer and urgent patients and a recovery plan in place for weekend sessions to mitigate the loss of core SLA activity.

Managers monitored and took action to minimise missed appointments. They reviewed the division's number and underlying causes of all cancellations by surgical specialty. Managers ensured patients who did not attend appointments were contacted. The division's number of monthly patient did not attend (DNA) cancellations never exceeded seven.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff coordinated care with other services and providers and made reasonable adjustments to help patients access services.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Ward staff used a care plan called avoiding falls level of observation assessment tool (AFLOAT) for all patients including those at risk of falls or with dementia. Staff scored this according to patient's clinical presentations such as confusion/delirium, challenging behaviours or postural hypotension to create a total score and would observe patients as frequently as necessary.

Wards were designed to meet the needs of patients living with dementia. We saw some wards offered dementia provision for patients. For example, ward B3 was considered dementia friendly. This ward had bus stop signs complete with timetable and another sign with the former hospital's name for local patients. This was intended to reduce patient wandering and provided a calm and safe place for them to sit.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Ward B3 staff could offer vulnerable adult patients a dementia friendly menu booklet incorporating the 'my life care' plan. This gave patients the option of what they like to be called, things staff must know about them, things that were important and their likes and dislikes. Staff hung these booklets on the end of patient's beds, so they were easily accessible.

In theatres we saw a child with autism was supported only by a minimum of people such as their mother and the operating department practitioner (ODP) to reduce their distress. Theatre staff helped keep the child occupied in a bed during their surgery.

The service had information leaflets available in languages spoken by the patients and local community. We saw some wards displayed NHS inpatient survey 2021 information called 'how was your experience of the hospital?' in four languages. We asked ward staff where they kept their leaflets to give patients and their families on discharge. Ward staff would print off leaflets according to patient need as they quickly went out of date. Staff could translate the information into any language or sized font accordingly.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The division used the common NHS telephone interpreting service language line. We saw signs on wards directing patients how to use this service with department client ID's they could ring. Ward staff helped patients when needed.

Surgery

Access and flow

People received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. However, patients could not always access the service when they needed it.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service's specialities with the largest waiting lists as of March 2022 were general surgery (5,163 patients), general surgery service (4,380), and ear nose and throat (ENT) (3,689). The service's total waiting list in March 2022 was 4.7% more than the previous month of February 2022.

At the time of inspection divisional leads told us their waiting lists were in such a good position they had accepted 800 mutual aid patients across several specialities from neighbouring trusts. The other team staff managed to change their working patterns to fill in gaps whilst maintaining their regular elective activity. The division's 52-week position had deteriorated accordingly, but up until March-April 2022 they only had around 100 patients of this type.

RTT performance

The division's referral to treatment times on completed admitted pathways within 18 weeks (%) had improved from June 2021 to June 2022. Their latest performance was 71.4%. This was well above the national average of 54.7%.

We reviewed divisional referral to treatment times (RTT) monthly data by site from June 2021 to May 2022. It showed the hospital consistently had the highest trust performance for the 12-month period, except for January 2022 when they were joint highest, achieving 66%. The hospital's monthly rate never dropped below 64%. The hospital's overall RTT rates had improved during the 12 months by 5%. Leads reminded us the division's RTT figures were impacted by their mutual aid elective work in three surgical specialties for neighbouring trusts.

The service's 18-week performance showed consultant-led RTT's three lowest performing specialities were other – paediatric (10%), other – other services (48.1%) and T&O (55%). The service's speciality with the most 52-week waits was ENT (275), general surgery (218) and oral surgery (173). After our inspection senior staff told us these were orthopaedics and urology due to mutual aid.

The service had a well-established process for clinical prioritisation at the point of entry onto waiting lists. The prioritisation was reviewed by clinicians at outpatient clinics or with their GP (at the point of entry). Theatre scheduling was a weekly 6:4:2 meeting looking 2 weeks ahead reviewing lists for priorities and long waiters attended by business managers who we were told then linked in with clinical managers.

We found some evidence of cross-speciality theatre allocation to address prioritisation and long waiters. The boards were completed every Monday and reviewed by the divisional triumvirate to formulate action plans. The biggest specialty risk areas were urology with 1,566 on the patient to list (PTL); 415 of which were priority P2 patients. At the time of our inspection the orthopaedics specialty had 18 patients over 78 weeks resulting from system wide mutual aid.

The hospital's theatre efficiency was 87% of available sessions. This exceeded the NHS gold standard utilisation rate of 70-80%.

However, the service had no system to support effective theatre in-list scheduling. This meant theatre utilisation rates were potentially less reliable as leads did not have any system data to support which percentage was effective.

Surgery

Cancellations

In the quarter from January to March 2022, cancelled operations (not treated within 28 days) for surgical specialties had seen a 7.4% improvement to 18.6%, compared to the previous quarter (26%). This was below the national average of 23%.

However, we were not assured the division had a process to address their same day avoidable cancellations and the underlying causes. This was due to limited theatre staff availability, limited theatre planning and the lack of a system to support effective theatre in-list scheduling.

The month with the highest number of patients unfit for surgery was 22 in February 2021. The number of cancellations due to staff unavailability rose during the year. For example, by December the division had 22 cancellations for this reason; 14 where theatre staff were unavailable, six anaesthetists unavailable and two surgeons unavailable.

We reviewed the cancellation reasons from 1 June 2021 to 28 June 2022. The most common hospital clinical reason was patients being unfit for surgery with 291 cancellations. The most common non-clinical reason was the list overrun with 115 cancellations.

Waiting lists

On our last inspection in September 2019 we found the service's patients whose operations were cancelled were not always treated within 28 days and some patients were still waiting more than 52 week waits for surgical treatment.

On this inspection we found the division had made significant improvements with mitigations in place for patients on their waiting lists. For example, the service undertook risk stratification for formal harm review processes for any 52-week wait breach or 104-day breach patients on their cancer pathway. Staff based risk reviews on clinical events; for example, one P4 laparoscopic cholecystectomy (gallbladder removal) patient clinically deteriorated prompting an admission. As a result, the service identified all these P4 patients as a high-risk group following this harm review case.

We reviewed the division's cancer performance report dashboard refreshed on 29 June 2022. The service saw 98.1% of patients with two-week wait referrals within 14 days. This was above the national target of 93%. The service also achieved the national standard of 98% for subsequent treatment (anti-cancer drugs) under their 31-day performance decision to treat to treatment.

However, the service only diagnosed 51.3% of patients within 28 days. This did not meet the national standard of 75%. The service also missed all three national standards for 62-day performance referral to first definite treatment. These were for urgent GP referral, screening service and consultant upgrades. The service narrowly missed national standards for first definitive treatment and subsequent treatment (surgery) under their 31-day performance decision to treat to treatment.

The service red, amber, green (RAG) rated, risk reported and displayed all the outpatient waiting list on their board. The longest wait on this list was one 103-weeks patient in ophthalmology.

The divisional specialties with the largest waiting lists in patient number terms were general surgery, general surgery service and ear, nose and throat service.

Surgery

In March 2022, some surgical specialties had the largest waiting lists and oral surgery was amongst the worst performing in terms of treatment within 18 weeks. The service also had the highest percentage of zero to under 18-week patients on their waiting list by time band within their Humber, Coast and Vale sustainability and transformation plan (STP). Support staff from one specialty felt patients from neighbouring trusts were being seen before their own 52-week waiters.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The division had good patient prioritisation in place for some specialties.

The division's oncology service waiting times were raised as a risk on the trustwide risk register confirm and challenge in July 2021. It stated the trust's waiting times for oncology patients were longer than expected due to the absence of consultant oncologists at a neighbouring trust. The division had also escalated concerns regarding their urology cancer waiting times and patient treatment delays.

We reviewed the division's bed occupancy summaries by site between September 2021 and June 2022 excluding day case wards. During this period the hospital's bed occupancy never exceeded 89%. This was above the overnight NHS risk threshold of 85% but was gradually improving. Their occupancy rate over the ten months had reduced by 0.6%.

We also reviewed the hospital's bed occupancy by ward from September 2021 to June 2022. The ward with the highest occupancy was ward B6 which ranged between 93.9% and 96.6% for two of the nine months. This ward's sustained high occupancy potentially impacted their divisional staffing vacancy rate, VTE assessment completion and recording of patient observations.

Managers and staff worked to make sure patients did not stay longer than they needed to. The division monitored and reviewed their average length of stay (LoS) for elective and non-elective patients by speciality. We reviewed this data from 1 June 2021 to 28 June 2022. The division's overall average LoS was 3.16 days, 2.44 for elective patients and 3.3 for non-elective. This met the latest 2020/21 NHS overnight standard of 4.3 days.

The division monitored and reviewed their weekly number of patients stranded for over seven days as part of the mortality and morbidity governance. We reviewed the latest data for 24 June 2022 position. The division added comments to explain why the patients were still stranded and any onward pathway or discharge planning.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Managers could not always work to minimise the number of surgical patients on non-surgical wards. On our last inspection in September 2019 we found medical outlier patients on surgical wards did not always receive timely medical reviews.

On this inspection surgical wards we visited had a high number of medical outlier patients. We heard one example where B7 ward staff had difficulties contacting the medical team for a patient who needed end of life care (EOLC) because nobody was answering their bleep. The ward sister identified their biggest issue with EOLC patients was lack of staff.

We reviewed the division's medical outliers data from 1 July 2021 to 30 June 2022. The hospital had a higher outliers rate of 1.71% during the 12 months. The hospital's rates were not consistently decreasing.

Managers monitored patient moves between wards/services. However, these were not kept to a minimum. We reviewed the division's ward transfers (when a patient moved from one ward to another) from July 2021 to June 2022. Their total number of ward transfers had risen by 248 during this period. The month with the highest number of transfers was May 2022 with 1,325.

Staff moved patients between wards at night. We reviewed the division's ward transfers as of 29 June 2022 including between 10pm and 6am (by night). This showed they had a total of 2,839 transfers between these times; 463 of these were due to capacity.

Managers and staff worked to make sure they started discharge planning as early as possible. The division calculated their total number of lost bed days as per the national discharge policy. This was done by number of days post discharge to assess (D2A) completion minus the first 24 hours. We reviewed these figures for May and June 2022. They showed the division's number of lost bed days totalled around the 400 mark for the first half of May, then dropped to around 250 for the latter half. The hospital's combined number of lost bed days for June fluctuated between 40-70% and showed some inconsistent improvement.

We were told divisional leads were working with external partners to define delayed discharges and capture this information fully and systematically. However, at the time of our inspection this work was not completed.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Ward patients we asked said they would ask staff members to help them access PALS information if needed.

The service clearly displayed information about how to raise a concern in patient areas. We saw ward areas display patient advice and liaison service (PALS) information on how patients could complain, when their offices were open and where they were based at both hospitals.

We also saw signs for comments, compliments or queries in four steps.

Managers investigated complaints and identified themes. The service's time to resolve complaints had significantly improved since our last inspection in September 2019. The division's average number of days taken to close formal complaints in June 2022 was 44 days. This was within the trust target of closing complaints within 60 days.

At the time of our inspection there were 35 complaints open, one was over 60 days.

Divisional leads told us they had undertaken a significant workpiece to improve their complaints position with a revised process for better individual oversight. All complaints raised were allocated to a lead investigator within each speciality. Leads received a weekly quad highlight report which showed their complaints position to review and check process. The divisional chief nurse and governance lead reviewed how to theme complaints within each speciality to feedback within their respective speciality groups.

The division's top categories of formal complaints received from 1 April to 5 July 2022 were around clinical treatment and patient feedback including communication, patient care, appointments or values and behaviours.

Surgery

Managers shared feedback from complaints with staff and learning was used to improve the service. The service had several ways to cascade learning division and trustwide as well as escalate staff concerns.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. However, leads were not always visible or responsive. They were not always approachable in the service for patients and staff.

Staff we asked knew who their immediate managers were and these managers understood the challenges for the service. However, managers were not always clear if or when to implement changes.

The service had a fairly new clinically-led divisional management structure.

We found a strong team leadership within theatres. However, leads did not always ensure the hospital's root cause analysis from never event recommendations and serious incident investigations were followed up after learning was shared with staff. The division's never event investigation root causes and recommendations were not always detailed enough. This meant leadership oversight of some environment and equipment issues in theatres was lacking.

The division's senior nursing managers walked the wards at least weekly and when on-call at weekends. However, we saw no senior management or lead visibility above matron level in any areas of the service. Staff also told us they did not see any cross-site management presence.

We found support from senior nursing and educational staff in theatres was poor. They had allowed long-standing theatre safety and environmental issues and their potential impacts to patient risk to continue. There was a lack of initiative to recruit, retain or second staff. Some support staff in one specialty felt their management were only interested in numbers and were unresponsive when they escalated issues such as late theatre cancellations and theatre staffing.

At the time of our inspection a trustwide rollout of leadership framework was underway to meet all requirements in every division. From 4 August 2022 all staff would be sent a guide outlining how leaders will be developed and supported. This was a grassroots up programme to help identify leadership gaps.

The weekly divisional triumvirate and quad meeting agendas and structure mirrored those of the trust's executive performance meeting. Items for discussions were risk and escalations, performance, and finance to ensure the strategy was progressing as planned, along with any issues relating to all specialties.

Surgery

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, leaders and staff did not understand and know how to apply them.

On our last inspection in September 2019 we saw limited evidence the division's draft vision and strategy had been developed with all relevant stakeholders.

On this inspection divisional leads we asked clearly outlined their strategic direction despite not being in their current triumvirate roles when the strategy was built in 2019. However, during inspection no managers or senior staff mentioned this strategy and those we asked were unsure of the strategic priorities. No onsite staff we spoke to could describe the vision for the service.

Leads outlined how their current strategy involved stakeholders. For example, they considered pathways with community primary care partners and collaborative work with the integrated care partnership (ICP) and systemwide. They explained their priorities were keeping 52-week wait patient numbers down, improving staff engagement and the working relationships between their divisional specialities. Leads were proud of their pace of change and marked improvements since 2019.

Culture

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, staff did not always feel respected, supported and valued.

We read divisional leads planned to address and improve the culture in theatres, particularly for junior staff in a fast-moving environment. Leads had an overarching separate action plan for theatres and some cross-site quality improvement work where they linked in with a trust associate director of culture.

The division had the second highest number (26) of FTSUG concerns raised by staff trustwide between 2021 and 2022.

However, some support staff for one specialty told us they had raised issues and made suggestions for improvement but did not feel listened to.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

On our last inspection in 2019 we did not see the service's governance, performance or risk issues escalated and discussed in an effective way. The governance structure internally within the division and externally within the trust needed strengthening to show evidence of risk and performance discussion.

Surgery

On this inspection we found divisional governance has significantly improved and the triumvirate and quad governance and management structures were now more embedded. Leads told us their governance and performance processes were stronger across all areas and they were better sighted on service issues. For example, on our last inspection the division had no governance triumvirate in place.

The division also held monthly speciality improvement meetings mirrored the same as executive meetings. This meant all leads were sighted on exactly the same things within each specialty as the leadership team. Leads told us they understood their roles' scope and would use each other's best qualities.

The division had a tiered structure of governance meetings in place with escalation routes to the divisional management team and from there to the executive team. The structure was supported by the surgery and critical care (S&CC) governance structure approved in March 2022.

Divisional governance issues were discussed at the S&CC group governance meeting. These meetings were held monthly, chaired by the clinical lead for governance and supported by a 'terms of reference'. Highlight reports were presented from the speciality meetings as well as reports on patient experience, incidents, serious incidents and the risk register. There was also an associated action plan. Service leads actively monitored attendance and papers at the divisional governance meeting. The division had only cancelled one meeting in April 2020 during the first wave of COVID-19.

The divisional board was held monthly for two hours and involved the divisional senior managers and covered governance, performance, operational issues, human resources (HR) issues and finance.

Speciality level governance issues were discussed at the speciality business meetings held monthly. These meetings covered governance, performance and finance items. Highlight reports were completed monthly from these meetings to escalate any risk and issues to the surgery and critical care governance group board meeting. The highlight reports captured performance, safety and quality.

The trust held quarterly confirm and challenge meetings and the division held their own equivalent monthly. The ward manager, head or deputy head of nursing and matron attended. Risk handlers who attended were given an allotted time to provide and further updates, make amendment requests and challenge the documented information quality. The agenda covered key quality and safety issues such as VTE, mandatory training, falls, rosters, the 15 steps action plan, NEWS and sepsis. Notes were taken and sent back to the ward manager as a prompt for actions to be completed by the next meeting. This process ensured frontline to board escalation of risks and information and frontline learning from incidents and complaints. Service leads felt there was variation in quality, frequency and documentation. They noted these meetings were more vulnerable to operational pressures due to attendees being frontline staff.

Service leads discussed mortality at the divisional governance meeting. At the time of our inspection general surgery and trauma and orthopaedics (T&O) were holding regular mortality meetings. Mortality learning where applicable was also identified from the trust's serious incident panel and from structured judgement reviews. This learning was in the integrated quality report. Leads felt mortality learning was an area which needed further work to collate learning from different sources and to provide assurance it occurred.

The service held monthly 6:1 meetings between the head or deputy HoN and the matrons to review key quality and safety issues. The meeting gave senior staff the opportunity to convey crucial messages and set topics were covered such as serious incidents, recruitment and finance.

Surgery

We reviewed the service's last CQC assurance information on 9 March 2022. Their next steps showed leads would continue to monitor governance performance and any further developments needed.

The 15 steps challenge was the service's ward-based governance review. All ward we visited had achieved 'good' or 'outstanding' ratings in their latest challenge. However, some wards displayed ratings which were several months out of date.

At the time of our inspection divisional governance document control was being overhauled and a new process was in place working towards 100% compliance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, leads were unaware of all their risks.

On our last inspection in September 2019 we saw limited evidence of identifying and escalating relevant risks and issues and identified actions to reduce their impact.

The division's actions since have included a governance arrangement documented in a framework format. The division also had an approved in-date terms of reference (ToR) and agenda for governance meetings where minutes followed the set standard and were not cancelled unless by triumvirate agreement. All actions were clearly identified with ownership and target completion timescales.

We felt assured the divisional management triumvirate had competent and capable knowledge and oversight of issues and performance.

However, the divisional triumvirate were unaware of all their risks, especially in theatres. As the hospital's WHO checklist compliance audit achieved 100%, we observed the risks of theatre staff omitting or not documenting vital stages of this checklist in practice were unmonitored. The hospital's WHO audit data was inconsistent and so the outcomes were less reliable.

The division's top area of concern noted in the June 2022 trust board papers was equipment noted as a considerable risk. We heard the division prioritised equipment risks and looked for other avenues to replace equipment. This process included identifying mitigation; where other equipment could be utilised where needed. We also read the division had submitted a bid for funding to support equipment replacement with a deadline of mid-July.

We reviewed the trustwide risk register confirm and challenge appendix for the top divisional risks. The shortfall in capacity within the ophthalmology service was added in April 2015 but last reviewed on 30 May 2022 with the risk status unchanged. The service had controls in place, action descriptions and progress. For example, they were working with the clinical commissioning group (CCG) to secure extra capacity within the independent healthcare sector.

A divisional risk added in June 2017 was around overall performance of the trust's number of cancer patients waiting over the 62-day performance target. The trust was aware their failure to treat these patients resulted in poor patient

experience and had the potential for clinical harm in some specialties. The likelihood of continuing to not achieve the 62-day standards was high due to some elements of the diagnostic or staging pathway being outside of the trust's control and sitting with a tertiary provider. However, the trust consistently achieved the 14-day and 31-day standards. This meant they were mitigating the risk as much as possible.

The division identified, reviewed and managed their vulnerable patients most at risk on waiting lists appropriately. Divisional leads had weekly cancer RTT waiting time meetings to challenge and review all their cancer PTLs. Their cancer performance backlog was reported weekly to the operational management group (OMG) and a trustwide clinical harm review process was in progress.

The division maximised their resources for optimal performance. Their latest admissions figures from March 2021 to February 2022 had improved compared to the year prior across elective, emergency and day admissions. For example, their elective admissions had increased by 52% and day admission figures compared favourably to NHS national averages.

Service and divisional level risks were identified from business meetings, governance, incidents, SIs and audit. Once staff identified a risk, the risk register template was populated and when completed was taken to the relevant speciality business meeting for their review and sign off. Once risks had been ratified, they were sent to the clinical governance meeting for final review and ratification. If the risk needed to be entered onto the risk register immediately, the risk and governance facilitator did so before sign off. An agreement was in place giving them authority to do so, from a senior triumvirate member. However, risks still had to be ratified for approval at both meetings.

All risks on the register were managed by the handler. Each risk was updated before the review date. The service-level risk register was a "live" document and therefore risks were updated as and when required with any changes or updates.

A divisional update in the trust board papers for June 2022 noted quality improvement with deteriorating patient and sepsis was ongoing. Divisional leads raised the issue of adding the deteriorating patient escalation and sepsis pathway management onto the risk register with relevant audit facilitators by 30 October 2021. This meant improved oversight and focus by divisional and risk leads positively impacted patient safety.

We reviewed minutes from the mortality improvement group (MIG) on 6 May 2022. The group had a continued focus on the deteriorating patient (DP) and sepsis with collaborative working between all divisions. The trust employed a clinical educator to support with the deteriorating patient in post until September 2022. The division focused on quality improvement (QI) with a QI lead two days per week to support their improvement plan delivery. Leads had completed a deep dive into all aspects of the DP and sepsis workstream to identify revised overarching objectives. This enabled the further cascade of education. Leads had also embedded stop and check huddles on wards including for the deteriorating patient. The division monitored observations via their DP and sepsis oversight group. Leads reviewed incidents relating to the deteriorating patient to identify if any learning was required.

Staff could also take new risks to the weekly triumvirate meeting if they needed divisional lead input. The risk register was also part of the integrated governance report which if necessary, any risk issues were highlighted at the clinical governance meeting.

However, despite our previous inspection findings and legal breaches, we could still see no indication some risk contributory factors and elements were being discussed at divisional level. For example, the SI panel meeting notes from 12 May 2022 showed at least two queries around the wider plan to address the WHO surgical checklist shortcomings in general and human factors were unanswered. This was a common theme in divisional SIs. This meant divisional leads and managers did not always ensure learning from risks was embedded.

Information Management

The service collected reliable data and analysed it. Data or notifications were consistently submitted to external organisations as required. However, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated and secure.

We found some of the trust's systems and processes for recording and monitoring clinical information were long-winded and convoluted. Staff often had to duplicate some documentation such as care plans and risk assessments due to delays uploading onto their clinical software system.

The division recognised there was limited interface between software packages which prevented some internal and external trustwide information sharing, including with other trusts or service providers. Staff complained to us their clinical software system information was outdated.

We found some IT systems staff used were incompatible – the trust's new clinical software system did not talk to the electronic prescribing and medicines administration (ePMA) so staff had to manually enter drugs for discharge on wards B3 and B7. Ward staff told us uploading treatment sheets for patients from ED onto ePMA was initially an issue when ePMA was first introduced. The clinical software system was also not always accessible to staff who undertook various roles. This meant theatre staff completed checklists manually and lack of WHO surgical checklist compliance data was not captured, learnt from or improved upon. Many theatre staff also told us the system prevented them from completing theatre registers.

However, in February 2022 the service worked with information services and an integrated technology company to produce better data reports of venous thromboembolism (VTE). All previous VTE assessments for current and previous patient visits could be viewed on the system.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The division had appointed professional nurse advocates (PVAs) to most wards to help support staff with their health and wellbeing. We saw ward B3 staff had wellbeing walks and bike rides planned to help work relationships. In theatres we saw all staff names were included in a giant jigsaw which displayed a picture of a theatre.

However, some ward staff told us they were unhappy as they did not have a transfer team so were given multiple workloads.

Maternity

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most completed it.

Midwifery and medical staff received and mostly kept up to date with their mandatory training and we saw improvement in compliance rates since our last inspection. Midwifery staff compliance rate was 82.74% and medical staff compliance was 74.24% against the trust target of 85%.

The mandatory training was comprehensive and met the needs of women and staff.

Staff we spoke with told us managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. However, the compliance rate for level three adult safeguarding training was low.

Midwifery and medical staff received training specific for their role on how to recognise and report abuse.

The trust compliance target of 85% was met for levels one and two adult and children safeguarding and PREVENT training. PREVENT is a government led programme which aims to safeguard vulnerable people from being drawn into terrorism.

Compliance for level three safeguarding children was almost met, at 84.44% against the trust target of 85%. However, compliance for level three adult training was still low at 50%.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns.We observed safeguarding for women and babies was incorporated into the daily multidisciplinary safety huddle.

In the cases of need, the named safeguarding midwives midwife supported discharge coordination with the local social services team, GP and mental health services. A joint ‘family file’ was maintained securely to ensure that all staff are aware of the current position.

The service had a policy for identification of female genital mutilation (FGM) and an escalation pathway. Women were asked routinely, and risk assessed if concerns were raised about FGM. Individualised care plans were made in liaison with gynaecology if required. A family approach to find siblings and protect babies was undertaken. The trust monitored rates of FGM and reported all cases to the Department of Health database.

Safeguarding leads were part of the local network for midwives to help share learning and promote good practice.

There was now a baby-tagging alarm system installed, a baby abduction policy and staff we spoke with told us they undertook unannounced baby abduction drills. Staff received feedback after a drill in May 2022, via a recently introduced lessons learned bulletin. This highlighted the urgency of ensuring safety of the baby when the baby tagging system alarmed. We also saw a divisional plan with clear actions to address areas of risk. This was last reviewed in June 2022, however, only one of the ten actions was completed by the action due date.

While on the wards, we observed the system alarmed several times, however, staff did not respond. When we asked staff about this, they told us 'it doesn't work properly and they are always false alarms'. Staff said they felt nothing was done about it when they reported their concerns about the system.

We saw reports of two occasions where babies were discharged with their tag still attached. The alarm sounded after the parents left the hospital grounds and the security doors did not lock. This meant the alarm system may not be fit for purpose and we were concerned the risk of baby abduction was still not sufficiently mitigated. This risk was not on the maternity risk register.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

There was an infection prevention and control policy in place. Compliance with infection prevention training was 100% for level one and 78.95% for level two against a trust target of 85%.

The service participated in 10 hand hygiene audits per month. Hand hygiene dashboard data we reviewed for the period March to May 2022 showed 100% compliance.

All clinical areas we visited were clean and had suitable furnishings which were clean and well-maintained.For example, all seating was impermeable and could be wiped clean.

Environmental cleaning was completed by domestic staff. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed cleaning schedules displayed on wards and posters indicating five-star ratings for cleanliness audits.

Staff followed infection control principles including the use of personal protective equipment (PPE).We observed staff complied with 'bare arms below the elbows' policy, in accordance with National Institute for Health and Care Excellence (NICE) guidance.

Staff cleaned equipment after patient contact and labelled equipment with 'I am clean' stickers to show when it was last cleaned.

We observed public areas had posters which promoted COVID-19 awareness, and hand gel stations.

Women were asked to adhere to the trust's COVID-19 infection prevention and control measures as part of the appointments booking process. For example, women were asked not to bring children to their appointments where possible and partners were not able to stay overnight. Women were asked to inform their midwife of a positive COVID-19 test or if living with someone else who tested positive. This information was clearly displayed on the trust website.

Maternity

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Maternity services were provided within a dedicated, custom made family services building. The service offered a labour, delivery, recovery and postnatal (LDRP) system of care; which allowed a woman to labour and deliver in the same en-suite room. There were 16 beds in single or two-bedded rooms, and 19 LDRP rooms. The unit also had one dedicated operating theatre, a family bereavement room, a high dependency room, a mobile or active birth room, and a water-birth room. In addition, there was an antenatal outpatient department, antenatal day unit and obstetric ultrasonography facilities.

A decommissioned anaesthetic room was used as a second theatre in the event of an emergency. This did not meet the environmental specification required in HTM 03-01 guidelines for specialised ventilation for healthcare buildings. For example, it did not have an air exchange system. There was also insufficient floor space. This was not on the risk register, and we were unclear whether a formal risk assessment was completed. However, senior managers explained its use was monitored closely and work was planned to improve the standard.

All fire extinguisher appliances inspected were signposted and serviced within an appropriate timescale. Fire exits and corridors were clear of obstructions.

Access to the wards and theatre was via a buzzer and camera entry system and staff had a clear line of sight to the entrance doors. Access to restricted clinical areas, for example, the utility rooms and ward milk kitchen, was controlled with key-pad locks.

There were systems for recording the service and planned preventive maintenance of equipment, identified through a central log and equipment compliance stickers, which indicated the dates tests were due. Most of the equipment we inspected was tested within due dates. The exception was in theatre where we saw resuscitaires, cardiotocography (CTG) machines, anaesthetic machines, digital thermometer and a warming machine several months overdue. We brought this to the attention of staff at the time and arrangements were made with the estates staff to ensure the tests were completed as soon as possible.

Staff carried out safety checks of most of the specialist equipment we inspected. For example, checking records for the emergency resuscitation equipment and neonatal emergency trolleys on the wards had no gaps. All weekly and daily checks of emergency equipment in the out- patient and day assessment departments were complete.

However, we observed the ward pre-eclampsia trolley, subject to weekly checks, had no checks recorded for 11 days prior to our inspection.

We found out of date blood sampling bottles on the ward post-partum haemorrhage emergency trolley. This meant there was a risk laboratory results could be affected if they were used. We brought this to the attention of a manager at the time and the blood bottles were replaced.

In theatre, we found out of date needles and oxygen masks. We brought this to the attention of staff at the time and the equipment was replaced.

Women we spoke with told us they could reach call bells and staff responded quickly when called.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Staff used a nationally recognised Modified Early Obstetric Warning Score (MEOWS) tool to identify women at risk of deterioration and escalated them appropriately. They used National Early Warning Score (NEWS) to identify babies at risk of deterioration and escalated them appropriately. This was recorded on an electronic platform accessible to all clinical staff.

Staff completed risk assessments for each woman at every contact, including place of birth, using a recognised tool, and reviewed this regularly, including after any incident.

Staff knew about and dealt with any specific risk issues. For example, staff used a nationally recognised sepsis six pathway, and completed venous thromboembolism risk assessments for all women. We saw evidence of 'fresh eyes' assessments if cardiotocography (CTG) was performed in accordance with policy and best practice. CTG is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour.

Staff shared key information to keep women safe when handing over their care to others. For example, we saw staff used the SBAR format at midwifery handovers and evidence of escalation of high-risk women, to obstetricians. SBAR is an acronym for situation, background, assessment, recommendation; a technique used to facilitate prompt and appropriate communication.

There was a policy in place for identification of suspected fetal abnormalities which described the escalation and referral process.

We observed shift changes and handovers between midwives and medical staff included all necessary key information to keep women and babies safe.

Nurse Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix. The trust was unable to evidence that bank and agency staff received a full induction.

Managers calculated and reviewed the number and grade of nurses, midwives, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

However, the service did not always have enough healthcare assistants and midwifery staff to keep women and babies safe from potential harm. Staffing and mitigation of associated risks remained a concern. For example, we reviewed planned versus actual staffing percentages for the year to May 2022. This ranged from 88.9% to 95.1% and indicated suboptimal staffing to be a persistent occurrence.

Most staff we spoke with told us suboptimal staffing was their primary concern and they often did not have sufficient rest and meal breaks.

Maternity

Managers monitored the effects of suboptimal staffing on the maternity dashboard. This was used to capture red flag indicators, as recommended by Birth Rate Plus and National Institute for Health and Care Excellence (NICE) guidelines. A midwifery red flag event was a warning sign that there may be concerns with midwifery staffing levels. The data we reviewed showed delayed induction of labour was a persistent issue however, one to one care in labour was achieved consistently.

Staffing was overseen by shift coordinators, who were mostly supernumerary. We were told they sometimes took low risk postnatal and antenatal women, to help. Staffing requirements were transcribed manually from the electronic safer staffing tool onto a paper maternity communication tool. Shift coordinators updated the paper communication tool four times a day to reflect changing acuity and staffing needs. However, we observed actual staffing levels were not always updated correctly on the live electronic roster. Therefore, for example if there was staff sickness cover required which the coordinator was unaware of, this meant there could be staff shortages that were not covered.

In addition, the ward staffing white board used to display planned and actual staffing was incomplete and not dated. When we asked staff about this, they told us planned and actual staffing was not usually displayed.

Managers we spoke with explained there were daily staffing meetings for oversight of maternity issues and operational meetings three times daily to escalate staffing issues.

The trust had a policy for safe staffing levels and maternity services escalation policy. These detailed how to address any shortfalls in staffing, for example, unexpected absence. An escalation approach via the shift coordinators, senior nurses and midwives on duty or relevant on-call teams was clearly defined. However, staff we spoke with shared concerns that when the unit was at capacity they were not permitted to close. Red flag data confirmed the unit was not closed in 12 months prior to our inspection.

Managers used of bank and agency staff and requested staff familiar with the service. Staff we spoke with told us the service often ‘relied on goodwill’ to cover staffing shortfalls and shifts that required cover were advertised on a staff social media group. Specialist midwives and community staff were also utilised. Red flag data showed there were 47 occasions in the year to May 2022 when community staff were called in to work on the unit.

The service had increasing vacancy rates; currently at 16.78% whole time equivalent posts and the trust continued active recruitment.

The service had increasing sickness rates. The trust sickness absence rate for nursing and midwifery staff within the maternity core service remained between 8-10% from September 2021 to March 2022. This was notably higher than the absence rate in March 2021 of 4%.

Managers we spoke with told us all bank and agency staff had an informal orientation but no formal documented induction. This meant there was a risk of harm to women and babies if staff were unfamiliar with equipment, policies and emergency escalation procedures.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe.

The medical staff matched the planned number; there were no gaps in the rota.

Medical staff we spoke with told us there was excellent teamworking and they felt well supported. They said, 'everyone is approachable' and they received appropriate supervision. This concurred with the 2021 General Medical Council national trainee survey which showed the overall satisfaction score was above (better than) the national aggregate.

The service had low vacancy rates for medical staff.

Sickness rates for medical staff were low. For medical and dental staff within the maternity core service, the absence rate fluctuated between 1 and 5% since March 2021. The service rarely used locum staff.

The service operated a 'consultant of the week' system and always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely.

Records were mostly kept on paper. The exceptions were observations and pathology investigations which were recorded on an electronic system.

The service audited records. However, the last trust wide maternity report for the period May to November 2021 provided limited assurance to the trust. We saw an action plan was in place and this included implementation of an electronic maternity records system. Staff we spoke with were aware of the action plan and told us about a planned online portal and application that allowed women to access their real-time maternity records over the internet through computer, tablet device or mobile phone. Managers we spoke with said this would likely improve record keeping compliance.

We reviewed ten sets of women's records and found no concerns with the quality of record keeping. They were comprehensive and all staff could access them easily.

When women transferred to a new team, there were no delays in staff accessing their records.

Staff compliance with mandatory information governance and data security training was 87.01% against the trust target of 85%. However, we observed records were not always stored securely. For example, on the wards, we saw records stored in unlocked filing cabinets without keys. This was not in accordance with the General Data Protection Regulation (GDPR). We brought this to the attention of the ward manager at the time and lockable filing cabinets were provided and notes secured by the end of the inspection.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. Most medicines were mostly stored safely.

There was a dedicated pharmacist for maternity services.

Staff followed systems and processes to prescribe and administer medicines safely.

Midwifery staff worked to patient group directions, and practice was underpinned by the trust patient group direction protocol. We saw guidance around midwifery exemptions was included in the trust's medicines code.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Prescription charts were held as paper records. Staff we spoke with said they had previously used an electronic system but reverted to paper due to information technology issues. Staff completed medicines records accurately and kept them up to date.

Staff stored and managed most medicines safely. However, staff did not record ambient room temperatures where medicines were stored. This meant the trust was not assured all medicines, for example, intravenous fluids, were stored in accordance with manufacturer's guidance. After our inspection we received assurance the trust was developing a formal policy to address this.

In addition, the drawers of the pre-eclampsia trolley in the ward corridor contained sealed boxes of medicines but the trolley drawers were not secured with tamper proof tags.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

There was an incident reporting policy and electronic reporting system in place. All staff we spoke with knew what incidents to report and how to report them. They gave specific examples of incidents, near misses and red flag staffing incidents they had reported, in line with the trust's policy.

Nine serious incidents relating to maternity were reported by the trust to the NHS Strategic Executive Information System (StEIS) from May 2021 to May April 2022.

Managers shared learning with their staff about serious incidents that happened across the trust and elsewhere. For example, in safety huddles and emails and a recently introduced bulletin called 'learning the lessons following a serious incident', which we saw displayed in staff areas.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Staff we spoke with gave specific examples of incidents where duty of candour was discharged, and this was confirmed in serious incident investigation reports we reviewed.

Deaths within the service were investigated as part of the service's serious incident process. Those involving babies were put through a multidisciplinary team (MDT) review using the Perinatal Mortality Review Tool (PMRT). The PRMT is a national programme aiming to standardise perinatal mortality reviews across NHS maternity services. Perinatal mortality review meetings were also undertaken. We reviewed investigation reports for stillbirths and neonatal deaths, including root cause analysis and outcomes and learning. We found managers investigated incidents thoroughly and women and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Maternity

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice.

Staff mostly followed up-to-date policies to plan and deliver high quality care. Most policies we saw referenced evidence-based practice and national guidance. However, not all policies and guidance they used were up to date. For example, the resuscitation policy we saw was due review October 2021 and the UK resuscitation guidelines seen on the resuscitation trolley were dated 2015. The most recent version was published in 2021.

In addition, a lessons learned report we reviewed, from a recent serious incident report into an intrauterine death, stated trust guidelines did not always reflect best practice from NICE Guidance and Royal College of obstetricians and gynaecologists (RCOG), which meant staff were unclear of the actions they should have taken. The trust put an action plan in place to address this.

The service planned to implement an additional team to enable the continuity of carer approach to midwifery care, including for black and minority ethnic women and those from socially deprived areas. The continuity of carer model is a way of delivering maternity care so that women receive dedicated support from the same midwifery team throughout their pregnancy. There were two established teams at Diana Princess of Wales hospital which deployed a shift-based model of continuity of carer. The national recommendation was that the birth availability model should be adopted to offer the most flexibility and provide better relational continuity of carer for women. However, we were told plans were paused due to the number of vacancies within the current establishment.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs, such as diabetes. Food was available to accommodate different cultural choices.

The service was accredited with the United Nations children's fund (UNICEF) Baby Friendly Initiative, a programme that accredits units for supporting best practice in infant feeding.

The service had specialist breast infant feeding midwives and support staff. Systems were in place for follow up of mothers on discharge.

Women had access to their own expressed milk whenever they needed. A milk fridge and bottles were provided. To ensure safety, access to the milk kitchen was protected with a keypad lock which staff opened as requested.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff prescribed, administered and recorded pain relief accurately. We observed a midwife asking if a woman was in pain and prescribed oral medicines were explained before being given.

All women we spoke with did not highlight any concerns with their pain management.

The service had access to an anaesthetist 24 hours a day. The service monitored delayed pain relief of 30 minutes or more on the local maternity dashboard. The data we reviewed showed two delays in the last 12 months. There were no delays to epidurals reported across the trust in the last six months.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in relevant national clinical audits. For example, they regularly submitted key performance indicator data to the NHS screening programmes database.

Local and NHS digital (NHSD) maternity dashboards were used to monitor the service and target areas for improvement. The service used them to maintain oversight of their care against other services.

The maternity dashboard was maintained monthly and reported on clinical outcomes such as level of activity, maternal clinical indicators (mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators and public health information. Trust dashboards also included staffing and incident overviews. Local dashboards were aligned to regional maternity systems dashboards. Senior leaders we spoke with were aware of their position against their own performance and that of services within the local area.

Outcomes for women were mostly positive, consistent and met expectations, such as national standards. For example, in the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) perinatal mortality surveillance report published in October 2021 (based on births in 2019), the stabilised and adjusted perinatal mortality rate at the trust was within 5% of the comparator group average for all births and those excluding congenital anomalies. This meant, not significantly different to expected.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, they conducted weekly ward assurances surveys to monitor compliance with patient wrist band information, recording allergy status, pain management and fresh eyes documentation.

Competent staff

The service made sure most staff were competent for their roles. Managers appraised midwifery staff's work performance and held supervision meetings with newly qualified staff to provide support and development. Managers made sure most newly appointed staff received an induction.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. For example, there was now an independent registered scrub nurse able to supervise in theatres at all times, in line with national standards.

All medical staff and most midwifery staff we spoke with told us they had received a full induction tailored to their role before they started work.

Newly qualified midwives undertook a preceptorship programme and competency assessment. They were supported throughout the programme and met regularly with their supervisor. Staff we spoke with were positive about the programme and the support it provided.

However, managers we spoke with told us there were gaps in the provision of regular clinical supervision. We were told the service was working toward implementing a professional midwifery advocate (PMA) model but this was not yet fully in place.

Managers supported midwifery staff to develop through yearly, constructive appraisals of their work. Staff reported they were supported to develop and access further training. Appraisal rates for maternity staff at the time of the inspection were 91% against a target of 90%. All medical staff we spoke with told us they received an annual appraisal. However, we were unclear whether all medical staff had received an appraisal, as appraisal rates we requested for medical staff were not provided by the trust.

The clinical educators supported the learning and development needs of staff, in accordance with the maternity training and skills needs analysis. Staff we spoke with told us they completed skills and drills training, for example baby abduction and pool evacuation, and said face to face training that was postponed due to COVID-19 restrictions had just recommenced. We saw the schedule of planned and 'live' training for the year. Staff engaged in multi-professional team training. Compliance with practical obstetric multi-professional training (PROMPT) was 85%. The PROMPT course covered the management of a range of obstetric emergency situations.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There was a human resources process to support management of individual staff members with consistently poor compliance.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, we observed multidisciplinary attendance on all ward rounds and prioritisation of patients depending on risk. We saw handovers followed the recognised SBAR format.

Staff we spoke with said they had a good working relationship with the multidisciplinary team (MDT). Midwives told us they were happy to raise concerns and challenge practice with medical staff where they felt this would help to keep women and babies safe.

Staff reviewed women's mental health and where required the service would work closely with colleagues from the local mental health teams.

We observed good MDT team working within theatre.

The service worked with tertiary centres and neighbouring trusts to support women and babies needing specialist care. Specialist midwives worked alongside consultant leads, community midwives and specialists at regional centres to provide MDT care and care planning for women.

Seven-day services

Not all key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway.

The maternity outpatient department (Acorn) had three clinic rooms. They were operational Mondays and Thursdays morning and afternoon, there were no clinics on Tuesdays and there was an anaesthetic clinic on Wednesdays afternoon.

The antenatal day unit operated Monday to Friday 9am to 5pm.

The maternity assessment unit was not operational 24 hours a day, but we were told opening times were increased to 8pm during the week and until 5pm at weekend.

Staff could call for support from doctors and other disciplines, including mental health services and some diagnostic tests, 24 hours a day, seven days a week. The exception was ultrasound scanning services, which were only available Monday to Friday 8am to 4pm with closure at lunch time for an hour. There was no scanning service out of hours. The lack of availability of ultrasound capacity required to assess fetal wellbeing meant the standards set by RCOG, NICE and Saving Babies Lives were not being met.

There was no maternity triage system in place. We noted triage delays in the emergency department and urgent care was on the trust risk register, but the lack of a maternity specific triage system was not. Managers we spoke with explained triage was expected to be available soon, but there was no defined start date.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards and departments. For example, infant feeding information and how to deal with crying babies.

There were also links to external leaflets on the trust website. These provided advice on topics such as vitamins in pregnancy, folic acid, flu vaccine, whooping cough and baby immunisations.

In addition, there were informational videos hosted by the UNICEF Baby Friendly Initiative about infant feeding and baby relationship building.

Maternity

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, the service was a national outlier for smoking due to population demographic. In response, the service implemented additional services to reduce the proportion of women smoking at time of book and delivery. We saw staff conducted carbon monoxide testing for all women and saw evidence in the records we reviewed this was being undertaken. Whilst in hospital all smokers were offered nicotine replacement therapy.

The service had information on its website to support women make healthier choices including smoking and diet.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. During our inspection we observed informed consent being taken and written consent being checked for women undergoing elective caesarean section. Consent for screening was also observed and staff we spoke with explained sonographers requested this if not completed.

Staff understood Gillick Competence and Fraser Guidelines and supported young women who wished to make decisions about their treatment. This was recorded in the records we reviewed.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Women we spoke with said staff treated them well and with kindness and 'would definitely recommend others to book and deliver here'.

Staff followed policy to keep women's care and treatment confidential. We saw staff maintain women's privacy and dignity whilst in theatre.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Maternity

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it.For example, women who struggled to breast feed told us how the specialist infant feeding team had helped them to breast feed successfully.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There was a specialist bereavement midwife in post. Bereavement training compliance was 83%. We saw a dedicated bereavement room available on the ward which was used when delivering bad news. There were enough LDPR rooms and single ensuite rooms to enable bereaved women to deliver and spend time with their baby.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service also supported women who had a previous difficult birth or pregnancy through their current antenatal period.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. We saw good practice regarding informed consent. Women's partners we spoke with told us they felt involved in decisions about care.

Staff talked with women, families and carers in a way they could understand. For example, women we spoke with whose babies required neonatal intervention said they were kept up to date throughout. We observed how midwives interacted and communicated with young people who anxious about their pregnancy.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. For example, via friends and family questionnaires and 'you said, we did' display boards.

Women gave positive feedback about the service.

The trust performed similarly to other trusts for all 19 questions in the CQC maternity survey (2021).

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Maternity

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service worked with their local maternity voices partnership (MVP)

The unit had two continuity of carer teams; Daisy and Poppy. The continuity of carer approach to midwifery provides women with a named midwife who follows them throughout pregnancy, birth and the postnatal period. The model was aimed at supporting the natural ability of women to experience birth with minimum intervention; the monitoring needed to ensure a safe pregnancy and birth, and the physical, psychological, spiritual and social wellbeing of the woman and family throughout the childbearing cycle. The continuity teams were configured to work within areas where women may be at greatest risk including those from more socially deprived areas.

The service had identified where their facilities and premises did not meet the needs of the service. For example, lack of access to ultrasound scanning out of hours and no triage facility. We were told plans were in place to develop triage however the pandemic had led to delays.

The service had systems to help care for women in need of additional support or specialist intervention. For example, links with mental health teams.

Systems were in place to communicate with a woman's GP if they did not attend an appointment.

Partners were able to visit but were not permitted to stay overnight due to the current COVID-19 guidance. However, women were able to have their partner to support whilst in labour.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

National guidance outlines that women should be provided with choices of places to birth. The service offered women the opportunity to birth at home or in hospital with MDT input. We saw place of birth was documented in all records we reviewed.

The service had information leaflets available in languages spoken by the women and local community. There were also leaflets available of the trust website, for example, planned caesarean birth and pain relief in labour. The website had a button which signposted users to use online translators to interpret information on the trust website.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. These were accessed via telephone or booked to attend in person.

A bereavement room was available support provided to women and their families by a bereavement specialist midwife. However, they worked cross-sites and staff we spoke with shared concerns that the service was 'stretched'.

A birth afterthoughts service was available for women who wished to talk about their previous birth or maternity experience and was run by the central delivery suite manager.

There was a perinatal mental health midwife and the service had links with a specialist nurse for learning disability and links with community services and mental health services via support workers. Women with special needs had enhanced birth plans in place and their partners were permitted to stay following individualised risk assessment. Staff received training on recognising and responding to women with mental health needs, and learning disabilities and compliance was 83% against the trust target of 85%.

Women were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

Most women could access the service when they needed it and received the right care promptly.

From January 2021 to December 2021, there were 3,584 deliveries at the trust.

The service had an escalation policy and procedures in place for the closure of the unit however dashboard data showed there were no unit closures in the last 12 months. Staff we spoke with were unable to recall the last time the unit was closed.

There was no triage system in place and all calls went through to the delivery suite. Managers we spoke with told us a bespoke triage service was under development and almost complete. A report we saw which detailed progress in the last year against the Ockenden report, stated there was progression with quality improvement projects, which included triage. However, we did not see a date for implementation. After our inspection the trust clarified the Birmingham Symptom Specific Obstetric Triage System (BSOTS) telephone triage (first phase) was due to commence 31/10/2022 and the second phase planned to commence March 2023.

Red flag data showed there had been 30 reported episodes of delays of two hours or more to inductions of labour due to staffing, once women had arrived on the unit, over the last year to May 2022.

The service reported five delays of 30 minutes or more between presentation onto the ward and being seen for the year to May 2022.

Staff we spoke with in outpatient areas told us there were processes in place to follow up women who did not attend appointments.

Managers and staff started planning each woman's discharge as early as possible.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. The trust displayed information about how to raise a concern in patient areas and on the website.

The complaints process was embedded, and complaints were dealt with in real time or via patient advice and liaison service (PALS). Staff we spoke with told us concerns were dealt with locally where possible and, escalated to managers if required.

Maternity

Formal complaints and concerns were raised on the trust's incident reporting system.

For the year to June 2022, family service complaints (which included 5.438.4% for maternity), accounted for 15% of the trust's total number.

Data provided by the trust indicated timeliness of managing and responding to PALS and formal complaints improved and the service now consistently met response time targets.

Staff we spoke with told us complaints were rare and were unable to provide any recent examples.

Data provided by the trust showed the trust received 104 compliments for family services, which included maternity, for the period June 2021 to May 2022. We saw thank you cards displayed on the wards which contained positive feedback for staff.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. However, they did not always understand and manage the priorities and issues the service faced. Ward managers and matrons were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership team was now established and stabilised. Maternity services operated within the trust's family services division, led by the dDivisional cClinical dDirector, supported by the Ddivisional gGeneral mManager, hHead of Mmidwifery and Hhead of Nnursing. There was also a deputy head of midwifery and a site matron responsible for obstetrics and gynaecology. Roles and responsibilities were clearly shown in an organisation chart available to all staff.

Although the service had no direct board level member the Hhead of mMidwifery presented to board where maternity was a key part of the agenda, for example, to provide updates about the Ockenden report action plan. Senior leaders we spoke with said they felt supported by the board.

Several registered and non-registered staff, including new starters and students we spoke with told us ward managers, shift coordinators and matrons were visible and approachable. However, they told us senior leaders above matron level were not visible. Some staff we spoke with said they would not recognise them if they came onto the ward.

When we discussed this with senior leaders, they told us there was a monthly virtual staff engagement meeting, to which all staff were invited. Band seven staff attended this mostly and numbers attending were between two and eight. However, these meetings were not minuted and although staff knew about the meetings, staff we spoke with said they did not have time to attend as staffing levels were low.

Safety champion leads for midwifery, obstetrics and neonates where in place. The service displayed how clinical staff could contact the leads.

Maternity

We saw the trust's plans for compliance with the NHS England Perinatal Clinical Quality Surveillance Model. This was a quality surveillance model intended to provide a consistent and methodical oversight of all services, specifically including maternity services.

Vision and Strategy

The service now had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

During 2019 to 2020, the trust reviewed and aligned its five-year quality strategy in line with the trust's strategic direction. The strategy based upon the National Quality Board's (NQB) 'Shared Commitment to Quality', set long term quality objectives linked to the trust's strategic objectives. Family services, which included maternity, now had a formal vision and strategy as described in the annual divisional business plan.

The supporting objectives were;

- to give great care
- to be a good employer
- to live within our means
- to work more collaboratively
- to provide Strong leadership

Plans and priorities were displayed on posters in the departments. These were aimed at development of leaders, recruitment and retention, building professional standards, provision of harm free care and focus on patient centred care.

We saw the trust engaged with the local community on its strategy through the maternity voices network.

Culture

Staff felt respected, supported and valued by colleagues but expressed concerns that they did not feel listened to by senior managers. Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

There was an equality and diversity policy and compliance for staff equality, diversity and human rights training was 97.4%. Harassment and bullying training compliance was 98.7%.

Staff we spoke with told us they were supported to access additional training and junior midwives were positive about their preceptorship and progression. For example, the trust had funded external courses, provided study leave and developed new roles such as the Avoiding Term Admissions Into Neonatal units (ATAIN) programme and clinical leadership training.

The trust hosted a recent listening event for band seven staff, and those who attended told us this had improved communication. However, some staff we spoke with told us they did not feel listened to by senior managers. For example, regarding concerns they repeatedly raised about staffing.

Staff were encouraged to report incidents and those we spoke with felt there was a no blame culture. Staff we spoke with knew about the freedom to speak up guardian.

Managers described local staff recognition initiatives to reward their staff.

Governance

Leaders did not always operate effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had clear governance processes in place which supported performance, recognised safety, patient experience and clinical effectiveness. These were defined in the trust's maternity risk management framework.

We saw evidence that monthly quality and safety committee meetings were quorate and attended by the whole MDT.

At ward level we saw team meetings covered safety, performance and key service updates.

Incidents were investigated and reports were produced with recommendations and lessons learned that linked to the findings. Deaths within the service were investigated, where appropriate, using the perinatal mortality review tool, discussed at perinatal mortality review meetings and reported externally in line with national recommendations.

The service engaged with external organisations and reported any notifiable incidents to relevant bodies including the Health and Safety Investigation Branch (HSIB) and learnt from completed investigations.

The service completed the maternity services assessment and assurance tool and submitted this to NHS England. The tool required services to complete a self-assessment against immediate and essential actions arising from the Ockenden report. The action plan was monitored at the quality improvement and monitoring group meeting.

Managers, medical staff, hHead of mMidwifery, Deputy Head of Midwifery, Ggovernance mMidwife and clinical safety staff reviewed safety incident reports weekly to identify themes and trends and shared learning. However, managers we spoke with explained these meetings were not minuted as actions and learning were added to the incident reports at the time. When we asked senior leaders about this, they told us they would consider recording minutes to evidence the decision-making process.

Learning was cascaded to staff in a newly introduced bulletin, at daily safety huddles, emails and bi-monthly ward meetings.

Team leaders at all sites met formally each month and this was minuted.

Maternity presence at the board was by invitation, for example, to present Ockenden report action plan updates.

Maternity

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated most risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Trust maternity services were supported by NSHE/I colleagues who conducted periodic insight visits; the most recent was in May 2022. The purpose of the visits was to provide assurance against the seven immediate and essential actions from the first Ockenden report. The report showed the trust made satisfactory progress with their actions; six of seven actions were compliant, and one was partially compliant. Risk associated with not completing all actions was noted on the trust risk register.

The trust board had oversight of maternity serious incidents. There was an agreement with the local maternity system (LMS) and process in place for external review of serious incidents to be provided between trusts.

We saw the risk register was discussed within governance meetings. However, we identified areas of risk that were not on the risk register. For example, the baby-tagging alarm system and risk of baby abduction, the use of suboptimal anaesthetic room as a second theatre and lack of maternity triage provision. This meant we were not assured all identified risks affecting the service in line with trust policy, were escalated to the risk register.

Performance dashboards were used to measure relative performance, rank against benchmarks and national targets, help to identify improvements and show trends for the previous 12 months. Targets were based on those sent by the LMS and the service reviewed their performance against others within the LMS.

We saw business continuity plans were in place for maternity services trust wide, which were reviewed annually. There was an up to date maternity services escalation policy.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Managers used information to manage the performance of the department against local and national indicators. Staff were made aware of their responsibilities in relation to data protection through annual information governance and data security training.

The trust aimed to implement an electronic patient records system but managers we spoke with explained this was delayed due to the pandemic.

The service collated and reported information in line with national requirements and best practice within maternity.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Women could give feedback about the service directly by raising concerns, complaints and compliments.

Maternity

The service had a strong relationship with their local Northern Lincolnshire maternity voices partnership (MVP) which met formally. We saw minutes of these meetings. Managers we spoke with gave examples of how the MVP had influenced service provision. For example, changing visiting hours and producing improved, clearer information for women and their families about induction of labour.

Trust maternity services were part of the Humber, Coast and Vale (HCV) local maternity system (LMS). The service actively engaged with their LMS, regional and safety improvement groups to share learning and improve outcomes for women and children.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Staff we spoke with told us they felt supported to develop their career.

The trust maintained close links with local universities and midwifery education leads and tutors to support student midwives with learning. Students we spoke with told us they always worked under supervision of a registered midwife and had enough time to complete academic work during placement. They told us they always had sufficient rest breaks and went off duty on time.

The service participated in the '15 step' ward assurance programme.