

Northern Lincolnshire and Goole NHS Foundation
Trust

Diana Princess of Wales Hospital

Quality Report

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Date of inspection visit: 13 - 16 October 2015, 6
November 2015 and 5 January 2016
Date of publication: 15/04/2016

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Requires improvement



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and gynaecology

Good



Outpatients and diagnostic imaging

Inadequate



Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Northern Lincolnshire and Goole NHS Foundation Trust from 13 – 16 October 2015 and performed an unannounced inspection on the 6 November 2015 and the 5 January 2016. This inspection was to review and rate the trust's community services for the first time using the Care Quality Commission's (CQC) new methodology for comprehensive inspections. The acute hospitals had been inspected under the new methodology in April 2014, we therefore carried out a focussed inspection of the core services that had previously been rated as inadequate or requires improvement. Due to additional information the inspection team also inspected maternity services and caring across the core services included this inspection.

Focused inspections do not look across a whole service; they focus on the areas defined by the information that triggers the need for the focused inspection. We therefore did not inspect children and young people's services or end of life services within the hospitals at the follow up inspection. Additionally not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected. At the inspection in April 2014 we found the trust was in breach of regulations relating to patient care and welfare, staffing, premises, staff support and governance.

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

Our key findings were as follows:

- There were significant gaps in the medical rotas for some specialities: both A&E and critical care services were not staffed in line with nationally recommended levels of consultants and A&E was not staffed to the trust's own recommended levels.
- Whilst the trust was actively recruiting to nursing posts, there remained a high number of nursing posts vacant on a significant number of wards and other services. Shift co-ordinators on each ward also had a cohort of patients to care for. On most wards there were two registered nurses overnight; frequently one of these would be bank or agency. This was raised at the time of inspection and the trust are undertaking a review of nurse staffing and developing the shift co-ordinator role.
- There was a backlog of patients requiring outpatient follow up and high levels of clinic cancellations resulting in patients being cancelled on multiple occasions. There was a lack of clinical involvement in the cancellation process and a lack of clinical validation of the patients who were waiting for follow up appointments.
- There was lack of oversight and accountability of the outpatient processes and associated backlogs with actions slow and lacking sufficient senior managerial involvement at core service level. The issues regarding outpatient backlogs had been raised at the inspection and the trust took immediate action to ensure the backlog of patients were reviewed and provided with appointments.
- There were gaps in learning from incidents in almost all services. We were not assured that following serious incidents and never events that learning was disseminated and any risks identified and actions taken. The leadership had not ensured that lessons learnt from a never event within ophthalmology had been robustly embedded and compliance monitored to prevent it happening again.
- At the time of the inspection the trust was a mortality outlier for deaths from acute bronchitis and cardiac dysrhythmias.

Summary of findings

- Staff were not aware of how to record minimum and maximum temperatures for medication fridges; what the recommended range was or that this was necessary for safety and efficacy of the medicines. We saw several examples where a temperature had been recorded outside of recommended range but no action had been taken.
- There had been managerial change within critical care which was beginning to have a positive impact with regard to development of critical care services. There had been significant improvements in the delivery and location of high dependency services at the Diana Princess of Wales Hospital since the initial comprehensive inspection of 2014.
- There was not sufficient resource identified, including specialist staff, training and systems in place to care for vulnerable people, specifically those with learning disabilities and dementia. However, there was a highly motivated and compassionate quality matron who had the lead for dementia and also learning disabilities.
- At our inspection in April 2014 we found that not all clinical staff had received safeguarding of children training up to the advanced level three. At this inspection, we found that clinical staff were now in the process of being trained up to level three in safeguarding children. However, the numbers of staff who had received the level three training was below the trust's 95% target. The records provided to us by the trust showed that no medical staff in the emergency department had undertaken level three safeguarding children training.

We saw several areas of outstanding practice including:

- The development of a pressure sore assessment tool known as a 'pug wheel' to support staff in the accurate identification of pressure damage. This had been developed by the tissue viability team.
- The "Frail Elderly Assessment & Support Team" gave elderly patients, immediate access to physiotherapy / occupational therapy assessment as well as nursing & medical assessment. Social services would also be involved in assessment with the aim of providing immediate treatment / assessment and initiation of community based care or services. The aim of this service was that patients should be able to return to their usual place of residence with the support of community services.

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

- The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels. This must include but not be limited to: medical staff within ED and critical care, nursing staff within medicine and surgery and midwives. It must also include a review of dedicated management time allocated to ward co-ordinators and managers. It must ensure adequate out of hours anaesthetic staffing to avoid delays in treatment. The trust must ensure there are always sufficient numbers of radiologists to meet the needs of people using the radiology service.
- The trust must ensure that staff at core service/divisional level understand and are able to communicate the key priorities, strategies and implementation plans for their areas. The trust must improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform.
- The trust must ensure that the significant outpatient backlog is promptly addressed and prioritised according to clinical need. Ensure that the governance and monitoring of outpatients' appointment bookings are operated effectively, reducing the numbers of cancelled clinics and patients who did not attend, and ensuring identification, assessment and action is taken to prevent any potential system failures, thus protecting patients from the risks of inappropriate or unsafe care and treatment.
- The trust must ensure equipment is checked, in date and fit for purpose including checking maternity resuscitation equipment and critical care equipment is reviewed and where required included in the trust replacement plan
- The trust must ensure that action is taken to address the mortality outliers and improve patient outcomes in these areas.
- The trust must ensure it acts upon its own gap analysis of maternity services across the trust to deliver effective management of clinical risk and practice development.

Summary of findings

- The trust must ensure the safe storage and administration of medicines. The trust must ensure staff check drug fridge temperatures daily and record minimum and maximum temperatures. Additionally it must ensure staff know that the correct fridge temperatures to preserve the safety and efficacy of drugs and what action they need to take if the temperature recording goes outside of this range. The trust must ensure the DPoW hospital discharge lounge has a facility and process for safe storage for medicines.
- The trust must review the validation of mixed sex accommodation occurrences, especially within the acute medical unit, to ensure patients are cared for in appropriate environment and report any breaches.
- The trust must ensure there is an effective process for providing consistent feedback and learning from incidents.
- The trust must ensure the reasons for do not attempt cardio respiratory resuscitation (DNACPR) decisions are recorded and in line with good practice within surgical services.
- The trust must ensure the five steps for safer surgery including the World Health Organisation Safety Checklist (WHO) is consistently applied and practice is audited in theatres.
- The trust must review the effectiveness of the patient pathway from pre-assessment, through to timeliness of going to theatre and the number of on the day cancellations for patients awaiting operation.
- The trust must ensure policies and guidelines in use within clinical areas are compliant with NICE guidance or guidance from other similar bodies and that staff are aware of the updated policies, especially within maternity, ED and surgery.
- The trust must have a process in place to obtain and record consent from patients and/or their families for the use of the baby monitors in ITU.
- The trust must ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation, especially in relation to: staffing; critical care and ensuring the essential equipment is included in the trust replacement plan.
- The trust must ensure there are adequate specialist staff, training and systems in place to care for vulnerable people specifically those with learning disabilities and dementia.
- The trust must stop using newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses on duty.
- The trust must ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours. The trust must continue to improve against the target of all staff receiving an annual appraisal and supervision, especially in surgery, and that actions identified in the appraisals are acted upon.
- The hospital must ensure the safe storage of medicines within fridges. The trust must ensure staff check drug fridge temperatures daily and record minimum and maximum temperatures. Additionally it must ensure staff know that the correct fridge temperatures to preserve the safety and efficacy of drugs and what action they need to take if the temperature recording goes outside of this range.

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

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

We found the service to be 'requires improvement' overall. This was a change from the April 2014 inspection rating of good overall with required improvement in relation to being safe. In 2015 we inspected and rated the effective domain as we did not rate this our 2014 inspection. We also inspected the responsive domain because of concerns raised.

- The service was not staffed in line with nationally recommended levels of consultants or to the trust's own levels. Although the trust told us there was 11 hours' per day consultant presence in the department we found this did not occur at the weekend. On Saturdays and Sundays the consultant presence was for three hours. Data provided by the trust showed that the nursing workforce was short by 4.19 whole time equivalent posts. Additional cover was also provided by agency staff and substantive staff working extra. Safeguarding training was improving. However, the numbers of staff who had received the level three training was below the trust's 95% target. This was the same with regard to mandatory training generally. Staff were offered support through appraisal and developmental training. Although some elements of this training had only recently started.
- Whilst the department had in place best practice guidelines including those produced by The National Institute for Health and Care Excellence and the Royal College of Emergency Medicine not all had been fully implemented or audited. There were breaches to the national standard of within 30 minutes for patients being handed over by ambulance staff to the emergency department team; between April and September 2015, of 2,343 (approximately 7-8%) patients waited longer than 30 minutes. Between April 2015 and November 2015 the national standard to achieve 95% of patients being seen in ED and a decision made to treat, discharge or admit within four hours was at or above the standard trust-wide in June, July and September 2015.

Summary of findings

- We found the department to be clean. We found the department to be well set out with their being an open and bright environment. Pain relief was offered to patients, and nutrition and hydration was provided.
- Staff were aware of incident reporting systems and there were forums where incidents were discussed with them. There were systems of multidisciplinary working. Systems and process for the taking of consent and the management of the Mental Capacity Act were in place.
- There was an acceptable level of support for patients with a mental health condition. There was a dedicated room for their assessment although when that room was not available other treatment rooms were used which did not have the same safety features. There had recently been specialist training undertaken by staff into the care of patients with a mental health condition.

Medical care (including older people's care)

Requires improvement



- Overall, we judged this service as 'requires improvement' although there were some areas of good practice and the service had shown improvement from the previous inspection. We rated safe as 'requires improvement' because:
- The provider could not consistently meet planned staffing levels due to large numbers of vacancies across the service.
 - The discharge lounge did not have enough safe storage for medicines.
 - On several wards, staff did not maintain the fridge temperatures within the required range to maintain safety and efficacy of drugs. Compliance with mandatory training requirements was below trust target, especially for medical staff, although rates had improved over the last twelve months. However there were some areas of good practice;
 - Staff protected patients from avoidable harm and abuse.
 - Staff reported incidents, shared learning and implemented actions to reduce future occurrences.
- We rated effective as 'good' because;
- The trust based policies and pathways on NICE and Royal College of Physicians guidelines and staff could access them easily.
 - Staff provided patients with pain relief and met their nutrition and hydration needs.

Summary of findings

- The hospital had improved access to special and soft diets and these were readily available on the medical wards at any time.
- Performance in national audits showed improvements on the previous year and the service had developed action plans where further improvement was needed.
- Emergency readmission rates at DPoW were better than the England averages for elective and non-elective patients, in its top three specialties. Reduction in harm was seen in the diabetic audit results.
- We witnessed strong multidisciplinary team working during our inspection.
- However; appraisal rates and training rates were still below the trust target in some areas, although they had improved significantly since the previous inspection.

We rated caring as 'good' because:

- We saw staff treat patients with care and compassion and protect their privacy and dignity at all times.
- Patients were happy with the care they received and found the service was caring and compassionate. Most patients spoke very highly of staff and told us that they, or their relatives, were treated with dignity and respect.
- We saw staff involved patients in their care.
- Nursing staff were very kind and gave immediate support to patients who were distressed.
- The response to the Friends and Family Test was 37.1%, which was better than the England average, between July 2014 and June 2015. Between July and September 2015 more than 95% of patients said they would recommend the service.

We rated responsive as 'requires improvement' because:

- Medical review of outlying patients was not consistent and discharges were often delayed.
- The hospital struggled with patient flow and bed pressures indicated by high numbers of medical patients boarded out (outliers) on other speciality wards and the number of bed moves.
- Mixed sex breaches occurred within the AMU and it was unclear how these formally assessed and reported.

Summary of findings

- Nursing staff had not yet received training regarding people with a learning disability. However, there were some aspects of good practice;
- Staff worked hard to meet patients' individual needs.
- Referral to treatment times for the trust was consistently better than the England average for all specialities.
- There were a number of initiatives to help patients to access the correct service or pathway and reduce the numbers of unnecessary admissions
- At ward level there was clear leadership and, previously concerning wards with new managers were able to demonstrate evidence of improvement in quality indicators.
- Staff told us that ward managers and matrons were supportive and approachable and they would have no hesitation about raising concerns.
- Managers and senior clinicians were aware of the risks and challenges faced by their services and there were a number of examples of innovation and service improvements.
- There were well-embedded processes for monitoring quality indicators and mechanisms in place to take improvement action where needed. However, there were some areas for improvement;
- Nursing and medical staff felt that vacancies in key clinical lead posts were delaying the strategic development of some specialities.
- Staff were not clear about the long-term vision for their services in all specialities.
- Ward managers told us they had limited management time due to being counted in the planned staffing figures to deliver patient care.

Surgery

Requires improvement



We rated surgery as 'requires improvement' overall. This was because:

- Surgical services did not always protect patients from avoidable harm and there was a limited level of assurance with safety measures. We found that although staff reported incidents of harm or risk of harm, the lessons learned from investigating them were not always fed back. Whilst there were some systems and processes in place to support the dissemination of this learning, staff told us that they

Summary of findings

did not receive or access feedback/learning from incidents. We were therefore not assured that learning was effective in preventing similar incidents in the future.

- In 2014, we said the trust must take action to ensure that there were sufficient qualified, skilled and experienced staff, particularly in surgical areas. During this inspection, we found substantial and frequent shortages of nursing staff and an increased number of agency staff being used. When staff shortages occurred, the skill mix of staff was not always a priority. The trust had run a significant recruitment campaign but the skill mix and retention of new staff remained an issue. Appraisal rates had improved since 2014, however still did not meet internal compliance targets and levels of compliance was variable. Newly qualified nurses, awaiting their national registration, were often included within the qualified staffing levels. Many staff commented on an increased amount of pressure for experienced/substantive staff due to the staff shortages. The overall number of vacancies had increased since our inspection in 2014 despite the trust's efforts at recruitment.

- We had concerns regarding the pre-assessment of patients; the assessment of early warning scores for deteriorating patients; and, the provision of emergency equipment. Assurance for compliance with the five steps for safer surgery was limited. Patients were at risk of not receiving effective care or treatment, as care provided did not always reflect current evidence-based guidance, standards and best practice. Implementation of best practice guidance was variable, with 65% of policies compliant with current National Institute for Health and Care Excellence guidance. National hip fracture audit data for 2014 showed DPoW performed better than the England average on most of the indicators. However, there had been deterioration in performance at DPoW in three of the areas reported on in 2014 compared to 2013.

- Services did not always meet patients' needs. They were not always able to access services for assessment, diagnosis or treatment when they needed them. There were breaches to national waiting times, especially in urology, pain procedures, ophthalmology and trauma and

Summary of findings

orthopaedics. Patients we spoke to and evidence we reviewed showed that patients were experiencing delays and cancellations of operations and procedures. Actions taken to deal with this were not always timely or effective. A number of medical patients were using surgical beds, which limited the availability of beds for surgical patients.

- When patients raised concerns or complained, they did not always receive satisfactory responses and outcomes. Complaints were not always used as an opportunity to learn. Patients' needs were not always taken into account.
- There was no surgical vision statement or overarching surgical strategy. We were told that some of the future service provision would be determined through the ongoing local health community "Healthy Lives, Healthy Futures" work stream. Risk issues were not always dealt with appropriately or in a timely way.
- It was noted in the 2014 inspection, that the senior management team was new at that time and had not had time to implement changes. During 2015 further senior management team change had taken place. Managers had not yet identified, prioritised and taken action on all of the issues of concern within surgery. Potential improvements from the introduction of the quality and safety days had not yet become an established route for learning. During the inspection we saw improved leadership on surgical wards from ward managers.
- The development of the Web V virtual ward administration computer system had made a positive impact on the documentation of patient risks.

Critical care

Requires improvement



We rated critical care as 'requires improvement' overall. Safe, effective, responsive and well led were rated as 'requires improvement' and caring was rated as 'good'.

- Staff at DPoW reported a lower number of incidents in comparison to staff at SGH. Staff at DPoW used mittens for patient safety but did not report this as an incident which was required by the restraint policy.
- Essential critical care equipment such as beds, mattresses and ventilators was old and staff described it as not fit for purpose. This had been

Summary of findings

added to the surgery and critical care risk register in 2009. There was no evidence that any action had been taken. Funding was not available for replacement in 2015/16 capital program.

- The units did not meet the requirements of national standards for nurse or medical staffing. A consultant intensivist was not available seven days and week and medical staff rotas did not promote continuity of care. A supernumerary senior nurse was not available 100% of the time as a clinical coordinator. The clinical educator post had been vacant for eighteen months at the time of our inspection. The high dependency unit (HDU) did not monitor patient outcomes. This meant that the unit was not able to compare its performance with other similar units in the country. Patient outcome data for the ITU was worse than data from other units in the region.

- Staff showed limited application of putting policies into clinical practice, for example, around patient consent and restraint. The vacant clinical educator post may be one of the reasons for this. New staff told us they had limited formal clinical bedside training

- The bed occupancy was higher than the national average. The number of delayed discharges from ITU was higher than the critical care network average. Ninety patients were discharged out of hours and 11 elective operations were cancelled due to a lack of critical care beds between April 2014 and March 2015. There had been one non-clinical transfer in the six months prior to our inspection. This was not in line with recommendations from Core Standards for Intensive Care (2013).

- The management team had not taken timely action on some of the issues identified on the risk register. Ageing and failing equipment that had an effect on patient and staff safety within ITU such as beds and ventilators had been on the risk register for up to six years. From the records of the service governance meetings we saw little evidence to suggest leaders reviewed the risk register or developed actions to mitigate risk.

However,

Summary of findings

- Recent changes had been made to the clinical leadership and there had been significant changes to the management of patients on HDU since our inspection in 2014.
- Some progress had been made to cross site working and standardisation of care across both sites.

Maternity and gynaecology

Good



We found maternity and gynaecology services to be 'good' overall. Safe was rated as 'requires improvement', and effective, caring, responsive and well-led were rated as 'good'. Our key findings were as follows:

- Women received care according to professional best practice clinical guidelines. Although we found some policies were out of date, the trust had identified this and steps had been taken to address it. Women had a named midwife responsible for their care during pregnancy and one-to-one care during labour.
- In September 2015, results of the NHS Friends and Family Test (FFT) showed that between 73% and 98% of women who used the service would recommend the labour ward to friends and family if they needed a similar service.
- The service had advanced midwife practitioners working there for several years and this innovation was a contributing factor in providing holistic high-level midwife-led care.
- At the Royal College of Midwives awards in 2014, the midwifery teams were recognised twice for promoting a 'normal birth experience' and were finalists in the 'supervisor of midwives team' category.

However we also found:

- Staff were encouraged to report incidents of harm or risk of harm and told us they had received feedback. However, some staff said they had not always received individual feedback after an incident. We also found there were outstanding incidents which had not been investigated for several months and the provider confirmed they had staff working on these. This could have meant there were risks where action had not been taken.
- Checks of emergency equipment were not being done consistently across the service. In one area, a

Summary of findings

stethoscope was missing from the equipment and had not been replaced for 12 days, which could have meant it was not available for use in an emergency.

- We also found the medicines trolley in the antenatal clinic was not locked and intravenous fluids in the in-patient unit were not stored in line with current guidance and legislation. The provider has been asked to send CQC a report as to the actions they are going to take to meet these requirements.

- The Kirkup Report, Gap analysis of the service had identified the need for a clinical risk midwife and a practice development midwife. However, although the management team were working to address this, neither had been appointed.

- The service had one midwife for every 30 births compared with a recommended ratio of one to 28. Although there were plans to deal with shortages and these were being managed with staff working overtime, not all staff managed to take breaks during their shift, which in some instances had lowered morale.

- In the antenatal clinic although the environment looked clean, there were gaps in the cleaning records. Not all equipment had been cleaned between uses, which could have resulted in a low risk of cross infection between patients.

Outpatients and diagnostic imaging

Inadequate



We found your outpatients and diagnostic imaging core service to be rated as 'inadequate' overall.

Safe, responsive and well-led were rated as 'inadequate' and caring was rated as 'good'. There was evidence of harm to patients within the outpatient services because of poor management of the follow up appointment system. There were no significant concerns identified within the diagnostic services we inspected where we found patients were protected from avoidable harm and received effective care.

- Between September 2014 and the time of the inspection, five serious incidents were reported in ophthalmology where patients had suffered harm due to delayed diagnosis and treatment. There was a lack of evidence to demonstrate feedback, follow up actions and learning from incidents in outpatients.

Summary of findings

- When we inspected outpatients at this location in April 2014, the service overall was rated as good, the effective domain was not rated and the responsive domain was rated as requires improvement. This was because the hospital had a high did not attend (DNA) rate (10.5%) and high levels of cancellations of outpatient appointments at (17.1%). We asked the provider to make improvements. On this inspection, we checked whether the provider made the improvements. We found the number of patients who did not attend outpatient clinics was still above 10% and the number of cancelled clinics in outpatients and ophthalmology had increased.
- There was a backlog of 30,667 outpatients without follow-up appointments. The service had no clear action plan to address the immediate clinical risk to patients. The trust continued to experience demand pressures in a number of OP specialties, including ophthalmology, orthopaedics and paediatrics. There was a lack of management oversight of the significant problems with the OP clinic booking systems. We asked the trust to take immediate action: the trust provided monitoring information following the inspection that indicated all patients in the backlog had been reviewed by 31 December 2015.
- Systems were in place in radiology to ensure that the service was able to meet the individual needs of people such as those living with dementia or a learning disability, and for those whose first language was not English. However, we found services in outpatients were not planned and delivered to ensure the additional needs of these patients groups were met.
- Systems were in place to capture concerns and complaints raised within both departments, review these and take action to improve the experience of patients. We found there were high numbers of formal and informal complaints about the administration of appointments in the OPD.

Diana Princess of Wales Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Outpatients and diagnostic imaging;

Detailed findings

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Background to Diana Princess of Wales Hospital

The trust provides acute hospital services and community services to a population of more than 350,000 people across North and North East Lincolnshire and East Riding of Yorkshire. Its annual budget is around £330 million, and it has 843 beds across three hospitals: Diana Princess of Wales (DPoW) Hospital and Scunthorpe General Hospital (each based in Lincolnshire) and Goole & District Hospital (based in East Riding of Yorkshire). The trust employs around 5,200 members of staff.

CQC carried out a comprehensive inspection between 23 and 25 April and on 8 May 2014 because the Northern Lincolnshire and Goole NHS Foundation Trust was placed in a high risk band 1 in CQC's intelligent monitoring system. The trust was also one of 14 trusts, which were subject to a Sir Bruce Keogh (the Medical Director for NHS England) investigation in June 2013, as part of the review

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

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

Our inspection team

Our inspection team was led by:

Chair: Jan Filochowski, Clinical and Professional Adviser at CQC; NIHR; Commonwealth Fund and IHI

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

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

Community Children's Nurse Manager, Community Matron, Health Visitor, School Nurse, Dentist, Community Paediatrician, Physiotherapist, District Nurse, Child Safeguarding Lead Nurse, EOLC Matron, Critical Care Doctor, Critical Care Nurse, A&E Nurse, Medicine Doctor, Medicine Nurse, Surgery Doctor – Surgeon, Surgery Doctor – Anaesthetist, Surgery Nurse, Theatre Nurse, Ophthalmic Nurse – Outpatients, Midwife Matron, Midwife, Consultant Obstetrician, Child Safeguarding –

Detailed findings

Trust wide, Clinical Director, Diagnostic Radiology Doctor, Junior Doctor, Student Nurse, and experts by experience (people (or carers or relatives of such people), who have had experience of care).

How we carried out this inspection

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

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

The inspection team inspected the following eight core services at the trust:

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

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG),

Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

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

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

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

Facts and data about Diana Princess of Wales Hospital

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

The trust provides a wide range of services out in the community as well as at its three hospitals: Diana Princess of Wales Hospital and Scunthorpe General Hospital (each based in Lincolnshire) and Goole & District Hospital (based in East Riding of Yorkshire).

The trust has 772 general and acute beds and 71 maternity beds.

Detailed findings

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

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

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

North East Lincolnshire is in the most deprived data set, and North Lincolnshire is in the fourth most deprived data set, compared to other Local Authorities. A significantly greater proportion of children live in poverty compared to the England average in both these areas.

East Riding of Yorkshire is less deprived, being in the second data set of Local Authorities. Proportionately fewer children live in poverty compared to the England average.

According to the Local Health Profile, the health of people in North Lincolnshire and North East Lincolnshire is generally significantly worse than the England average. The health of the population in East Riding is generally better than the England average, apart from smoking at delivery and the level of recorded diabetes.

The trust was last inspected on 23 to 25 April 2014 and on 8 May 2014 (with an unannounced inspection on 6 May 2014) and was found to overall to 'require improvement', although it was rated as 'good' for having caring staff.

Our ratings for this hospital



Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. When we inspected Urgent and Emergency Care in April 2014, we rated it as 'good' for caring and well-led and therefore these domains were not inspected during this inspection.

Urgent and emergency services

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

Information about the service

The emergency department saw 61,307 patients between April 2014 and March 2015. This was an average of 174 patients a day. Of this yearly attendances 20% were children aged under 16.

Between April 2015 and September 2015 the department saw 32,458 patients, 6,127 of whom were children. Of the total attendances over this period 7,330 were admitted.

The department treated all emergencies except for major trauma. The emergency department was open 24 hours a day, seven days a week.

The department was divided into areas for the treatment of minor and major illness and injury and for resuscitation. There were four bays in the resuscitation room, one of which was used for children. In the majors area there were 13 cubicles. There was also a minors area which had a room for triage and rooms for the treatment of minor injuries and illnesses. There was also an area by the ambulance entrance with four bays where patients could be placed whilst they waited for a cubicle in the majors' area. These treatment rooms were used by emergency nurse practitioners (ENPs), emergency department doctors and GPs. There was a room for the care and treatment of children and young people that was adjacent to the department. Children would go there to wait after being booked in at reception. This area was managed by children's services.

During our inspection, we spoke with six patients and relatives, and 35 members of staff. We observed care and treatment being undertaken. We also reviewed clinical records, and policies and procedures. Our inspection team

consisted of a Care Quality Commission inspector, three experienced emergency department nurses and a Mental Health Act Assessor. The Mental Health Act assessor also produced a report under the terms of the Mental Health Act 1983.

Urgent and emergency services

Summary of findings

We found the service to be 'requires improvement' overall. This was a change from the April 2014 inspection rating of good overall with required improvement in relation to being safe. In 2015 we inspected and rated the effective domain as we did not rate this in our 2014 inspection. We also inspected the responsive domain because of concerns raised.

The service was not staffed in line with nationally recommended levels of consultants or to the trust's own levels. Although the trust told us there was 11 hours' per day consultant presence in the department we found this did not occur at the weekend. On Saturdays and Sundays the consultant presence was for three hours. Data provided by the trust showed that the nursing workforce was short by 4.19 whole time equivalent posts. Additional cover was also provided by agency staff and substantive staff working extra. Safeguarding training was improving. However, the numbers of staff who had received the level three training was below the trust's 95% target. This was the same with regard to mandatory training generally. Staff were offered support through appraisal and developmental training. Although some elements of this training had only recently started.

Whilst the department had in place best practice guidelines including those produced by The National Institute for Health and Care Excellence and the Royal College of Emergency Medicine not all had been fully implemented or audited. There were breaches to the national standard of within 30 minutes for patients being handed over by ambulance staff to the emergency department team; between April and September 2015, of 2,343 (approximately 7-8%) patients waited longer than 30 minutes. Between April 2015 and November 2015 the national standard to achieve 95% of patients being seen in ED and a decision made to treat, discharge or admit within four hours was at or above the standard trust-wide in June, July and September 2015.

We found the department to be clean. We found the department to be well set out with there being an open and bright environment. Pain relief was offered to patients, and nutrition and hydration was provided.

Staff were aware of incident reporting systems and there were forums where incidents were discussed with them. There were systems of multidisciplinary working. Systems and process for the taking of consent and the management of the Mental Capacity Act were in place.

There was an acceptable level of support for patients with a mental health condition. There was a dedicated room for their assessment although when that room was not available other treatment rooms were used which did not have the same safety features. There had recently been specialist training undertaken by staff into the care of patients with a mental health condition.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



We found the service to be 'requires improvement for safe services because:

- Staff were aware of incident reporting systems and there were forums where incidents were discussed with them. However, not all staff were aware of a recent "never event" that occurred in the department.
- The service was not staffed in line with nationally recommended levels of consultants or to the trust's own levels. Although the trust told us there was 11 hours' per day consultant presence in the department we found this did not occur at the weekend. On Saturdays and Sundays the consultant presence was for three hours. Data provided by the trust showed that the nursing workforce was short by 4.19 whole time equivalent posts (7%). Additional cover was also provided by agency staff and substantive staff working extra shifts. The service was not meeting the requirements for children's nurses in the emergency department.
- Patient group directions were used by nursing staff although they were not always reviewed on a regular basis. Safeguarding systems were in place and staff undertook training, and were aware of their responsibilities in the reporting of any suspected incidents. Safeguarding training was improving. However, the numbers of staff who had received the level three training was below the trust's 95% target. This was the same with regard to mandatory training generally.
- Data on time to initial assessment for patients arriving by ambulance for the period April 2015 to October 2015 indicated that out of a total of 11,805 patients 11,420 (96.7%) were assessed within 15 minutes whilst 11,507 were assessed within 30 minutes. The number of patients who waited more than 30 minutes to be assessed was 298 (2.5%).
- We found the department to be well set out with an open and bright environment.

Incidents

- Staff were aware of the trust's incident reporting system and told us they knew how to report incidents of harm or risk of harm. Staff told us they received feedback regarding incidents if they requested it and there was a system of learning from incidents.
- We reviewed meeting minutes that showed incidents were discussed at unplanned care business and governance meetings attended by senior staff. Feedback to staff who did not attend these meetings was through an informal "huddle" which occurred before the start of each nursing shift at which incidents were discussed. We observed these "huddles" taking place. There was also a board in the staff room where feedback on incidents was posted. It was also contained in the department's home page on the trust's intranet.
- There was a "never event" in 2014 that was classified as a "retained foreign object post procedure". We found that although senior staff were aware of this incident not all clinical staff were aware of it or the associated learning. It is important that all staff were made fully aware of serious incidents such as never events. These are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between May and August 2015 the emergency department reported no severe incidents and six moderate incidents. Five of these incidents related to patients that attended the department with pressure sores, whilst one related to an incident that involved a patient.
- In May 2015 there was a report that a patient had waited more than 10 hours because of delays in the specialist team coming to the emergency department to assess them.
- A recent theme identified by staff involved blood specimens not being labelled properly.
- The trust informed us that the one item of risk for the emergency department on the trust risk register was whether they would be able to meet the contractual performance targets for 2015/16. No other information related to specific patient safety issues in the emergency department were supplied.

Duty of candour

Urgent and emergency services

- Staff we spoke with were aware of the trust's duty to openly investigate severe and moderate patient safety incidents, and keep patients and their relatives informed of the progress of their investigations, and the final results of those investigations.

Cleanliness, infection control and hygiene

- The department was visibly clean and uncluttered; including waiting area, sluices and toilets. Bins were clean and not overfull and there were adequate bins for both clinical and general waste. All sharps' bins were below the marked level.
- There were hand washing facilities and hand cleaning gel throughout the clinical areas of the department. There were no reported cases of clostridium difficile or methicillin-resistant staphylococcus aureus (MRSA) within the department from April 2015 – October 2015.
- We inspected textile curtains that were used in the majors' area and found them to be clean. However, there was no printed label on them to say when they had last been washed. It is important that a record is kept to ensure washable equipment is clean.
- We reviewed the results of hand hygiene audits undertaken in the department between January and July 2015. In January, February, May and June 100% compliance was recorded.
- Between January and July 2015 environmental infection control audits were undertaken in the department. We reviewed these audits which had action plans, with details of when actions were completed, for areas that required attention.
- In the 2014 patient survey of emergency departments a score of 8.5 out of 10 when asked if the department was clean. This was organised on a trust wide basis and included the emergency departments at Diana, Princess of Wales Hospital (DPoW) in Grimsby and Scunthorpe General Hospital (SGH).
- The level of infection control training for the directorate of medicine, of which the emergency department was a part, was at 76% for nursing staff against a trust target of 95%. Medical staff had achieved 100%.
- However, in the resuscitation room at both DPoW and SGH we found that airway management equipment was not in sealed sterile packaging. This equipment should be kept in sealed packaging to keep them sterile.

Environment and equipment

- There was a separate entrance for patients that walked into the department with minor injuries and illnesses to those that were conveyed by ambulance.
- To enter the reception area people had to walk through the main hospital entrance and turn right for the emergency department. This prevented patients walking into the department by accident or using it as a thoroughfare for the main hospital.
- The doors from the reception area into the treatment areas were locked to prevent unauthorised access. However, there was easy access to a triage room that had two doors; one that patients entered from reception and one into the treatment areas.
- The main department was brightly lit with the different clinical areas marked out logically.
- The resuscitation room was large with the equipment stored where it could be easily accessed in an emergency. There was also single electronic key access to drugs cupboards to prevent delays.
- Entrance from the ambulance bay was clear and wide allowing for patients to be brought into the resuscitation room while others were handed over to majors area staff.
- Although children entered the same entrance as adults they were taken to children's waiting area where there was play equipment. This area was staffed by registered children's nurses from the children's department.
- There was a room where the families of patients who were dangerously ill or had died in the department could sit. Near to this was a viewing room where people could view loved ones who had recently died.
- There was a designated room where patients with a mental health condition could be seen by mental health practitioners. There was an alarm strip and the room had been adapted so that medical equipment could be removed.
- We observed staff checking emergency equipment such as defibrillators and ventilators. There were also books in which a record was made of these checks, that were undertaken on a regular basis.

Medicines

- Nursing staff used patient group directions in order to administer drugs. However, we found that not all the patient group directions had been recently reviewed. In order for medicines to be managed safely patient group directions must be reviewed on a regular basis.

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- We found that controlled drugs were correctly stored and administered. Appropriate records were kept including a record of the disposal of out of date drugs.
- Drugs' fridges were temperature controlled and the temperatures were regularly recorded in line with recommended guidelines. The recorded temperatures were at the correct levels. However, not all staff we spoke with were aware what the correct temperature was.

Records

- The department used an electronic patient record system that was printed off into hard copy notes when the patient was transferred to the ward.
- We observed nursing and medical staff completing patients' clinical records appropriately and safely.
- We reviewed six patient records and found that they had all been completed appropriately except with regard to the documentation of pain scores.
- We found that agency staff could not use the trust's computer systems and databases. This therefore meant that trust staff had to make entries for them which led to delays in getting blood test results and getting other clinical information.

Safeguarding

- All grades of staff we spoke with were aware of how to report safeguarding incidents on the electronic reporting system. They were also aware of the processes for the investigation of suspected safeguarding incidents.
- There were systems in place for the reporting of safeguarding incidents relating to both adults and children. Staff had electronic access to the safeguarding registers for both adults and children, and told us they had a good working relationship with social services safeguarding teams.
- At our inspection in April 2014 we found that not all clinical staff had received safeguarding of children training up to the advanced level three. At this inspection, we found that clinical staff were now in the process of being trained up to level three in safeguarding children. However, the numbers of staff who had received the level three training was below the trust's 95% target.

- The records provided to us by the trust showed that no medical staff in the emergency department had undertaken level three safeguarding children training. Records showed that 53% of medical staff had undertaken levels one and two training.
- With regard to nursing staff the records we were provided with referred to "DPoW Medical Ward A&E (2622)". We understood this to refer to nursing staff in the emergency department. This showed that 63% of this group of staff had undertaken level three safeguarding children training. They also showed that 95% had taken level one training whilst 93% had taken level two training.
- The percentage of administration and reception staff in the ED who had undertaken level one safeguarding training was 100%
- We were also provided with the figures for staff who had received safeguarding adults training. This had all been taken at level one and stood at 60% for medical staff, eighty eight percent for nursing staff: "DPoW Medical Ward A&E (2622)", and 92% for administration and reception staff.
- It was therefore the case that in the majority of instances the trust target of 95% of staff having received this training had not been met.

Mandatory training

- Staff we spoke with told us that there mandatory training was up-to-date or they were booked onto courses.
- Records provided to us by the trust were for the directorate of medicine, of which the department was a part, were between 21% and 85%. The 21% was for medical staff who had taken blood transfusion training.

Assessing and responding to patient risk

- There was a system for assessing ambulance patients that arrived in the department although we found that when the department was busy there was a delay in the assessment taking place.
- Times to initial assessment were provided by the trust on a trust-wide basis and included Scunthorpe General Hospital and Diana Princess of Wales Hospital emergency departments; and the minor injuries unit at Goole District Hospital. The data for the median time to

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initial assessment of ambulance patients between April 2014 (the time of the last inspection) and April 2015 ranged between zero minutes in April 2014 and one minute in April 2015.

- Over the same time frame information indicated that patients waited between 40 and 50 minutes following assessment before treatment was commenced. Although these figures were better than the median figures for emergency departments in England as a whole they showed long waits between assessment and treatment.
- The trust provided data on time to initial assessment for patients arriving by ambulance for the period April 2015 to October 2015. Out of a total of 11,805 patients 11,420 (96.7%) were assessed within 15 minutes whilst 11,507 were assessed within 30 minutes. The number of patients who waited more than 30 minutes to be assessed was 298 (2.5%). Out of this number 211 waited over an hour to be assessed. Seven patients waited over four hours to be assessed whilst 67 waited more than two hours.
- Patients that attended the department with minor injuries or illness could be seen after initial triage assessment by an emergency department doctor, and emergency nurse practitioner (ENP) or a GP.
- We observed the triage of patients who self-presented at reception. All the appropriate checks were undertaken and then patients were sent to the minors or majors areas for treatment.
- Patients that walked into the department but following triage were found to have a more serious illness or injury were taken round to the majors' area or the resuscitation room.
- There was a system for assessing ambulance patients that arrived in the department although we found that when the department was busy there was a delay in the assessment taking place. Ambulance crews told us that on such occasions they had to go round to the nurses' station in the majors' area to find a nurse to assess the patient.
- Recognised clinical risk recording tools, such as MEWS (modified early warning score) and PEWS (paediatric early warning score), were used to record patients' vital signs, and describe any deterioration in their condition and the actions taken.
- Systems were in place for escalating care when a patient's clinical condition deteriorated.

- There was a sepsis screening tool for the management of patients attending with a suspected diagnosis of sepsis.
- Handovers where assessments of patient risk were discussed took place in the form of huddles where the nursing shifts would discuss the patients in the department and their clinical condition. We observed these huddles and found that appropriate information was passed over.

Nursing staffing

- The trust provided establishment levels for July 2015 which showed an establishment of 62.13 whole time equivalent (WTE) qualified nurses and healthcare assistants (HCAs). There were 57.94 WTE in post which left a variance against establishment of 4.19 WTE. This meant that 6% of nursing posts were vacant.
- With regard to qualified nurses the establishment levels for July 2015 showed an establishment of 45.19 WTE. There were 41.68 WTE in post which left a variance of 3.51 WTE. This meant that 7% of qualified nursing posts were vacant.
- The matron for medicine who was responsible for the leadership management of the emergency department nursing team told us they used a nationally recognised staffing tool. They told us this was one that had been produced by The National Institute for Health and Care Excellence (NICE) and the Royal College of Nurses (RCN). They told us they were in the process of assessing staffing in the trust's emergency departments.
- There were also daily reviews of nurse staffing levels in the department.
- The trust had recently recruited new nurses from Europe. Additional cover was also provided by agency staff and substantive staff working extra shifts.
- In order to cut down on the amount of agency staff used, the trust was incentivising its own staff to work additional shifts as bank staff in the department. These are temporary nursing staff who do not work for agencies but are directly employed by the trust as part of a nursing Bank.
- There was no registered children's nurse on duty on every nursing shift. Although during the day children with medical conditions were seen in dedicated children's unit staffed by children's nurses. However, surgical cases were seen in the emergency department itself. This unit was also not open at night. National guidance from the Royal College of Paediatrics and

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Child Health recommends all emergency departments receiving children have a lead Registered Children's Nurse and sufficient Registered Children's Nurses to provide one per shift.

- Out of these hours assistance was provided by registered children's nurses from the paediatric wards.
- There were four registered children's nurses working in the department. In order to increase these numbers the department were supporting two nurses a year to train as registered children's nurses. We were told that no more than two nurses could be sent on the course because of financial constraints.
- There were 20 emergency department nurses who held the European Paediatric Advanced Life Support certificate. This was an ongoing programme of training and support.
- We reviewed the nursing rota for the period 26 October 2015 to 17 January 2016. The rotas were available on the trust's intranet as part of an electronic rostering system.
- The staffing was normally in the ratio of ten qualified nursing staff to two health care assistants, or nine qualified nursing staff to three health care assistants, during the day. Many staff would work long days of about 12 hours. There were eight qualified nurses and one health care assistant at night, with another health care assistant working a twilight shift to about midnight.
- Staff would cover all areas of the department, with specific staff rostered to work in the minors' area, whilst others would cover majors and resuscitation areas.
- When we visited the department there were between eight and ten qualified nurses, and three health care assistants on duty. Two of the qualified nurses were emergency nurse practitioners.
- We found that because of the shortage of qualified nurses agency nursing staff were used regularly. For the month of November they were looking to cover 20 shifts with agency staff.

Medical staffing

- We found the service was not staffed in line with nationally recommended levels of consultant cover, or to the trust's own levels. Staffing levels provided by the trust for July 2015 showed an establishment of five whole time equivalent (WTE) emergency department consultants. There were 3.60 WTE in post which left a

variance against establishment of 1.40 WTE. The establishment figures showed that two whole time equivalent locum consultants were working in the department.

- The Royal College of Emergency Medicine (RCEM) recommends there should be 10 whole time equivalent consultants as a minimum in every emergency department that had attendances of between 50,000 and 80,000 patients a year. The emergency department treated 61,307 patients between April 2014 and March 2015.
- In information provided to us prior to the inspection the trust said that: "Consultant Hours present per day – 11 hours per day..."
- We reviewed 13 weeks of medical rotas covering the period 1 November 2015 to 31 January 2016. for the emergency department. We found that between Monday and Friday there was a consultant presence in the department of 11 hours. However, on Saturdays and Sundays consultant presence in the department was for three hours.
- The rota for the week commencing Monday 2 November 2015 showed 9 hours of consultant presence on the Monday, whilst for Tuesday to Friday the presence was for 11 hours. On Saturday and Sunday there was a consultant in the department for three hours on each of these days.
- For the rota for the week commencing Monday 9 November there was 11 hours consultant presence on Monday to Thursday. On Friday the rota showed consultant presence in the department from 9am to 5pm; eight hours cover. On Saturday and Sunday there was a consultant in the department for three hours on each of these days.
- There was 11 hours consultant presence in the department over the December and January Bank Holidays.
- There was a 24 hour presence, seven days a week, of middle and junior grade doctors.
- There was an establishment of nine whole time equivalent middle grade doctors with five WTE in post. There was an establishment for seven WTE junior doctors with five WTE in post.
- Figures provided by the trust showed that 36% of all medical posts in the emergency department were vacant. This included consultants and junior doctors.
- Locum doctors, some of whom were employed on a long term basis, were used to cover vacancies at all

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levels within the department. The associate medical director told us there was a budget for locum doctors held by the department. They said they were intending to convert this budget into a substantive medical budget in order to recruit more doctors to substantive positions.

- For the rota for the week commencing Monday 2 November twenty middle grade shifts out of 47 were covered by locum doctors. There was a similar ratio for the other 12 rotas we reviewed.
- The associate medical director told us that because of a shortage of emergency department doctors nationally they were recruiting consultant and middle grade doctors in the Indian subcontinent.
- We were told that six emergency nurse practitioners had been identified that would be trained to work as practitioners in the majors and resuscitation areas. This would take some of the workload pressures off the medical staff. However, this training had not started.
- We found that during the week there were three consultants in the department between 9am and 5pm, and one between 9am and 8pm. There was also an on-call consultant who was available 24 hours a day. Overnight the on-call consultant would stay in hospital accommodation. They were supported by five middle grade doctors who covered shifts between 8am and 1 am the next morning, whilst two more worked between 10pm and 6am and 10pm and 8am. There were also six junior doctors who covered the 24 hour period.
- There was no specially trained paediatric emergency medicine consultant in the department. However, this was not a requirement for emergency departments that has attendances of less than 16,000 children a year. The department saw less than that number of children.
- The general training for emergency medicine consultants does include training in paediatrics.
- We were told that when required paediatric medical assistance was provided by paediatric doctors working in the main hospital.

Major incident awareness and training

- We found there was a major incident plan, with sub-plans for CBRN (chemical, biological, radiation and nuclear) incidents. There was also a lead consultant for major incidents and emergency planning.
- There was also a protocol in the department for the reception, isolation and treatment of patients presenting with suspected Ebola.

- There was a designated room which contained decontamination facilities for use during a CBRN incident. This room also contained hazardous material suits, breathing apparatus and other equipment.
- Although there had been no recent live major incident exercise a table top exercise had been undertaken with staff from Humberside Airport.
- Staff had received major incident and Ebola training. There had also been CBRN training in October 2015.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We found the core service to be 'good' for providing effective services because:

- Whilst the department had in place best practice guidelines including those produced by the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine not all had been implemented or audited. The results of the Royal College of Emergency Medicine 2014/15 audit of mental health in the emergency department were in the lower quartile of all trusts in England. There was no evidence of a re-audit of the department's sepsis screening tool since 2014, or a previous RCEM audit of sepsis.
- At the time of the inspection the percentage of nurses who had received appraisals was at 77%, against a trust target of 90%. Developmental training sessions were in place, although some elements of this training had only recently started. There had been no recent training of staff in the care and management of patients with a mental health condition.
- There were good systems of multidisciplinary working and there was a seven-day service available for patients, but not always supported by onsite ED consultant presence. Systems and process for the taking of consent and the management of the Mental Capacity Act were in place. There was also reasonable staff knowledge of consent procedures and the Act. Staff offered patients pain relief, food and drink.

Evidence-based care and treatment

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- We found the emergency department had in place best practice guidelines in the care and treatment of patients. These included those developed by The National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM).
- NICE and other guidelines were available on the trust intranet although in some cases these guidelines were out-of-date.
- An audit of the trauma team activation had been undertaken. A report had been produced and an action plan was underway. This was aimed at improving the response times for the trauma team who were called down from the main hospital when a trauma case was admitted to the resuscitation area.
- The trust had taken part in RCEM audits. Clinical staff we spoke with were aware of the results and the action plans.
- Information provided by the trust said that other audits that were planned, but not commenced, were a medicine documentation audit, and an audit of combined foot and ankle x-ray referrals.
- It was also intended to audit previous RCEM audits to ensure that there had been improvements.
- However, there was no evidence of an audit of the department's sepsis screening tool since 2014, or a previous RCEM audit of sepsis. In the 2013/14 RCEM audit of sepsis the department had not met the standards regarding when the received antibiotics.
- In 2014/15 the trust participated in the national CQUIN (Commissioning for Quality and Improvement) for implementing the sepsis care bundle and reported its progress to the commissioners on a quarterly basis.
- In the 2014 patient survey of the trust's two emergency departments, the trust performed about the same as other trusts departments for patients being able to access suitable food and drink. This resulted in a score of 5.7 out of 10.
- Water was made available for patients and there was a vending machine in the waiting area.
- Healthcare assistants were allocated on a daily basis to attend to the nutrition and hydration needs of patients. If patient's nutrition and hydration needs had been met this was indicated by a smiley face on the board in the majors area.

Patient outcomes

- In a Royal College of Emergency Medicine (RCEM) 2014/15 audit of mental health provision DPOW ED scored worse for one of the fundamental standards and met the other. The audit found that the emergency department did not have a: "Dedicated assessment room for mental health patients." This ED also scored worse for three of the six developmental standards and better for one.
- In the Severe Sepsis audit 2014 DPOW ED scored in the upper quartile (better) for four of the 12 indicators and lower (worse) in one.
- In an RCEM audit of 2014/15 into the initial management of the fitting child the DPOW ED scored in the lower England quartile for the fundamental standard and scored in the lower England quartile for three of the four developmental standards.
- In the April 2013 – December 2014 Trauma Audit and Research Network (TARN) report it was found that the outcomes for trauma patients had improved in comparison with the 2012/13 audit.
- We also reviewed an initiation document for a planned audit of trauma team call-outs that was to be undertaken in November 2015.

Competent staff

- The appraisal rates we received were for the directorate of medicine at Diana, Princess of Wales Hospital, of which the emergency department was a part. They showed that 77% of nursing staff had received appraisals against a trust target of 90%. The figures for medical staff stood at 83% whilst administration and clerical staff was at 94%.

Pain relief

- In the 2014 patient survey of emergency departments, the trust performed about the same as other trusts in questions regarding pain relief. Data was trust-wide and indicated that 5.7 out of 10 patients felt there was not a long wait for pain, whilst 7.6 out of 10 patients felt staff did all they could to manage their pain. These scores were similar to the England average.
- We observed nursing staff offering pain relief medicine to patients, and spoke with patients who in the majority of cases told us they were offered pain relief.
- We reviewed six clinical records and found that in four of them pain scores had been documented.

Nutrition and hydration

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- The senior nurse in the emergency department told us they had changed the timing of when they did appraisals which would allow them to improve the percentage of staff that had an appraisal within the year.
- Training sessions that involved other departments, including the intensive therapy unit and the clinical decisions unit, had been arranged and were displayed on a board in the senior nurse's office.
- Training in mental health was being rolled but not all staff had received the training.
- Other training days for all grades of staff had recently commenced in the department. We saw an attendance register for various teaching sessions led by a senior consultant.
- We spoke with a recently qualified nurse who was waiting for their registration so that they could work as a fully qualified nurse. They told us they were fully supported in the department and had recently finished a 'care camp' where they had learned advanced practical skills such as cannulation, venepuncture and catheterisation.
- A 'newly qualified competency' book had been devised by emergency department staff in order to assist newly qualified nurses who were starting in the department.
- We also spoke with a third year student nurse who was on an eight week placement in the department who had been given a mentor to provide clinical supervision.
- We found there healthcare assistants were offered advanced skills training so that they could put cannulas into patients and put on plaster casts.
- Clinical and managerial supervision was provided for staff.

Multidisciplinary working

- There was a multidisciplinary approach to the management of flow within the hospital with regular meetings which were attended by representatives from throughout the hospital, including from the emergency department.
- There was a flow coordinator in the department who liaised with the bed managers and clinical staff to move patients through the department and up onto the wards.
- There were systems in place for the prompt transfer of patients to the regional neurosurgical unit at Hull.
- There was a system for the referral of victims of domestic violence to agencies who could offer them assistance.

Seven-day services

- The emergency department offered a seven-day service with consultants available on-call when they were not in the department. However, there was only three hours per day consultant presence in the department at weekends.
- There was 24 hour access to the x-ray department which was located next to the emergency department.
- There was portering cover provided seven days a week.
- The April 2013 – December 2014 Trauma Audit and Research Network (TARN) report it found that the median time for the wait for a CT (computed tomography) scan was 50 minutes, which was an improvement on the 2012/13 results.
- There was seven day access to a mental health crisis team although they were not based in the department and could take up to two hours to arrive.

Access to information

- The department used an electronic patient record system that was printed off into hard copy notes when the patient was transferred to the ward.
- Discharge letters were prepared for GPs and there was a multi-agency referral form for patients who required input from mental healthcare professionals, who worked for another trust.
- There were electronic recording systems in place so that staff could view diagnostic and test results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with understood the principles of consent including the Gillick Competency guidelines, which relate to the obtaining of consent from children and young people.
- We observed clinical staff obtaining consent from patients before commencing treatments.
- We were informed by an emergency department consultant that patients requiring sedation before undergoing procedures in the department provided written consent.
- We observed clinical staff obtaining consent, from both adults and children, before undertaking procedures. This would often take the form of them explaining the procedure to patients and recording their agreement in the patient record.

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- The majority of staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- A form was available to be completed by clinical staff when assessing patients' mental capacity.
- Records for the directorate of medicine at Diana, Princess of Wales Hospital, of which the emergency department was a part, showed that 85% of nursing staff had undertaken Deprivation of Liberty Safeguards level one training, against a trust target of 95%. The attainment for medical staff was at 46% whilst for administrative and clerical staff it was 50%.
- Trust records for the emergency centre showed that 47% of medical staff had undertaken Mental Capacity Act training, whilst 93% of nursing staff had taken the training.
- These figures were below the trust target that 95% of staff should have received this training.
- Staff we spoke with gave a mixed picture of learning from complaints with some staff saying they were informed of the learning whilst others, particularly junior staff, told us they were not.
- There was a flow coordinator in place to improve the patient journey through the department.
- We found there was an acceptable level of support for patients with a mental health condition. There was a dedicated room for their assessment although when that room was not available other treatment rooms were used which did not have the same safety features. There had recently been specialist training undertaken by staff into the care of patients with a mental health condition.

Are urgent and emergency services caring?

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

Requires improvement



We found the core service to be 'requires improvement' because:

- Not all staff were aware of how to contact professionals to help communicate with people who may be deaf or unable to understand/speak English.
- There were breaches to the national standard of within 30 minutes for patients being handed over by ambulance staff to the emergency department team, with some waited over one hour. Between April and October 2015, of 2,343 (approximately 19.5%) patients waited longer than 30 minutes.
- Between April 2015 and November 2015 the national standard to achieve 95% of patients being seen and a decision made to treat, discharge or admit within four hours ranged from approximately 93% to almost 96% across all sites.

Service planning and delivery to meet the needs of local people

- We found that the trust had been working with the ambulance service so that an electronic monitoring system could be provided that would be able to accurately monitor the turnaround times for ambulances.

Meeting people's individual needs

- There was a pathway for children that segregated them from adults after they had been triaged. They would be taken through to the specialist children's waiting and treatment area. However, this area was not open 24 hours a day although it was closed at times when fewer children were likely to attend the emergency department. We found there was an acceptable level of support for patients with a mental health condition. There was a dedicated room for their assessment although when that room was not available other treatment rooms were used which did not have the same safety features. There had recently been specialist training undertaken by staff into the care of patients with a mental health condition.
- Interpreting services were available for people whose first language was not English. Due to the emergency nature of the emergency department this was normally provided by professional staff over the telephone.
- There were systems in place for providing professional sign language support for patients who were profoundly deaf and communicated through British Sign Language (BSL). We were informed that the trust had arrangements in place that allowed them to contact

Urgent and emergency services

sign language interpreters at short notice. However, not all staff we spoke with were aware of this system, and there were no electronic interpretation solutions for when interpreters could not be contacted.

- If staff wanted to access patient advice leaflets, departmental, specialty or NICE guidance and protocols they could do so through the trust intranet.
- Patient advice leaflets were available in non-English languages.
- Leaflets providing information about support services for the recently bereaved were available and could be sourced in non-English languages.
- There was a room where the families of patients who were dangerously ill or had died in the department could sit. Near to this was a viewing room where people could view loved ones who had recently died.
- The needs of people of faith were met by a multi-faith team in the hospital, which was contactable on a 24 hour basis throughout the year. This team could obtain support from representatives of the different religious faiths.
- There was a domestic violence lead for the department who encouraged staff to complete the multi-agency referral forms.

Access and flow

- Between April 2015 and November 2015 the national standard to achieve 95% of patients being seen and a decision made to treat, discharge or admit within four hours ranged from approximately 93% to almost 96% across all sites. The trust was at or above the standard in June, July and September 2015.
- Between April and September 2015 a total of 7,330 patients (22.6%) were admitted to the hospital, whilst 197 were transferred to another healthcare provider.
- The trust provided us with data that was produced by the ambulance service. This recorded the time patients waited before being handed over from the ambulance crew to emergency department staff. The national standard is that this should be done in less than 30 minutes. This showed that between April 2015 and October 2015 a total of 2,343 (approximately 19.5%) patients waited more than 30 minutes. Over the same period 196 patients waited over one hour before handover. In October, the month of our inspection 30 patients waited between one and two hours to be handed over.

- Ambulance crews told us that they had experienced extended waits to hand over patients. They said short handovers were completed on arrival and full handovers once the patient was transferred to the emergency department team. They recounted occasions when they had continued to treat patients whilst they were on ambulance trolleys in the corridor.
- Ambulance crews told us that on such occasions they had to go round to the nurses' station in the majors' area to find a nurse to assess the patient. We found during our observations of a busy evening shift that patients waited longer than 30 minutes before handover or assessment. Nursing staff told us that they did not assess the patients until they were handed over, although they were aware of their condition when ambulance staff booked them in.
- It was also the case there was no electronic system that allowed joint handover times to be recorded. Electronic handover systems prevent situations where the records of trusts and ambulance services differed leading to disputes about the times. The trust and the ambulance service were in the process of putting in place an electronic handover system. However, it was not in operation when we visited the department.
- GPs worked in the department between 9am and 9pm and took those patients who had attended with primary care conditions. There was an out-of-hours service run by GPs that was located away from the emergency department.
- There were electronic systems to monitor access and flow in the emergency department. There was a flow coordinator who was responsible for tracking patients as they made their journey through the department. They contacted specialty teams and support services to ensure that patient flow was smooth, and through the bed and site managers were able to ensure that bed space on the wards was made available. They told us that if they received any resistance to requests they made they were actively supported by the consultants and other senior staff.
- A system was also agreed that where it was not possible for the specialty teams to see a patient in good time, and if there was a bed available, the emergency department consultants were able to send the patient to the ward.
- Patients we spoke with told us they had experienced long waits for treatment and that this was their main area of concern.

Urgent and emergency services







- Between April and September 2015 a total of 718 patients left the department without being treated. A total of 369 patients left the department having refused treatment.

Learning from complaints and concerns

- There was evidence from unplanned care and governance minutes that the lessons from complaints were shared. We were also told that they were discussed at the huddles that took place during a nursing shift change.
- Staff gave a mixed picture with some staff saying they were informed of the lessons of complaints whilst others told us they were not.
- As with other areas related to the provision of information the assistant medical director had introduced a system where staff were encouraged to ask about any issues of concern.

Are urgent and emergency services well-led?

Medical care (including older people's care)

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

Information about the service

Diana, Princess of Wales Hospital (DPoW) provided acute medical services on seven medical wards, an acute medical unit (AMU), a coronary care unit (CCU), a catheterization laboratory or cath lab, and a discharge lounge. The medical directorate included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, stroke, gastroenterology, endocrinology and haematology.

The medical service for the whole of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) received 44,873 admissions between January 2014 and December 2014. DPoW hospital had 21,500 admissions of which; 3% were elective admissions, 41% emergency admissions, and 55% day cases.

In July 2014, CQC carried out an announced comprehensive inspection and rated the service overall as requires improvement. Although, caring was good the safe, effective, responsive and well-led domains were rated as required improvement.

We visited all of the medical wards including AMU, CCU, the cath lab and discharge lounge.

We spoke with 25 patients and carers, and more than 60 staff. We attended a number of focus groups and we observed staff deliver care on the wards. We looked at 16 sets of medical records, 10 medicine cards, and reviewed the trust's performance data.

Summary of findings

Overall, we judged this service as 'requires improvement' although there were some areas of good practice and the service had shown improvement from the previous inspection.

We rated safe as 'requires improvement' because:

- The provider could not consistently meet planned staffing levels due to large numbers of vacancies across the service.
- The discharge lounge did not have enough safe storage for medicines.
- On several wards, staff did not maintain the fridge temperatures within the required range to maintain safety and efficacy of drugs. Compliance with mandatory training requirements was below trust target, especially for medical staff, although rates had improved over the last twelve months.

However there were some areas of good practice;

- Staff protected patients from avoidable harm and abuse.
- Staff reported incidents, shared learning and implemented actions to reduce future occurrences.

We rated effective as 'good' because;

- The trust based policies and pathways on NICE and Royal College of Physicians guidelines and staff could access them easily.

Medical care (including older people's care)

- Staff provided patients with pain relief and met their nutrition and hydration needs.
- The hospital had improved access to special and soft diets and these were readily available on the medical wards at any time.
- Performance in national audits showed improvements on the previous year and the service had developed action plans where further improvement was needed.
- Emergency readmission rates at DPoW were better than the England averages for elective and non-elective patients, in its top three specialties. Reduction in harm was seen in the diabetic audit results.
- We witnessed strong multidisciplinary team working during our inspection.

However; appraisal rates and training rates were still below the trust target in some areas, although they had improved significantly since the previous inspection.

We rated caring as 'good' because:

- We saw staff treat patients with care and compassion and protect their privacy and dignity at all times.
- Patients were happy with the care they received and found the service was caring and compassionate. Most patients spoke very highly of staff and told us that they, or their relatives, were treated with dignity and respect.
- We saw staff involved patients in their care.
- Nursing staff were very kind and gave immediate support to patients who were distressed. The response to the Friends and Family Test was 37.1%, which was better than the England average, between July 2014 and June 2015. Between July and September 2015 more than 95% of patients said they would recommend the service.

We rated responsive as 'requires improvement' because:

- Medical review of outlying patients was not consistent and discharges were often delayed.

- The hospital struggled with patient flow and bed pressures indicated by high numbers of medical patients boarded out (outliers) on other speciality wards and the number of bed moves.
- Mixed sex breaches occurred within the AMU and it was unclear how these formally assessed and reported. Nursing staff had not yet received training regarding people with a learning disability.

However, there were some aspects of good practice;

- Staff worked hard to meet patients' individual needs.
- Referral to treatment times for the trust was consistently better than the England average for all specialities. There were a number of initiatives to help patients to access the correct service or pathway and reduce the numbers of unnecessary admissions.

We rated well-led as good because:

- At ward level there was clear leadership and, previously concerning wards with new managers were able to demonstrate evidence of improvement in quality indicators.
- Staff told us that ward managers and matrons were supportive and approachable and they would have no hesitation about raising concerns.
- Managers and senior clinicians were aware of the risks and challenges faced by their services and there were a number of examples of innovation and service improvements. There were well-embedded processes for monitoring quality indicators and mechanisms in place to take improvement action where needed.

However, there were some areas for improvement;

- Nursing and medical staff felt that vacancies in key clinical lead posts were delaying the strategic development of some specialities.
- Staff were not clear about the long-term vision for their services in all specialities. Ward managers told us they had limited management time due to being counted in the planned staffing figures to deliver patient care.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



We rated safe as 'requires improvement' because:

- The provider could not consistently meet planned staffing levels due to large numbers of vacancies across the service.
- The discharge lounge did not have enough safe storage for medicines.
- On several wards, staff did not maintain the fridge temperatures within the required range to maintain safety and efficacy of drugs.
- Compliance with mandatory training requirements was below trust target, especially for medical staff, although rates had improved over the last twelve months.

However there were some areas of good practice;

- Staff protected patients from avoidable harm and abuse.
- Staff reported incidents and implemented actions to reduce future occurrences.

Incidents

- There had been 153 incidents reported during August 2015, in the medical care service. Thirty-nine of these were classified as resulting in moderate harm or above and 117 resulted in low or no harm. The largest category of incidents was those relating to slips, trips and falls.
- There were no Never Events in this core service between August 2014 and July 2015.
- Between August 2014 and July 2015 there were 27 Serious Incidents, of these; 12 were pressure ulcers, seven were unexpected deaths, three were related to safeguarding of vulnerable adults, there were two diagnostic incidents and three others.
- There were 129 pressure ulcers between July 2014 and July 2015, with most of them occurring in the six months between July and January.
- There were 42 falls with harm, and 29 catheter urinary tract infections in the same period.
- Staff were aware of how to report incidents using the electronic incident reporting system "DATIX" and how to escalate incidents to their line manager.

- Incidents reported on the IT system were automatically flagged to the ward manager for attention and investigation.
- Staff felt they were encouraged to report incidents and be open and honest with patients when a mistake was made or a patient suffered harm.
- All staff had received written information regarding duty of candour with their payslips and were able to tell us what this meant.
- There was mixed feedback regarding sharing of messages from incidents. Staff in one of the focus groups told us that they did not receive feedback from incidents. However, staff in ward areas told us that following investigation, the outcomes and lessons learnt were discussed at ward or department meetings.
- Staff were able to give us examples of where information and learning from incidents had been shared.
- Pharmacy staff told us they received training on incident reporting and feedback from medication incidents were shared with members of their team.
- Feedback and learning from incidents was also shared with staff through newsletters, emails and sometimes at handover.
- A panel of senior nurses reviewed the root cause analysis and robustness of the investigation of falls. Nurses, from the wards involved in the incident, were also able to attend the panel discussions. The manager of the stroke ward told us the ward staff had received extra training because of falls investigations.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring analysing patient harms and 'harm free' care. All the medical wards recorded the Safety Thermometer information monthly.
- A notice board on Ward C6 said that there had been one patient fall and no pressure ulcers in September 2015.
- AMU had three falls and no pressure ulcers in the last month.
- Information on the stroke unit indicated there been no avoidable falls or pressure ulcers in the previous month.
- All wards displayed their safety thermometer information for patients and visitors to see.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

- Handwashing facilities were available throughout the wards and we observed hand gel dispensers at the entrance to the ward, each bay and side room.
- Monthly hand hygiene audits for all medical wards at DPoW hospital between January 2015 and July 2015 showed 100% compliance.
- We observed a nurse on AMU who did not use hand gel when exiting a side room where there was an infected patient.
- We observed a consultant and Dr using personal protective equipment (PPE) when talking to an isolated patient and use hand gel on leaving the room. However, as the patient had diarrhoea, a full hand wash using soap and water would have been more appropriate on this occasion.
- Ward C6 was extremely clean and appeared well organised.
- We observed effective decontamination procedures in the endoscopy unit. Dirty equipment was decontaminated in a utility room then passed through a steriliser before being removed at the other side directly into the clean room for drying and storage.
- Appropriate containers for segregating and disposing of clinical waste were available and in use across the departments and we saw that PPE, used linen and waste was disposed of correctly.
- We observed correct handwashing technique on Amethyst and Kendall wards and nursing and housekeeping staff demonstrated good infection prevention and control knowledge when questioned.
- There were good processes in place in endoscopy to ensure flow and separation of clean and dirty scopes.
- Following an outbreak of Clostridium Difficile (CDiff) on ward C5 staff had received additional infection control training. There was a training log of dates of training and attendees.
- We saw that flushing of taps and showers was undertaken three times a week on the stroke unit and it was recorded that this had happened. The ward manager also told us that the ward had been free of CDiff for two years.
- Between June 2014 and April 2015, there was one case of MRSA in this trust, this happened in February 2015.
- There were 27 cases of C Diff and 17 cases of MSSA between June 2014 and April 2015. The rates per 10,000 bed days were similar to the England average
- The environment in the ward areas appeared clean and well maintained. Daily cleaning checks were displayed and up to date.
- Ward C6 was very organised and free from clutter. We saw that store cupboards had laminated pictures of contents displayed on the doors, which helped staff locate equipment, quickly, when needed. We also saw a checklist for staff to use when preparing equipment for drain insertion.
- The ward manager on CCU told us that that there was ageing equipment on the unit that needed replacing such as telemetry monitors and beds. This equipment was serviced and maintained in working order until it could be replaced. A bid for replacing this equipment had been successful and equipment ordered.
- Staff told us that they received medical device alerts when a safety issue was identified.
- The environment in the ward areas appeared clean and well maintained. Daily cleaning checks were displayed and up to date. Responsibilities for elements of ward cleaning were displayed to ensure staff knew what they were responsible for.
- Staff said that equipment to meet patient needs was available.
- Resuscitation trolleys were available along with portable oxygen and suction. We saw daily and weekly checks of this equipment were up to date and that trolleys were kept clean.
- On Kendall ward, we saw that there were some unsecured O2 cylinders in the corridor. The sluice room was cluttered and some items were stored on the floor.
- Other equipment such as commodes and hoists were clean and labelled as ready for next use.
- There was some high level dust on Kendall ward.
- We observed bed areas were clean and uncluttered.
- We looked at the results of the patient-led assessments of the care environment (PLACE). DPoW achieved a privacy and dignity score of 84.65 % in 2015 against the national average of 86.03%.
- We saw there were three specialist chairs out of use on the stroke ward that had been waiting for repair for several weeks.

Medicines

- We found a widespread issue regarding the monitoring and control of drug fridge temperatures. For example, we observed on the stroke unit that seven out of the last fourteen recordings had been outside of the

Environment and equipment

Medical care (including older people's care)

recommended range and there were no recorded actions or escalation to medical engineering or pharmacy. AMU fridges had four missing checks in October. Staff on the stroke ward and AMU were not aware of how to record minimum and maximum temperatures, what the recommended range was or that this was necessary for safety and efficacy of drugs. Staff did not know what action should be taken if the temperature was outside the range of 2C-8C.

- Some wards only monitored and recorded a single temperature reading.
- Amethyst and Kendall wards did however keep fridge records correctly and these were up to date. None of the recordings on these wards had been outside of the recommended range.
- There was a lack of safe storage facilities for medicines in the discharge lounge, discharge medicines were kept on the side in the utility room. This door had no lock and the medicines were stored on top of a worktop. There were lockable cupboards but these were not used. The staff nurse told us there had been "prescription on discharge" (POD) lockers in the previous location of the discharge lounge but these had not been moved to the new location. It was unclear how controlled drugs or items requiring refrigeration were stored in this area. Staff felt CCU facilities could be used for this but had not done this so far.
- We looked at ten medicine prescription cards. Gaps noted on medicine cards were; reasons for omission of dose was not recorded in five out of eight cases, where this was applicable, and two out of four cards did not state the reason for no venous thromboembolism (VTE) prophylaxis. Two out of four patients' assessments for self-medication were not completed.
- A pharmacist told us that VTE audits from the AMU showed only 60-70% compliance and that this was slow to improve. The pharmacist was unaware if there was an identified lead for improving VTE compliance.
- Two patients we spoke with told us they were happy with the explanations given regarding their medicines and could tell us the reasons for changes made.
- On AMU, emergency medicines were checked weekly and records were kept up to date. However, four 500ml NaCl 0.9% (salt solutions) were found to have expired. The manager told us that there was no system to review

the expiry dates of the fluids. Ward support staff carried out the topping up of IV fluids but they were not aware of any procedure that they needed to follow, such as rotation of stock or checking of dates.

- On the C1 wards, IV fluids were stored behind a locked door and all were in date. We saw that controlled drugs were stored securely and balances were all correct.
- The pharmacy team were collecting information on using the medicines safety thermometer. This included; reconciliation of medicines, allergy status, number of regular medicines, medication omissions, critical medicine omissions and high-risk medicines.
- The pharmacists were readily available to ward and medical staff to provide help and advice on administration of medicines to patients who had swallowing difficulties such as availability in liquid form and whether tablets could be safely crushed.

Records

- Patient's records were a combination of both electronic and paper records.
- A range of risk assessments were included within the electronic records for example; falls, manual handling, Waterlow, nutrition and body mass index (BMI), bed rails, early warning scores and neurological observations.
- The electronic "WebV" system incorporated a range of icons, which made it easy for health professionals to see risks associated with each patient, such as; if a patient was suffering from dementia or confusion or if they were a high risk of falls. It was also easy to see at a glance whether any risk assessments were outstanding.
- We looked at 16 sets of medical records and 10 medicine cards, which were in the main completed to a good standard. Medical and nursing records were clear, contemporaneous and concise.
- Gaps in medical records included six incomplete VTE assessments, four incomplete pressure ulcer assessments within the six-hour target, two incomplete nutritional assessments, three missing falls assessments, four records were missing name and grade of recorder and four were missing a record of time seen by consultant following admission.
- Diagnosis and medical management plans, nursing assessment, daily ward rounds, NEWS escalation, MDT discussions and discussions with family were all clearly documented.

Medical care (including older people's care)

- We saw three notes trolleys on the corridor on Amethyst ward were not locked but the notes trolley on Kendall was kept locked.

Safeguarding

- There was a dedicated lead for safeguarding and staff were aware of this.
- Staff we spoke with were able to give an example of a recent safeguarding issue and how they had dealt with it.
- Staff were clear how to escalate safeguarding concerns and had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff had good links with the mental health crisis team and the vulnerable adults' team.
- Staff on the stroke ward told us they had good support from the mental health team if they were unsure regarding any aspect of mental capacity such as results of dementia screening.
- Compliance with safeguarding training exceeded the 80% target in all but one module. Compliance with adult safeguarding training for the medical service at DPoW was 84%. Compliance with children's safeguarding training was level one 86%, level two 82% and level three 51%.

Mandatory training

- Most of the staff we spoke with told us they were up to date with their mandatory training. We were told that mandatory training compliance on C1 was good and mandatory training compliance was 79% on Ward C6.
- We saw training records on C1 Kendall showed staff had attended mandatory training and staff were able to articulate key messages from courses recently undertaken.
- The training record on C6 showed five staff were overdue basic life support training, however staff were booked onto the course and all other training was up to date.
- Some staff were concerned that agency staff did not receive an induction.
- Nursing staff had improved greatly with mandatory training compliance. For three out of 13 modules compliance was over 90%, seven modules were between 75% and 89% compliance and three modules were between 60% and 71%, these were equality and diversity, blood transfusion awareness and fire safety.

- Medical staff compliance with mandatory training was poor with all but two modules below 50% compliance.

Assessing and responding to patient risk

- All wards used the national early warning score (NEWS) system to identify patients' whose condition was deteriorating. Nurses recorded observations appropriately and escalated concerns in accordance with the guidance.
- We saw there were standard operating procedures and escalation procedures displayed for managing the deteriorating patient. The staff we spoke with were able to explain the procedures for managing the deteriorating patient.
- We observed the use of a system called "Web V" to manage and monitor patients. Staff used the system in conjunction with the National Early Warning Score (NEWS), which allowed staff to monitor whether patients were receiving timely repeat observations and whether their condition was improving, stable or deteriorating.
- During a consultant ward round, we observed a patient have a seizure and how staff responded to this situation. There did not appear to be a clear lead during this emergency. No one timed the seizure, brought the crash trolley or used the emergency call bell. We observed that the incorrect oxygen mask was used in the first instance and then changed to a reservoir mask. No one recorded the observations taken during the seizure and they did not show on the patient's record.
- On one ward, staff reviewed patient risk assessments every weekend and the ward manager checked these on a Monday. This had been a recent initiative implemented by the ward manager with the support of the matron.
- We saw that the electronic patient board displayed missing risk assessments such as VTE or falls. This made it easier for staff to identify this and complete the assessments required. We noticed that the ward clerk on one of the wards printed a list regarding VTE assessments not completed on AMU to draw this to the attention of junior medical staff; however, we were told that these were not always completed in a timely way.
- There was a commercial baby monitor, which had visual and sound capability but no recording capacity in use monitor in the single cubicle in CCU. The screen was located at the nurses' station and could not be viewed from anywhere else. Staff told us it was in use in case the patient could not use the call bell but could hold

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their hand up or make some noise. It was also used when staff were in the room in case they needed assistance and were not able to reach the emergency call bell. Staff told us the monitor was turned off or covered during personal care to maintain a patients' privacy and dignity.

Nursing staffing

- The endoscopy unit had 14 whole time equivalent (wte) registered nurses (RN) and 17 wte Health Care Assistants (HCAs). At the time of our visit, the unit had 3.28 nurse vacancies and approximately three wte HCA vacancies.
- There were six wte RN vacancies on the stroke ward but two new appointments were due to start in the near future. The ward manager told us she and the senior nurses had undertaken a recent table top exercise (using the Safer Nursing Care Tool) looking at the acuity of patients on this ward. The result of this had been that one post changed from a qualified to an unqualified staff member but the overall establishment had not changed. Staff told us there was reliance on agency staff to fill mainly qualified shifts on this ward but there tended to be continuity of agency staff who worked here.
- We found some newly qualified registered nurses working in a band 4 role until their professional registration was received.
- AMU had 10 vacancies but were waiting for four overseas nurses and one newly qualified nurse to commence in post soon.
- Patients we spoke with in AMU, short stay and C1 Hollies and Kendall thought there were enough staff on duty to care for the patients on the unit but were also aware that the nurses were working very hard "non-stop" to get tasks done. Patients on Hollies and Kendall thought the wards were sometimes short of staff at night.
- The ward manager on the CCU told us this unit's nurse staffing numbers were generally good with some gaps in shifts covered by regular staff working additional hours.
- Ward C1 Hollies had 26 beds with planned staffing levels of four RNs and four health care assistants on duty during the day and two RNs and three HCAs overnight. The patients had high dependency (levels 1a and 1b) needs. From Saturday 31 October to Saturday 7 November there were staff shortages every day, some of which were filled by bank staff. On the 1, 2, and 3 November each morning shift only had three RNs on duty.
- During our unannounced inspection on the night of 5 January 2016, we found that on ward C1 (Kendal ward), there was one substantive, registered nurse on duty with an agency nurse and two bank health care assistants. The staff reported that they regularly only had one substantive member of staff on duty. On 4 January 2016, during the day, a registered nurse was absent which, meant a registered nurse was moved from another ward until 2.30pm then an agency registered nurse and a registered nurse from another ward were moved to cover the evening shift; neither had worked on the ward before. Continuity of care was affected by regular staff moves.
- Kendal ward had seven substantive registered nurses employed in addition to the ward manager to cover the ward shifts; this included one newly qualified staff member who had not been assessed to administer medicines. This meant there were insufficient substantively employed staff to cover the rota and staff frequently worked extra shifts. Staff described themselves as feeling 'shattered' due to fatigue.
- Staff on Kendall ward told us that they felt staffing occasionally fell to potentially unsafe levels. On 23 shifts (16% of shifts) during August 2015, the staffing levels on this ward were lower than that planned. Ten of these shifts were short of an unqualified staff member and 13 were short of RNs.
- There were staff shortages on all of the wards we visited to some degree. Most areas tried to cover gaps with their own staff and only use bank or agency when necessary, however wards were not always able to fill all shifts. Unfilled shifts for the remainder of the medical wards, during August 2015, were as follows; AMU 62 unfilled shifts (43%), C6 25 unfilled shifts (19%), C5 16 unfilled shifts (13%), C1 Hollies 15 unfilled shifts (12%), Amethyst 32 unfilled shifts (9%) and CCU 8 unfilled shifts (9%).
- Nurses told us that a number of experienced staff had left the organisation in recent months or gone to work in other areas such as the High Dependency Unit (HDU). This meant that even when vacancies were filled there were a high number of new or inexperienced nurses in some areas.
- The turnover rate for nursing staff on the medical wards, September 2015, was 16.8% and the sickness rate was 5%.
- Staff were moved from one ward to another if this was needed to maintain patient safety.

Medical care (including older people's care)

- Wards clearly displayed staffing levels with photos and names of all staff.
 - Staff rosters were prepared eight weeks in advance and were signed off by the matrons. Staff did have the opportunity to make requests and swap shifts if needed.
 - We saw that the staff on Kendal ward had altered the way that patient care was organised to better meet the needs of patients. This was to ensure more help was available for those patients with the highest needs.
 - Ward C5 occasionally had patients receiving Non Invasive Ventilation (NIV). Usually these were step down patients from the HDU) and rarely these were newly initiated treatments. The ward manager was aware that patients who had just started NIV required a 1:2 nursing staff to patient ratio and would move staff around or request extra staff to ensure this was possible.
 - Staff on ward C5 reported that there was not enough qualified staff and a large reliance on agency staff.
 - Wards managers were included in the qualified staff numbers for four out of five of their working days with one day allocated as a management day.
 - Newly qualified RNs awaiting NMC registration were included in the number of qualified staff although they were unable to perform certain tasks, such as unsupervised medication administration. More experienced staff provided ongoing supervision for these nurses.
 - The use of bank/agency staff was 6.8% for this trust compared to the England average of 6.1%.
- Medical staffing**
- There were proportionately less consultants and registrars in this trust, 28% and 29% compared to the England averages of 34% and 39% respectively. There were proportionately more junior and middle career grade doctors in this trust 30% and 13% compared to the England averages of 22% and 6%.
 - There were junior Drs and a specialist registrar on site 24 hours, seven day a week. Consultants were available on an on-call basis out of hours and were easily accessible to junior members of the medical team.
 - Three acute physicians had left the trust in the last year and this had included the clinical lead for the AMU. Specialist, consultant physicians were covering the unit on a rota basis and twice-daily post take (admission) ward rounds took place. Cover included 24 hour seven day a week on-call and operated on a consultant of the day basis. Consultant ward rounds included day two reviews of patients who had not yet gone to a speciality ward. Doctors reported that this current system sometimes disrupted speciality clinics.
 - Nursing staff on AMU felt they had to chase doctors to review patients who had been on the unit longer than two days. They did not always know what time consultants would be available to complete ward rounds for these patients and some days they did not attend at all. Nursing staff had escalated this to the matron and business manager. Both nursing and medical staff felt the unit suffered from a lack of medical leadership.
 - The trust had a proactive approach to medical recruitment and the management team were actively seeking suitable applicants both nationally and abroad.
 - Three advanced care practitioners who supported the medical team had also left and had not been replaced due to recruitment difficulties.
 - Staff told us that junior medical cover for the AMU was good and rotas for the acute medical teams were well organised. Extra medical cover was made available for weekends and a member of the medical team saw patients every day.
 - A Junior Dr told us it was sometimes difficult to book leave due to shortages of cover available.
 - Patients on Hollies wards commented that they saw a Dr every day.
 - The 10 bedded CCU had input from four cardiologists. Although there was not a dedicated SpR (specialist registrar) and Junior Dr covering the unit, the nursing staff felt that medical staff responded in a timely way when they were requested and told us the patients were seen by the medical team every day. Nursing staff told us that consultants were approachable and easily accessible when needed.
 - One patient on a medical ward and waiting for a Percutaneous Coronary Intervention (PCI) told us a consultant cardiologist had not reviewed them for two weeks. We escalated this to the medical team on CCU who were aware of this and were taking action to ensure this happened. The consultant responsible for this patient had been absent from work and other consultants had not seen the patient during their absence.
 - The cardiology ward staff felt that the one specialist registrar (SpR) for cardiology was not enough to adequately cover all the things required of this post

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holder such as clinics, CCU, Cath lab and provide enough ward cover. The staff felt this reduced availability of senior decision-making and extended patients' length of stay / delayed discharges.

- We were also told that there were shortages of staff grade doctors. Junior doctors at the focus group expressed a concern that there was not enough medical staff cover at night.
- Junior Drs told us they enjoyed their jobs and that the teaching and support from consultants was good.
- We observed a day to night medical handover. The handover was organised and well structured. All wards and patients were reviewed using the WebV electronic system and all patients identified as 'at risk' were discussed. Newly admitted patients were reviewed and treatment plans and outstanding jobs were communicated to the night team, as were the details of the consultant on call after 8pm. Patients who were waiting transfer to a ward from AMU and A&E and length of waits were highlighted. The medical team checked the status of blood test results and viewed diagnostic images directly on the system during the handover. Nursing shift leaders, critical care outreach and site managers were present at the medical handover.
- An operational, site handover took place following the medical handover, which discussed bed state, nursing staffing pressures and whether bank or agency staff had been secured and contingency plans for staff or patient movement. This ensured both nursing and medical staff were aware of bed pressures, availability of critical care beds and patients waiting beds as well as highlighting the patients who may need medical or critical care outreach support during the night.
- Drs who were covering the medical wards at night took hand written notes of tasks outstanding and patients needing review. We were told that printed lists could be downloaded but this was cumbersome and time consuming. There was no electronic record made or distributed of the medical handover.
- Gastroenterology teams each had two junior doctors and a SpR and part of the cover arrangement included two part time GPs. A SpR told us that a consultant was on site all day Saturday and Sunday and on-call workload was manageable. We were told that admissions tended to peak on an evening and there were sometimes delays in patients being seen as there were a reduced number of doctors available at this time.

- Medical staff told us the medical handover could be improved, as there were not enough computers to make this as effective as it could be and that there was not enough time to keep updating the handover record.
- The respiratory and stroke ward staff told us that medical cover was good with a registrar allocated to the ward. Consultants were also easily accessible for staff.

Major incident awareness and training

- The trust had a major incident plan, which provided guidance on the actions needed when a major incident occurred.
- Staff were aware of the major incident plan and business continuity plans and knew where to access these online.
- A winter management plan was also in place to manage increased bed pressures over the winter period.

Are medical care services effective?

Good



We rated effective as 'good' because;

- The trust based policies and pathways on NICE and Royal College of Physicians guidelines and staff could access them easily.
- Staff provided patients with pain relief and met their nutrition and hydration needs.
- The hospital had improved access to special and soft diets and these were readily available on the medical wards at any time.
- Performance in national audits showed improvements on the previous year and the service had developed action plans where further improvement was needed.
- Emergency readmission rates at DPoW were better than the England averages for elective and non-elective patients, in its top three specialties.
- Reduction in harm was seen in the diabetic audit results.
- We witnessed strong multidisciplinary team working during our inspection.

However;

Appraisal rates and training rates were still below the trust target in some areas, although, they had improved significantly since the previous inspection.

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Evidence-based care and treatment

- Policies and pathways were based on NICE and Royal College of Physicians guidelines and were available to staff and accessible on the trust intranet site.
- Staff demonstrated awareness of policies, procedures and current guidance. They knew how to access this information on the trust intranet and on the ward.
- We checked policies and procedures and found that almost all of these were evidence based and up to date. The exceptions to this were the VTE policies and the "Nursing Staff Performing And Or Teaching Blood Glucose Monitoring" which were past their review date.
- Ward managers carried out local audits such as hand hygiene and documentation audits. Managers shared results with staff at team meetings and results were displayed on wards in staff areas.
- Pharmacy felt the absence of an identified medical lead for the VTE audit improvements meant that action and improvement was slow.
- We saw that a patient on AMU was started on antibiotics for a urine infection without requesting a mid-stream urine sample. This was outside of trust guidance.
- Quality matrons audited wards against compliance with a number of key quality indicators such as staffing, sickness, appraisals, capacity, friends and family test, patient harm and infection control practice. This helped identify areas where improvements were needed and wards were supported with any action needed.

Pain relief

- Patients in AMU and short stay told us that pain relief was good and staff asked them every time they took observations, if they needed painkillers. We overheard a nurse discussing pain relief with a distressed patient in a side room.
- Drs did not routinely offer Emla cream (a local anaesthetic) to patients having arterial blood gases taken but we saw that a Dr gave this to a patient on AMU who was particularly anxious about having this test.
- Patients and relatives were happy with the pain relief on C1 Hollies and Kendall and told us that they received this when requested.
- There was a pain management specialist within the trust and the Macmillan nursing service provided advice and support and were able to prescribe pain relief and anticipatory drugs for patients needing them.

- Patients told us that they received pain relief as needed and were asked at each medicines round if any pain relieving medication was needed.

Nutrition and hydration

- Nursing staff used a nutritional screening and assessment tool incorporated into the patient admission record to assess patients on admission and reassessed patients weekly.
- We looked at patient menus and saw a range of food choices were available to the patient. The menus also highlighted choices such as healthy, gluten free, diabetic and soft consistency options.
- Staff told us they could access soft diets from the kitchen for patients up until 6pm. If patients required soft diets after this time, nursing staff were able to provide build-up soup, porridge and yoghurt or custard pots.
- A choice of soup, sandwiches and warm meals were available at lunchtime for patients waiting in the discharge lounge. Water was available for patients to help themselves and nursing staff offered patients hot drinks regularly.
- Patients on the C1 wards told us there were always drinks available.
- We observed drinks were available in reach of patients and that staff gave assistance to patients who needed it.
- We saw that food and fluid charts were completed correctly.

Patient outcomes

- Emergency readmissions to DPoW hospital within 28 days of discharge from medical wards was better than the England average for all of its top three specialities, for elective and non-elective admissions.
- Diana, Princess of Wales Hospital National Diabetes Inpatient Audit (NaDIA) (2013) results were better for 16 out of 20 indicators when compared to the England average. Areas of care which scored worse than the England average included; foot risk assessment within 24 hours of admission, seen by the MDT within 24 hours and being in control of own diabetes care.
- DPoW had made huge improvements in reducing harm resulting from the inpatient's stay with all indicators being much better than the England average. For example, the rate for medication errors had been

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reduced from 32% in 2011 to 5% in 2013 compared to the England averages of 40% in 2011 to 37% in 2013. Similar improvements were evident for prescription, management and insulin errors.

- The trust had taken some recent actions to provide training to nursing staff regarding foot risk assessment and had developed a poster to remind staff of the importance of this risk assessment. Documentation was being reviewed and updated with plans to roll out across both hospitals by the end of December 2015.
- Diana, Princess of Wales Hospital scored better than the England average in the Myocardial Ischaemia National Audit Project (MINAP) for the proportion of Non-ST-elevation myocardial infarction (nSTEMI) patients seen by a cardiologist (99%), but worse than the England average on the number of patients admitted to a cardiac unit or ward and patients referred for or receiving angiography during admission. Performance against all three indicators had shown improvement from the previous year.
- Diana Princess of Wales Hospital had a mixed result on the Sentinel Stroke National Audit Programme (SSNAP), scoring D overall for the period October – December 2014. (A being best and E being worst). The stroke team had reviewed the latest report and identified some actions to improve performance in this audit. It had been recognised that the SSNAP results for scanning and thrombolysis were affected in part by patients being transfer to Scunthorpe General Hospital (SGH) as the clock for the four-hour target starts when the patient arrives at DPoW and diagnosis is made. Delay of diagnosis in the hospital would also affect the time taken for patients to receive thrombolysis.
- Patients returning to DPoW from SGH were not always able to access a bed on the stroke unit due to beds being taken up with other medical patients and were sometimes transferred to another medical ward. Recent data from quarter 1 2015/16 indicated an improvement in the number of stroke patients who had spent 90% or more of their time, as an inpatient, on a stroke unit.
- Diana, Princess of Wales Hospital performed worse than the England average on all indicators related to in-hospital care in the National Heart Failure Audit 2013/14. For indicators related to discharge, they performed better than the England average for four out of the seven indicators. The indicators that were worse than the England average were with regard to referral to a heart failure liaison service.

- At the time of the inspection, the trust was a mortality outlier for deaths from acute bronchitis and cardiac dysrhythmias.
- Mortality of medical patients were regularly reviewed by a number of clinically led, work streams, learning recommendations and actions were fed into the Mortality Performance & Assurance Committee who oversaw the work streams and would support implementation of improvement actions.

Competent staff

- The appraisal rates for medical staff in this core service for DPoW hospital was 83% and the appraisal rate for nursing staff was 77% (September 2015).
- Most of the staff we spoke with had received an appraisal in the last 12 months.
- The ward manager of AMU and Short Stay told us the rate for staff in that area was approximately 90%. Nurses on the AMU confirmed they had completed an appraisal with their line manager.
- The appraisal rate for Ward C6 was 92%.
- A matron informed us that she had weekly supervision with her line manager.
- Two HCAs we spoke with said they did not have regular supervision with their line manager but meetings were held if there were any issues to raise. HCAs from the focus group felt opportunities for training, to extend their role were not readily available, and one had been turned down for additional training, as they were not a registered nurse. They told us there was little in the way of career progression for HCAs ready to move from a band 3 to a band 4 role.
- Junior medical staff from across departments told us training at DPoW was good.
- The pharmacy team provided training in prescriptions and medicines management for medical students and junior doctors.
- Training opportunities were available for registered nursing staff wishing to develop in their role and staff confirmed they had received additional training relevant to their role. Staff on medical wards had received additional training, such as care of chest drains, tracheostomies, NIV, arterial blood gases and hi-flow oxygen.
- HCAs, administration staff and RNs on Amethyst and Kendall wards told us they had completed mandatory training and had other training relevant to their role.

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- There were plans to rotate RNs through A&E, AMU and short stay to widen the skill set of the nurses working in these areas and to provide development opportunities.
- Staff had received training regarding dementia. Training courses were available and uptake was good although this did mean staff sometimes had to wait for an available place.
- The operational matron told us the year to date target for accessing this training was 40% and the service had achieved 60% to date.
- Macmillan nurses had provided training regarding the new end of life tool, which staff on the stroke ward were to pilot.
- Staff nurses were aware of what they needed to do to meet NMC revalidation requirements.

Multidisciplinary working

- Staff spoke to us about positive working relationships with members of the multidisciplinary team (MDT). Pharmacists, physiotherapists and occupational therapists visited the wards daily.
- We saw documentary evidence of MDT working and observed multidisciplinary discussions and interactions during our inspection. We saw where risk assessments, such as food and nutrition assessments, had resulted in referral to the dietetic department and how subsequent advice and treatment had been communicated to the patient, family, other staff and had been incorporated into discharge planning.
- CCU staff reported good MDT working with the cardiologists, other medical staff and allied health professionals such as physiotherapists, dieticians and occupational therapists.
- Kendall ward staff told us that specialist nurses such as the diabetes specialists provided regular support and the heart failure nurses visited the ward every day. Dietetic staff told us MDT relationships were good and praised the ward staff for their effective team working.
- The stroke ward had dedicated physiotherapy and occupational therapy staff and also received designated input from social work, speech and language, dietetic and psychology services. This ward had a daily MDT board round / discussion of patients and a weekly more formal MDT meeting with the consultants. We saw that the MDT who worked well together providing a holistic service to stroke patients and all had input into patients' rehabilitation and discharge planning.

- Staff told us that rapid response services in the community were helping to provide enhanced services to care for patients in their own home and prevent unnecessary hospital admissions.

Seven-day services

- Gastroenterology consultants were onsite at the weekend and there were plans in place to introduce a formal seven day on call bleed rota across DPoW and SGH sites from November 2015.
- Patients and staff on the medical wards could access seven-day physiotherapy, pharmacy and Macmillan nurse support.
- There was seven-day pharmacy cover provided for the AMU.
- Imaging services were available on an out of hour's on-call basis 24 hours, seven days a week.
- Junior medical staff were available 24 hours a day on site, Consultants were on-call on a roster system, and on-call rotas were available for key staff out of hours.

Access to information

- Medical, nursing and allied health professional staff had access to patient information, risk assessments, test results and diagnostic images via the WebV system, which was accessible on all medical wards and departments.
- To improve timeliness of communication with GPs nursing staff on the CCU were responsible for completion of electronic discharge summaries, which had previously been a Junior Dr task.
- Feedback from the HCA focus group and medical staff was that there were not enough computers to access things like emails and e-learning during work time. The HCAs told us they often accessed e-learning at home in their own time.
- Junior Drs felt that access to computers limited the effectiveness of medical handovers in that it was difficult to update electronic handover documents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of how to gain both written and verbal consent from patients and their representatives. Members of the MDT usually undertook mental capacity assessments and best interest decisions in discussion with each other.

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- The learning disability lead was available to attend best interest decision meetings if needed.
- Staff we spoke with were able to describe their responsibilities in obtaining consent in relation to the requirements of the Mental Capacity Act (MCA) 2005.
- MCA training compliance data for the nursing staff at DPoW was 85% and 48% for medical staff. The trust target was 95%
- Deprivation of Liberty safeguards (DOLS) training compliance data for the nursing staff at DPoW was 85% and 46% for medical staff. The trust target was 95%.
- Nurses on the endoscopy unit had undergone additional training to take patient's consent.
- During an unannounced visit, we saw that there was information displayed in the cubicle in CCU to inform patients and relatives that a visual and sound monitor was in use and that recordings were not made. Staff told us they discussed this with patients and gained verbal consent, however this was not documented.
- The CCTV policy was at hand next to the monitor at the nurses' station; however, this was due for review. The trust planned to complete a Privacy Impact Assessment and related actions by 31 October 2015.

Are medical care services caring?

Good



We rated caring as 'good' because:

- We saw staff treat patients with care and compassion and protect their privacy and dignity at all times.
- Patients were happy with the care they received and found the service was caring and compassionate. Most patients spoke very highly of staff and told us that they, or their relatives, were treated with dignity and respect.
- We saw staff involved patients in their care.
- Nursing staff were very kind and gave immediate support to patients who were distressed.
- The response to the Friends and Family Test was 37.1%, which was better than the England average, between July 2014 and June 2015. Between July and September 2015 more than 95% of patients said they would recommend the service.

Compassionate care

- The medical service at this hospital had a better response rate in the Friends and Family Test than the

England average, between July 2014 and June 2015, 37.1% in comparison to 34.5%. AMU, Amethyst and C1 Kendall were the only wards not managing to achieve a response rate higher than the England average during this time. The average response rates for these wards were 23%, 33% and 34% respectively.

- More recent data from June to September 2015 showed a lower response rate than the England average at around 15% for July and August and 18% for September 2015 compared to 25%, 27% and 25%.
- The percentage of patients who would recommend the medical service at DPoW to friends and family for July and August and September 2015 was 95-96%, which was comparable with the England average.
- This trust performed mainly within the middle 60% of trusts in the Cancer Patient Experience Survey 2013/14, although they performed in the bottom 20% for seven indicators and in the top 20% for two indicators.
- Results from the CQC inpatient survey were similar to other trusts, although they were amongst the 20% worst performing trusts for the question about doctors talking in front of the patient as if they were not there.
- We spoke with one patient on Ward C6 who said he had experienced excellent care and felt he was treated with dignity and respect. He had seen a consultant every day but not always the same one.
- Notice boards on AMU and Ward C6 displayed that 100% of patients on the ward had their needs met.
- We observed the matron for AMU comforting a patient who had a fall the previous night.
- We spoke with six patients in AMU and short stay and all were happy with the care they received. A patient with a needle phobia told us she was particularly impressed with the way the doctors had supported her during the insertion of a cannula. Patients told us nurses on AMU were kind, caring, and patient and they worked very hard to provide excellent care.
- We observed the nurse in the discharge lounge offering patients, who were waiting, food and drink and keeping them updated.
- We observed the housekeeping staff being helpful and kind to patients and relatives on Kendall ward. Relatives on this ward reported that all staff were kind and caring and that communication had been good.
- We observed the ward clerk on Amethyst ward had a particularly kind and helpful manner when dealing with telephone enquiries.

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- We spoke with nine patients and carers on C1 (Hollies and Kendall) and they told us that they were happy with the care provided from all staff, doctors, nurses and cleaners.
- Nursing and medical staff told us they would be happy to have relatives or friends cared for here.
- Staff were observed as being cheerful and motivated and patients looked very well cared for with personal items in their rooms and bed tables and buzzers were within reach.
- We did see one incident of a RN taking a phone call from a relative and was clearly speaking about a patient's condition while walking around the ward.

Understanding and involvement of patients and those close to them

- We observed the nurse in the discharge lounge kept patients up to date regarding the progress of their discharge letter and medications.
- Patients and relatives in AMU and C1 wards told us they had options explained to them regarding tests and treatment and they understood what was happening and why.
- We observed that the members of the consultant ward round on AMU did not always introduce themselves to patients, however, good explanations were given and a patient's request to have family present during blood sampling was accommodated. We also observed that the team attended one patient before a used commode had been removed from the bedside.
- A relative on AMU told us that communication was good and we observed good involvement of patients in discussion around use of medicines and availability of Pain relief

Emotional support

- We saw a member of staff on Amethyst ward comforting a patient who was upset.
- There was a quiet room set aside for patients and relatives to use if they were distressed and needed some privacy away from the main ward area.
- Clinical nurse specialists were available for a range of services such as; learning disability, Infection prevention and control, tissue viability, Macmillan nurses and the cancer specialist team.
- There was a chaplaincy service across the trust.

Are medical care services responsive?

Requires improvement



We rated responsive as 'requires improvement' because:

- Medical review of outlying patients was not consistent and discharges were often delayed.
- The hospital struggled with patient flow and bed pressures indicated by high numbers of medical patients boarded out (outliers) on other speciality wards and the number of bed moves.
- Mixed sex breaches occurred within the AMU and it was unclear how these formally assessed and reported. trusttrustNursing staff had not yet received training regarding people with a learning disability.

However, there were some aspects of good practice;

- Staff worked hard to meet patients' individual needs.
- Referral to treatment times for the trust was consistently better than the England average for all specialities.
- There were a number of initiatives to help patients to access the correct service or pathway and reduce the numbers of unnecessary admissions.

Service planning and delivery to meet the needs of local people

- We spoke with two police officers, who visited AMU often, with patients, and felt that a fast track system was needed for people in custody due to the impact this had on the service, disruption and extra anxiety for other patients and the resource implications of having two officers stationed at the hospital for extended periods.
- Operational managers told us that ambulatory care had been piloted a couple of years ago but this had not been sustained, although work was ongoing to determine how this could work.
- Discharge lounge was spacious bright and relaxed but signage to it was misleading and difficult for relatives to find. There were 14 chairs and one bed for patients in the lounge, the nurse's desk was outside the lounge but there was an observation window to enable her to view the patients.
- On Amethyst ward, a massage and therapy room was set up for patient treatments.

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- Work was ongoing to provide and improve integrated services that were closer to patients' homes, through the "Healthy Lives, Healthy Futures" strategy.

Access and flow

- Non-elective / emergency patients were predominantly admitted from the accident and emergency department (A&E) to the Acute Medical Unit (AMU). The unit also accepted admissions via GP referral to the Specialist Registrar. Routine / elective admissions and outpatients were admitted directly to the relevant base ward.
- The AMU was a 27 bedded unit, which aimed to assess and transfer patients within 24 hours. Staff told us that length of stay was however often up to 72 hours. AMU admitted patients 24 hours a day. When the AMU could not discharge patients home, they transferred them to the short stay ward or a medical inpatient ward. There were two consultant ward rounds during the day and the consultant allocated patients to the most appropriate ward where there was a bed available.
- The short stay ward was adjacent to the AMU and had an additional 12 beds. Stay on this ward was intended to be up to 72 hours. However, staff reported that length of stay was often up to one week and sometimes exceeded two weeks.
- Generally, a junior doctor saw patients on the AMU within four hours and a consultant within 12 hours. The admitting medical team had ward rounds morning, afternoon and evening.
- Staff told us that following the loss of the clinical lead for AMU it was sometimes difficult to ensure patients received a timely review. There was a consultant of the day process in place for emergency admissions and a dedicated Dr was in place for the short stay unit.
- Handover from the AMU to the wards used a situation, background; assessment and recommendations approach (SBAR).
- Coronary patients admitted to DPoW could have various investigations and treatments on site, including angiogram, in the catheterization laboratory or cath lab. Patients who required Percutaneous Coronary Interventions (PCI) (examination with diagnostic imaging equipment used to visualize the arteries of the heart and the chambers of the heart and treat stenosis or abnormality) such as angioplasty or stenting needed to be transferred to Scunthorpe General Hospital for these procedures.
- The cath lab also provided a nurse-led service for day case treatments of cardio version (a procedure that can restore a fast or irregular heartbeat to a normal rhythm.)
- There was no ambulatory care at the hospital at the time of the inspection.
- Referral to treatment times (RTT) all specialty groupings were above the 90% standard for the 18 week wait and had been consistently better than the England average since July 2014. General medicine and Rheumatology had achieved 100% of patients meeting the 18 week wait standard.
- The trust was on a par with the England average for national cancer waiting times.
- The endoscopy unit manager told us that there had been no two week wait breaches for the endoscopy unit. However, demand was increasing and the unit was looking at seven day opening to address this. All nursing staff had signed a seven day contract in preparation for this. Staff were on call on Sundays if needed for emergency scoping. During out of hours patients were transferred to Scunthorpe General Hospital if necessary.
- Staff on the wards told us that access to CT and Ultrasound scanning was usually within seven days for inpatients.
- Since quarter one 2013/14, bed occupancy in this trust had been better than the England average. Bed occupancy was at 87% in quarter 4 2014/15.
- Despite the better than average bed occupancy, it was apparent from the medical and operations handover and discussions with the bed managers that the hospital was constantly under pressure for empty beds. Medically fit patients were often moved as outliers to surgical wards to free up beds in AMU and on other medical wards.
- Staff on medical wards told us they sometimes felt under pressure to move patients when they felt this was inappropriate. Staff reported that this was because they may have had concerns about the medical condition of the patient or the time of night, the move was requested. The hospital policy was that patients should be assessed as medically fit for transfer by a consultant; however, staff indicated this did not always happen.
- Due to bed pressures there were large numbers of medical patients outlying on surgical wards. Between November 2014 and October 2015 there were 821 medical patients boarded out on to surgical wards. The majority of these were on surgical ward B4. Staff on this ward told us that patients on this ward did not always

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receive timely medical review. Other trust wide data indicated that percentages of outlying patients had improved from April 2015 when this was 3.1% to 2.4% in June 2015, however it was difficult to know if this improvement had been sustained as more recent data was not available.

- Information regarding bed moves between April 2014 and March 2015 indicated that, across the medical service for the trust, 48% of patients were moved once during their stay, 13% were moved twice, 3% three times and 2% of patients were moved 4 or more times. This equated to 336 patients across both hospital sites being moved four or more times during their hospital stay.
- There was a 1% improvement of numbers of patients being moved two and three times during their stay from the previous year.
- During the unannounced visit, we saw a 99 year old patient moved at 02.30am and another patient with confusion was also moved during the night.
- The electronic patient system allowed filtering of all patients, in the medical service, by consultant and enabled staff to print a list of all outlying patients needing a review. This reduced the risk of outlying patients being "lost". Staff on the stroke unit told us they did not experience any major issues getting patients reviewed.
- When we were visiting C5 there was a cardiology patient who was waiting for a procedure at SGH. The patient told us they had been on the ward for two weeks and although junior doctors had been to see him, he had not had a senior review in this time. Nursing staff confirmed this was the case and this issue was escalated to Drs on CCU. The trust provided a timeline for this patient and took immediate action to rectify this situation.
- The average length of stay in this hospital was better than the England overall average for elective patients. However, the stay was longer for elective gastroenterology and rheumatology patients. The length of stay at DPoW for these two specialties was 5.9 days for gastroenterology and 3.6 for rheumatology, compared to an England average of 3.1 days for both specialties.
- Non-elective patients in the specialty of respiratory medicine had a similar length of stay to the England average. The length of stay for geriatric medical patients was 6.8 compared to the England average of 10.1 and general medical patients had an average stay of 7.1 compared to the England average of 6.4.
- The stroke unit had 18 rehabilitation beds open all of the time but could flex up to 25 beds if needed. There was no acute stroke service at DPoW. Patients who had just suffered a stroke and needed thrombolysis had to attend SGH for this. There were no issues transferring patients to the hyper-acute stroke unit at Scunthorpe when necessary.
- Following acute treatment, stroke patients were ideally repatriated to DPoW for the remainder of their treatment and rehabilitation; however, there were often no beds available for the stroke patients to return to. We were told that patients were often discharged from SGH before a bed could be re-allocated at DPoW for them to return to. The day we visited the stroke unit at SGH there were five patients waiting for transfer back to DPoW.
- During the inspection, we observed that there were only two stroke patients on the stroke unit and the remainder of the ward was full with general and elderly medicine patients. The ward sister informed us that numbers of stroke patients on the ward had been very low over the past few months and had fallen to one patient, one day in the last week. The remainder of that week there had been 2-5 patients on the ward requiring stroke rehabilitation.
- Data we looked indicated that early supported discharge of stroke patients had improved from 55% in April 2015 to 69% in June 2015.
- Some of the wards we visited were mixed speciality such as Kendall ward, which had 17 cardiology beds and 10 elderly medicine beds. We were told that the lack of SpR input on this ward led to delayed discharges.
- Between April 2013 and May 2015, 50% of delayed transfers of care were due to the patient waiting for further NHS non-acute care. Completion of assessment resulted in 30% of delayed transfers of care and waiting further NHS non-acute care resulted in 50% of delayed transfers of care between April 2013 and March 2015 across the whole of NLaG NHS trust.
- Staff on ward C6 told us that it was difficult to meet their target for discharges early in the day, as some consultants were unable to carry out ward rounds until the afternoon. Staff told us that the other main reasons for delayed discharge included, waiting for medication and transport.
- There was no documented audit of delayed discharges or transfers from CCU.
- There was evidence of clear discharge planning from Amethyst and Kendall wards. We spoke with three

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patients who reported they and their families had been involved in the plans for their discharge. There was good documentation of discharge plans and discussions with patients and families.

- There was a community “Home to Home Team” who visited the wards on a daily basis to facilitate discharge, however nursing staff told us waiting for social care or placement remained the main reason for delayed discharge.
- During our visit, the discharge lounge had two patients using the facility and two others waiting to come from wards. We were told that this was not a typical day and the area was usually much busier. The patients told us they had not been waiting long in this area.
- There were two new initiatives to aid patients to access the correct service or pathway. The “Frail Elderly Assessment & Support Team” was just getting off the ground with the support of the clinical commissioning group. Elderly patients were to be streamed differently when they attend A&E or AMU they would have immediate access to physiotherapy/ occupational therapy assessment as well as nursing & medical assessment. Social services would also be involved in assessment with the aim of providing immediate treatment / assessment and initiation of community based care or services. The aim of this service was that patients should be able to return to their usual place of residence with the support of community services.
- There was also the “Rapid Access, Time Limited” team, which was a community based service and aimed to prevent hospital admission and or ensure patients accessed the correct pathway.

Meeting people's individual needs

- Where an interpreter was required, staff used a telephone service called 'The Big Word'. This automated service could be booked directly by the ward staff. Dual handsets were provided for the patients and staff.
- Face to face, interpreters were booked through the PALs department for situations where telephone conversations were inappropriate.
- Information leaflets were not readily available in different languages, however staff told us they could get these translated if needed.

- Recent work had been undertaken to improve access to and provision of British Sign Language and this was advertised in a recent staff newsletter. However, staff we spoke with were unsure how to arrange this type of interpreting service.
- Communication aids were available from member of the speech and language team for patients with communication difficulties or learning disabilities.
- There was lots of written information for patients and carers available on Amethyst and Kendall wards. Notice boards gave information about visiting times, staff uniforms and staff roles, infection control, getting ready for discharge, dietary advice and a range of medical conditions such as hypertension.
- Patients with complex needs were seen to have comprehensive multidisciplinary team care plans, which included details for social workers and other community agencies. Patients were aware of care plans made and arrangements with other agencies in relation to discharge.
- The trust had undertaken a gap analysis regarding what was needed to provide better care for people with a learning disability (PWLD). Some of the actions had been to provide new staff with an awareness of the needs of PWLD and this was being offered at induction. There was also to be bespoke training on wards where a need had been identified. However, staff we spoke with had not had this training yet.
- Feedback from the PWLD focus group indicated that this group of patients did not always feel they were involved in decision making at this hospital as much as they could be.
- Staff had access to a lead nurse for learning disability for advice and support when needed.
- The ward manager on C5 told us there were two dedicated bays on the ward for dementia patients however it was not always possible to have all dementia patients in this area.
- The wards were using “My Life” leaflets and memory boxes to facilitate care for this group of patients.
- AMU did not appear to operate a red tray or jug system to highlight patients who needed additional support with eating and drinking.
- During the announced and unannounced inspections on three occasions, we observed female patients being cared for in a male bay on AMU. We were aware that the matron had discussed this with one of the female patients following admission and reassured her that she

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would be moved as soon as possible. It was unclear whether the male patients in the room had been similarly consulted. The hospital had not reported any mixed sex breaches during 2014 / 2015 and it was unclear how the matron assessed breaches on AMU against guidelines for reporting. We raised this with the trust and they confirmed that in December 2015, following their validation, the trust was declaring breaches in respect of five patients on AMU. In terms of the other patients affected, this equated to 28 breaches.

- The Endoscopy Unit had a separate waiting area for male and female patients to provide privacy and dignity.
- Patients on AMU told us that they saw doctors quickly and nurses came quickly in response to call bells. They also told us tests had been performed promptly and doctors kept them informed. One patient had observed that the nurses were very patient with older patients who could not help themselves and helped them to eat. Patients said they knew what the plan was for their care and had information regarding transfer to longer stay wards.
- Patients and relatives on C1 Hollies and Kendall told us that when patients asked for help it was given.
- We saw a board displayed outside a patient's single room asking staff to leave the window in the room shut as this was what the patient preferred.

Learning from complaints and concerns

- Nursing staff and ward managers tried to deal with complaints and concerns from patients and relatives immediately if possible. They told us that few were escalated to the matron or to formal processes.
- There were 86 informal concerns or issues raised, through the Patient Advice and Liaison service (PALS), for the medical service between April 2015 and June 2015 and 19 formal complaints for the same period.
- The largest themes in the complaints for this core service were; standard of care from nurses and doctors, missed or delayed diagnosis and issues relating to discharge.
- PALS information on how people can raise concerns and/or complain was publicly displayed and available.
- A ward sister shared the details of a recent complaint with us and explained how this had been responded to by changing practice. We were told that learning from complaints was shared with staff using email communication.

- The ward managers told us that complaints are shared with staff in order to improve services to patients. Staff confirmed this was the case and told us formal complaints were not received very often.
- In response to patients and relatives concerns that ward C6 needed to be more secure for vulnerable patients, a lock with a timer had been fitted to the entrance doors.
- We looked at a complaint response from the service, found it to reflect a thorough investigation, and demonstrated appropriate apology and duty of candour as well identifying improvement actions.
- Patient experience boards were prominently displayed and up to date.

Are medical care services well-led?

Good



We rated well-led as 'good' because:

- At ward level there was clear leadership and, previously concerning, wards with new managers were able to demonstrate evidence of improvement in quality indicators.
- Staff told us that ward managers and matrons were supportive and approachable and they would have no hesitation about raising concerns.
- Managers and senior clinicians were aware of the risks and challenges faced by their services and there were a number of examples of innovation and service improvements.
- There were well-embedded processes for monitoring quality indicators and mechanisms in place to take improvement action where needed.

However, there were some areas for improvement;

- Nursing and medical staff felt that vacancies in key clinical lead posts were delaying the strategic development of some specialities.
- Staff were not clear about the long-term vision for their services in all specialities.

Ward managers told us they had limited management time due to being counted in the planned staffing figures to deliver patient care.

Vision and strategy for this service

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- It was evident in staff behaviours across the medical service that they adopted the organisational aim of ensuring quality. Patient experience and patient safety was central to their interactions with patients.
- There was clear vision for improvements to some clinical services such as stroke services and gastroenterology although it was recognised that staffing issues and vacant clinical lead posts in some specialities was inhibiting development. This was particularly the case in Cardiology and AMU.
- All staff were aware of the “Healthy Lives, Healthy Futures” strategy and that this meant people taking more responsibility for their own health, alongside moving services closer to home. Ward staff had not felt any great impact from this work as yet and recognised that this was a long term plan.

Governance, risk management and quality measurement

- Ward managers were aware of key issues on their wards and worked with operational and quality matrons to improve the services they delivered through regular cycles of audit, monitoring of quality indicators and improvement actions. For example, one ward had received additional training following the results of falls investigations; another had infection control input when their audit results had highlighted areas of poor practice.
- Trust wide and medical service wide risk registers were in place and were regularly reviewed and updated. There was a comprehensive risk register for the medical service, which showed that existing / ongoing risks had been reviewed between January and August 2015.
- Wards did not have local risk registers; however, staff told us they would raise issues with the ward manager or matron who would escalate to the head of nursing. Ward sisters were unsure if issues they raised were formally recorded in any way. Staff reported that when they had reported risks such as shortage of nebulisers and falls sensors the managers had listened and they had requested the equipment needed.
- Matrons and senior nurses were clear how to escalate risks through the relevant governance processes.
- Results of ward audits against measures of quality were entered onto a dashboard, which was shared with staff through team meetings, and results were displayed in staff areas. Ward managers could demonstrate improvements to quality measures over time.

- Ward managers and matrons discussed any items or wards showing as 80% compliance or less at the nursing forum chaired by the chief nurse. Actions were agreed at this meeting and support / improvement mechanisms were put in place where needed.
- There were internal quality assurance systems and processes in place to investigate and review any clinical concerns or issues and to make recommendations and improvements. For example, work streams had been introduced to undertake mortality reviews around clinical specialities.
- Managers were clear about the risks their departments or services faced and minutes of governance meetings clearly demonstrated discussion, escalation and actions taken.

Leadership of service

- At ward level there was clear leadership of the services however; ward managers told us that they had limited management time due to being counted in the planned staffing figures to deliver patient care. This had a negative impact on their ability to lead and manage their ward as effectively as they would have liked.
- The ward managers were supported by an operational matron and a number of quality matrons. Matrons gave good support to the ward managers regarding day to day operations as well as monitoring performance against quality indicators.
- There were clear lines of accountability from the service leaders to the frontline staff.
- Staff felt very well supported by ward managers and matrons but felt there was frequent changes to middle management and that these were not always communicated well.
- Four members of staff commented that the chief executive was very approachable when on walkabout. Staff told us the senior nurse was visible and approachable.
- A number of ward managers were new in post and had been appointed to improve standards of care.
- The Unit Manager on AMU had been in post for three weeks. She told us that she liked to have a presence on the ward and not spend too much time in her office.
- The matron for unplanned care had been in post for seven weeks. She said that she felt well supported by the Head Nurse. The matron visited AMU every morning to discuss staffing, and any issues, which need addressing.

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- We were told that AMU did not have a dedicated consultant to lead the unit and that there was no constant senior clinical leadership on the unit. Staff did not know who was acting as clinical director for the unit and did not know who was taking responsibility for clinical governance and audit.
- There were two medical trainees based on the AMU who organised the medical staff and consultant cover. They felt well-supported and told us they could access senior medical staff when they needed to.
- A matron informed us that she has monthly meetings to discuss finance, governance and human resource issues including managing sickness.
- Sickness absence levels across the trust were similar to the England average (January 2011 – January 2015)
- The trust had mixed results on the NHS Staff Survey (2014). There was a worse than expected response rate 30% against a national rate of 42%. The trust scored worse than expected on effective team working, percentage of staff reporting incidents and near misses, feeling secure about raising concerns, contribution to improvements at work and use of patient feedback to inform decision making.
- The trust scored better than expected on six indicators, which included; staff being satisfied that their role made a difference to patients and being satisfied with the quality of care they could deliver.
- Where patient feedback had named staff in a positive light, the ward managers were informed and the staff member would receive a thankyou letter from the chief executive or her deputy.
- Staff told us that the head nurse was supportive and approachable and had visited AMU to thank HCAs for providing good care to patients.
- Staff told us that the introduction of a blended shift pattern had not been popular and felt the organisation had not listened to them during the consultation process. Some staff expressed the view that the new shift pattern had resulted in nurses leaving the organisation or going to other areas to work.
- There was line manager training available for all ward managers and junior sisters to attend.
- Messages were shared across the organisation using weekly newsletters and the Chief executive had introduced a blog to improve two-way communication with staff.
- A relative commented on Kendall ward that it was difficult to get to see the senior nurse.
- It was reported that the cardiology service was currently without a lead consultant and that this needed to be addressed as soon as possible.
- The CCU manager felt that relationships with the matron and senior nurse were good and that the chief executive of the trust would listen to issues raised by any member of staff.
- Staff told us that clinical lead vacancies existed in a number of specialities such as cardiology, AMU and elderly medicine and that recruitment to these posts was vital to clarify direction of travel and lead service developments.
- Not all clinicians felt that communication and engagement with the executive management team were good.
- Staff told us that they would be confident to raise any concerns they had with their managers.
- On C1 Kendall, the ward manager had been in post for six months and had a clear vision for the ward. Staff were engaged in change and the focus for all was the needs of the patients. Audits on this ward demonstrated continuing improvements and this was well communicated to staff.
- The ward sister held monthly meetings with her staff and encouraged them to contribute to the agenda. Lists were visible to all staff to show where things needed to improve, for example outstanding appraisals.
- The ward managers felt well supported by their senior managers and quality matrons although they did not always have monthly 1-1s with their supervising matron.

Culture within the service

- A matron we spoke with said she felt valued as a member of staff. She received good support from her peers.
- Staff told us that ward managers were supportive and approachable and they would have no hesitation about raising concerns.
- The executive team did ward walk rounds from time to time and were available for staff to speak to or raise concerns.
- Staff told us pressure from site managers to move patients could negatively affect staff morale, especially when a nurse disagreed with the move on grounds of patient condition or time of night. It was very frustrating

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for nurses to have “two people with clipboards” arrive to tell them they had to move a patient when they were working short staffed and trying very hard to give the best possible care.

Public engagement

- The wards displayed the FFT results on “you said we did boards” so patients and public could see changes made because of their feedback. Patient feedback was taken seriously and a patient panel had been established, within the trust, to look at and help make improvements from patient experience information.
- Following feedback on the AMU, the ward manager had purchased earplugs for patients to request if they were disturbed by noise at night.

Staff engagement







- A ward sister told us that staff had been encouraged to be open and honest and had been prepared for the inspection by senior management.
- Good feedback for individual staff was shared with their line manager. The staff member received a letter of thanks and was considered for a star award.
- Staff were encouraged and recognised for elements of good practice. One ward sister told us she had received a prize for the most friends and family test feedback. HCAs told us they received good feedback relating to patient care.

- Staff attending the HCA focus group told us they were listened to by their ward managers but that sometimes they felt their manager's hands were tied by managers that were more senior.
- The chief nurse was visible to ward staff and matrons were seen on the wards every day.
- The chief executive had recently introduced a blog to facilitate staff engagement.

Innovation, improvement and sustainability

- The “Frail Elderly Assessment & Support Team” gave elderly patients, immediate access to physiotherapy / occupational therapy assessment as well as nursing & medical assessment. Social services would also be involved in assessment with the aim of providing immediate treatment / assessment and initiation of community based care or services. The aim of this service was that patients should be able to return to their usual place of residence with the support of community services.
- The “Rapid Access, Time Limited” team, which was a community based service and aimed to prevent hospital admission and or ensure patients accessed the correct pathway and the community “Home to Home Team” who visited the wards on a daily basis to facilitate discharge
- The stroke ward was piloting new initiatives around extended visiting and the new end of life pathway.

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

Information about the service

Diana, Princess of Wales Hospital (DPoW) provides day surgery and inpatient surgical treatment for NHS patients across a range of specialities, including colorectal surgery, Ear, Nose and throat (ENT), ophthalmology, orthopaedics, urology, and general surgery. Surgical beds are located on inpatient wards and day case ward. Eight operating theatres are available.

Between January 2014 and December 2014 there were 41,020 surgical episodes of care carried out in the trust with 19,600 carried out on the DPoW site. Day cases accounted for 60% of all episodes with emergency admissions 26% and elective admissions 14%.

We ask the same five questions of all the services we inspect; are they safe, effective, caring, responsive to people's needs, and well led?

At our last inspection in July 2014, we found that surgery 'required improvement overall. We rated surgery as 'good' for being effective, caring and responsive and 'requires improvement' for being safe.

During this inspection, we reviewed progress made against the action plan for improvement produced by the trust following the 2014 inspection.

We visited all surgical wards and the pre-assessment clinic. We also visited 8 operating theatres and the post anaesthesia care unit.

During the inspection, we reviewed 22 sets of care records. We spoke with 24 patients, 4 relatives and 42 members of staff, including ward managers, nursing staff, medical staff

(both senior and junior grades) and allied health professionals such as pharmacy and physiotherapy staff. We received comments from patients to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

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Summary of findings

We rated surgery as 'requires improvement' overall. This was because:

- Surgical services did not always protect patients from avoidable harm and there was a limited level of assurance with safety measures. We found that although staff reported incidents of harm or risk of harm, the lessons learned from investigating them were not always fed back. Whilst there were some systems and processes in place to support the dissemination of this learning, staff told us that they did not receive or access feedback/learning from incidents. We were therefore not assured that learning was effective in preventing similar incidents in the future.
- In 2014, we said the trust must take action to ensure that there were sufficient qualified, skilled and experienced staff, particularly in surgical areas. During this inspection, we found substantial and frequent shortages of nursing staff and an increased number of agency staff being used. When staff shortages occurred, the skill mix of staff was not always a priority. The trust had run a significant recruitment campaign but the skill mix and retention of new staff remained an issue. Appraisal rates had improved since 2014, however still did not meet internal compliance targets and levels of compliance was variable. Newly qualified nurses, awaiting their national registration, were often included within the qualified staffing levels. Many staff commented on an increased amount of pressure for experienced/substantive staff due to the staff shortages. The overall number of vacancies had increased since our inspection in 2014 despite the trust's efforts at recruitment.
- We had concerns regarding the pre-assessment of patients; the assessment of early warning scores for deteriorating patients; and, the provision of emergency equipment. Assurance for compliance with the five steps for safer surgery was limited. Patients were at risk of not receiving effective care or treatment, as care provided did not always reflect current evidence-based guidance, standards and best practice. Implementation of best practice

guidance was variable, with 65% of policies compliant with current National Institute for Health and Care Excellence guidance. National hip fracture audit data for 2014 showed DPoW performed better than the England average on most of the indicators. However, there had been deterioration in performance at DPoW in three of the areas reported on in 2014 compared to 2013.

- Services did not always meet patients' needs. They were not always able to access services for assessment, diagnosis or treatment when they needed them. There were breaches to national waiting times, especially in urology, pain procedures, ophthalmology and trauma and orthopaedics. Patients we spoke to and evidence we reviewed showed that patients were experiencing delays and cancellations of operations and procedures. Actions taken to deal with this were not always timely or effective. A number of medical patients were using surgical beds, which limited the availability of beds for surgical patients.
- When patients raised concerns or complained, they did not always receive satisfactory responses and outcomes. Complaints were not always used as an opportunity to learn. Patients' needs were not always taken into account.
- There was no surgical vision statement or overarching surgical strategy. We were told that some of the future service provision would be determined through the ongoing local health community "Healthy Lives, Healthy Futures" work stream. Risk issues were not always dealt with appropriately or in a timely way.
- It was noted in the 2014 inspection, that the senior management team was new at that time and had not had time to implement changes. During 2015 further senior management team change had taken place. Managers had not yet identified, prioritised and taken action on all of the issues of concern within surgery. Potential improvements from the introduction of the quality and safety days had not yet become an established route for learning. During the inspection we saw improved leadership on surgical wards from ward managers.

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- The development of the Web V virtual ward administration computer system had made a positive impact on the documentation of patient risks.

Are surgery services safe?

Requires improvement



We rated surgery as 'requires improvement' for safe because:

- In 2014, the trust was asked to take action to ensure that there were sufficient qualified, skilled and experienced staff, particularly in surgical areas. During this inspection, we had concerns over shortages of nursing staff and an increased number of agency staff were being used. A significant recruitment campaign had occurred, however the skill mix and retention of the new staff employed remained an issue. Newly employed staff, were often working within the numbers for registered nurses, which placed an increased amount of pressure on experienced staff.
- The service did not always protect patients from avoidable harm and there is a limited level of assurance about safety. Safety concerns were not always highlighted, in a comprehensive or timely way. We found that although staff reported incidents of harm or risk of harm, the lessons learned from investigating them were not always fed back. Whilst there were some systems and processes in place to support the dissemination of this learning, staff told us that they did not receive or access feedback/learning from incidents. We were therefore not assured that learning was effective in preventing similar incidents in the future.
- We had concerns regarding the pre- assessment of patients. The senior management team were aware of the issue and "acceptance that improvements could be made", was noted in the theatre action plan.
- We reviewed data from a spot-check internal audit report on the assessment of early warning scores for deteriorating patients from April 2015. This showed low compliance with NEWS score assessment standards of between 25% to 57%. However, nursing audit data we reviewed for July 2015 showed improvement to 93.2% compliance with the patient indicator standards including recording NEWS scores.
- During the inspection we raised that checklists and protocols for resuscitation equipment were not upto

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date in some areas we visited. Immediate action was taken by the ward manager to address this. Assurance for compliance with the team brief element of the five steps for safer surgery was limited.

- Although compliance with mandatory training had increased to 82% in November 2015, it was still below the trust required level of 95% compliance

Incidents

- A centralised national computer system was used to report and investigate incidents. Surgical areas reported 1,907 incidents (rated as harm which was moderate, severe, resulting in death or abuse) to the National Reporting Learning System (NRLS) between July 2014 and August 2015. Reported incidents showed three graded as death, one graded as severe harm, 34 graded as moderate harm, 604 graded as low risk harm and 1,265 graded as no harm/near miss.
- Senior nursing and medical staff reviewed the incidents reported and analysed the data to identify any trends, monitor actions and learning. The top three categories of incidents reported were patient accident (451 of 1,907 incidents), implementation of care and ongoing monitoring (429 of 1,907) and infection control incidents (264 of 1,907).
- Nursing and medical staff we spoke to, were all aware of the centralised system for reporting and staff could describe their roles in relation to the need to report, provide evidence, take action, triage or investigate as required. Staff did however report to us that they did not complete incident forms following every incident; Some staff we spoke with also said that they did not receive individual feedback on incidents they had reported, although the IT system had a mechanism to provide this.
- Staff told us that learning from incidents was shared internally through staff meetings, communication books and white boards within staff only areas; daily team briefings were in use on one area to share information between staff members. Trust wide surgery group learning from incidents was limited. A surgical quality and safety meeting had been developed and all medical, and senior nursing staff were invited to attend, to discuss themes and issues identified through governance. This meeting had been held on three occasions pre the inspection, although it was difficult to understand how messages from this newly established meeting had been cascaded to ward level staff to date.
- Serious incidents are incidents that require further investigation and reporting. Nineteen serious incidents (SI) were reported, within the surgery group during the reporting period August 2014 to July 2015. Themes included pressure ulcers, delays in diagnosis, surgical error and unexpected death. We reviewed four reports and noted a good quality of investigation and identification of lessons learned; however dissemination of the report, implementation of lessons learned and evidence of change in practice could have been emphasised further.
- Never events (NE) are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level. The surgery group reported three never events in the reporting period August 2014 and July 2015. All the never events reported were due to surgical error and all occurred on the DPoW site. Senior staff we spoke to, were aware of the never events, however some junior staff, even within the areas where the never event occurred, were not aware, or were aware via “hearsay” rather than from the formal cascade system. One never event in 2015 involved wrong lens implantation in ophthalmic surgery. The organisation in recent years has had 11 repeated similar events. Within the 2015 report following the NE it was highlighted that failure to embed cross-site recommendations and actions following a previous NE were one of the root causes identified. The incident occurred in early 2015 and was highlighted mid-2015, however despite recommendations made in the never event report, during the inspection we observed a lack of consistency between how staff were collecting lenses and the recommendations in the report and the procedure in the governance minutes. Staff told us that surgeons did not agree with all the actions and recommendations within the NE report. Governance minutes we reviewed for August 2015 confirmed a surgeon’s view that; “there is never going to be an identical system in terms of getting every consultant minimum requirement to ensure this type of incident does not happen again”. It was not clear from the minutes of this meeting whether the procedure detailed in the minutes had been ratified. As no consistent approach or Standard Operating Procedure was in place across all theatres to check ophthalmic lenses prior to implantation, there was potential for a similar incident to happen again.

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Duty of Candour

- All staff we spoke to were all aware of duty of candour requirements and described it as being “open and honest” and “telling patients about incidents when they occurred”. Staff provided us with examples about its’ use. Records of duty of candour discussions were documented on the central incident reporting system.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and ‘harm free care’. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots), and catheter and urinary tract infections (CUTIs).
- During the 2014 inspection, safety thermometer data was clearly displayed on information boards on every surgical ward area. During this inspection, safety thermometer data was not always on display in the clinical area. A specific section of the quality board was available for display, however this section was found to be not completed in every area visited during the inspection or unannounced inspection.
- In the reporting period July 2014 to July 2015, 77 incidents of harm were reported in the surgical area with 54 pressure ulcers, 16 falls and 7 CUTIs.

Cleanliness, infection control and hygiene

- The infection prevention and control (IPC) training delivered both face to face and via e-learning. The IPC team delivered face-to-face training. IPC training compliance rates for the Surgery group training were 79% with a trust target of 95%.
- Ward managers, on a monthly basis, undertook measurement of compliance with key IPC trust policies such as cannulation, environmental cleaning and catheter management. The Matron and IPC team completed verification of the audit.
- During the inspection, we observed compliance with the ‘bare below elbows’ and theatre uniform policy.
- Hand hygiene audit data showed compliance of 100%. During the inspection, we noted good availability of alcohol hand rub. Soap dispensers we reviewed were all in working order. We noticed good compliance with hand hygiene principles in theatres but within one ward area (B4), we observed staff not always using hand hygiene principles between episodes of patient care.

- Within the trust, reported cases of hospital acquired infections were above the thresholds agreed, with one reported case of Methicillin resistant staphylococcus aureus (MRSA) and two reported cases of hospital acquired Clostridium difficile (C.diff) in the reporting period April 2014 to April 2015.
- Pre-operative surgical patients were screened for MRSA. Compliance with the MRSA and C.diff policy was audited; compliance was approximately 90-100% between January 2015 and July 2015 against a trust target of 100%.
- Surgical site infection data showed a low level of surgical site infections, with one knee replacement infection and no hip replacement infection, or repairs of neck of femur fracture infection noted during the reporting period January to March 2015.
- Environmental cleaning schedules were available and displayed. We reviewed patient led assessment of the care environment (PLACE) results and noted a score of 95.57%, slightly below the national average of 97.57%. We inspected all surgical wards and all theatres and found that cleanliness was generally good. The inpatient environment was visually clean.
- Domestic staff we spoke with, were knowledgeable about their role and principles to prevent cross infection.
- Equipment cleaning labels provided assurance to patients that re-usable patient equipment was clean and ready for use. During the inspection cleanliness labels were available and used. However, their use was not always consistent or documented with the date of cleaning or the name of the person who had carried out cleaning.
- All commodes we observed were clean and in good condition. Cleanliness labelling was used; however, not every label was signed and dated.
- Within the theatre suite, we saw a large number of blood stained shoes used within theatres. There appeared to be no procedure or a responsible person to clean these.
- Water checklists used for recording flushing of water systems we reviewed were complete. Water coolers were in place however no evidence of flushing or testing of these was available on the ward environment.

Environment and equipment

- Storage for equipment was poor in some areas and the patient environment was cluttered, with shared patient equipment such as fans, drip stands and chairs, which

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made cleaning difficult. We found theatre trolleys stored in the main corridor, these were not covered with protective sheeting or marked as clean, and not protected from tampering.

- The theatre environment was requiring refurbishment. A strategy and planning document outlined actions required with timescales to identify when this work was scheduled.
- We reviewed the trolley used for difficult airway access and noted that it was difficult from visual observation to identify what equipment was single use or how it was decontaminated. This trolley also appeared over stocked for emergency access. This did not reflect recent improvements suggested by the Difficult Airway Society. It is recommended by the Difficult Airway Society to have clearly and concisely labelled drawers and they suggest downloading images to label difficult airway trolley drawers, to enable easy access to equipment in emergency situations.
- Records of resuscitation equipment testing were not always evident, when we highlighted this to the ward manager they took immediate action. Resuscitation policies on or adjacent to the trolley were out of date. Defibrillation equipment was shared between some wards; in one area wards B3 and B4 defibrillation equipment was different to standard trust equipment. Having different equipment made training and declaring competency difficult, especially for staff who moved around the hospital. Post inspection, the trust provided information that showed for consecutive years, at each site, two types of defibrillators had been used due to the Trust changing the manufacturer.
- When using heat generating equipment in operating theatres surgical smoke is produced. Surgical smoke scavenger systems are in place to protect patients and staff from risks of ill health from exposure to surgical smoke. We observed that surgical smoke scavenger systems in theatres were available but not in use. It is recognised that no specific legal requirement for surgical departments to install smoke extraction systems is available, however employers must comply with COSHH regulations to control the exposure of their staff from surgical smoke. The Health and Safety Executive note that there is sufficient evidence to consider the use of surgical smoke extraction devices in reducing the levels of smoke exposure for health care workers." The British Occupational Hygiene Society

standards recommend that evacuation and filtering of surgical smoke systems is used; however, it is noted that occasions are possible where the machine could prevent surgical access and would not be used.

- Within theatres, we observed surgical tape also used to attach surgical drapes to drip stands, rather than clips. Sticky tape and surgical tape was used to attach posters to walls in the theatre area, which can leave a residue, which is difficult to clean and prevent cross infection.
- In one area, visited equipment used for patient moving and handling (PAT slides) was damaged which could harm patients on moving.

Medicines

- During the 2014 inspection, fridge temperature checking was highlighted as not occurring regularly. During this inspection, we reviewed fridge temperatures and noted that maximum and minimum fridge temperatures were not documented accurately on every record. The actual temperature was higher than the acceptable limit on the majority of occasions. The trust was informed of this during the unannounced visit; we reviewed temperatures again and found little change in recording practices or whether action was taken consistently.
- Within the wards, medicines and controlled drugs (CD) were stored safely. Within the theatre environment, the risk register documented controlled drug cabinets as non-compliant since 2008 with little action taken. We observed medications being prepared and left on a unit during an operation. We also witnessed local anaesthetics medications not locked away. CD books we observed were up to date and signed appropriately.
- The pharmacy team had developed medication safety thermometer audits; these audits were undertaken monthly and covered missed doses and inappropriate prescribing. This data was shared with the wards on a monthly basis.
- Medication charts we reviewed were accurately completed.
- The new WEB V computer system had three pharmacy icons to indicate at a glance that; the pharmacy team had seen the patient and required no action; medication required reviewing; or required pharmacy follow up.
- Wards had access to medications within the ward and department areas. Emergency medicine cupboards and an on-call service were also available.

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- One surgical area had a large number of medication errors recorded. When we reviewed this, notable good practice was highlighted in relation to barring staff who had made errors from administering medication and reinstating medication competence documents.

Records

- We reviewed 22 sets of medical and nursing care-plans whilst on site, the majority fully completed, legible, and completed in a timely manner. We did observe some records where patient details were not documented on every page. The trust used a paper patient records system for nursing and medical documentation; records were stored in a locked trolley when not in use. In one area we visited, medical records were not locked, and were unattended.
- All surgical wards completed risk assessments; these included risk assessments for blood clots, falls, pressure ulcers and malnutrition. All records we reviewed were completed.
- Review dates on forms were not always clear, we found medical and surgical Venous Thromboembolism (VTE) forms in use which had different review dates and it was not clear from the forms when they were due to be reviewed again.
- In 2014, the trust was asked to ensure the reasons for 'do not attempt cardio respiratory resuscitation' (DNACPR) decisions were recorded and were in line with good practice guidelines. DNACPR records we reviewed during the inspection showed mixed levels of documentation in terms of discussion with family members to put the DNACPR in place. We observed that no review of the DNACPR decision had taken place post-operatively when the emergency situation may have changed. This was also the case when patients were diagnosed medically fit, or when they were transferred between hospitals. It is recognised as good practice to record further discussions throughout the patient's hospital stay. There was no consistent approach to completing DNACPR records.
- A computer system had been developed since the last inspection. Web V contained patient assessments and care records.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction,

followed by three-yearly safeguarding refresher training. We were unable to review individual surgical compliance data as the trust told us they do not collect this data in this format.

- Nursing and medical staff we spoke to were aware of their responsibilities and pathways to protect vulnerable adults and children, including escalation to the relevant safeguarding team as appropriate.

Mandatory training

- In 2014, the trust was asked to ensure that all staff attend and complete mandatory training, particularly for safeguarding children and resuscitation. We reviewed mandatory training records for the surgery group, which showed overall training compliance of 82% in November 2015 against a year-end trust target of 95%. Although not yet achieving the trust's own compliance rate (95%), improvements were noted from 2014 training levels; surgical wards had improved from 74% in 2014 to 82% in November 2015. One notable exception was a surgical ward area where a member of staff had been allocated responsibility for mandatory training and this had led to 90% of staff achieving compliance. Theatre staff compliance rates had improved from 64% in 2014 to 82% in November 2015.
- Medical staff compliance with mandatory training had improved from 59% in 2014 to 71% in November 2015.
- Although mandatory training compliance rates had increased, staff within some areas expressed that they did not get time to undertake e-learning or face-to-face training due to staffing and activity levels. Some staff told us they were completing e-learning within their break times.
- We were unable to review individual training compliance data as the trust told us they do not collect this data in this format.

Assessing and responding to patient risk

- In 2014, the trust was asked to ensure the World Health Organisation Safety Checklist (WHO) was fully embedded and audited appropriately in theatres. Internal audits in 2014 showed compliance with WHO audits below 80%. The hospital undertakes the five steps for safer surgery procedures and audit including the WHO checklist. Audits of retrospective documentation reviewed during this inspection showed 70% compliance in February 2015; however, in August 2015 the level of assurance had dropped to "limited"

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assurance with the team brief element of the audit.

During the inspection, we observed two WHO checklists taking place and we noted variable elements were completed; however new staff entering the theatre were not introduced during the list. The inspection team raised concerns that the name of the person completing the record has been removed from the WHO audit document. The trust told us after the inspection that this was to encourage full team responsibility for completion. .

- We reviewed theatre booking forms and noted that allergies, complications, signature of doctors undertaking bookings, were not documented on the booking form. No highlighted section for high-risk patients was available on the form, which made infection risks or latex allergies less obvious. We discussed this with the theatre management team and staff told us this information would be communicated verbally and no formal process existed, the trust informed us post inspection, that the booking forms were being reviewed.
- The computerised patient system allowed for the assessment and recording of National Early Warning Scores (NEWS) to be recorded. This score was highly visible on the ward, used during handover meetings in central areas and whilst medical staff were on-call in the hospital. Audit data we reviewed from a spot-check internal audit report on the assessment of early warning scores for deteriorating patients April 2015, showed limited assurance and poor compliance with observations recording, increasing observation frequency, and informing senior staff when patients were deteriorating. Compliance results were between 25% to 57%. Nursing audit data we reviewed for July 2015 showed improvement to 93.2% compliance with the patient indicator standards including recording NEWS scores.
- One of the recent never events was linked with changes to theatre lists. We reviewed how theatre lists were changed and communicated to staff. Most staff within the theatre environment told us that changes to theatre lists were made regularly and provided us with examples of this occurring, and a lack of communication when changes to lists occurred. During the inspection we reviewed current arrangements for the management of emergency theatre lists at this hospital and noted no formal procedure was in place. Staff told us that a surgeon-to-surgeon discussion is

held to arrange priority on lists. It was noted on the theatre action plan that improvements to emergency theatre booking procedures had been reviewed and a form had been produced, however it required agreement and implementation. The deadline for completion of this process was noted as August 2015.

- Within the risk register, emergency buzzers in theatre were identified as a risk leading to confusion occurring due to different alarms sounding and potential for delays in responding. This has been documented on the risk register since 2013, with little or no apparent action taken.
- Concerns were raised during the inspection and corroborated in discussion with staff, over the pre-assessment process and the staffing levels. Staff we spoke with, said there was no anaesthetic cover in pre-assessment clinic and few pre-assessment pathways were available. This resulted in patients listed for day case operations when they were unsuitable and required overnight stay. An number of surgical cases were cancelled, due to inappropriate pre-assessment. The senior management team were aware of the issue and; "Acceptance that improvements could be made", was noted in the theatre action plan. As pre assessment clinics were not all located together on site, the senior management team said they were currently unaware of how many pre-assessment appointments were available, however they were undertaking a capacity and demand assessment. The senior management team told us a business case was in progress to offer anaesthetic support to pre-assessment clinics.
- Specialised prevention equipment (e.g. specialist boots) can be placed on patients to prevent blood clots forming during operations. There were no specific protocols in place for staff to decide whether to use the preventative equipment on high-risk cases. In discussion with senior staff, we were told this was an individual surgeon's decision.

Nursing staffing

- At the 2014 CQC inspection, there were 27 whole time equivalent (WTE) trust wide surgical vacancies reported. During this inspection, the senior management team told us that the current vacancy rate is 50 WTE registered nurse vacancies within the surgical and critical care division. The trust was actively recruiting to

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nursing vacancies across the trust with a large overseas recruitment taking place. All staff we spoke to were concerned about the number of nursing vacancies, and all wards we visited had vacancies.

- The Safer Nursing Care Tool was in use in the surgical areas; the acuity of patients was assessed and recorded into the Web V system three times a day. The staff we spoke to were aware of their responsibility to update the system. The matrons reviewed patient acuity and flexed staff up or down where feasible. The trust had identified a planned staffing ratio of 1:8 nursing staff to patients with an aspirational ratio of 1:7.
- During the inspection we saw ratios on some wards of 1:9 and 1:12. During an evening visit we saw that staff were being moved around many areas to improve staffing levels. On the same evening patients told us that in their opinion there “wasn’t enough staff”.
- We reviewed staffing rotas on every area visited; we reviewed 672 shifts (52 days) in detail and found that staffing levels for registered nurses were below the established levels on 22% of occasions. On 367 occasions, the registered nurse establishment included agency staff. On average 26 different agency staff were used per month. When wards did meet established staffing levels, this was often with agency staff and newly qualified nurses awaiting their professional registration. On ward B4, out of 84 shifts reviewed, more than two agency staff were on duty for 11 occasions.
- We reviewed the amount of agency and bank staff usage and noted a large amount of agency staff in use. For example, on two particular wards, 66 agency registered nurse shifts were used over a 28-day period; these shifts were filled with 38 and 54 different agency registered nurses.
- A large amount of recruitment had taken place throughout 2014-15.. During the inspection, concerns were raised that newly qualified recruited nurses awaiting their professional registration were recorded as band 4 staff but being counted in the numbers for registered nurses (RNs) on duty. These staff needed extra supervision and could not carry out tasks, such as administering medicines that RNs could. This placed extra responsibilities on the existing RNs. We reviewed duty rosters and noted that on every surgical ward we visited, nurses awaiting their professional registration were being included in the RN numbers. Out of 61 duty shifts we reviewed, these band 4 nurses were counted as RNs on 44 occasions.
- During the unannounced inspection we were made aware that a memo had been circulated to Matrons since the inspection, advising managers not to roster newly qualified nurses awaiting their registration as registered nurses if less than 2 substantive qualified RNs were on duty. Staff we spoke to, told us that whilst working as newly qualified nurses awaiting their registration were not allowed to administer medication. Senior management confirmed this.
- These nurses also required a second signature on documentation and could not undertake complex wound dressings. This level of extra supervision required, when already short staffed, was increasing pressure on other registered nurses to support the new member of staff, although this level of support was not demonstrated in the numbers of RNs on duty.
- A large amount of international recruitment had taken place and staff spoke to us about language difficulties of some of the staff recruited. We had received similar concerns from some stakeholders and patients pre inspection. When raised with the trust we were told that all nurse candidates must have intermediate level English as a minimum requirement before being selected for interview. Following induction all candidates must reach the level 2 standard.
- One surgical ward had a large number of medical outliers and an agreement in place that they could increase staffing levels when a threshold of medical patients had been reached. This ward did not have a large amount of substantive staff and relied heavily on bank and agency staff. These medical patients had highly complex clinical needs, and high levels of acuity. Discharge arrangements of these patients were often more complicated than surgical patients.
- In the previous year, a new shift system had been implemented; this shift system consisted of “blended shifts” which were a mixture of early, late and long day shifts. Staff we spoke to told us that this shift system had led to an increased number of staff leaving the trust. Some areas had subsequently returned to the previous shift pattern of just long days. The trust acknowledged that staff had left due to the shift changes and also said they had left for community roles.
- Shift co-ordinators on each ward also had a cohort of patients to care for. This was raised at the time of inspection and they informed us they were undertaking a review of nurse staffing levels and developing the shift co-ordinator role.

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- Staff told us that due to staff shortages, they did not always get time to complete records accurately and record information on the IT system.
- The senior management team were aware of the staffing issues and were collectively working on new role development such as Band 4 theatre assistant roles, and advanced care practitioner roles. Some of these new roles, such as ACPs would take over 12 months to implement in order to ensure appropriate training and qualifications had been obtained.
- Recent information supplied by the trust in January 2015 indicated that a nursing establishment review had been undertaken on surgical wards, the recommendations were for an improved nursing establishment on ward B4, B6 and B7 at DPoW.
- Staff had handovers twice a day, with “safety huddles” throughout the day as required. We observed a safety huddle and found this to be thorough, informative and staff appeared knowledgeable about their patients.

Surgical staffing

- In 2014, there were around 15 medical staff vacancies in surgery. The senior management team told us that the current vacancy rate within the surgery group was approximately 10 WTE from 80 WTE substantive consultant posts. There were no consultant vacancies within the anaesthetic division.
- Consultant medical staff were accessible 24 hours a day, seven days a week.
- Within surgery, lower rates of medical staffing than the England average levels were noted: consultant staffing at 37% trust level against a 41% England average. This was also the case for registrar grade medical staff at 24% against a 37% England average. However, there was an increased number of middle grade staff at 23% against an 11% England average, and junior doctor grades at 16% compared to a 12% England average, during September 2004 to September 2014.
- Prior to the inspection, we were aware of junior medical staff raising concerns about induction training. However during the inspection junior medical staff we spoke with did not raise these concerns with us.
- Medical staff handover took place formally, twice a day at 8am and 8pm.

Major incident awareness and training

- Staff we spoke to were not aware of any major incident scenario training sessions being carried out in the previous year.

Are surgery services effective?

Requires improvement



We rated surgery as ‘requires improvement’ for effectiveness because:

- We had concerns over patients not receiving evidence based care or treatment. Care and treatment provided did not always reflect current evidence based guidance, standards and best practice. Implementation of best practice guidance was variable, with 65% of policies compliant with NICE guidance at the time of the inspection.
- In 2014, we asked the trust to ensure there is an improvement in the number of fractured neck of femur patients, who had surgery within 48 hours. Internal trust targets indicated this was still not occurring within 48 hours consistently. National hip fracture audit data for 2014 DPoW performed better than the England average on most of the indicators. However, there had been deterioration in performance at DPoW in three of the areas reported on in 2014 compared to 2013. The trust’s target for patients with fractured neck of femurs having surgery within 36 hours in 2015-16 was not being met.
- Appraisal rates had improved since 2014, however still did not meet internal compliance targets of 95%, and levels of compliance were variable.

Evidence-based care and treatment

- Departmental policies were based on nationally recognised best practice guidance, for example National Institute for Health and Care Excellence (NICE guidance). However, data supplied to us by the trust, showed that in September 2015 65% of policies were fully compliant with NICE guidance, 26% were partially compliant and 7% were yet to be assessed..
- Local and national resuscitation guidelines and policies located on the resuscitation trolley were found to be out of date (dated 2005). New guidelines were available on the local intranet, which were published in 2015.
- Enhanced recovery care pathways we reviewed for orthopaedics were undated, or did not have a review date included.

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Pain relief

- We observed pain relief being administered appropriately and patients we spoke to, told us when they requested pain relief they received it quickly and appropriately.
- Pain scores were in use; they were paper based rather than recorded on the new computerised system. Abbey pain scales are pain scales designed to assess the pain level of patients living with dementia. Abbey pain scores were in use within the hospital, however their use was sporadic and not embedded. Staff we spoke to, were aware of the need to use these documents. Following the inspection the trust told us that the Abbey pain score chart had only been implemented shortly before the inspection.
- A chronic and an acute pain management team were available at DPoW. The acute pain specialist nurse had a case load of post-operative patients, mainly surgical. They were available 5 days a week. The team also attended a joint school for implant patients and pre-operative clinics as required. Training on pain management was taking place on a mandatory training programme within the trust for registered nurses. The acute pain team had also managed to secure time on a training programme for HCAs commencing in January 2016.
- Anti-nausea medication was prescribed and administered as required when pain relief was prescribed.

Nutrition and hydration

- In 2014, the trust was asked to review access to the provision of soft diets outside of mealtimes. During the inspection staff we spoke to confirmed that patients had access to hot and cold snack food choices out of hours. Soft diet choices of porridge, soup and yogurts were available as well as hot and cold drinks.
- Since the 2014 inspection the trust had implemented hydration stations to provide hot drinks and soup 24 hours, although we saw these trolleys on wards visited, it was not clear to the inspection team that these were for patients to use. The trust confirmed that these were operated by staff when patients requested additional drinks.
- Malnutrition Universal Screening Tool (MUST) was used, within the trust to identify adults who were at risk of

malnourishment. MUST nutritional assessments were recorded on the WEB V computer system and an action prompted response was required on a weekly basis to review the assessment.

- Although some patients told us the quality of food was poor, most patients we spoke to said it was acceptable. We reviewed patient led assessment of the care environment (PLACE) results and noted that the food was scored at 86.09 % against a national average of 88.49%. Although slightly lower than the national average, this score was an improvement on the 57.7% score within the 2014 inspection report.

Patient outcomes

- In 2014, we asked the trust to ensure there was an improvement in the number of patients with fractured neck of femur who received surgery within 48 hours. At the time of the 2014 inspection, 73.9% of fractured neck of femur patients had surgery within 48 hours at this hospital, compared to the England average which was 87.3% during 2013.
- National hip fracture audit data for 2014 showed DPoW performed better than the England average on six out of the seven indicators. However, there had been deterioration in performance at DPoW in three of the areas reported on in 2014 when compared to 2013 data, including the proportion of patients having surgery on the day or the day after admission which was lower (60.2%) than the England average (73.8%) and lower than in 2013, when the hospital scored (73.9%).
- There was conflicting evidence with the range of compliance with this target. The internal trust performance dashboard indicated that the best practice tariff target for patients with fractured neck of femur having surgery within 36 hours was 100%. This data showed that the trust only met this on approximately 20% of occasions between March 2015 and May 2015.
- We reviewed the neck of femur action plan and saw a different internal target for patients having surgery within 36 hours, which was 75%. The action plan indicated that in May 2015 compliance was 61.4%, yet the performance dashboard we reviewed for May 2015 showed compliance at 15%. We discussed performance against the 36-hour target with the senior management team and an action plan had been developed to identify why patients were not having surgery within the first 36 hours.

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- We reviewed the organisational plan and saw that one of the priorities was to reduce surgery-related harm (moderate and above) occurring in the trust across all surgical specialities, with a particular focus on harm in orthopaedic surgery. It stated this was to be delivered by fostering a good safety culture, better teamwork and by building a pro-active safety measurement and monitoring framework that supports a continuous learning culture.
- The trust continued to contribute to all national surgical audits and we noted good performance in both the bowel and lung cancer national audits.
- We found the National Emergency Laparotomy audit 2014 showed that 18 out of the 28 measures were not available. For the 2015 patient audit results, the hospital scored 5 out of 11 measures as red.
- The trust participation rate and outcomes for the patient reported outcomes (PROMS) measures showed similar performance to other hospitals.
- Elective and non-elective urology and colorectal surgery and general surgery patients had a lower risk of readmission against the England average between December 2013 and February 2015.
- Enhanced recovery care pathways we reviewed for orthopaedics were undated, or did not have a review date included.

Competent staff

- In 2014, the trust was asked to ensure that staff have appropriate appraisal and supervision. In 2014 compliance rates for nursing staff having appraisals varied between wards and theatres from 27% up to 93%. The trust had an internal target to achieve 95% compliance for appraisals by April 2014.
- Appraisal records we reviewed for April 2015 to November 2015 showed that 69% (428/623) of staff within surgical areas had received an appraisal. Wards had achieved overall 82%; however, some wards had individual compliance lower than 50%. Within the theatre environment, 65% of staff had received an appraisal.
- When nursing appraisals had taken place, it was not always evident where training needs had been actioned.

- National guidance recommends that medical staff have an appraisal at least once a year. In 2014 appraisal rates were 56% to 100%. Records we reviewed during this inspection indicated that appraisal rates for medical staff were approximately 90% in May 2015.
- The nurse in charge of the shift declared bank and agency competence using an induction checklist.
- Newly appointed staff underwent an induction process and spent time at a “care camp” a two-week classroom based training programme. They also had a period of supernumerary status on the ward. New starters we spoke to told us about comprehensive induction packages.
- The acute pain team had undergone extra training to allow them to prescribe pain relief during working hours. This extra skill helped patients to receive pain relief in a more timely fashion, rather than having to wait for medical staff to prescribe.

Multidisciplinary working

- Staff spoke to us about positive working relationships within the surgical areas.
- Pharmacists, physiotherapists and occupational therapists visited the wards Monday to Friday. We observed discussions between members of the MDT and they appeared clear, appropriate and knowledgeable.
- We spoke to staff from continuing care services that were in the hospital and noted an organised transfer of care between hospital and community on the DPoW site.

Seven-day services

- Routine surgery was performed Monday to Friday, with emergency surgery being performed at weekends and evenings.
- Physiotherapy, imaging services and pharmacy provision was available on an out of hours on-call basis, seven days a week.
- Junior medical staff were available 24 hours a day on site, Consultants were on-call on a roster system and on-call rotas were available for key staff, out of hours.

Access to information

- Nationally recognised patient administration systems were in use providing access to patient administration, booking, radiology and pathology services.

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- A new virtual ward patient administration system had been developed and launched within the trust in the previous year. This system alerts staff and records when a patient observation were due. It gave access to test results and could be used as a bed management system. The functionality was displayed on large screens within the nurse base of a ward area and allows staff to easily view details of a patient's care. Icons were highly visible on the system showing assessments that had been carried out. One notable highlight was the ability to take and store a picture of patients at admission, in case of patient identification issues.
- A process was in place to provide agency staff with passwords for the computer system; however, staff did talk to us about this process not always working due to the workload of the staff involved. Staff also told us that on occasions, there is pressure on substantive staff to share IT passwords with agency staff: non-supply of passwords increases the workload of substantive staff as they have to record all observations on the system for the agency worker. Information governance and safety risk were also increased if staff shared passwords, or inputted observations taken by other staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent from patients was gained via both verbal and non-verbal routes. The staff we spoke to, were aware of how to gain both written and verbal consent from patients and their representatives.
- Consultant medical staff sought consent from patients prior to operations or procedures. Junior medical staff were able to gain consent from patients on completion of a consent passport for individual procedures. We noted specific consent forms within ophthalmology; these were specific to the type of surgery being performed and had risks identified. These could be signed by nurse specialist.
- Where patients lacked capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative), that could legally make those decisions on behalf of the patient.
- Staff we spoke to were able to describe their responsibilities in relation to the legal requirements of the Mental Capacity Act (MCA) 2005.

- Deprivation of Liberty Safeguards (DoLS) training compliance data for the Surgical group was reviewed and were noted to be 85%, with a trust target of 95%.

Are surgery services caring?

Good



We rated surgery as 'good' for caring because:

- Patients were mainly well supported by staff and treated with dignity and respect. However, a minority of patients did not feel well supported or cared for, some patients who used the service and those who were close to them, had concerns about the ways staff treated patients.
- Comments from patients, staff and relatives prior and during the inspection were mainly positive; however some negative comments were received.

Compassionate care

- We spoke to 24 patients over five ward. In three areas visited, patients told us that the staff were caring and patients were happy with the care they received. However, in two areas we visited, three patients said that communication was poor and relatives gave examples of poor nursing handover and poor telephone communication.
- Two comments we received during the inspection via "share your experience" web forms highlighted negative aspects of care around privacy, dignity and staff attitude.
- When we observed staff going about their work, we saw neutral to positive interactions. Staff in the theatre suite were caring and providing good levels of communication and reassurance to patients.
- We reviewed PLACE assessments for privacy, dignity and wellbeing and noted that the trust scored 87.25% against the England average of 86.03%
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. It was noted that the response rate for this hospital was the same as the England average at 36.5% and generally there was a higher proportion of surgical patients who would recommend the service.
- A project was in place to pilot open visiting times. Staff we spoke to expressed concern about the project,

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however they did not feel able to raise concerns and they felt that they had to complete the whole project. Relatives we spoke to, liked open visiting, especially around meal times to help to feed their relative.

- Two wards B6 and B7 had a ward action plan in place, this action plan highlighted various negative aspects of care, for example poor communication, ward leadership, poor patient satisfaction and pressure ulcer acquisition. This action plan had been reviewed regularly and many of the actions were now complete.

Understanding and involvement of patients and those close to them

- Patients we spoke to said that they felt that they had been involved in their care decisions and the risks and benefits of surgery had been discussed with them. Patients told us they were happy with the information they received prior to and during their procedure.
- Some relatives we spoke to told us that they felt access to staff via the telephone was difficult. One relative expressed that they had to “chase” staff to ensure information provided was accurate, especially when bank staff were on duty.
- On one ward we visited a patient was living with dementia and had been very unwell in previous weeks, staff had flexed visiting times for the family to allow for longer periods of visiting.
- Patient feedback boards: We saw “you said, we did boards”, one of these boards detailed feedback from patients. Some of the feedback we observed was about patients using mobile phones in the night disturbing other patients. Signs had been developed as a result; to encourage patients not to use mobile phones overnight.
- Patients we spoke to were aware of their discharge arrangements and actions required prior to discharge occurring.

Emotional support

- Clinical nurse specialists were available for a range of services such as infection prevention and control, tissue viability and cancer specialist team.
- Chaplaincy services were offered throughout the trust.

Are surgery services responsive?

Requires improvement



We rated surgery as ‘requires improvement’ for responsive because:

- Services did not always meet people’s needs. Patients were not always able to access services for assessment, diagnosis or treatment when they need to. There were long waiting times, especially in urology, pain procedures, ophthalmology and trauma and orthopaedics.
- Patients were experiencing delays and cancellations of operations and procedures. Actions taken to address delays or cancellations were not always taken in a timely or effective manner. A high level of medical outliers was observed in surgical beds.
- When patients raised concerns or complaints they did not always receive satisfactory responses and outcomes. Complaints were not used as an opportunity to learn. Good practice was noted in the ability to take pictures of patients living with dementia or learning difficulties on the new computer system to aid identification. We also saw a specific theatre list for patients with learning difficulties.

Service planning and delivery to meet the needs of local people

- Most services were commissioned by the two local clinical commissioning groups.
- There was an ongoing strategic review of the configuration and sustainability of health and social care services across the geography of North and North East Lincolnshire called “Healthy Lives, Healthy Futures”.
- There had been reviews of some surgical services for example Ear, Nose and Throat (ENT) and Ophthalmology and theatres. These had identified the number of surgical procedures which were required to meet the referral demand. The senior management team spoke with us about the challenge of implementing the recommendations due to issues with physical space, availability of staff, and balancing of job plans.
- The senior medical team were unaware of how many pre-assessment appointments were required to assess

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correctly the number of patients being referred. They were also unaware of the length of time each operation required and whether enough theatre time was available.

Access and flow

- The target Referral to Treatment Time (RTT) is set within the NHS as 18 weeks from referral from GP to treatment time. Since July 2014, RTT performance had been generally below the 90% standard, data reviewed for May 2015 showed improved performance, at 92%. The England average performance during the same time period had also been below the standard. ENT, Trauma and Orthopaedics, and Ophthalmology specialities provided at the trust did not meet the standard.
- The percentage of patients (with all cancers) waiting less than the set target times of 14, 31 and 62 days from urgent GP referral to first definitive treatment, was 97.2% for 14 day treatment in Sept 2015. This was higher than the 93% England average for the same period. It was 100% for 31-day treatment (again higher than 96% England average for the same period) and it was 84.8% for 62-day treatment in Sept 2015, which was slightly higher than the 84% England average. However urology and gastrointestinal cancer referrals at the trust did not meet the 85% target in March or April 2015.
- Theatre utilisation data was reviewed and noted to be at 84.5% April to June 2015; with 47% of operating lists overrunning between November 2013 and October 2014.
- The trust had commissioned an external consultancy company to investigate efficiency and productivity within theatres. This work identified a number of areas where improvements could be made, from both a quality/patient experience and financial benefit perspective. A theatre efficiency action plan we reviewed was detailed as to the issues and identified timescales for completion.
- There was a high 'on the day' cancellation rate of around 9%. We reviewed current on the day cancellation data supplied to us by the trust. 240 patients were cancelled for clinical reasons and 180 patients for non-clinical reasons, between March 2015 and May 2015. High rates of patient cancellations, both clinical and non-clinical, show issues within bed management, pre assessment and patient flow within the surgical area.
- The average length of stay in the trust for elective surgery ranges from slightly to significantly higher than the England average. In general surgery, the average length of stay is 5.0 days against the England average of 3.1 days. For non-elective surgery the length of stay is significantly lower than the England average, especially for trauma and orthopaedics at 4.7 days against an England average of 8.5 days.
- Due to bed pressures a large number of medical patients were noted in the surgical bed base. These patients were classified as medical outliers and on one area visited, we noted 15-20 medical patients in surgical beds. Staff spoke to us about medical outliers not getting reviewed regularly by appropriate or responsible medical teams. Also due to the increased number of consultants attending the ward, nursing support available to consultants for ward rounds was limited. When medical outliers were placed in surgical beds, this decreased the number of beds available for surgical patients. Resulting in patient's operations or procedures being having to be cancelled, or surgical admissions to other surgical areas. For example, we witnessed surgical outliers on the trauma and orthopaedic ward.
- Consultant listing and pre-assessment of patients was not always appropriate as many patients were listed as day cases then converted to overnight stays were identified on admission or prior to operation. This unplanned approach makes bed management difficult and can increase the stress on patients and families. Staff we spoke to and lists we observed, corroborated this view. Staff all spoke to us about list overruns and the order of lists having often been inappropriate. Staff gave examples of complex cases with multiple morbidities having been listed as day cases and then converting to needing overnight admission.

Meeting people's individual needs

- Following the 2014 inspection, the trust was asked to review access to British Sign Language interpreters (BSL). Staff we spoke to confirmed they knew how to ask for interpreters.
- In the previous year, specially adapted rooms had been developed to care for patients who were living with dementia. These rooms had been developed to improve the experience of patients with dementia and had been designed with a specific colour scheme, low-level beds, facilities to have music playing, and dementia friendly equipment was supplied in the bays. Staff we spoke to

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were all very proud of these rooms; however, staff expressed the view that patients living with dementia were often moved out of these specially adapted rooms to other ward areas with non-dementia friendly environments due to the bed pressures within the hospital. They felt that moving patients living with dementia was upsetting to the patient and relatives and led to a poor experience of care. We witnessed patients with dementia being moved out of these specific rooms and being transferred to other areas during the inspection.

- Although dementia training was available as a training module, staff expressed to us that not enough spaces were available to attend this training. A matron was designated as lead for dementia within the trust; however, a specific nurse specialist was not available to support dementia care within the trust.

Learning from complaints and concerns

- Data supplied to us from the trust to review showed us that within the surgery group at this hospital there were 22 current open complaints from the period of September 2014 to August 2015. All had only been open since June 2015. Themes of these complaints included all aspects of clinical treatment (11/22), communication (6/22) and admission and discharge issues (2/22). Data we reviewed supplied by the trust showed that the surgery group was achieving 100% complaints investigated and agreed with complainant in timescale during April 2014 to April 2015.
- The surgery group had recently seen an increase in complaints associated with trauma and orthopaedics at DPoW.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patient or relatives as required. Senior staff we spoke to were aware of the number of complaints and the themes received for their area.

Are surgery services well-led?

Requires improvement



We rated surgery as 'requires improvement' for well led because:

- There was a lack of effective follow up and systems in place to gain assurance that learning from previous never events had occurred.
- The delivery of high quality surgical care was not assured; there was no overarching surgical strategy or vision. Whilst there were plans in place for some specialities, there was no process in place to review overall surgical strategy and individual strategies competed against each other for priority. We were told that some of the future service provision would be determined through the ongoing local health community's "Healthy Lives, Healthy Futures" work stream. Risk issues were not always dealt with appropriately or in a timely way.
- Leadership was variable; we saw improved leadership on surgical wards from ward managers. It was noted in the 2014 inspection, that the senior management team was new at that time and had not had time to implement changes. The senior management team had also been changed again in 2015, with a new Assistant Chief Operating Officer, and various clinical leaders. Managers had not yet identified, prioritised and taken action on all of the issues of concern within surgery.
- The development of the Web V virtual ward administration computer system had made an impact on the documentation of patient risks. Improvements from the introduction of the quality and safety days had not yet become an established route for learning..

Vision and strategy for this service

- Strategic documents had been developed for some individual surgical specialities such as theatre, breast, ENT and Ophthalmology.
- No overarching surgical strategy was available, encompassing all surgical specialities, so it was difficult to identify the top priorities within surgery overall.
- We were told that some of the future service provision would be determined through the ongoing local health community's "Healthy Lives, Healthy Futures" work stream. Individual ward visions were available in some areas.
- No specific surgery group vision was available.
- There was a trust operational plan for 2015-2016 which included some speciality surgical plans but not a comprehensive plan for surgery.

Governance, risk management and quality measurement

Surgery

- There was a lack of robust follow up and systems in place to gain assurance that learning from previous never events had occurred. Never events from previous years in ophthalmology had been repeated in 2015.
- Since the last inspection, a bi-monthly joint cross-site MDT quality and safety meeting had been introduced and three had been held. All surgical staff were invited to attend and emergency cover was provided in surgery during these meetings. We reviewed two sets of meeting minutes and noted good attendance and a well-organised, informative meeting, sharing current clinical information. At one of these meetings, a clinician had presented the outcome of never events.
- We reviewed individual sets of governance meeting minutes for speciality services and noticed mixed levels of attendance, key themes around incidents, complaints and lessons learnt were not always discussed.
- We reviewed two sets of surgical and critical care governance meetings minutes and noted good attendance and good documented discussion of incidents, complaints and serious incident investigations (SI). However, many front line staff told us they did not always receive individual feedback.
- Performance was reported using a monthly dashboard which showed rates of pressure ulcers, mandatory training and other performance data.
- Risk registers were reviewed and we noted that risks dated back to 2005, some with little or no apparent action. Examples of risks included provision of equipment, ophthalmology, storage and staffing. It was unclear from the register what controls were in place to mitigate some of the risks or the rationale for the grading of the risks. For example the ophthalmology services was initially graded as a moderate risk yet there had been known cases of harm to patients, and following actions being taken it remained at the same grade.
- The senior management team said that balancing activity, ward and department staffing and finance were their top challenges.

Leadership of service

- In early 2014, the clinical leadership structure had changed and was not fully embedded. During this inspection all staff we spoke to, were aware of the leadership structure. The senior management team had also been changed again in 2015, with a new Assistant

Chief Operating Officer, and various clinical leaders.

These changes meant there had been a lack of focussed leadership and the issues of concern within surgery had not yet been identified, prioritised and acted upon.

- Many wards had a new ward manager and although the new leaders had made an impact on leadership in their areas, their work was not fully embedded.
- Staff working within the recovery area spoke positively about their team leader.
- Staff we spoke to working on the DPoW site were not always aware of their colleagues working in Scunthorpe General Hospital (SGH) in the same field. This could hamper sharing lessons learned from incidents and complaints, especially as the trust had two sites providing a similar service. Cross-site working (working in all hospitals belonging to the trust) and joint meetings for some medical and senior staff had only recently been introduced.
- Nursing staff spoke positively about colleagues and their management structures. Four matrons supported the surgical area. One area we visited said that they did not know who their matron was and said the matron had never visited. A 'Clinical Friday' had been developed which was an initiative where all matrons worked on the wards.
- Some senior nurse meetings were held across both sites.
- In one particular area visited we noted an increased level of organisation and actions required to comply with audit timetables, in the period between the inspection and the unannounced inspection.

Culture within the service

- Staff morale within surgical areas of the hospital was mixed. Staff in some areas said it was fantastic to work at the hospital and were positive about colleagues, however, some staff had concerns about skill mix and poor dementia care.
- Ward managers talked to us about a deflated, unhappy group of staff; however, they did say things were getting better due to ward manager stability.
- The senior management team acknowledged that in one particular area staff morale had; "some way to go". Some staff also told us they felt isolated and blamed.
- Staff we spoke to, told us that the senior management was not visible on the wards or departments, however, the senior management team told us they were conducting walk rounds.

Surgery

- The majority of staff we spoke to all said they felt able to raise concerns.
- Staff we spoke to, said they were proud of the teams and the resilience of their team. One ward we visited was extremely motivated and positive and all the staff we spoke to in that area were committed to the same purpose.
- A degree of silo working was apparent; this could have hampered the sharing from lessons, incidents and complaints especially as the trust had three sites.

Public engagement

- We saw notice boards on the wards displaying 'you said we did' information with details of how the ward had responded to feedback from patients.

Staff engagement







- Weekly newsletters were produced for staff; open forums with general managers and the chief executive were in place.

- Ward managers also spoke about an 'open door policy' for staff to discuss issues with them.

Innovation, improvement and sustainability

- The biggest improvements in the trust and the surgery group since the last inspection were the development of the quality and safety day and the development of Web V system. Some other innovations included a 'Dragons Den' initiative allowing staff to bid for funding for specific projects and equipment.
- The IPC team had developed C.diff awards to highlight days free from infection.
- The biggest challenge to sustainability of the surgery group was the finances and the overall financial position of the trust.
- The senior management team told us that The biggest challenge to sustainability of the surgery group was the geography, multi-site multisite provision and the overall financial position of the trust

Critical care

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

Information about the service

Northern Lincolnshire and Goole NHS foundation trust provided Critical care services at Diana, Princess of Wales Hospital at Grimsby (DPoW) and Scunthorpe General Hospital (SGH). The surgery and critical care directorate managed the service.

The intensive therapy unit (ITU) at DPoW had seven beds, five in an open bay and two side rooms. It was staffed to care for five level three patients (who require advanced respiratory support or a minimum of two organ support) and two level two patients (who require pre-operative optimisation, extended post-operative care or single organ support). Intensive Care National Audit and Research Centre (ICNARC) data showed that between April 2014 and March 2015 there were 478 admissions with an average age of 63 years. Sixty eight percent of patients were non-surgical, 11% elective surgical and 21% emergency surgical. The average length of stay on ITU was four days.

The high dependency unit (HDU) at DPoW had seven beds, two bays with three beds and one side room. It was staffed to care for seven level two patients. Since our 2014 inspection the HDU moved into the surgery and critical care directorate with ongoing input from the respiratory physicians.

During the inspection we visited ITU and HDU. We spoke with five patients, one relative and 25 members of staff. We observed staff deliver care, looked at 10 patient records and four medication charts. We reviewed staff records and

trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

In April 2014 CQC carried out an announced comprehensive inspection. The overall rating for this service was inadequate. For each domain we rated safe as inadequate; effective as requires improvement; caring as good; responsive as requires improvement; and well led as inadequate.

Critical care

Summary of findings

We rated critical care as 'requires improvement' overall. Safe, effective, responsive and well led were rated as 'requires improvement' and caring was rated as 'good'.

- Staff at DPoW reported a lower number of incidents in comparison to staff at SGH. Staff at DPoW used mittens for patient safety but did not report this as an incident which was required by the restraint policy.
- Essential critical care equipment such as beds, mattresses and ventilators was old and staff described it as not fit for purpose. This had been added to the surgery and critical care risk register in 2009. There was no evidence that any action had been taken. Funding was not available for replacement in 2015/16 capital program.
- The units did not meet the requirements of national standards for nurse or medical staffing. A consultant intensivist was not available seven days and week and medical staff rotas did not promote continuity of care. A supernumerary senior nurse was not available 100% of the time as a clinical coordinator. The clinical educator post had been vacant for eighteen months at the time of our inspection. The high dependency unit (HDU) did not monitor patient outcomes. This meant that the unit was not able to compare its performance with other similar units in the country. Patient outcome data for the ITU was worse than data from other units in the region.
- Staff showed limited application of putting policies into clinical practice, for example, around patient consent and restraint. The vacant clinical educator post may be one of the reasons for this. New staff told us they had limited formal clinical bedside training
- The bed occupancy was higher than the national average. The number of delayed discharges from ITU was higher than the critical care network average. Ninety patients were discharged out of hours and 11 elective operations were cancelled due to a lack of critical care beds between April 2014 and March

2015. There had been one non-clinical transfer in the six months prior to our inspection. This was not in line with recommendations from Core Standards for Intensive Care (2013).

- The management team had not taken timely action on some of the issues identified on the risk register. Ageing and failing equipment that had an effect on patient and staff safety within ITU such as beds and ventilators had been on the risk register for up to six years. From the records of the service governance meetings we saw little evidence to suggest leaders reviewed the risk register or developed actions to mitigate risk.

However,

- Recent changes had been made to the clinical leadership and there had been significant changes to the management of patients on HDU since our inspection in 2014.
- Some progress had been made to cross site working and standardisation of care across both sites.

Critical care

Are critical care services safe?

Requires improvement



We rated safe as 'requires improvement' because:

Staff at DPoW reported a lower number of incidents in comparison to staff at SGH. Staff at DPoW used mittens for patient safety but did not report this as an incident which was required by the restraint policy.

- Essential critical care equipment such as beds, mattresses and ventilators was described by staff as not fit for purpose. Staff reported equipment failure as an incident.
- Nurse staffing was not in line with Core Standards for Intensive Care (2013). The trust provided copies of the rotas for both units. During August 2015 the actual number of staff on ITU was lower than the planned number on 24 shifts and on five shifts on HDU. This meant there may not have been a senior nurse as a supernumerary clinical coordinator on the units on these shifts.
- The units did not meet the requirements of the Core Standards for Intensive Care (2013) for medical staffing, for example, twice daily ward rounds did not take place at the weekend and consultant work patterns did not deliver continuity of care as the consultants covered one day at a time. Out of hours junior medical staff covered ITU, theatre, wards and ED referrals and obstetrics. Staff recognised the potential threat to patient safety and reported the service felt stretched. The clinical lead had submitted a plan to change the rota but approval from the trust to recruit to the consultant posts required was awaited.

However,

- There had been significant changes to the management of patients on HDU since our inspection in 2014. The service had introduced a junior doctor post who was based on the unit during the day.

Incidents

- There were no never events reported between August 2014 and July 2015.

- There was one serious incident reported between September 2014 to August 2015. This involved a patient who had developed Legionnaire's disease. The trust reported this to the Health and Safety Executive, carried out a full investigation and developed an action plan.
- During our inspection in 2014, we found incident reporting to be lower in this ITU than at SGH ITU and this was still the case at this inspection. There was also a difference in the grading of incidents between both units. This unit reported 69 incidents between September 2014 and August 2015, 12% of these were graded as very low, 71% low and 17% moderate. Themes of the incidents were skin and pressure damage, out of hours discharges and supply of medications.
- Information on the trust's quality dashboard for June 2015 shows 38% of incidents reported in ITU were coded/graded in the expected timescale.
- Staff were able to tell us how to report an incident and the themes of the incidents reported. Staff received feedback from managers directly, through the communication board in the staff room and the trust newsletter for incidents that had occurred outside of the directorate. Two junior doctors gave us examples of feedback they received across directorate after reporting incidents that involved separate departments.
- Serious incidents and a mortality review were discussed at the bi-monthly surgery and critical care quality and safety day.
- There was no multi professional critical care specific morbidity and mortality meeting which was not in line with the Core Standards for Intensive Care (2013). In the minutes of the critical care provision group meetings in June and July 2015 the clinical lead suggested a monthly mortality and morbidity meeting should be held on each site.

Duty of Candour

- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate or significant harm.
- Senior staff had an awareness of the duty of candour although they had no specific training on it. Information on it was displayed on the wall on HDU.
- A junior doctor gave us an example of an open and honest care following an incident.

Critical care

- Following an incident that involved moderate harm, a letter was sent to the family with contact details of a matron who would be responsible to liaise with the family throughout the investigation.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- Safety thermometer information was not displayed on the units.
- There had been seven pressure ulcers and one fall recorded in the service between July 2014 and July 2015.

Cleanliness, infection control and hygiene

- Both units were visibly clean.
- The unit had five cases of unit acquired methicillin resistant staphylococcus aureus infection between April 2014 and March 2015.
- The unit had one case of unit acquired clostridium difficile between April 2014 and March 2015.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Results from monthly hand hygiene audits between January and July 2015 showed 100% compliance on both units. Between 10 and 20 staff were audited on each occasion.
- Results from the MRSA policy to practice audit between January and July 2015 showed 100% compliance.
- Results from the clostridium difficile policy to practice audit between January 2015 and July 2015 showed 100% compliance. However, ITU reported one incidence of hospital acquired clostridium difficile in February 2015. A root cause analysis had been completed for this and the case was found to be unavoidable.
- The infection prevention and control team carried out a frontline ownership infection control audit on ITU in June 2015, compliance was 91%. Concerns raised in this audit were around storage of products on the floor due to lack of other space, labelling of clean equipment and fridge temperatures not being recorded daily.
- ITU had facilities for respiratory isolation.

Environment and equipment

- Both units were secure with access via an intercom.
- There was limited storage on both units; some equipment was stored in unused bed spaces or in the corridor.
- HDU had been refurbished since our inspection in 2014. On both units bed spaces in use were clear, unobstructed and uncluttered.
- There was an adjoining corridor from ITU to the operating theatres.
- The units provided mixed sex accommodation for critically ill patients according to Department of Health guidance. The bed spaces were separated by curtains to maintain patients' privacy.
- Equipment on ITU was visibly clean but not consistently labelled with the date it had been cleaned on. Daily sink flushing records were complete.
- On HDU daily sink flushing records were complete and equipment cleanliness checks were complete. The blood gas machine quality checks were complete and six pieces of equipment that we checked were in date for portable appliance testing (PAT).
- Matrons completed a monthly environmental audit. ITU compliance was between 98% and 100% between April and June 2015. HDU compliance was between 91% and 94%, the issues raised on HDU were concerned with storage and dust on equipment.
- We observed evidence on both units that nurses had completed equipment training. Junior medical staff told us equipment was explained to them during their induction but a record was not kept of this. During our inspection we saw a piece of medical equipment in use on a patient that required calibrating, the nursing staff informed the medical staff of this and action was taken to calibrate the equipment.
- On ITU the ward daily checks were undertaken twice daily, they had not been completed on four out of 122 occasions.
- Staff checked the defibrillator daily. Records for this and the transfer equipment, trolley and checklist were complete.
- The ageing beds on ITU had been on the risk register since 2009. Staff told us they were not fit for purpose as they did not have the ability to weigh patients and frequently broke down. Incident reporting data submitted by the trust supported this.

Critical care

- ITU had a limited supply of air mattresses. Staff told us the process for cleaning the mattresses had improved but there was still a risk that sufficient would be available to patients. This had been on the risk register since 2013.
- The ventilators on ITU were old and repairs would not be supported by the manufacturer from 2017. This had been added to the risk register in 2010 and a procurement plan was being put in place.
- ITU had insufficient electric sockets and extension leads were being used at the time of our inspection. This was added to the risk register in 2012 and the use of extension cables was described as a trip hazard. The senior management team were in the process of obtaining quotes for work to address this.
- One commercial baby monitors which had visual and sound capability but no recording capacity was in use in one of the side rooms. The screen was located at the nurses' station and could not be viewed from anywhere else. Staff told us one of the reasons for the use of the monitors was in case staff in the room needed assistance and were not able to reach the emergency call bell.

Medicines

- Medicines on both units were stored appropriately. Staff checked fridge temperatures daily. Records were complete and temperatures were within the recommended limits. However, staff did not record the minimum or maximum temperature of the fridge, only the current temperature was requested on the trust template. This was not in line with national guidance.
- In addition to the trust medication administration record (MAR) there was a separate ITU MAR with pre-printed drug regimes. This had recently been introduced, staff were concerned that medication such as VTE prophylaxis and proton pump inhibitors (medication to protect the stomach) was not automatically transferred to the trust MAR which may lead to medicines being missed. There was no evidence that this had occurred or been reported as an incident.
- We reviewed four MARs. On two charts the antibiotics did not have a review date documented on and on one chart there was no indication documented for the antibiotics.

- There had been three medication errors reported on ITU and five medication errors reported on HDU between April 2014 and March 2015. This was less than 1% of medication errors reported at DPoW.
- ITU achieved 100% and HDU achieved 90% compliance on the trust-wide re-audit of safe and secure handling of medicines.
- On ITU some intravenous medications were not stored in a locked cupboard. We discussed this with the ward manager who was aware of the guidance for storage of these medications; however, due to the lack of storage on the unit and a reduction in the frequency of pharmacy delivery there was no other option for storage of the medication. The room was next to the nurses' station, not within easy access of patients or visitors and the issue was noted on the medicines' audit.

Records

- We reviewed ten sets of both medical and nursing records. They were all accurate, complete and in line with Core Standards for Intensive Care and professional GMC and NMC standards.
- Medical staff completed a daily critical care assessment proforma that met the National Institute of Health and Care Excellence (NICE) CG50 (acutely ill adults in hospital; recognition and response to acute illness in adults in hospitals) guidance.
- Doctors completed a medical discharge summary that accompanied the patient to the ward on discharge from the ITU.
- We requested evidence of local documentation audits from the trust but none were submitted. This meant we were unable to assess the quality and standard of the completion of records across the service.

Safeguarding

- All staff we spoke to were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns. Staff knew how to access to trust's safeguarding policy and the safeguarding team.
- One hundred percent of ITU nursing staff, 96% of HDU nursing staff and 97% of medical staff had completed safeguarding adults training.
- Ninety seven percent of ITU nursing staff had completed safeguarding children level one and level two training. One hundred percent of HDU staff had completed safeguarding children level one training and 96% level two training. No nursing staff in the service had

Critical care

completed safeguarding children level three training. Ninety three percent of medical staff had completed safeguarding children level one and level two training. One hundred percent of medical staff had completed safeguarding children level three training.

Mandatory training

- Mandatory training included moving and handling, resuscitation training and fire training.
- Information provided by the trust showed that 88% of nursing staff in ITU, 90% of nursing staff in HDU and 84% of staff in the critical care outreach team had received mandatory training. This was below the trust target of 95%.
- We saw evidence that medical staff's mandatory training was up to date.
- A ward manager told us that availability of training and staff being moved off the unit to cover vacancies on the wards had affected the mandatory training rate.

Assessing and responding to patient risk

- The unit stabilised children over the age of six months whilst waiting for the retrieval team. There was an up to date policy for this. Staff we spoke to demonstrated knowledge of this policy.
- The critical care outreach team provided a service from 07:30 to 20:00 seven days a week. The hospital at night team managed patients outside of these hours.
- Information provided by the trust showed that the critical care outreach team received 800 referrals in the last twelve months.
- A nurse consultant had recently been appointed in the deteriorating patient team. The critical care outreach team were part of this team as was a sepsis nurse and a vascular access nurse.
- The trust used a recognised national early warning tool called NEWS which indicated when a patient's condition could be deteriorating and require a higher level of care.
- All the risk assessments were completed in the ten records we reviewed. These included falls, moving and handling, nutrition, tissue viability and VTE.
- There had been significant changes to the management of patients on HDU since our inspection in 2014. In July 2015, the anaesthetists became formally involved in HDU in order to bring the level 2 beds in line with level 2 care patients received in ITU. All staff we spoke to on the unit told us that patient care and medical cover had greatly improved as a result of the changes.

- Consultant physicians had admitting and discharge rights to HDU. Respiratory physicians reviewed respiratory patients daily Monday to Friday and the ITU consultant reviewed non respiratory patients daily Monday to Friday. Nurses contacted the on call medical team out of hours.
- An anaesthetic junior doctor was based on the unit Monday to Friday 08:00 to 17:00, nurses reported there was no delay in obtaining a medical review of patients.
- The junior doctor on HDU explained the process they would go through to escalate concerns and receive senior support. There had been no incidents of delay in receiving medical care.
- Further integration of HDU and ITU was planned once recruitment was complete. This would involve nursing staff rotation between the units prior to combining to become one nursing team and anaesthetists having admission and discharge rights on HDU.

Nursing staffing

- A substantive HDU ward manager had been appointed since our 2014 inspection.
- Nurse staffing met the Core Standards for Intensive Care (2013) minimum requirements of a one to one nurse to patient ratio for level three patients and a one to two nurse to patient ratio for level two patients.
- Both units displayed the planned and actual staffing figures. The ITU had an establishment of two WTE band seven, 4.8 WTE band six, 28.19 WTE band five registered nurses and 2.58 band two healthcare assistants. This meant that at times band five nurses managed the unit, this was included in the band five job description. Senior staff thought this was important as part of the band five development.
- There was one WTE band seven vacancy and 5.25 WTE band five vacancies on ITU.
- The trust provided copies of the ITU rota, during August 2015 the actual number of staff was lower than the planned number on 24 shifts. The HDU had an establishment of one WTE band seven, one WTE band six, 18.86 WTE band five registered nurses and 1.35 WTE band two healthcare assistants. This meant that at times band five nurses managed the unit, this was included in the band five job description. Senior staff thought this was important as part of the band five development.
- There were 1.29 WTE band five vacancies and 0.06 WTE band two vacancy on HDU.

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- The trust provided copies of the HDU rota, during August 2015 the actual number of staff was lower than the planned number on five shifts.
- The establishment on both units had been increased to include a supernumerary coordinator 50% of the time seven days a week. On both days of our inspection the actual number of nurses on ITU was one below the planned number which meant that there may not have been a supernumerary coordinator. We reviewed 14 days prior to our inspection, on six days there was a reduced capacity to have a supernumerary coordinator. This was not in line with the Core Standards for Intensive Care (2013).
- Recruitment was ongoing; the ward manager explained that the critical care outreach team, HDU staff or bank staff would be used to maintain the required nurse to patient ratio.
- The trust offered staff who worked in specialist areas a financial incentive to work on the nurse bank.
- New staff and students completed an induction; we saw evidence of completed induction checklists.
- The ITU ward manager told us the frequency of using agency staff was increasing. During our unannounced inspection on 6 November 2015 we reviewed the nursing rota for two weeks from 26 October 2015. Agency staff had been used on three out of 14 days. The nurse in charge was responsible for observing agency nurses and completed a feedback form for the agency. The trust used an agency that supplied staff that were critical care trained.
- Out of hours two junior medical staff were on site. One was responsible for theatre and the other one covered ITU, wards and ED referrals and obstetrics. They were supported by a consultant on call who was available within 30 minutes.
- During our unannounced inspection on 5 January 2016 we reviewed the anaesthetic rota for that week. Medical staff worked evening shifts and night shifts for theatre and ITU, five of the seven evening shifts and four of the seven night shifts in theatre were covered by trust medical staff working overtime or locum shifts. Four of the seven ITU evening shifts were covered by trust medical staff working overtime or locum shifts. The evening shift for the following day (6 January 2016) did not have medical cover at the time of our unannounced inspection.
- Staff recognised the potential threat to patient safety and reported the service felt stretched. They told us there had been no reportable incidents because of strong team work but were aware of the risk. We were told there had been instances where staff stayed beyond their planned shift to support the team. Junior staff told us they felt supported out of hours and comfortable to call the consultant to come in to help.
- The management team planned to move to a separate ITU/HDU and anaesthetic rota. The clinical lead was awaiting approval to recruit the consultants required to adequately staff a split rota. The proposed cover would be one consultant on ITU 08:00 – 16:00 Monday to Thursday, one consultant on HDU 08:00 – 16:00 Monday to Thursday and one consultant responsible for ITU and HDU 08:00 – 21:00 Friday to Sunday.
- The consultant to patient ratio did not exceed the range of 1:8 or 1:15, which was in line with best practice guidance.
- There was a named lead consultant for induction. Junior medical staff explained the process in the department, introduction to the critical care hub, equipment, role and educational supervisors.
- Operating department practitioners supported the medical staff on ITU.
- We observed a medical handover; this took place in the doctor's office, was structured and included a discussion about patients on the unit and referrals received from elsewhere in the hospital. An electronic handover system was used that ensured information

Medical staffing

- Thirteen consultants covered the service. A consultant was based on the ITU between 08:00 and 21:00 Monday to Friday and available on call within 30 minutes out of hours. A second on call anaesthetist was on site 24 hours a day seven days a week.
- The consultant based on ITU Monday to Friday was responsible for reviewing the non-respiratory HDU patients.
- The unit did not meet the requirements of the Core Standards for Intensive Care (2013) for medical staffing, for example, twice daily ward rounds did not take place at the weekend and consultant work patterns did not deliver continuity of care as the consultants covered one day at a time.

Critical care

was shared, for example, microbiology, outstanding jobs and limitations of treatment. The electronic system kept a record of when the handover took place and who was in attendance.

Major incident awareness and training

- Senior staff were able to clearly explain their continuity and major incident plans. The actions described were in line with the trust's major incident plan and ITU nurse in charge action card.
- Staff knew how to access the major incident and continuity plans on the intranet.

Are critical care services effective?

Requires improvement



We rated effective as 'requires improvement' because:

- HDU did not collect data so it could monitor patient outcomes. This meant that the unit was not able to compare its performance with other similar units in the country. The unit had recruited to an audit clerk post and Intensive Care National Audit and Research Centre (ICNARC) data was going to be collected once the member of staff was in post.
- Patient outcome data for the ITU was worse than data from other units in the region.
- The service did not have a clinical educator which was not in line with Core Standards for Intensive Care (2013). The post had been vacant for eighteen months. This meant new staff had limited study days. There was a lack of evidence of knowledge of policy into practice, for example, staff awareness of the restraint policy and the use of mittens for patient safety.
- Staff used a baby monitor to observe at the nurses station patients in one of the side rooms. We observed an occasion when this was not turned off during patient care. Staff showed limited understanding of the need to obtain consent from patients and relatives for the use of the monitor. Staff did not record whether patients gave consent.

However,

- Evidence that care and treatment was based on current evidence based guidance, standards and best practice had improved following our 2014 inspection, however, some policies remained in draft or were waiting to be updated.
- ITU had more than the recommended number of nurses who had completed a post registration critical care qualification.

Evidence-based care and treatment

- The surgery and critical care group and respiratory physicians produced a new HDU operational policy approved in August 2015. This was based on national standards, for example Department of Health Comprehensive Critical Care.
- Critical care policies and guidelines for the critical care service were in the process of being reviewed and standardised across both sites. Staff were aware of the Core Standards for Intensive Care (2013) and there was evidence that the reviewed policies and guidelines were based on up to date best practice and in the standard trust format.
- The clinical lead showed us a timetable for the planned review of out of date guidelines. The critical care website had been updated and new guidelines that had been produced, for example, protective ventilation were available on there.
- We reviewed a draft copy of the new policy for pain, agitation, delirium and sedation that was based on NICE and other relevant guidance. At the time of our inspection staff did not complete delirium screening. Two members of staff we spoke to had limited awareness of delirium screening and there was concern it would be difficult to introduce without a clinical educator.
- The policy for children and young people requiring ICU/ HDU at SGH and DPoW had been updated in 2014 and was based on current guidance.
- A consultant was developing a new acute kidney injury protocol based on NICE guidance; this was not available for us to view at the time of our inspection.
- We observed a ward round. Staff used a ward round checklist and completed a structured system based assessment of the patient which included a review of care bundles, sedation holds and protective ventilation. The treatment plan was clearly communicated to the patient and staff and documented on the daily assessment form.

Critical care

- Physiotherapists completed rehabilitation assessments and produced a treatment plan but there was limited evidence of awareness and compliance with NICE CG83 rehabilitation after critical illness by staff on both units.

Pain relief

- We reviewed patient records and observed staff assessing pain and giving support to patients requiring pain relief.

Nutrition and hydration

- Nurses completed a nutritional assessment using the recognised malnutrition universal screening tool (MUST). If the patient was unable to step onto the scales staff had to estimate the body mass index range using the mid upper arm circumference measure as the beds did not have the facility to weigh. The nutritional assessments were up to date in the 10 records we reviewed.
- A dietician visited ITU daily; nurses on HDU completed a referral to the dietician for them to assess a patient.
- One patient on HDU was on a food chart, we reviewed this and it was complete.

Patient outcomes

- There was no outcome data including mortality rates for the HDU. The unit had recruited to an audit clerk post and Intensive Care National Audit and Research Centre (ICNARC) data was going to be collected once the member of staff was in post. This would allow the service to benchmark and compare its outcomes with similar units.
- We reviewed the ICNARC data for the ITU from 1 April 2014 to 31 March 2015. The standardised mortality ratio was 1.07, this was higher than other units in the critical care network but within the acceptable range. The crude mortality was 23% which was higher than the critical care network average.
- There was eight early readmissions between 1 April 2014 and 31 March 2015, this was 2.4% of all admissions and higher than the critical care network average.
- The audit lead showed us evidence of the audit register. The service participated in the national tracheostomy audit, the national cardiac arrest audit and the national emergency laparotomy audit. Reports were being compiled or presentations were pending, so action plans were not yet available.

- The critical care outreach team collected patient outcomes in the trust electronic database, Wardwatcher.
- There was no evidence of participation in the network audit of compliance with NICE CG83 rehabilitation after critical illness.

Competent staff

- We saw evidence that 75% of nursing and healthcare staff on ITU had a completed appraisal. 100% of nursing appraisals were up to date on HDU; we reviewed six staff files and found evidence that competencies and appraisals were up to date.
- Senior staff encouraged nurses to register for Nursing and Midwifery Council revalidation and were awaiting the appointment of a trust lead for further guidance.
- Sixty eight percent of nurses in the service had completed a post registration critical care qualification. This was above the minimum recommendation of 50%.
- New members of nursing staff received an induction. New staff in ITU were allocated a mentor and had a supernumerary period of between four and eight weeks depending upon their previous experience.
- Nurses on ITU completed a local competency package. This was based on the national competency framework for adult critical care nurses.
- Nurses on HDU completed a different competency framework to ITU at the time of our inspection. The ward manager told us when staff began to rotate to ITU the ITU competency framework will be used.
- The HDU ward manager was completing a master's degree in critical care.
- The clinical educator post had been vacant since April 2014. Staff and the management team all told us that this role was missed and recruitment into it was a priority.
- Staff who had joined ITU in the last six months had only attended one ITU study day.
- Staff on ITU raised concerns about the recruitment of new staff and plans to rotate HDU staff into ITU if the clinical educator post remained vacant.
- Staff in the critical care outreach team were involved in education in the trust. They delivered training on non-invasive ventilation, suction and tracheostomies and were a centre for the ALERT and BEACH courses (multi-professional courses that train staff in recognition of patient deterioration and actions to treat the acutely unwell).

Critical care

- Student nurses told us they felt well supported with good mentorship and learning opportunities during their placement.
- Junior medical staff told us they met with their educational supervisor and had ITU specific education sessions based on the Royal College of Anaesthetists and Faculty of Intensive Care Medicine every two weeks. They thought there were good opportunities to complete work based assessments and learn procedures. We saw evidence that junior medical staff had attended a local transferring the critically ill patient course.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on both units and at the bedside during our inspection.
- The 10 records we reviewed had evidence of a consultant admission review and treatment plan.
- There was a lead physiotherapist for ITU who visited the unit twice a day. Nurses told us they had access to occupational therapy and speech and language therapy when required and a dietician visited the unit daily.
- A physiotherapist visited HDU daily and treated people at the nurse's request. Nurses had access to an occupational therapist, dietician and other members of the multidisciplinary team by referral.
- A pharmacist visited both units daily.
- The critical care outreach team visited the ITU every morning and were made aware of the planned discharges. Information provided by the trust showed that the critical care outreach team followed up between 91% and 100% of patients discharged from critical care from April 2014 to March 2015.
- The critical care outreach team visited HDU on request from the HDU staff.

Seven-day services

- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.
- Physiotherapy was provided Monday to Friday and an on call service was available out of hours and the weekend.
- Consultants completed a ward round once a day on ITU at the weekend which was not in line with the twice a day recommendation from the Core Standards for

Intensive Care (2013). The management team had submitted a strategy to the trust board requesting support with recruitment to enable the service to deliver this.

- A consultant anaesthetist and respiratory physician completed a ward round once a day Monday to Friday on HDU. The medical team on call covered HDU out of hours and reviewed patients at the weekend. This was not in line with national guidance. The management team had submitted a strategy to the trust board requesting support with recruitment to enable the service to deliver this. Critical care support was always available when requested.

Access to information

- Relevant policies and guidelines were available electronically on the critical care hub and a paper copy was kept in a folder at the bedside. The folder contained a list of review dates for all the guidelines.
- Staff were able to access blood results and x-rays via electronic results services.
- Medical staff completed a paper discharge summary. There was a plan to convert this to an electronic record that would be shared with the GP. A timescale was not available for this at the time of our inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to demonstrated some understanding of consent, the mental capacity act and deprivation of liberty safeguards.
- Mental capacity act and level one deprivation of liberty safeguards training were part of the trust's mandatory training programme. The trust provided information on training participation at directorate rather than ward level. Eighty nine percent of nursing staff and 72% of medical staff had completed mental capacity act training. Eighty nine percent of nursing staff and 70% of medical staff had completed level one deprivation of liberty training in the surgery and critical care directorate. This was below the trust's compliance target of 95%.
- We reviewed the folder where deprivation of liberty safeguards applications were stored. These had been completed fully for appropriate patients.
- Staff showed limited understanding and application of the trust's restraint policy. Staff told us they would document in the patient records when mittens were

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applied to a patient for their safety, there was little evidence that staff considered the use of mittens to be restraint. The restraint policy stated a capacity assessment and risk assessment should be completed prior to the use of any restraint and an incident form should be completed. Staff did not indicate any awareness of this. We reviewed the incident reporting data submitted by the trust from September 2014 to August 2015 and there were no incidents of the use of mittens reported. Staff told us they had used mittens on patients for their safety in the last year.

- Staff told us the baby monitor was in use in one of the side rooms in case the patient could not use the call bell but could hold their hand up or make some noise. Staff told us the monitor was turned off or covered during personal care to maintain patients' privacy and dignity. During our inspection we witnessed staff delivering care to a patient with the monitor on. We informed the nurse in charge of who responded immediately and the monitor was turned off.
- There was no information displayed to patients or relatives to inform them that a monitor was in use and staff showed limited understanding of the need to obtain consent for the use of the monitor.
- We reviewed the records of the patient in the room with the baby monitor in. They had been moved into the room three days earlier, there was no documentation of communication with the patient or relatives about the monitor. Staff had documented some care that had not been carried out as the patient had not consented to it but there was no documentation about consent to the monitor.
- We informed the matron regarding our concerns with the baby monitor and limited understanding of consent and restraint and they said they would address this immediately. The trust planned to complete a Privacy Impact Assessment and related actions by 31 October 2015.
- On our unannounced visit on 6 November 2015 the side room where the baby monitor was in place was empty. A draft Privacy Impact Assessment for the use of the monitors had been developed and was due to be ratified at the trust governance and assurance committee on 16 November 2015. Information for patients and relatives was displayed in the side room.
- On our unannounced visit on 5 January 2016 staff had removed the baby monitor from the side room and the nurses' station on ITU and it was kept in the storeroom.

A process for the use of a visual monitor within critical care was displayed at the nurses' station. This flowchart did not have a date or review date on, staff we spoke to were aware of the change in practice.

Are critical care services caring?

Good



We rated the service as 'good' for caring.

- Patients were supported, treated with dignity and respect, and were involved in their care. Feedback from patients and those close to them was positive about the way staff treated people.
- We observed staff on HDU were quick to answer call bells. A patient on the unit told us they felt safe and always received assistance when they needed it.
- All staff communicated in a kind and compassionate manner with both conscious and unconscious patients.
- The multidisciplinary team involved relatives and patients in discussions about their care. Nurses and relatives completed a diary for patients during their stay on ITU.

Compassionate care

- We were told by management that the units did not participate in the NHS Friends and Family Test because patients were infrequently discharged directly home.
- We observed staff maintaining patients' privacy and dignity was maintained with the use of the curtains. Two unwell patients were being cared for in side rooms.
- We observed medical staff discussed the treatment of a patient away from the main clinical area to respect confidentiality.
- We observed call bells within patients' reach on HDU and witnessed two examples where staff answered them within 20 seconds.
- All staff communicated with both conscious and unconscious patients in a kind and compassionate way. We witnessed an upset relative being comforted in a compassionate manner by staff.
- We spoke with a patient with a chronic health condition who had been a patient on HDU a number of times. They told us they always felt safe and confident with the staff and always received assistance when requested.

Critical care

Understanding and involvement of patients and those close to them

- All the patients and the relative we spoke to told us they were happy with their care and had been kept informed of their treatment and progress by the nurses and doctors.
- We observed a pharmacist involving a patient on HDU in their medicines reconciliation.
- One relative told us they were had been able to visit outside of the visiting hours to suit family commitments.
- Staff told us that discussions around limitation of treatment took place among the multidisciplinary team. The doctors included the family in the discussion and the patient if it was appropriate. We witnessed a discussion between a nurse and doctor and the plans to speak with the family and the withdrawal of treatment. Staff made a timely referral to the organ donation specialist nurse.
- Nurses started a diary for patients in consultation with their relatives. Staff and relatives made entries in the diary during the patient's stay on the unit.
- Staff spoke confidently about their skills in end of life care. Families would be allowed open visiting and the patient would be moved to a side room if one was available.

Emotional support

- Staff told us of the frustration delayed discharges caused because of the psychological effect it had on patients. A member of staff told us about a situation where a 23 year old patient was mobile on ITU and ready to be discharged to a ward but no beds were available. They had to use a commode at their bedside and there were no shower facilities on the unit.
- Staff were able to describe the process of referral to the mental health crisis team and reported that they usually responded quickly.

Are critical care services responsive?

Requires improvement



We rated responsive as 'requires improvement' because:

- The bed occupancy was higher than the national average. The number of delayed discharges from ITU was higher than the critical care network average.

Ninety patients were discharged out of hours and 11 elective operations were cancelled due to a lack of critical care bed between April 2014 to July 2015. There was one non-clinical transfer in the six months prior to our inspection. This was not in line with recommendations from Core Standards for Intensive Care (2013).

However,

- There was a low number of complaints in the service.

Service planning and delivery to meet the needs of local people

- The service worked with leads from the other directorates in the trust to plan service delivery. We saw evidence of this in the minutes of the critical care provision group meetings.
- The critical care outreach team ran a nurse led follow up clinic; there was no multidisciplinary involvement. Patients who had been ventilated were invited to attend. The nurses were unable to directly refer patients to services but offered support and advice and made referrals to the patients GP.
- A waiting room was available for visitors on ITU which had a water fountain, television and radio and relevant information, for example, the nurse and consultant in charge on the unit, reduced parking rates, access to chaplains and national support organisations (ICU steps). The visitors' room could also be used for overnight accommodation if required.
- The waiting room for visitors on HDU was located on the ward next door; staff said this was problematic at times.

Meeting people's individual needs

- Staff on both units explained the process of how to access an interpreter if required.
- Staff told us they had limited experience caring for patients learning disabilities. They were unaware of a specialist nurse for learning disabilities in the trust and said they would seek support from the nurse in charge if they needed.
- Staff told us they had training on dementia and felt able to care for patients with dementia due to the nurse to patient ratio in critical care. The trust submitted information on training participation prior to the

Critical care

inspection; this did not contain any details of dementia training. Staff used the 'This is Me' document if patients were admitted with one but did not start one on the unit.

- Routine dementia screening for patients over the age of 75 was completed, staff were able to access the screening tool on the intranet.
- Staff told us the frequency of caring for bariatric patients was increasing. The units hired equipment from a specialist company. Staff told us the equipment was readily available.

Access and flow

- Information submitted by the trust showed bed occupancy in the service was consistently above the national average. It ranged between 83% and 98% from April to September 2015.
- All staff we spoke to told us delayed discharges were a frustration on ITU. Data from the April 2014 to March 2015 ICNARC report showed that the number of delayed discharges at DPoW was 163. This was 44% compared with 49% at SGH. Both units were higher than the critical care network average which was less than 40%.
- Staff thought the causes of delayed discharges was a shortage of ward beds and they did not feel the bed management team prioritised critical care discharges appropriately.
- April 2014 to March 2015 ICNARC data showed 90 patients had been discharged from ITU out of hours. This does not meet recommendations from Core Standards for Intensive Care (2013).
- One patient had been transferred to another ITU for a non-clinical reason between April 2015 and July 2015. This is not in line with national guidance.
- Eleven elective operations were cancelled between April 2014 to July 2015 due to a lack of critical care beds.
- Access and flow information was unavailable for HDU as the unit did not currently collect data. An audit clerk had been recruited and this data collection would start once the member of staff was in post.
- We saw evidence that staff reported one incident of mixed sex accommodation occurrence due to a delayed discharge between September 2014 and September 2015. These incidents were reported internally to the trust mixed sex accommodation lead. Information submitted by the trust prior to our inspection reported no mixed sex accommodation breaches. The unit worked within the trust's privacy and dignity policy

which stated that staff should "aim to ensure that patients never share a bay with patients of the opposite sex unless whilst waiting to be moved or whilst being cared for in critical care." This was not in line with Department of Health Guidance (November 2010) where it stated mixed sex accommodation was "not acceptable when a patient no longer needs level two or three care, but cannot be placed in an appropriate ward." On our unannounced inspection on 5 January 2016 we reviewed the mixed sex occurrence records. Staff had reported an occurrence on 2 November 2015 where the patient had experienced a 75 hour and 45 minute delay. This was not in line national guidance or the clinical commissioning groups arrangements.

Learning from complaints and concerns

- Staff told us of two complaints that had been made since April 2015, both related to doctors communication. There was limited evidence in the governance meeting minutes that we reviewed of investigations or sharing learning from the complaints. Senior staff told us learning from complaints took place in other forums, for example, the quality and safety day. We requested an example of an investigation into a complaint, the trust submitted examples but none related to this service.
- Both units displayed information on how to make a complaint. Staff explained how they would manage an informal complaint, this was documented in the patient record but a log of informal complaints was not kept by the ward managers.

Are critical care services well-led?

Requires improvement



We rated well-led as 'requires improvement' because:

- The service did not act on issues they identified on their risk register. These delays affected staff and patient safety. Minutes of their governance meetings did not show that they effectively reviewed the risk register or developed actions. The risk register did not list out of hours medical staffing as a risk. There was no formal plan to mitigate risks to patients caused by a potential delay in their care.

Critical care

- The critical care strategy had been developed in line with the trust's Healthy Lives Healthy Futures. A large financial commitment was required to meet the strategy.

However,

- Recent changes had been made to the clinical leadership and some progress had been made since our inspection in 2014 to cross site working and standardisation of care across both sites. All staff we spoke to felt supported, however, morale varied across the units.

Vision and strategy for this service

- The management team recognised there were gaps and deficiencies in the critical care service and had developed a critical care strategy. The strategy reflected the short-term requirements in response to our 2014 inspection and also the long-term requirements of the trust.
- The vision was for HDU to be solely managed by critical care where the intensivists would have admitting and discharge rights once recruitment and training was complete. There would be the flexibility to care for level two and three patients on both ITU and HDU.
- The management team understood a large financial commitment was required to meet the strategy. This had been developed in line with the trust's Healthy Lives Healthy Futures commitment to continue to provide acute care at both the Scunthorpe and Grimsby hospital sites.
- Staff we spoke to understood the vision and strategy to be working towards a service in line with national guidelines and standards with ITU and HDU fully integrated. There would be one nursing team working across both units and a separate anaesthetic and intensivist rota.
- The management team planned to rotate ITU and HDU nursing staff between the units from February 2016 with the units being managed by one ward manager in 18 months' time.

Governance, risk management and quality measurement

- The management team explained the governance structure and assurance process within critical care. The monthly senior management, governance and critical care provision group meetings all fed into the trust governance meeting.
- The directorate had held three quality and safety days bimonthly that had multidisciplinary attendance from both units.
- We reviewed minutes from these meetings and saw there was some evidence of sharing of learning from incidents, reviews of audits and action plans.
- We reviewed the risk register and found there had been significant delays in taking actions on issues that had an effect on patient and staff safety within ITU. Ageing and failing beds had been on the risk register since 2009, ventilators that required more frequent repairs and would not be supported by the manufacturer in 2017 had been on the risk register since 2010 and failing mattresses had been on the risk register since 2013. In all cases there were limited controls in place.
- The management team were not aware of the problems experienced by nursing staff in relation to the failing beds and mattresses, we reviewed the incident report submitted by the trust, and one incident had been reported between January and August 2015. The management team acknowledged that the focus had been on the strategy and planned to review the risk register as a matter of urgency.
- Staff on the unit were aware of the current risks and how to escalate these. Senior staff added risks to the risk register.
- Medical staffing, particularly out of hours and overnight cover was not on the risk register. Informal arrangements were in place for consultants to be requested to come in if required, however, the management team were unable to give evidence of any formal plans to mitigate against the risk to a potential delay in patient care. Long term plans were to consider the role of critical care practitioners and splitting the anaesthetic and intensivist rotas, these both involve recruitment and training.

Leadership of service

- The associate medical director and clinical lead were aware of most of the challenges ahead and could identify key actions that were required to improve the service.

Critical care

- Some progress had been made since our inspection in 2014 to cross site working and standardisation of care across both sites. We saw evidence of both units using some of the same guidelines and documentation.
- Recent changes had been made to the clinical leadership of the units and the management team were aware it would take time to engage all staff in the changes and embed the new structure of leadership.
- Junior medical staff told us they felt like a valued member of the team and that the consultant body were approachable and supportive.
- Nursing staff on ITU told us they felt supported by the ward manager and deputy ward manager.
- Since our inspection in 2014 a full time ward manager had been appointed on HDU. All the staff we spoke to on HDU felt supported in their work by the ward manager.
- Senior nursing staff had training in leadership, appraisals, root cause analysis, investigations and complaints.

Culture within the service

- Staff we spoke with felt supported, able to raise concerns and that the culture on both units was open and honest.
- Morale varied between the units. Nursing staff on ITU told us morale was lower due to delayed discharges, being moved off the unit to cover gaps in staffing on the wards and the introduction of payback shifts by the trust. Nursing staff we spoke to on HDU told us morale had improved since the 2014 inspection.
- Staff had a mixed reaction to the planned integration of ITU and HDU, a concern from staff about this process was the impact of the vacant clinical educator post.
- We observed members of the senior management team working as part of the clinical team on ITU, they appeared approachable to staff.
- Staff sickness was between 1-3%, lower than the England average.

Public engagement

- The units did not complete a formal patient or relative survey; thank you cards from patients and relatives were on display and a comments box was available on the ITU.

- The critical care outreach team fed back any comments from the follow up clinic. The ward manager did not keep a formal log of this feedback; it was shared with staff through meetings.







Staff engagement

- The units held regular staff meetings, we saw evidence of sharing of information from incidents, complaints and communication of relevant trust information in the meeting minutes.
- A noticeboard in the staffroom on ITU displayed information on training, information sharing, audit results, staff meetings and social events.
- A consultant led handover working group had involved junior medical staff.
- Staff on HDU told us there was good communication from the ward manager both verbally and sharing written information.
- A small number of staff felt communication was top down and that there had been limited engagement of clinical staff in the planned merge of ITU and HDU and associated staff rotation.

Innovation, improvement and sustainability

- The service was actively involved in the regional critical care network.
- An audit clerk had been recruited to HDU and it was planned to collect ICNARC data in the future.
- Following our inspection in 2014 a medical discharge summary was now completed to ensure appropriate clinical information was shared between specialities. A check list for the ward round had been developed, we saw this used consistently during our inspection.
- Pharmacy had introduced a new ITU specific prescription sheet across site.
- The trust had developed a deteriorating patient team. This comprised of a nurse consultant, a sepsis nurse specialist, a peripherally inserted central catheter nurse specialist and the outreach team. Recruitment was complete but not all members of the team were yet in post.
- The matrons in the trust met weekly to discuss the trust nursing workforce, this included incentives and awards for staff and there was a clear focus on succession planning in the service.

Maternity and gynaecology

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

Information about the service

Northern Lincolnshire and Goole NHS Foundation Trust provided maternity and gynaecology services over three sites. There were consultant-led units at Diana, Princess of Wales Hospital in Grimsby and Scunthorpe General Hospital and a midwife-led unit at Goole District Hospital. Community midwifery services were provided at all three sites.

The maternity service in Grimsby had 33 beds and provided care for women through pregnancy, childbirth and afterwards. There was no dedicated labour ward; women remained in the same room for their whole stay in hospital unless they needed to go to obstetric theatres. The service was available 24 hours a day, seven days a week.

Women received care in the pregnancy assessment centre, where they had their first scan and any other test required during pregnancy.

The centre also dealt with complicated, high-risk pregnancies – such as for women with hypertension or diabetes. Services offered included clinics for women having a vaginal birth after having previously had a caesarean section and to prepare women for caesarean sections. The centre also provided clinics for smoking cessation, fetal medicine and teenage pregnancy.

Midwives looked after women with low-risk pregnancies in the community and referred them to the centre only when necessary.

The gynaecological and female breast ward (Laurel ward) had a four-bed and a two-bed unit and single en-suite

cubicles. Gynaecological services included termination of pregnancy and referral was by the patient's GP, nurse or family planning clinic, or by the patient herself. The service was confidential and discreet. Once a patient had been referred, they were sent an appointment to see a nurse counsellor to discuss their treatment and care.

Between January 2015 and September 2015, there were 1,911 births in the hospital maternity unit.

We inspected the service from 13 to 16 October and on 6 November 2015. The inspection team included CQC inspectors, two midwife specialist advisors and a consultant obstetrician.

We inspected the maternity and the termination of pregnancy service.

During the inspection, we:

- spoke with nine women who used the service and two people accompanying them;
- spoke with 64 staff, including midwives and community midwives, nurses, health care assistants, doctors, consultants, anaesthetists, cleaners and senior managers;
- held a staff focus group meeting to hear their views of the service they provided;
- inspected nine sets of care records and reviewed the trust's audits and performance data.

The hospital provided services across North and North East Lincolnshire. According to the Local Health Profile, the health of the population in these areas was significantly

Maternity and gynaecology

worse than the England average. North East Lincolnshire was in the bottom 20% of local council areas in England in terms of deprivation, and North Lincolnshire in the bottom 40%.

Summary of findings

We found maternity and gynaecology services to be 'good' overall. Safe was rated as 'requires improvement', and effective, caring, responsive and well-led were rated as 'good'.

Our key findings were as follows:

- Women received care according to professional best practice clinical guidelines. Although we found some policies were out of date, the trust had identified this and steps had been taken to address it. Women had a named midwife responsible for their care during pregnancy and one-to-one care during labour.
- In September 2015, results of the NHS Friends and Family Test (FFT) showed that between 73% and 98% of women who used the service would recommend the labour ward to friends and family if they needed a similar service.
- The service had advanced midwife practitioners working there for several years and this innovation was a contributing factor in providing holistic high-level midwife-led care.
- At the Royal College of Midwives awards in 2014, the midwifery teams were recognised twice for promoting a 'normal birth experience' and were finalists in the 'supervisor of midwives team' category.

However we also found:

- Staff were encouraged to report incidents of harm or risk of harm and told us they had received feedback. However, some staff said they had not always received individual feedback after an incident. We also found there were outstanding incidents which had not been investigated for several months and the provider confirmed they had staff working on these. This could have meant there were risks where action had not been taken.
- Checks of emergency equipment were not being done consistently across the service. In one area, a stethoscope was missing from the equipment and had not been replaced for 12 days, which could have meant it was not available for use in an emergency.
- We also found the medicines trolley in the antenatal clinic was not locked and intravenous fluids in the

Maternity and gynaecology

in-patient unit were not stored in line with current guidance and legislation. The provider has been asked to send CQC a report as to the actions they are going to take to meet these requirements.

- The Kirkup Report, Gap analysis of the service had identified the need for a clinical risk midwife and a practice development midwife. However, although the management team were working to address this, neither had been appointed.
- The service had one midwife for every 30 births compared with a recommended ratio of one to 28. Although there were plans to deal with shortages and these were being managed with staff working overtime, not all staff managed to take breaks during their shift, which in some instances had lowered morale.
- In the antenatal clinic although the environment looked clean, there were gaps in the cleaning records. Not all equipment had been cleaned between uses, which could have resulted in a low risk of cross infection between patients.

Are maternity and gynaecology services safe?

Requires improvement



We rated the service as 'requires improvement' for safety. This was because:

- There were outstanding incidents which had not been investigated for several months; the provider confirmed they had staff working on this backlog. This could have meant there were unknown risks, where action had not yet been taken. Staff told us they were encouraged to report incidents. Feedback from incidents to staff varied: some staff said they had received feedback whilst others said they had not always received individual feedback after an incident.
- We found the checks of emergency equipment were not being done consistently across the service and in one area, a stethoscope had not been replaced for twelve days. We also found in the antenatal clinic not all equipment was cleaned between use.
- The medicines trolley in the antenatal clinic was not locked and intravenous fluids in the in-patient unit were not stored in line with current guidance and legislation.
- Women during labour received one to one care and escalation procedures were in place to ensure there were sufficient staff. However, the current midwife to birth ratio was 1:30 against a recommended ratio of 1:28 and although there were plans to address shortages, these were being managed with staff working overtime. Staff did not always manage to take their allocated break during their shift which in some instances had lowered morale.
- The clinical areas were clean. However, cleaning records in the antenatal clinic had not been completed from 3 August 2015 to the date of inspection. We also found that not all equipment was cleaned between use, which could have resulted in a low risk of cross infection between patients.

We also found:

- Staff had received safeguarding training and procedures were in place to protect people from abuse.
- There was a good standard of record keeping and records were kept safe in line with data protection rules.

Maternity and gynaecology

Incidents

- Between August 2014 and July 2015 there were no never events reported. Never events are serious, preventable safety incidents that should not occur if the available preventive measures had been implemented.
- We found there was a 'Maternity Services Trigger list which staff followed for incident and near miss reporting.' This list also provided a guide to staff as to those incidents which required escalation as serious untoward incidents.
- Midwives and staff told us they were encouraged to report incidents and were able to explain the procedure. Between August 2014 and July 2015 there had been five serious incidents reported across the trust in women's services. An example of these was: There had been a Core Network switch fault which had resulted in an information technology crash of network services. Information showed there were business continuity guidelines in the event of a similar network failure in the future.
- A supervisory investigation into two of the incidents was carried out; a root cause analysis (RCA) had taken place into the remaining three incidents. An RCA is a method of problem solving that tries to identify the root cause of incident. When incidents do happen, it is important lessons are learned to prevent the same incident occurring again. An action plan and recommendations summary had been shared with staff.
- However when we inspected we found there were 31 incidents which had not been investigated and remained outstanding since June 2015. On the 18 November 2015, the Head of Midwifery and the Obstetric Clinical Operations lead told us a member of staff had been working through the incidents and would continue to do so; twenty five remained outstanding.
- Before our inspection, the trust provided a 'Maternity Incidents Overview Report' (8 October 2015). Within the report it identified the actions that had been taken to address incidents. It stated all incidents were sent to the management team including Operational Matron, Head of Midwifery and Risk & Governance Facilitator and staff confirmed this. It stated, escalation of any potential serious incidents were verbalised to the management team and acted upon in a timely way. A concise RCA was undertaken into incidents which were not classified as a serious untoward incident.
- Information provided by the trust told us 'all incidents, complaints, PALs concerns and claims were analysed and reported on a monthly basis to the Women's and Children's Directorate Governance Meetings for their oversight and action if necessary.'
- Forums where incidents were discussed included the monthly clinical governance meeting, clinical review meeting and perinatal meeting with multidisciplinary team members, trust governance & assurance committee, departmental meetings including monthly team leader meetings, operational meetings, supervisor of midwives meetings and strategy & delivery meetings.
- The clinical review committee met monthly and the minutes of the meeting dated 10 April 2015 showed the staff who attended those meetings included: Lead Supervisor of Midwives, Head of Midwifery, obstetrics and gynaecology consultants, midwives, consultant anaesthetists, and other medical staff. Agenda items discussed included a review of clinical incidents, actions and learning.
- Perinatal mortality and morbidity meetings took place on a monthly basis. Cases were discussed and included, themes, recommendations, actions and learning; where appropriate.
- Staff told us when they had completed incident documentation there was an area of the form they could request individual feedback and when completed this had been the case. However, some staff also reported they had not always received individual feedback when having reported incidents.
- Staff across the service reported they had received feedback from incidents in newsletters, emails, in team meetings and one to one meetings with their manager where they had been involved. The feedback was to disseminate learning from incidents or other concerns which had occurred within the trust.
- We saw changes as a result of learning from incidents. For example, due to poor record keeping staff had not recorded a woman's wishes in relation to them having screening for Downs syndrome and the screening had been missed. As a result all midwives routinely discussed Downs syndrome screening at 14-16 week of pregnancy to eliminate missed screening and documented discussion outcomes. Staff from this department were able to tell us about the incident and the action taken following lessons learned. We were also informed the policy for antenatal screening was updated to reflect the change in practice.

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Duty of Candour

- The trust had a policy document relating to 'Being open and Duty of Candour' dated July 2015.
- Staff gave an example where duty of candour was used, following an incident. The mother was spoken with directly; informed in person of why their care had not gone according to plan and they received a written response from a senior member of staff. This showed the trust was open and transparent with patients about their care and treatment when things went wrong.
- One member of staff was not aware of the duty of candour.
- Additionally, the complaints procedure showed meetings were offered to give feedback to patients when things had not gone according to plan. Staff were made aware of lessons learned and these were included in the Women and Children's Group Newsletter.

Cleanliness, infection control and hygiene

- Staff reported they had infection control training; information provided by the trust showed infection control training across women's services was 85%; some staff that had recently started working there had yet to receive their training.
- We saw the trust had an infection control policy and staff knew where to locate a copy.
- Trust policies were adhered to in relation to infection control; such as the use of hand gel and 'bare below the elbow' dress code.
- Hand wash audits we reviewed showed 100% compliance.
- Women's services, including gynaecology were clean. However records in the antenatal clinic (Acorn suite) had not been completed from 3 August 2015 to the date of inspection. The records also showed that recording had been done inconsistently in all areas identified to be cleaned.

Environment and equipment

- Access to the inpatient area was via an intercom system and staff were able to monitor people visiting and leaving.
- A system was in place for the security of babies in the hospital and staff reported it had worked well. This meant no one could leave the unit with a baby without sounding an alarm.

- There was no dedicated labour ward; women remained in the same room from admission to discharge, other than having to go to obstetric theatres where required. The facilities was divided up into four areas, each had single rooms and two larger, two bedded bays; A total of 33 beds.
- We saw equipment was available to meet people's needs. For example, piped oxygen and cardiotocograph (CTG) machines. However in the antenatal clinic we found the CTG belts were not cleaned between each use. (Cardiotocography is a means to record the fetal heartbeat and uterine contractions during pregnancy).
- A bariatric theatre table was not available in the anaesthetic room which on occasions used as a second theatre. We were informed a second table would be purchased and in the interim should one be needed there was one available in the main theatre.
- In the antenatal clinic the resuscitation trolley had not been checked consistently and in line with current guidance and legislation. Between July and 9 October 2015 it had been checked a total of nine times. The Resuscitation Council (UK) recommends the frequency of equipment checks will depend upon local circumstances but should be at least weekly. On the inpatient maternity ward, there were 12 days where the neonatal resuscitaire was without a stethoscope before it was replaced and on Honey Suckle and Jasmine units there were gaps in the resuscitation trolley equipment records. This could have meant it was not available for use in an emergency situation.

Medicines

- We found in the antenatal clinic the medicines trolley was not locked and in the inpatient unit intravenous fluids were not safely stored in line with guidance or legislation.
- We saw prescription charts had been completed correctly, dated and signed.
- Medication refrigerators; A random sample of temperature recordings were inspected and satisfactory records had been maintained.

Records

- We inspected nine sets of care records and found they were of a good standard of record keeping. The records included: a situation, background, assessment, recommendation (SBAR) transfer record which was used

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when handing over care between staff. The tool was used in maternity services where there may be multiple handovers between staff and it assisted in improving communication.

- Venous thromboembolism (VTE) risk assessments had been completed in all of the records inspected during the ante natal, labour and post-natal period, clear birth plan pathways, risk assessment tools, growth charts had all been completed.
- The service used the Modified Early Obstetric Warning Score (MEOWS). This assessment tool enabled staff to identify and respond to the need for additional medical support if required. The MEOWS identified directions for escalation, and staff were aware of the appropriate action to take if patients scored higher than expected. We looked at completed charts; the documentation had been completed appropriately.
- Arrangements were in place to ensure checks were made before, during and after surgical procedures in accordance with best-practice principles. This included completing the 'five steps to safer surgery' World Health Organization (WHO) surgical safety checklist. The documentation we inspected had been completed correctly.
- Consent had been recorded; there were detailed recovery from theatre observations, fluid balance charts, obesity care pathway where appropriate, cardiotocography check stickers, evidence of good MDT working, medical involvement, care planning and daily reviews by medical staff.
- 'A 'Fresh eyes approach' (Fitzpatrick and Holt, 2008) was used when monitoring fetal wellbeing through the use of cardiotocography (CTG), to improve patient's safety. The 'fresh eyes' could enhance the accuracy of cardiotocography interpretation as the tracings were viewed by more than one person.
- Staff told us as part of their annual supervision with their supervisor, they had three sets of records audited and discussed as part of their learning.
- In March 2014 the directorate achieved compliance against Level 2 National Risk Management Standards, achieving 10/10 for the quality of record keeping.
- A medical records audit commenced across the trust in April 2015. Results showed the records were dated and legible, however they were not always signed. The trust also provided a document which showed a record keeping audit across the trust had been taking place and due for completion in November 2015. The

objective of the audit was to monitor compliance with basic standards for record keeping, involve midwifery staff in auditing their own practice and provide evidence to support the trusts National Health Service Litigation Authority accreditation.

Safeguarding

- Data provided by the trust showed 89% of staff had received adult safeguarding training, and 80% of staff had received level three children's safeguarding training. We were told by senior managers this was because new medical staff had joined the service in August 2015 and they were yet to complete their mandatory training.
- There was a trust wide safeguarding lead for adults and children, and a named midwifemidwifemidwife for safeguarding.
- We found there were procedures in place for protecting adults and children from abuse; Staff were able to explain the procedure for reporting allegations or suspected incidents of abuse, including adults and children.
- We saw documentation and a screening tool used in the antenatal period, for identifying domestic abuse.
- Staff were aware of safeguarding procedures which included: The early identification and reporting of Female Genital Mutilation (FGM); the response in the event of a suspected or actual child abduction (policy– Review date April 2018).
- Women received a leaflet at booking about 'Having a Safer Pregnancy' and this included information about the trusts zero tolerance to violent, threatening and abusive behaviour.

Mandatory training

- Staff confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training. Staff confirmed they had attended annual multidisciplinary skills drills obstetric emergency study days.
- Staff also reported should there be a number of staff who had not had specific training they the trust would put on a training day for the unit.
- Information from the trust dated October 2015 showed staff had annual obstetric skills and drills training in areas such as cord prolapse, post-partum haemorrhage and 83% of staff had completed their three yearly mental capacity act training.

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Assessing and responding to patient risk

- There were guidelines and risk assessment relating to labour and/or delivery in water and staff were able to give examples.
- The unit used the Modified Obstetric Early Warning Scoring (MOEWS) and staff were aware of the appropriate action to be taken if women scored higher than expected.
- Arrangements were in place to ensure checks were made before, during and after surgical procedures in accordance with best-practice principles. This included completing the 'five steps to safer surgery' World Health Organization (WHO) surgical safety checklist. The documentation we inspected had been completed correctly.
- The screening co-ordinator told us they had just completed an annual report relating to antenatal screening; this was not available at the time of the inspection.

Midwifery staffing

- Data provided at the inspection showed the birth to midwife ratio was 1:30. This was slightly worse than the national recommendation of 1: 28. This is recommended by the Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (Royal College of Obstetricians and Gynaecologist 2007).
- The records inspected showed women in labour received one to one care and this was confirmed by women using the service and staff. We did not see any trust data that had been collected to monitor and confirm this.
- September 2014 to August 2015 women's and children's services sickness rates were an average of 4.1% across the trust.
- We saw a comprehensive daily staffing situation report and it included the dependency of patients/women using the service; this was supported by an escalation process to manage staffing levels. (Dated 23 June 2015). Following the inspection we were provided with a copy of the revised policy for safe staffing levels, (the date of issue was 18 November 2015). The document stated how, the current establishment for Northern Lincolnshire and Goole Maternity Service was 30 midwives per 1000 births excluding midwives in other

- roles e.g. Head of Midwifery, operational matron, consultant midwife, safeguarding, substance misuse and domestic violence midwives, breast feeding midwives, and the ante natal screening coordinator.
- During our inspection midwives told us they were asked to take on other things which did have an impact on their roles. Such as a midwife with a special interest in safeguarding.
- Staff reported they did not always have time to attend meetings.
- Safe staffing levels were monitored and managed on a daily basis by the co-ordinator for each area and the overall responsibility was with the delivery suite co-ordinator. The duty rota was in paper and electronic format. (E-rostering). Staff told us the rotas were completed three weeks in advance so they were able to plan and address shortfalls. We inspected the duty rota for 12 October 2015 to 08 November 2015. We saw the staff had identified shortfalls where there were potential staff shortages. They told us they used bank staff and this included their own midwives who through good will covered the shifts.
- At the November 2015 unannounced visit we reviewed the staffing from the 1 – 7 November 2015. The planned staffing was nine midwives and four HCAs per shift. There was only two days when bank staff were not used. On two of the seven days the number of midwives was eight as no bank staff could be secured to work the shifts. Shifts had up to three bank midwives at any one time.
- Staff reported the shifts were 12 hours long and they were entitled to a one hour break. However, due to the nature of the role and the requirements of the unit, this was not always possible.
- Staff told us the community midwives would be called in as part of the escalation process to support staffing levels, however this was rarely needed.
- The labour ward co-ordinators were supernumerary in line with good practice guidance; however we were told some would allocate themselves a patient.
- We found each area had visible planned and actual staffing levels for staff and people to see.
- On the week of the inspection and the visit on the 6 November 2015, the staffing levels were the same as those planned. However, most days bank staff were used to fill rotas.
- On one of the delivery units there was an extra midwife to the numbers and we were told this person was

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available to work between the units. One of the two midwives on one of the other units had gone to theatre and this left one of the care staff together with a midwife responsible for six people.

Medical staffing

- Information provided by the trust showed consultant and registrar anaesthetist labour ward cover was 9am – 5pm on site Monday to Friday. Between 5pm – 9am including weekends, a registrar was on duty and a consultant was available on-call.
- There were seven consultant obstetricians with an on call arrangement of 1:6. This meant they were on call one out of six weekends. Figures showed a consultant was on site between the hours of 9am - 7pm Monday to Friday, and Saturday 9am - 2pm. Consultant on call cover was then provided Monday to Friday 7pm - 9am, and at the weekend 1pm - 9am (with an overlap of 1 hour between 1 – 2pm). This was in line with the Royal College of Obstetricians & Gynaecologists (RCOG) best practice standard for consultant labour ward cover.
- The CQC data pack showed across DPoW and SGH hospital sites there were 42 whole time equivalent (WTE) medical staff; 25% of whom were consultants compared to the England average of 35%. Middle grade staff levels were 21% compared with the 8% England average and there were 39% registrars and 14% junior doctors. These compared with the England average of 50% and 7% respectively.
- Medical staff were available when needed and staff reported antenatal patients were seen each day in line with current guidance. Patients told us they received consultant and medical care which met their needs.
- We observed the medical handover which was attended by the consultant, registrar, two junior medical staff, an AMP and the labour ward co-ordinator. The labour ward co-ordinator gave feedback about the staff on the whole unit and the junior doctors gave feedback on the patients who had been admitted.

Major incident awareness and training

- We saw there was a major incident plan which outlined the roles and responsibilities of staff in each area.
- Midwives attended skills and drills training each year and there were scenarios based on maternal and neonatal emergencies.

Are maternity and gynaecology services effective?

Good



Overall, we rated the service as 'good' for providing effective services. This was because:

- One to one care and pain relief of choice was available for women in labour.
- Information about outcomes for women were routinely monitored and action taken to make improvements.
- Staff had the skills, knowledge and experience to do their job.
- Women received care according to professional best practice clinical guidelines. However, we found some policies were out of date; the provider had identified this and steps had been taken to address the situation.
- The stillbirth rate and the induction of labour rate were higher than the national average.

Evidence-based care and treatment

- The delivery of care and treatment was based on guidance issued by professional and expert bodies. The maternity services used a combination of National Institute for Health and Care Excellence (NICE) guidelines (for example, QS22, QS32 and QS37) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. For example, Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. This helped to determine the treatment they provided.
- We found policies were written in line with national guidance and reviewed at the Obstetrics and Gynaecology Clinical Governance meetings, where a consultant obstetrician was present. For example: The 'Mental Health Act Standard Operating Procedure' Guidelines had been reviewed and authorised at the Obstetrics and Gynaecology Clinical Governance in September 2013 with a review date of September 2016. Staff told us they were encouraged to report if they found any policies and guidance out of date. At the time of the visit we found several policies out of date and this was brought to the attention of managers. For example, the 'Planned Caesarean Section' guidelines were approved April 2010 and the review period was April 2013. They told us they had identified a number of

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policies were due for renewal at the same time and were in the process of updating them. We saw records of minutes of meetings where the policies had been agreed and approved following their review. We also saw the approval of the policies were a standing agenda item at this meeting. However, there was not a standard operating procedure in place should the second theatre (anaesthetic room) need to be used.

Pain relief

- Women we spoke with told us they had received their pain relief of choice during labour.
- Pain relief was available and this included use of the birthing pool, Entonox, epidural and pethidine.

Nutrition and hydration

- Women were given advice on healthy lifestyle choices and nutrition during pregnancy; we saw information relating to this in the antenatal clinic and available in each area we visited.
- The service had two Infant feeding leads, one with a parent education element to the role (1.00 WTE).
- The service had achieved level 2 UNICEF Baby Friendly in July 2015. The UNICEF Baby Friendly initiative is a worldwide programme that encourages maternity hospitals to support women to breastfeed.
- The trust dashboard figures showed the breastfeeding initiation rates DPoW ranged between 59.8% in October 2014 to 70.6% in September 2015, the trust target was 74.4%. During our visit, women told us they had been encouraged and supported in feeding their baby. There was an up to date breast feeding policy and guide.

Patient outcomes

- The CQC 'Intelligence Monitoring Report' – May 2015, did not identify any maternity outliers.
- Between January 2015 and September 2015, the total number of births was 1935. Fifty-six of these gave birth in the pool (2.8%).
- The dashboard information showed: Between October 2014 and September 2015 the normal delivery birth rate was 69.3%. This was above the national average of 60.1%. The induction rate was 28.5% and was slightly higher than the trust threshold of 25%. However, the rate of vaginal delivery following induction was good.

The elective lower segment caesarean section (LSCS) rate was 8.4%, against the national average of 10.9%, and the emergency LSCS rate was 11.9%, which was lower than the national average of 15.1%.

- The still birth rate for the same period was 5.8% compared to the national average of 4.6%
- Also in response to the increase in stillbirths, the service had produced a booklet 'Having Safer Pregnancy' which was given to all women in the antenatal period.
- The third degree tear rate was higher than expected and an audit of this showed this was following forceps delivery and performed by one clinician. Appropriate action had been taken with the individual concerned.
- The National Neonatal Audit Programme (NNAP) 2013 showed the service met one out of the five standards. They scored 95% for all mothers who delivered their baby between 24 and 34+6 weeks of pregnancy had received a dose of steroids; this compared to the national standard of 85%.
- 'Patterns of Maternity Care in Yorkshire and the Humber 2011/2012' had been carried out and next the next publication is due out in January 2016.

Competent staff

- The service employed Advanced Midwife Practitioners (AMP), who when on duty wore different uniforms to define their role. The AMP's undertook some duties traditionally carried out by senior house officers, contributed and lead on the care of women, and this included high risk antenatal patients.
- Midwives had statutory supervision of their practice and staff confirmed they had access to a supervisor of midwives for advice and support 24 hours a day. Information provided by the trust showed out of 223 midwives, 98% had completed their annual supervisory review.
- Five midwives who had not had their review included: one was on maternity leave, one on long term sick leave; three had booked to have their reviews within the month. Two of these staff were slightly behind date as their manager had been on sick leave and was on a phased return to work.
- Information also provided by the trust showed several midwives were trained in new-born and infant physical examination (NIPE). This helped with flow in the service and a better outcome for women and their families.

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- Community and staff who worked in the unit told us they had updated training each year to maintain their skills and competencies; this included perineal suturing.
- We spoke with newly qualified staff and were told the hospital was a good place to work. They said they had a named Supervisor of Midwives, preceptorship and support in their role.
- Information provided dated 9 October 2015, showed 100% of consultants were up to date with their appraisals and 86% of middle grade doctors. This was the same across the trust.
- The Kirkup report gap analysis across the trust had identified the need for a Clinical Risk Midwife and a Practice Development Midwife, and the management team were working to address these shortfalls.

Multidisciplinary working

- Staff reported communication and information sharing between departments and cross site working to help improve joint working across the trust. For example, the midwives at DPoW hospital had worked supernumerary in delivery suite at SGH; this had helped them reflect and share good practice as a team. Information from the trust in the 'Maternity Incident Overview Report' showed as changes following efforts to 'learn lessons' Grimsby and Scunthorpe co-ordinators would rotate to ensure sharing and learning from different ways of working and good practice promoting a trust approach to service provision. We saw this was now taking place and staff shared their experiences.
- Staff told us the consultants were all very approachable. They had good relationships with the medical staff in the care of patients and they worked well as a team.
- Staff worked closely with children's services to care for babies admitted to the transitional care unit. (Transitional care is where babies who need a little more nursing care and monitoring can stay.)
- Monthly perinatal mortality and morbidity meeting were attended with paediatricians.
- Monthly clinical reviews meetings were attended by all clinicians who were available to attend. They jointly discussed proposed actions and learning taken place.
- Communication was sent to GPs via email on discharge from the service. This detailed the reason for admission and any investigation results and treatment undertaken.
- Clinicians worked closely with GPs and social services when dealing with safeguarding concerns, such as child protection.

Seven-day services

- Consultant obstetricians were available on site each day and were available outside these times through on call arrangements.
- The maternity unit has a dedicated operating theatre which was available for use 24 hours per day, seven days per week.
- Anaesthetists were on site 24 hours a day.
- A pharmacy service was available and this included Saturday mornings. An emergency supply of medicines was available out of hours.

Access to information

- There was relevant clinical information displayed in the antenatal clinic for women and their partners to read.
- A 'Hand held book' was used for recording women's antenatal, intra partum and postnatal care. This was kept by the women during their care and was completed as part of a record of their care between GP's, midwives and obstetricians where appropriate.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- There was a policy for consent to examination or treatment, with a review date of June 2017.
- Records reviewed showed women were consented appropriately and correctly for surgical procedures. This included consent for surgical or medical termination of pregnancy (ToP) in line with the Abortion Regulations 1991 and the Department of Health guidance, in reference to the Royal College of Obstetrician and Gynaecologists Guidelines (RCOG): The Care of Women Requesting Induced Abortion (2011) and the trust's consent policy.
- We found the midwives understood the purpose of the MCA (2005) and the Children's Act 1989 and 2004.
- Information provided by the trust showed 85% of staff had received MCA and DoLS training.
- Staff knew about Gillick competency assessments of children and young people. These were used to check whether these patients had the maturity to make decisions about their treatment.

Are maternity and gynaecology services caring?

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Good



We rated the service as 'good' for caring. This was because:

- The unit provided individualised care to people using the service and they were treated with privacy, dignity and respect.
- In September 2015, feedback received from the NHS Friends and Family Test showed: 73% of women would recommend the antenatal service and 98% of women would recommend the labour ward to friends and family if they needed similar care or treatment.
- The trust had midwives with a lead role in bereavement. They provided support, compassion and care for women and their families in time of bereavement.

Compassionate care

- In September 2015, feedback received from the NHS Friends and Family Test showed: 73% of women would recommend the antenatal service and 98% of women would recommend the labour ward to friends and family if they needed similar care or treatment.
- The service scored 3.5 out of a 5 star rating for involvement of women in decisions about their care and promoting dignity and respect.
- One person commented, "I had a very positive experience giving birth in Blueberry. I had great confidence in my fantastic midwife and in the medical team. Everyone I encountered was exceptionally friendly, courteous and supportive. The Neonatal, where my baby went for the treatment of jaundice, is superb! The staff are exceptional in this unit."
- The trust scored similar to other trusts in the CQC maternity survey 2013, for antenatal care, labour, birth and postnatal care. There were three areas they scored better than other trusts and these included: How women were spoken with during labour and birth; were they treated with respect and dignity and their confidence and trust in the staff during their labour and birth.
- When in labour, women were encouraged to bring their birthing partners with them and they were made to feel welcome.
- Although there was no privacy signage on the individual patient room's, staff were seen knocking on doors prior to entering.

Understanding and involvement of patients and those close to them

- In the CQC survey completed in 2015, for being involved enough in decisions about their care during labour and birth, women scored the trust 8.5 out of 10 (which was about the same as other trusts and no change from the 2013 score).
- Women felt supported by staff: Feedback on the NHS website in October 2015 showed that although a woman was not able to have a normal delivery as they wished and had a caesarean section, they found their experience 'faultless.' "The midwives were amazing and helped calm mine and hubby's nerves and helped with breast feeding after the birth. Hospital was clean and whilst we were left to be a family at this most special time, help was always on hand."
- Where a women posted they were not happy with the service received, a representative from the trust apologised and suggested they contact the patient advice and liaison team. This showed the staff was understanding and supportive of the person's needs.

Emotional support

- There were policies and procedures for supporting parents in cases of stillbirth or neonatal death. This included referral to the Blue Butterfly group, which was facilitated by the chaplaincy and offered support to families following bereavement.
- Access was available to a midwife with an interest in bereavement and there were facilities to ensure women and their families were supported following bereavement.
- Postnatal women were also given a leaflet 'Afterthoughts' informing them of a service available, to enable mothers or their partners to return for a one to one appointment with a midwife. This was to help them understand aspects of their care, answer questions, alleviate anxiety or dispel confusion.
- We saw letters/cards of appreciation and positive comments about people's experience of the unit.

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Are maternity and gynaecology services responsive?

Good



We rated the service as 'good' for being responsive. This was because:

- Services were planned and delivered to enable women to have the flexibility, choice and continuity of care to meet their needs.
- There was access to an interpreter services for women whose first language was not English.
- Complaints were taken seriously and acted upon in an agreed timescale.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to enable women to have the flexibility, choice and continuity of care wherever possible. Women had the option to delivery at home, in the midwifery led unit at Goole, SGH or DPoW hospital NHS Foundation trust.
- The trust was aware of the risks to the service such as staffing levels and skill mix, geography of the three trust sites and investment in community services. It worked with local commissioners of services, the local authority, other providers, GPs and patients to co-ordinate care that met the health needs of women.
- Gynaecological services were provided and were a nurse led Advanced Nurse Practitioner (ANP) service supported by three consultants. The service operated Monday to Friday 9am – 9pm. Women were seen in clinical rooms where the ANP could perform a scan if required. The ANP's each had a specialist role and these included: gynaecology scanning; colposcopy, and oncology. The service operated Monday to Friday 9am – 9pm. Women were seen in clinical rooms where the ANP could perform a scan if required.
- The Early Pregnancy Assessment Unit (EPAU) was nurse led with access to a doctor when needed. The service was available Monday to Friday and Tuesday pm. At the appointment and at that clinic dating scans take place, and the ultrasound department provided a service at the weekend where necessary in meeting patient's needs.

Access and flow

- The service had not closed between January 2014 – June 2015
- Bed occupancy for women's services 2014/2015 was between 41.4% - 55.1%. This was lower than the England national average of 60% and in line with the Royal College of midwives recommendations.
- The trust did not collect data on the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. However, none of the women we spoke with described any time when they were left unattended.
- Between January to September 2015, 15.2% of women in labour had received an epidural anaesthetic. Women were told prior to admission the availability of epidural anaesthetics and those spoken with during our visit told us they had received an epidural within 30 minutes of their request. Staff confirmed that should the anaesthetist be needed in another area in an emergency, the epidural anaesthetic could be delayed.
- Dedicated anaesthetic sessions were available during the day for theatre cover and we were told it had been very rare a session had been cancelled. We were also told, the anaesthetic room was available to be used as a second theatre should it be needed in the event of an emergency.
- The screening co-ordinator monitored the antenatal screening. This included, the follow up of screening for Downs' syndrome and making sure women had received their scans. We were told this also acted as a failsafe to ensure women had access to attend clinics, and there was a care pathway in place relating to this.
- Gynaecological services included medical and surgical TOP's and was a nurse led clinic. A doctor was also present in clinic should support be needed and for the signing of consent forms. (Please see effective domain with regards to consent and Gillick competency assessments.) Should a teenager be admitted, the consultant midwife for teenage pregnancy could be contacted for support and advice. Counselling facilities were provided before treatment and were available during and following inpatient stay.

Meeting people's individual needs

- On the hospital site they had disabled parking and wheelchair access.

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- Staff could access interpreter services if required for women whose first language was not English and a Signing services was available.
- Within the Women and Children's group there were seven specialist midwife roles in place to support and advise women with specific needs: a Consultant Midwife for Teenage Pregnancy and Sexual Health with a Public Health Lead (1 WTE); Two Infant Feeding Leads, one with a parent education element to their role (1 WTE and 1 x 0.8 WTE); An Antenatal Screening Co-ordinator (1 WTE) and Safeguarding Midwives (1 WTE, 1 x 0.8 WTE and 1 x 0.2 WTE). There were no specialist midwives for patients with bariatric or alcohol problems.
- There was a lead obstetrician who had a lead role for diabetes, endocrine disorders, and teenage pregnancy.
- Women carried their own paper records with them and had contact numbers for the delivery suite and midwives should they need advice or need to go into the unit.
- Information booklets and guidelines were available and these included: Role of Birth Partners, Vitamin K, and Information for Parents, Having a Safer Pregnancy, Parent education classes, health education and advice to achieve and maintain a healthier lifestyle.
- Information provided by staff showed smoking was a problem in Grimsby; 25% of women were found to be smokers.
- The 'Baby Clear' initiative had been funded by Public Health in North East Lincolnshire Regional to tackle increasing rates of mothers smoking in pregnancy. The majority of midwives who worked in this area had received training. The screening was offered at booking to every pregnant woman and they discussed the effects of carbon monoxide recordings. A Stop Smoking practitioner then contacted them within 48 hours of being seen in clinic and offered them an appointment.
- There was access to public telephones, television, internet, a shop and a café.
- A tour around the maternity unit could have been arranged by phoning the service. We saw information in the ward and departments about the hospital chaplaincy; offering spiritual, religious and pastoral care; support to staff, patients, their relatives and friends. The service could be accessed via the ward/department staff or by telephone, was available on-call out of hours, and included when a person's need was urgent.
- In meeting women's individual needs during their stay, each of the four obstetric inpatient areas had a room which had been designed for a specific use. For example, on the Jasmine area was a birthing pool room; Honey Suckle had a room designed for disabled access; Holly had a high dependency room and Blueberry had a bereavement room.
- The community midwives in planning and delivering the service to meet local people's needs, had advertised on the intranet for 'Pregnant ladies in Louth' to attend community midwives sessions to help them prepare for their forthcoming arrivals. The information also stated the sessions would be carried out on the first and third Saturday of each month from 1pm to 4pm. This was to meet the needs of women in the community and provide information and advice on labour, delivery and the first few hours with their new-born baby.

Learning from complaints and concerns

- The service had a system in place for handling complaints and concerns. Their complaints policy dated March 2015, was in line with recognised guidance. The trust had a designated complaints manager and a customer service department.
- We saw information on the intranet and on the notice board in the antenatal clinic advising patients and visitors of how to complain. The leaflet available in the clinic was called, 'Tell us what you think, customer services' And 'How to make a complaint suggestion or pay a compliment about our hospitals.' The role of the customer service manager and the department were explained in the information and there were contact telephone numbers and addresses to assist patient in accessing these services. The office was situated inside the main entrance.
- There was a 'Complaints and Concerns Training Workbook' for staff to complete and be signed by their manager to show they had completed the training. This was to give staff an awareness of the procedures to follow should someone wish to express their concerns or complain.
- Staff we spoke with were aware of the complaints policy and the procedure to follow should someone wish to complain.
- They told us they were made aware of lessons learned from complaints and these were included in staff emails, newsletter and team meetings.

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- Evidence provided by the trust titled, 'Directorate of Performance Assurance Detailed Complaints Performance Analysis 20 October 2015' stated, 'Since early 2014, the trust had offered complainants the opportunity to meet with clinical staff early on in the process to explain the clinical context, if required, and most importantly listen and respond to questions.' This was then said to be followed up by a letter outlining the verbal discussions already held. This meant in some instances the trust time scale for closing a complaint could be prolonged. However it also meant complainants were offered the opportunity early on in the process to discuss and receive answers to their concerns during these face to face meetings.
- Information was seen in the quarterly 'Trusts Governance and Assurance Committee' report (dated 14 September 2015), that an analysis of complaints had taken place by the complaints manager. The information showed between August 2014 and June 2015 100% of complaints across the trust had been closed each month within their agreed timescale.

Are maternity and gynaecology services well-led?

Good



We rated the service as good for well led. This was because:

- There had been several changes in management and changes continued as DPoW, SGH and GDH were working more collaboratively, attending joint meetings and sharing good practice.
- The majority of staff told us, they knew who the Chief Executive was and they communicated well. They told us their line managers were approachable, supportive and they felt listened to.
- The Maternity Service Liaison Committee (MSLC) was run by a group of parent representatives who worked with the midwives, doctors, healthcare professionals and commissioners to guide and influence maternity services at the trust.
- Following publication of the Kirkup report, the trust's gap analysis identified the need for a Clinical Risk Midwife and a Practice Development Midwife. The management team were working to address these shortfalls.

Vision and strategy for this service

- A copy of their 'Strategic Plan Document 2014-19' was seen on the internet. Its vision and values had been created with input of staff from all levels of the organisation; they reflect their shared values, ideals and principals and strengthened their commitment to put patients first. An example of their shared values was: 'We care about quality and patient safety. We care about positive experiences for patients, carers and staff.and we care about doing the right thing, each time, every time.'
- In each of the areas we visited they had developed their own vision and values to reflect the care they provided.
- Information provided by the trust dated 8 October 2015, stated they had "a business plan to recruit a practice development midwife post to ensure learning lessons continue from all complaints, incidents or general feedback enabling and supporting colleagues in the team through one to one working." "Looking into a triage service for both sites." And "Improve morale and team working."

Governance, risk management and quality measurement

- The trust's gap analysis following publication of the Kirkup report identified the need for a Clinical Risk Midwife and a Practice Development Midwife. Discussions during the inspection and following with the Head of Midwifery and Obstetric Clinical Lead, confirmed there was a need for the post; the shortfall in not having them had been added to the trust risk register. The practice development midwife post and job description was said to have been agreed and funded. A business case had also been made for the Clinical Risk Midwife post and agreed. We were told the funding for the post would be secured later in the month. We were also told, clinical governance and risk was everyone's role and monthly clinical governance meetings reviewed and reallocated the severity of the open risks.
- The clinical governance meetings for the maternity service met monthly. We saw the minutes of the meeting for July 2015 covered areas such as: The Governance Dashboard, complaints analysis report, lessons learned and action plans, RCA incident action plans, risk register, NICE guidance and action plan,

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safety alerts, mandatory training updates, trust mortality morbidity updates, falls action plan to address shortfalls and lessons learnt. This showed the service monitored and responded to identified risks.

- The 'Women and Children's Group Risk Management Strategy' (version 5.1, expiry date March 2017,) had been written as integral part of the trust wide Risk Management Strategy and outlined their responsibilities. It set out the commitment of the Women & Children's Group to manage risk and their strategy for achieving this objective. The objectives included: 'Support and develop staff to be fully risk aware, where risk management is imbued within the service culture and is integrated into the working practices of all grades and disciplines of staff. 'Encourage the open reporting of incidents, within a culture of fair blame and ensures that lessons are learnt from those mistakes and that measures to prevent recurrence are promptly applied.'
- The Children's Services Governance, Obstetrics & Gynaecology Governance, and the Trust Governance & Assurance Committees had approved the strategy in February and March 2014.
- The document included the reporting and management of incidents and referred to the trust wide policy, 'Incident Reporting Policy/Procedure.' Staff we spoke with, including the Risk Manager was able to describe the risk management processes and the procedure for reporting and management of incidents.

Leadership of service

- Management structures showed clear lines of accountability and staff were aware of their roles and responsibilities.
- Staff told us they knew who the Chief Executive was and they communicated well. They had a 'Blog,' sent out emails, communicated through team meeting, visited the unit and keep staff informed.
- Local leadership was reported to be good.
- Managers encouraged staff to participate in on-going learning, professional development and were open to ideas and suggestions to improve the service.

Culture within the service

- The majority of staff told us there was an open culture and they were encouraged to report incidents and risks.

- There had been several changes in management and changes continued as DPoW, SGH, and GDH were now working together, they attended joint meetings and sharing good practice.
- Staff told us they felt listened to and supported.

Public engagement

- We spoke with the Chair of the Northern Lincolnshire, Maternity Service Liaison Committee (MSLC). The MSLC was run by a group of parent representatives who worked with the midwives, doctors, healthcare professionals and commissioners, to guide and influence maternity services at the trust. The Chair told us the trust were open and honest with the MSLC and part of their role included attending clinical governance meetings and development of maternity guidelines.
- As part of their role, the MSLC looked at what was working and what needed to change. We were told meetings took place every two months; meeting minutes for April 2015 showed eight people attended and included patient representatives, Head of Midwifery & Gynaecology, a Supervisor of Midwives, and a Breastfeeding Support Midwife. Items discussed included: a Tongue-tie referral pathway for breastfed babies; the maternity dashboard figures and steps the service were taking to reduce the stillbirth rate, and perinatal mental health. We saw from the minutes, a working group had met (, the midwife with lead role for public health was part of this group) to discuss perinatal mental health and they were drafting recommendations for the Maternity Partnership Board. This information would to be discussed at a subsequent MSLC meeting. This showed the provider was proactive in working with the public and people who used the service in improving its services.
- The trust also had a 'Quality and Patient Experience committee,' and a 'Patient Experience Strategy.' The committee had carried out an inpatient survey and identified three areas for improvement; these areas were not part of women's services.

Staff engagement

- Staff reported they had an annual 'Our Stars 2015' awards ceremony for staff of Northern Lincolnshire and Goole NHS Foundation Trust. The most recent ceremony had been held on Friday 2 October 2015. The event had seen nine awards given to dedicated staff and volunteers.

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- Monthly briefing took place to keep staff up to date with events across the trust. Staff talked about, monthly team/across site meetings they attended, where incidents, learning, training and changes were discussed. We saw minutes of the monthly managers meetings. The meetings were well attended by manager from women's services across the trust.
- Monthly briefing took place to keep staff up to date with events across the trust. We heard how information relating to incidents, training, and changes were discussed. The meetings were attended by managers from each hospital and the location of those meetings were alternated between the DPoW and SGH sites. Staff told us these meetings helped them keep informed and were well attended.


Innovation, improvement and sustainability

- The service had successfully secured funding of £36,550 from the Nursing Technology Fund. This was a national

fund, which the Prime Minister establishment in 2012 to support nurses, midwives and health visitors to make better use of digital technology. These monies provided a bespoke Web V 'virtual ward' system and flat screen computers were installed in all ward.

- Digital pens for community midwives were also purchased as part of the funding and will be used to write on specially designed patient notes; the community midwife would then place the pen in a docking device which would upload the information on a computer without the midwife having to spend time re-inputting the data into the computer. The pens had been purchased and the system was reported to go live at the beginning of November 2015.
- The service has had AMP's and ANP's working there for several years and this innovation is a contributing factor in providing holistic high level midwifery and nursing led care.

Outpatients and diagnostic imaging

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

Information about the service

The Diana, Princess of Wales Hospital (DPoWH) in Grimsby had outpatients (OP), radiology, and phlebotomy departments. These were part of clinical support services within the trust. Pathology services, known as 'Path Links' was a directorate in its own right.

The outpatients department (OPD) held a range of outpatient clinics, which included ophthalmology, general surgery, elderly medicine, cardiology, dermatology, gastroenterology, respiratory, diabetes, urology, neurology and ENT. The ophthalmology clinic was separate from the main outpatients' areas. The OPD also held clinics off-site at Cromwell Road; we did not visit this location during the inspection. There were four zones in the OPD at DPoWH; zone 1 was ophthalmology OP and zones 2 to 4 were general OP.

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

There were pathology laboratories on site, which provided a 24-hour, seven-day service and a phlebotomy service. Phlebotomy held clinics five days a week and provided a

service to the inpatient wards six days a week. Ward staff took blood samples on the inpatient wards on Sundays; pathology wanted to extend their phlebotomy service to seven days a week, but this depended on funding approval.

Between 1 October 2014 and 30 September 2015, the OPD at DPoWH held an average of 1896 clinics per month and saw 200,824 patients. Radiology attendance figures at the DPoWH site during this period was 194,855.

During the inspection, we visited the outpatients, ophthalmology, radiology, pathology and phlebotomy departments. We did not inspect diagnostic imaging at the last inspection; therefore, all five domains were included at this inspection visit.

We spoke with eight patients and carers in ophthalmology and urology waiting areas and five patients in radiology, who shared their views and experiences of the service with us. We also spoke with 38 staff including two consultant radiologists and a consultant urologist, the planned care manager, outpatient's nurse manager, secretarial staff, healthcare support workers and administrative staff.

We reviewed 10 patient care records in radiology and five in the outpatient's ophthalmology clinic to track patient's care.

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Summary of findings

We found your outpatients and diagnostic imaging core service to be rated as 'inadequate' overall. Safe, responsive and well-led were rated as 'inadequate' and caring was rated as 'good'. There was evidence of harm to patients within the outpatient services because of poor management of the follow up appointment system. There were no significant concerns identified within the diagnostic services we inspected where we found patients were protected from avoidable harm and received effective care.

Between September 2014 and the time of the inspection, five serious incidents were reported in ophthalmology where patients had suffered harm due to delayed diagnosis and treatment. There was a lack of evidence to demonstrate feedback, follow up actions and learning from incidents in outpatients.

When we inspected outpatients at this location in April 2014, the service overall was rated as good, the effective domain was not rated and the responsive domain was rated as requires improvement. This was because the hospital had a high did not attend (DNA) rate (10.5%) and high levels of cancellations of outpatient appointments at (17.1%). We asked the provider to make improvements. On this inspection, we checked whether the provider made the improvements. We found the number of patients who did not attend outpatient clinics was still above 10% and the number of cancelled clinics in outpatients and ophthalmology had increased.

There was a backlog of 30,667 outpatients without follow-up appointments. The service had no clear action plan to address the immediate clinical risk to patients. The trust continued to experience demand pressures in a number of OP specialties, including ophthalmology, orthopaedics and paediatrics. There was a lack of management oversight of the significant problems with the OP clinic booking systems. We asked the trust to take immediate action: the trust provided monitoring information following the inspection that indicated all patients in the backlog had been reviewed by 31 December 2015.

Systems were in place in radiology to ensure that the service was able to meet the individual needs of people such as those living with dementia or a learning disability, and for those whose first language was not English. However, we found services in outpatients were not planned and delivered to ensure the additional needs of these patients groups were met.

Systems were in place to capture concerns and complaints raised within both departments, review these and take action to improve the experience of patients. We found there were high numbers of formal and informal complaints about the administration of appointments in the OPD.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Inadequate



At the last inspection in April 2014, we rated outpatients as 'good' for being safe. During this focussed inspection visit we identified significant safety concerns in outpatients. We rated the service as 'inadequate' for being safe because:

- The high numbers of clinic cancellations and lack of robust follow up of cancelled appointments led to delays in patients receiving treatment and diagnosis. There were seven serious incidents between September 2014 and the time of the inspection. Five of these were in ophthalmology and two in other outpatient specialties. These related to delays in diagnosis and had resulted in permanent harm to patients.
- The root causes of these incidents included delayed treatment due to cancelled appointment and failure to follow up in a timely manner. There was not enough evidence to show the service gave feedback, developed follow up actions or learnt from incidents. Practice had not been changed in response to the incidents, which had been reported
- Staff could not easily access resuscitation trolleys in both outpatient areas in the event of an emergency, which put patients at risk
- There were regular unfilled shifts for nursing and support staff in the department at the time of the inspection. The centralised Clinical Administration Support Team (CAST) appointment bookings team did not have enough staff and did not have the training and support in place to ensure patients were booked for appointments according to clinical need
- Staff we spoke with in the OPD did not know about business continuity plans or their role in the event of a major incident.

Incidents

Outpatients

- Record submitted by the trust showed there had been 166 incidents reported in outpatients between

September 2014 and August 2015. Of these, 146 (88%) had occurred at the DPoWH site and included incidents at satellite clinics held at the Cromwell Road site and a local medical centre.

- Themes from incidents included overbooking and under booking of clinics, delays in patients being seen by staff, problems with patient notes being available, cancelled clinics and patients turning up for clinics when their appointments had been cancelled
- We found ophthalmology outpatients had reported 96 incidents between April and October 2014; the majority of these related to the administration of appointments, and some related to equipment failures.
- Nursing staff in ophthalmology told us they reported and escalated overbooked clinics to the OP nurse manager but they did not complete an incident report.
- The OP nurse manager told us they filled in incidents for problems with clinics, but not if they sorted out the problems identified before the day. Nursing staff told us they knew with how to report incidents on the hospital's 'Datix' incident reporting system.
- Since September 2014, the trust had reported five serious incidents (SIs) in ophthalmology, four at the Grimsby site and one at the SGH site. There had also been one never event in ophthalmology. There had been two SIs in other outpatient specialties. The SIs and never events reported were all related to delays in diagnosis. Delays in clinic appointments and missed follow up appointments were a recurring theme in the investigation reports into these incidents. The planned care manager told us they had not been involved in the SIs in ophthalmology, they explained these incidents were in the surgery division.
- Although the trust had investigated these incidents, it was unclear what actions the trust had put into place to prevent any future incidents occurring. Staff we spoke with were unaware of any changes to systems and processes. There was a lack of urgency about taking actions following these SIs and never events; one senior member of the executive team told us, "There have only been five serious incidents in ophthalmology."
- The clinical support services (CSS) management team told us they had no control over OP bookings and did not know why OP clinics were cancelled. They told us they would share any root cause analysis (RCA) reports via governance meetings, lessons learned newsletters, team briefs and quality and safety days. However, staff in OP said there was no shared learning about RCA

Outpatients and diagnostic imaging

investigations; they said the incident reporter received feedback about individual incidents. One service manager told us there were, “Odd ones mentioned in the staff newsletters but these were not frequent or often.” The OP nurse manager told us the results of root cause analysis (RCA) investigations were discussed at the ophthalmology business meetings. However, they said there was a lack of shared learning further across the organisation.

- During our visit, the OP nurse manager told about an incident where a patient with a failed corneal graft had come in via A&E over the weekend. This patient had not been seen in ophthalmology since March 2014 and only had vision in one eye, which had deteriorated significantly in that time.
- Staff we spoke with, including managers were unable to explain the requirements of the duty of candour. They did however, talkd about being open and honest with patients when a mistake had been made and giving them an apology.
- The duty of candour sets out specific requirements that providers must follow when things go wrong with care and treatment. Any patient harmed by the provision of a healthcare service must informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Diagnostic Imaging

- There had been no serious incidents or never events in radiology at this site between August 2014 and July 2015.
- In the diagnostic imaging department, all staff were aware of hospital policies and procedures and knew how to report incidents. Staff told us they knew with how to report incidents on the hospital's 'Datix' incident reporting system.
- Between 1 October 2014 and 8 October 2015; 418 incidents had been reported in radiology at DPoWH. The highest number of incidents were categorised as 'Other incident to do with assessment' (56 incidents), followed by 'documentation' (26) and 'Access, admission, transfer, discharge other' (26)
- Radiology staff we spoke with confirmed learning from incidents was discussed within the teams and at team meetings. Staff in ultrasound told us they were not aware of any recent incidents.

Cleanliness, infection control and hygiene

Outpatients

- Clinical and non-clinical areas in OP appeared visibly clean and tidy, with equipment stored appropriately.
- We reviewed the monthly hand hygiene audit for August 2015 and saw that the OPD had scored 100% and the 'Frontline ownership audit tool infection prevention and control (IPC)' had an overall score of 98%.
- Between October 2014 and June 2015, hand hygiene audits in OPD at this site showed 100% compliance every month.
- We reviewed IPC records held within the OPD. We saw these included records of legionella flushing of sinks. These were all completed as required. We asked staff, including the nurse manager, about the recent legionella cases which had occurred at the hospital; they were aware there had been cases but they did not know where the cases had occurred or where the contamination had come from. This meant important IPC information was not being shared with staff across the organisation.
- We noted the curtains in some of the OP clinical rooms did not have any way of identifying when they had last been changed or cleaned; The nurse manager said that the domestic supervisor had a rolling programme of curtain changes and kept the records. These records were not available in the OPD.

Diagnostic Imaging

- Clinical and non-clinical areas in diagnostic imaging appeared visibly clean and tidy, with equipment stored appropriately. However, not all sharps bins in clinical areas were correctly labelled and sharps bins awaiting disposal were not labelled. We raised this with staff who rectified this during the inspection.
- We saw staff complied with IPC policies, for example wearing personal protective equipment (PPE) and participating in hand hygiene audits
- Between October 2014 and June 2015, hand hygiene audits in X-ray, special procedures, MRI, CT and ultrasound at DPoWH showed 100% compliance every month.
- Radiography staff described to us how they would manage patients with potential communicable diseases, or infections. This was in line with the departmental policy.

Outpatients and diagnostic imaging

- Radiology at the DPoWH site had not reported any infection control incidents between 1 October 2014 and 6 October 2015.

Environment and equipment

Outpatients

- There were four zones in the OPD at DPoWH; zone 1 was ophthalmology OP and zones 2 to 4 were general OP.
- We found the hospital signage to help patients find the OP departments was confusing and staff we spoke with agreed with our observations. While we were looking at the signage on the main hospital corridor to the different OP departments, three patients asked us for directions to the OPD.
- The OP nurse manager told us the toilets adjacent to the general OP reception area were due to be refurbished and they were expecting to get a water fountain, "In the next few weeks." They said this water fountain was being paid for out of charitable funds. Information provided by the trust showed incidents had been recorded relating to the lack of drinking water available for patients at the DPoWH sites. This showed the service had taken action to resolve this issue.
- The patient waiting room space for ophthalmology patients was uninviting, cramped and unsuitable for patients with severe low vision. The majority of the patients attending this facility were middle aged to elderly and had some degree of vision impairment.
- Staff in ophthalmology told us that not all of the clinic rooms had vision charts and if they had it would take the pressure off the two rooms that currently had vision charts. They also said the department only had one machine for doing 'visual fields' and this meant these were done at a separate clinic.
- The nurse manager told us the service had introduced a bleep system, so that patients could take the bleep with them elsewhere in the hospital while they were waiting for their appointment. They said there were 36 bleeps available but uptake had been poor, possibly because the range over which the bleeps worked was variable and they did not work in some areas of the hospital.
- The resuscitation trolley in the ophthalmology outpatient clinic was stored behind a locked door, which had a keypad for entry. We checked the medications and stock and found they were all in date and checks were completed as required.

- The resuscitation trolley in the general outpatient's area was in Amethyst Ward, the adjacent chemotherapy day ward, and was not easily accessible to OP staff. There were three sets of doors between the trolley location and the OPD, which did not open automatically. The OP nurse manager told us the trust's resuscitation team had checked the location of this trolley and deemed it satisfactory.
- Resuscitation trolley medications in the general OP were all in date and records showed staff checked the trolleys daily.

Diagnostic Imaging

- The facilities and premises were appropriate for the radiology services delivered there. The department was on the ground floor of the hospital and was easily accessible for patients with mobility problems or physical disabilities.
- The environment was clean, tidy, uncluttered, spacious and free from trip hazards.
- The trust had a register of equipment and the service reports we reviewed were all up to date.
- During the course of our inspection, we observed specialised PPE was available for use within radiation areas. Staff told us they were provided with appropriate PPE to undertake their role safely. Staff were seen to be wearing personal radiation dose monitors and these were monitored in accordance with legislation.
- We looked around the radiology departments at DPoWH and saw restricted access areas were locked appropriately and signage clearly indicated if a room was in use. Radiological protection/hazard signage and restriction of access signs clearly displayed throughout the departments Patient changing facilities were appropriate.
- On first day of the inspection, records showed the resuscitation trolleys had not consistently checked. As a result of the issues we raised, we found all of the issues had been rectified and responsibility for checking changed to radiology staff when we revisited these areas two days later
- Staff could not locate the records of the daily check of the defibrillator in the interventional radiology room. Staff dealt with this immediately when they became aware of the issue.
- There was a paediatric resuscitation trolley in the department.

Outpatients and diagnostic imaging

Medicines

Outpatients

- We checked medicines storage in ophthalmology OP; all medicines were found to be stored securely and in date. Staff told us the pharmacy department replenished the stock levels on a weekly basis.
- Records showed staff were not recording minimum and maximum fridge temperatures for the ophthalmology clinic. Staff we spoke with were not aware of this, although the record forms had columns for recording maximum and minimum temperatures.
- No drugs were stored in the drugs cupboard in general OP and there were no drugs fridges in this area.

Diagnostic Imaging

- Fridge temperatures were being checked but staff were not recording minimum and maximum. Two dates in the month the fridge temperature had not been recorded. Medicines stored in the fridge were anaesthetics only.
- We observed an injection left on top of the trolley; this was not secure. Staff dealt with this issue immediately when we pointed it out.
- The medicines cupboard was locked and the key was security controlled. Medicines we checked were all within expiry date and the checklist was up to date.

Records

Outpatients

- At the time of inspection, we saw patient personal information and medical records were managed safely and securely within the OPD. Patient care records were all paper based.
- We saw from incident records that staff would sometime see patients without their notes, if these could not be located. We saw examples where medical staff saw patients using only their referral letter. This meant there was a risk the staff member carrying out the consultation did not have all of the patient information required. Reception staff told us one of the main issues was patient notes not being available for the clinics.
- We checked five sets of care records in ophthalmology OP; we found they all contained complete medical and nursing notes, and accurately completed documentation, including consent forms. One patient's

record was a temporary file. Staff explained these were used if the original records were not available or it was a same day referral from the emergency department or the patient's GP.

Diagnostic Imaging

- At the time of inspection, we saw patient personal information and medical records were managed safely and securely in radiology.
- The service used a combination of paper referrals, from GPs, and electronic referrals. Ninety percent of referrals to ultrasound were electronic.
- We checked ten electronic patient records, including the MRI safety checklists. We looked at records from April, August and October. We found one record had no MRI safety checklist scanned and one record had the checklist scanned but the radiographer had not signed it.
- The department used the Picture Archiving and Communications System (PACS) and a Radiology Information System (RIS). PACS is a nationally recognised system used to report and store patient images. This system was available and integrated across the three trust hospitals sites (Goole, Grimsby and Scunthorpe). The PACS system at the trust also linked with the system at the local trust.
- We found there was no documentation audits at the time of the inspection, the radiology manager added these audits to the annual audit schedule during the inspection.

Safeguarding

Outpatients

- Safeguarding training was mandatory for all staff in the department. According to the trust mandatory training submissions at 23 September 2015, the compliance rate for safeguarding training for outpatients nursing staff at DPoWH was 100% for safeguarding children (levels 1 and 2) and 90% for adults. The trust target for training compliance was 95%.
- One member of staff told us the safeguarding pathway was ambiguous and that staff had raised this with the OP nurse manager so that they could follow it up with the safeguarding team.

Diagnostic Imaging

Outpatients and diagnostic imaging

- The radiology department had safeguarding policies and guidance in place for both children and adults.
- Safeguarding training was mandatory for all staff in the department. According to the trust mandatory training submissions at 23 September 2015, the compliance rate for safeguarding training in the radiology department at DPoWH was 100% for safeguarding children (levels 1 and 2).
- Safeguarding adults training rates were 100% in MRI, 74% for medical staff, 96% in general radiology and 93% in ultrasound. The trust target for training compliance was 95%.
- Staff told us they used the hospital's Datix incident-reporting system for reporting safeguarding concerns.
- Staff we spoke with knew who the lead safeguarding staff in the trust were for children and adults. They were aware of their responsibilities regarding safeguarding and knew how to escalate any concerns.
- Ultrasound staff told us a parent or guardian would accompany a child during a scanning procedure.
- Staff told us they felt the local line managers were supportive, and said they had no problems escalating safeguarding concerns.

Mandatory training

Outpatients

- Staff we spoke with told us their mandatory training was up to date. They told us they were notified when it was due for renewal.
- Nursing staff in ophthalmology told us the training and development in the department was good.
- Mandatory training figures submitted by the trust showed overall compliance rates of 82% for information governance, 87% for equality and diversity, 85% for infection control and 85% for moving and handling. However, these figures were not broken down by hospital site or core service.

Diagnostic Imaging

- Radiology staff, including administrative and support staff, told us their mandatory training was up to date. They explained the training was a mixture of e-learning and face-to-face sessions.
- Data submitted by the trust showed compliance rates for resuscitation training for radiology nursing staff,

general, MRI and ultrasound staff at the DPoWH site was 100%. For Mental Capacity Act training, medical staff compliance was 58%, general radiology staff was 85% and MRI and ultrasound staff were 100%.

- Staff we spoke with were unsure whether IR(ME)R training for radiology staff was mandatory. IR(ME)R training records were not included in the trust submissions relating to training.

Assessing and responding to patient risk

Outpatients

- When we asked the OP nurse manager about the care of deteriorating patients, told us they had been on an 'Alert course' about deteriorating patients. Records showed 100% of OP nursing staff at the DPoWH site had received resuscitation training.
- Reception staff in the general OP told us the main issue were with patients that did not receive their cancellation letter or not received their new appointment letter. They said there had been four or five patients who had turned up to the dermatology that afternoon who had not received their cancellation letter. Staff told us this was a frequent issue at all outpatient clinics, including the satellite clinics at Cromwell Road.

Diagnostic Imaging

- Policies, procedures and local rules were in place in radiology; we observed that the local rules were on display.
- Radiology, including ultrasound, used a three-stage patient identification process; the receptionist checked the name, date of birth and recent address, GP, or telephone number. The health care assistant (HCA) carried out the three-stage check again prior to procedure and the radiology staff or sonographers did the same. Inpatients were identified using their identification bracelets.
- Staff could not locate the radiology WHO checklist policy during the inspection. We found that radiology was using a modified version of the World Health Organisation (WHO) safety checklist and these were different in the different modalities. This meant the service was not following National Patient Safety Agency (NPSA) best practice.

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- When we raised this to the managers, they told us the department would adopt this as standard across all modalities. They said the adoption of the NPSA standard would be proposed and discussed at the next governance meeting, scheduled for 28 October 2015.
- We observed diagnostic reference levels (DRLs) were available to staff in folders in the X-ray rooms. Risk assessments, including COSHH risk assessments, were all up to date.
- All staff were observed to be wearing body dosimeters (dose meters) on the front of their torso. A radiation dosimeter is a device that measures exposure to ionizing radiation. The manager told us staff changed their dosimeters every two months. We saw the dose meters had their expiry date on back.
- We reviewed recent reports from RPA inspection visits, IR(ME)R inspections and general X-ray system performance and radiation protection reports.
- Radiography staff were able to describe their responsibilities under the IR(ME)R regulations, how they would carry out pregnancy checks and how they would carry out patient identification checks.
- Staff told us the Radiation Protection Advisor (RPA) carried out a full audit every year. The RPA met with radiology staff in the trust bi-monthly.
- The manager told us the department had appointed and trained Radiation Protection Supervisors (RPS). Their role was to ensure that equipment safety and quality checks and ionising radiation procedures were performed in accordance with national guidance and local procedures.
- All three sites used National Early Warning Scores (NEWS) for the management of deteriorating patients in radiology.
- We observed staff assisting patients with moving and handling safely.

Nursing staffing

Outpatients

- There was a dedicated team of outpatient nurses, receptionists and support workers working in the OPD. The OP nurse manager said they did not manage the reception staff that work in the OPD.
- We reviewed the OPD staff rotas between 20 September and 17 October 2015. We saw regular unfilled shifts for registered and unregistered staff. For example, on the week of the inspection there were 11 unfilled half-day

shifts for registered staff and seven unfilled half-day shifts for unregistered staff. Between the 5 and the 11 October (the week prior to the inspection visit) there were 35 unfilled half-day shifts for orthoptics staff, 60 unfilled half day shifts for unregistered staff and 18 unfilled half day shifts for students.

- Staffing information submitted by the trust showed there were 9.53 WTE nurses in post in the OPD at bands 5 to 8 and the establishment was 10.47 WTE. There were 20.24 WTE staff at bands 1 to 4 in post and the establishment was 22.22. Total staffing establishment was 32.69 and there were 29.77 WTE in post, leaving a shortfall overall of 2.92 WTE.
- Nursing staff in ophthalmology told us there were a limited number of staff nurses working in that area. The OP nurse manager told us, “The trained staff (qualified nurses) are so stretched.”
- The OP nurse manager told us they did not know what their establishment should be. They said they produced the weekly staffing rotas but the staffing levels were based on historical rotas. They confirmed the OPD did not use an acuity tool.
- They said there were three registered nurses off on long-term sick leave; this was 25% of their establishment. They thought they had one nurse vacancy (made up of hours released from people retiring), however the planned care manager had not confirmed this to them. The OP nurse manager confirmed the trust was not recruiting for nursing staff in the OPD and support staff in the OPD were up to establishment..
- The OPD did not use any bank or agency nursing staff and occasionally used bank support workers. Staff told us retention was good in OP and staff turnover was low.

Pathology staffing

- Pathology managers told us there were currently no vacancies for biomedical scientists in pathology or phlebotomists in phlebotomy.

Clinical administrative staffing

- Several staff told us there was, “A lot of staff off sick in the CAST team.” Reception staff who rotated into the CAST team told us, “The workload there (in the CAST team) is massive.”
- The service manager told there were 16 staff in the CAST team, which was made up of a mixture of receptionists and appointment clerks. However, when we went to the

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CAST booking office at 4pm, we found three staff working there. They explained the fourth staff member on duty that day was on reception duties. All of the other 12 desks were unused due to staff leaving.

- Reception staff on duty in general OP on the day of the inspection were band 2 'Clinic Ward Clerks.' They told us they worked on reception desks and in the CAST bookings office.
- There was administrative support for bookings at DPoWH.

Diagnostic Imaging

- There were sufficient numbers of appropriately trained and skilled staff to meet patients care and treatment needs in radiology. Radiology did not use any agency staff.
- Medical staff told us there was, "Little secretarial support" for radiology. They said the current clerical staff worked hard but were overloaded which meant consultants often ended up doing clerical work. They suggested the trust needed to look at improving administrative and clerical support.
- There was no administrative support for ultrasound bookings, the health care assistant (HCA) for family services administered the bookings for that patient group.
- There were 15 band 7 sonographers and 6 HCAs in ultrasound. There were 2.6 WTE sonographer vacancies and locum sonography staff were covering these.
- Sickness in ultrasound had increased in the month prior to the visit. However, the team covered for the shortfall and there was no evidence of impact on patients; for example, there was no increase in backlog.
- The radiology service had positive recruitment procedures and had recently recruited from abroad. At the time of the inspection there were 4.5 WTE vacancies in general radiology; the manager told us that interviews were planned.
- Radiology staffing information submitted by the trust was for radiology across all three sites. The total number of staff in radiology was 223.32 including 11.8 medical staff. Non-medical staff included radiographers, qualified nurses, healthcare assistants and clerical staff.
- The radiology manager told us the department did not use any bank or agency staff in general radiology. Bank staff were used in ultrasound, CT & MRI at the DPoWH site.

Medical staffing

Outpatients

- Medical staffing for outpatients clinics along with clinic capacity and demand were managed within each clinical division, such as medicine and surgery. The divisions reviewed and managed their own mandatory training, appraisal and revalidation for medical staff.
- A consultant urologist told us the urology clinics were, "Really really busy". They said demand was increasing but the number of urology consultant staff had not increased in line with demand.
- The service manager in ophthalmology told us there were two middle grade vacancies in ophthalmology and one doctor had retired and come back part time. They felt the root cause of the problems in ophthalmology was that, "We don't have enough doctors." This affected the service's ability to cope with the increasing capacity in ophthalmology.

Pathology

- The pathology general manager told us there was one vacancy for a consultant microbiologist in pathology, out of an establishment of six.

Diagnostic Imaging

- There were significant numbers of medical staff (radiologist) vacancies at the time of the inspection. Documents submitted by the trust showed the service had 10 WTE radiologist vacancies; there were 11 radiologists in post and a 0.8 WTE locum consultant radiologist for the three trust sites. Staff we spoke with confirmed there were 10 radiologist vacancies.
- Medical staff at the hospital told us four full time radiologists and one part time radiologist for this site 'cross covered' for each other. A sixth radiologist was due to come back to work full time.
- Staff we spoke with told us there were plans to recruit between five and eight radiologists from India; these new recruits were awaiting confirmation from the General Medical Council.
- Radiologists provided an on call service from home out of hours.

Major incident awareness and training

Outpatients

Outpatients and diagnostic imaging

- The OP nurse manager told us there had been a table top exercise about major incident awareness four years ago and there was a major incident policy available on line.
- Outpatients staff we spoke with felt the OPD staff would not be involved in a major incident, but they were not sure. The OP nurse manager was unaware of any business continuity plans for the OPD.

Diagnostic Imaging

- There was a hospital major incident policy and business continuity plan. Staff we spoke with were aware of their role in these contingency plans should a major incident occur. For example, ultrasound staff aware that the emergency generators would support their equipment in the event of an electrical failure.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective domain for diagnostic imaging was inspected but not rated and outpatients was not inspected for this domain. We found:-

- Radiology policies, procedures and audits complied with national regulations and standards. The service monitored radiation exposure, participated in relevant audits and held discrepancy meetings.
- All patient appointments were within six weeks of their referral. Staff could access patient information, such as x-rays and medical records, easily. Medical records were a mixture of electronic and paper records.
- Staff in radiology received appropriate training and professional development to carry out their roles and there was evidence of good multidisciplinary working. Radiology nursing and general staff were just below the compliance target of 95% for their annual appraisal.

However:

- Routine operational responsibilities of the role were delegated to the nuclear medicine technologist including reporting of the scans, with little support from the ARSAC (administration of radioactive substances

advisory committee) licence holder. The ARSAC licence holder was a consultant radiologist for the North Lincolnshire and Goole trust; this licence is required to administer specific radioactive materials to patients.

Evidence-based care and treatment

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- Policies and procedures were available on the trust intranet. These complied with Radiology Protection Association (RPA) and Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) guidance and requirements. These included procedures:-
 - To identify correctly the individual to be exposed to ionising radiation (the three stage identification check)
 - Making enquiries to establish whether female is or pregnant or breastfeeding
 - To ensure clinical evaluation of medical exposures
 - To minimise patients receiving accidental unintended dose ionising radiation
- Procedures for scanning were based on NICE (National Institute for Health and Clinical Excellence), Royal College guidelines and best practice guidance. For example in ultrasound, staff were using positive identification checks and the department had IPC policies and procedures.
- In ultrasound, two sonographers told us they were quality-assuring (auditing) each other's reports but the process of audit was not formalised or planned. They told us the audit schedule, "Could be improved."
- The trust had an annual plan for audits in radiology, this included audits relating to IR(ME)R. Staff told us their next IR(ME)R audit was due to be completed in February 2016. The trust had an IR(ME)R inspection report every three years.
- The IR(ME)R trust wide audit on compliance with IR(ME)R report from March 2015 showed 'significant assurance' that the guidance relating to ionising radiation regulations were being followed.
- Results of this audit showed an improvement in the results for clinical evaluations being present in the notes

Outpatients and diagnostic imaging

compared with previous audits. The results from previously audited areas have improved across the trust with compliance of more than 90% at each site; DPoWH compliance had improved from 59% to 98%.

Patient outcomes

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- Between 1 October 2014 and 30 September 2015, the diagnostic imaging department saw 194,855 patients at the DPoWH site. Radiology waiting time data submitted by the trust showed all patients attending the DPoWH were seen within 6 weeks of their referral.
- The diagnostic department undertook a range of national statutory audits to demonstrate compliance with the radiation regulations. For example, diagnostic imaging had a procedure for the use of diagnostic reference levels (DRLs). We saw that the RPA audited DRLs; records reviewed showed compliance was good overall.
- The service was aware of recommended national reference doses for radiation exposure. Diagnostic reference levels were an aid to optimisation in medical exposure. We observed that DRL exposure checks and local rules were on display.
- We reviewed an example of a CT audit across two different hospital sites, SGH and DPoWH, carried out on 25 September 2015. This audit showed that overall DRL compliance was good. However, there were some differences in doses across the two hospitals and some doses had increased since the last audit. There were actions for the RPS to take to optimise the relevant protocols and the audit was due for review in October 2016.
- The radiologists held regular discrepancy meetings; this showed the department complied with Royal College of Radiology (RCR) Standards. We reviewed a monthly audit report for June 2015 by the external company carrying out outsourced CT work. This showed any discrepancies were forwarded to the radiologists and the report was reviewed at the discrepancy review meetings.
- All patients in this audit had their radiation dose recorded on the RIS; this was an improvement from the last audit where this figure was 61%.

Competent staff

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- Managers told us formal arrangements were in place for induction of new staff and rotating radiographers. Rotating radiographers had their own induction packs and we reviewed these documents. Managers signed off staff induction documents on an ongoing basis.
- There were bespoke induction packs for different grades of staff. One receptionist, who had been in post for seven weeks, told us they had received a good induction and several training courses were already completed. Radiography staff we spoke with were able to describe the local and trust induction procedures.
- Staff told us they were encouraged to undertake continuous professional development and that this was supported within the department. Staff said they were given opportunities to develop their clinical skills and knowledge through training relevant to their role. For example, sonographer staff in ultrasound told us managers had supported their professional development through links with a nearby teaching hospitals trust. One sonographer related how the trust had supported them to move from radiology into ultrasonography.
- Nuclear medicine services were provided at the DPoWH site. One of the consultant radiologists held the administration of radioactive substances advisory committee (ARSAC) licence for the North Lincolnshire and Goole trust. An ARSAC licence is required to administer specific radioactive materials to patients. The service was supported by medical physics experts based at a local NHS trust within an SLA.
- The routine operational responsibilities of the role had been delegated to the nuclear medicine technologist including reporting of the scans. We heard this was often with little support from the ARSAC licence holder themselves.
- Radiation Protection Supervisors were trained externally; we were shown a certificate to confirm this training for the head of CT, dated July 2015. The RPA at another local NHS trust was developing an e-learning programme to assist with ongoing training and updated for the RPSs.

Outpatients and diagnostic imaging

- At the time of the inspection, the service was undertaking some partnership working with a nearby trust to look at training more radiologists and strengthening the service with their support. There was a Service Level Agreement (SLA) with the nearby trust to provide radiation protection and medical physics expert cover; radiologists we spoke with confirmed this.
- Information submitted by the trust showed the clinical supervision for the four nursing staff in radiology at DPoWH had expired and become overdue on 10 September 2015.
- Radiologists had a formal process of appraisal and regular contact with the other trust radiology departments, including telecom meetings every fortnight.
- Staff we spoke with told us their appraisals were up to date. Information submitted by the trust showed performance and development reviews (appraisals) for medical staff in radiology at the DPoWH site were 100% compliant.
- Appraisal rates for non-medical staff in radiology were 86% for nursing staff; 89% for general staff; 95% for MRI staff and 100% for ultrasound staff. The trust target was 95%.

Multidisciplinary working

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- We observed good working relationships between radiographers, radiologists, managers and support workers and administrative staff within the department.
- Staff told us the support provided by the medical physics department required improvement; they told us actions were in progress to achieve this at the time of the inspection.
- Ultrasound staff told us there was no lone working within the department, there was always an ultra-sonographer and an HCA at all times. General radiology staff told us there was no lone working.

Seven-day services

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- General radiology provided a 24-hour seven-day service with core hours from 8.30am to 5pm and reduced staffing (2 radiographers and 1 HCA) outside these hours.
- CT was open from 7.30am to 8.30pm with on call outside these hours with a 30-minute response time. CT radiology on call was outsourced to an external company from 8pm to 7am at the Scunthorpe and Grimsby sites.
- MRI was open from 7.30am to 10.30pm seven days a week, there was no out-of-hour's cover.
- Ultrasound provided a seven-day service and was open 8am to 6pm Monday to Friday and 9am to 5pm at weekends. The radiologist provided emergency cover out of hours. Sonographers told us they never worked alone, including at weekends. They always had a HCA with them.

Access to information

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e learning.
- Staff were able to access patient information such as x-rays and medical records appropriately, through electronic and paper records.
- There were integrated PACs and RIS systems across all three sites in radiology. This facilitated reporting from all locations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients

- Domain not included in this inspection.

Diagnostic Imaging

- Staff received training in the Mental Capacity Act and data submitted by the trust showed 100% compliance with this training in MRI and ultrasound, 85% in general radiology 93% for nursing staff and 58% for radiologists at the DPoWH site. The trust's training compliance target was 95%.

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- The overall compliance rate in clinical support services for mental capacity act was 92%, against a trust target of 95%.
- Staff we spoke with in radiology understood the consent procedures and demonstrated knowledge about mental capacity. They told us if a patient could not identify themselves, for whatever reason, the procedure would not proceed.
- Staff explained that consent for procedures was implied, and patients were not required to sign to give written confirmation for their consent.
- Staff told us that if a GP referred a patient to the department and there was no clinical history then they would return the referral and request more information.
- For hospital inpatients, staff explained that they would check the patient's wristbands. Referrals from the inpatient wards were electronic.

Are outpatient and diagnostic imaging services caring?

Good



At the last inspection in April 2014, we rated outpatients as 'good' for being caring. Diagnostic imaging was not inspected at the last inspection. We rated the core service as 'good' for being caring because:-

- Staff in outpatients and radiology demonstrated a good level of rapport in their interactions with patients and relatives. Patients said all the staff were caring, friendly and helpful. We heard staff introducing themselves to patients and observed staff respected patients' privacy and dignity.
- Patients and relatives told us staff involved them in their care and treatment, and they understood why they attended the hospital. They said staff provided appropriate emotional support and reassurance when they needed it.

Compassionate care

Outpatients

- We spoke with six patients in ophthalmology and one in urology and they were all positive about the service and the care they received from all staff. They said staff were very polite, kind and caring. One said, "I have no complaints, the staff here are wonderful."

- They told us they had no concerns apart from changed and cancelled appointments. One patient in ophthalmology told us, "It's usually standing room only in this waiting area." Another told us they had received four separate letters from the hospital and a telephone call, all relating to this one appointment.
- The urology consultant we spoke with told us they felt their patients got good care; they said patients were not "rushed through" even when the clinics were running late.
- Staff in ophthalmology all told us they thought their patients got good care.

Diagnostic Imaging

- We heard staff talking with patients in a polite and courteous manner and reception staff greeting patients in a polite and courteous manner
- We observed staff member assisting a patient to the toilet, while maintaining the patient's privacy and dignity. We heard them discretely check whether they had finished and whether they needed any assistance. This member of staff then escorted them to their destination elsewhere in the hospital.
- We spoke with five patients in the radiology waiting areas who told us they were happy with their care. One patient said their care had been, "Excellent in CT."
- Results of a survey in nuclear medicine carried out between 1 February 2015 to 18 March 2015 showed all fifty-five patients found the staff to be polite and well-mannered.

Understanding and involvement of patients and those close to them

Outpatients

- We spoke with six patients in ophthalmology and one in urology; they all told us they understood why they were attending the hospital and happy about their involvement and understanding of the treatment they were undergoing. They confirmed staff had made sure they understood the treatment options available to them.
- One patient in urology said, "I presume because I've been put back that there's nothing drastically wrong." They also said it would be useful to know which consultant they would be seeing. They said their letter just said Mr X (consultant's name)'s team.

Diagnostic Imaging

Outpatients and diagnostic imaging

- We spoke with five patients in the radiology waiting area and their feedback about understanding and involvement was mixed. For example, one patient's letter had not told them they should not eat and drink before their procedure; fortunately, they had not eaten or drunk anything that morning so could still have their procedure.
- Another patient told us they felt there was, "Little explanation" on their letter about the scan they were waiting to have. They said they had phoned the department twice for more information about their test and been told a nurse would call them back. However, they had not received a call back.

Emotional support

Outpatients

- We observed and heard staff speaking with patients in a kind and caring manner.
- Patients told us they were happy with the care and support from staff. One patient in the ophthalmology waiting area said, "I would be happy to raise concerns with staff if I needed to."
- Staff in urology gave all of their patients a contact card so they could contact the department directly if they had any issues. Calls went through to an answerphone out of hours and the consultant nurse specialist (CNS) told us there were around 20 messages a day from patients. Staff could access these voicemails from any computer. The CNS said, "It really works well."
- The urology consultant told us the clinics were so busy, they did not think it was fair for staff or patients.

Diagnostic Imaging

- Staff were heard introducing themselves to patients. We observed that all staff (radiologists, radiographers and support workers) talked kindly to patients and reassured them during their procedures.

Are outpatient and diagnostic imaging services responsive?

Inadequate



At the last inspection in April 2014, we rated outpatients as 'requires improvement' for being responsive. This was because the hospital had a relatively high did not attend rate (10.5%) and high levels of cancellations of outpatient appointments (17.1%).

At this inspection we rated the core service as 'inadequate' for being responsive because:

- There were long backlogs of outpatient appointments. Patients waited a long time for follow up appointments, or not getting one when they needed one. This meant there was a risk of delays in patients receiving care and treatment. The trust had identified some of the issues in March 2015 and actions to improve the backlog were in progress at the time of the inspection. However, these had not been effective in significantly improving the position.
- The 'did not attend' (DNA) rates in outpatients had improved slightly since the last inspection but cancellation rates had increased.
- There was a backlog of 30,667 patients who needed a follow up appointment and did not have a date. Following the inspection, we asked the trust to act on this immediately. They provided weekly updates and in January 2016 told us that all patients in this backlog had now been validated. Patients either had been discharged, given an appointment or were identified as waiting for an appointment in the future.
- Patients in did not have a positive experience because of problems with repeated appointment cancellations in all of the outpatient clinics. In addition, there was poor communication between booking staff, OP staff, consultants and patients about cancelled and rearranged clinics.
- The trust had undertaken work on capacity and demand in the different specialties; this showed a lack of capacity in some specialties to meet the on-going demand pressures.

Outpatients and diagnostic imaging

- The OP service did not have reliable systems or processes to meet the needs of different patient groups. This included those in vulnerable circumstances or with additional needs.
- The service received a high number of formal and informal complaints about the service because of the problems with appointments and follow up.

Service planning and delivery to meet the needs of local people

Outpatients

- The service had increased capacity by running outpatient clinics out of hours and at weekends for several months, to ensure patients had their appointments booked and to reduce the backlog. When we asked the nurse manager about the capacity and demand work they said it had been, “Going on for ever, it must be over a year.”
- The trust was moving towards booking teams being located within each specialty, instead of in the centralised CAST bookings team. Staff we spoke with felt this would be an improvement on the current bookings processes.
- Since the last inspection, outpatients had introduced a reminder system using text messages for patients and the ophthalmology department was piloting call reminders, to ensure patients were aware of their appointments. However, there was a lack of evidence to show this had achieved the desired impact on did not attend rates.
- Information services had produced a report to show how many patients had been contacted via the SMS text reminder service regarding their OP appointment; the percentages were quite low. The quality of both the format and recording of the patient’s mobile number in the PAS demographic screen needed to be improved. Several staff told us there were issues with the service not having up to date phone numbers for patients. They said this was a longstanding problem and they were unaware whether any actions were being taken to resolve this.

Diagnostic Imaging

- Mobile CT and MRI sessions five days a week increased capacity within radiology and ensured patient access targets were met.

- The radiology workload sometimes reached a position where there was a reporting backlog. When this happened, reporting was outsourced. Staff told us the recruitment of new radiologists from abroad should ensure outsourcing would be reduced or not required in future.

Access and flow

Outpatients

- The management of the clinical administration systems and processes for booking outpatient appointments within the trust lacked oversight by qualified and experienced staff. We found that clinic clerks cancelled whole clinic lists, or part of clinic lists. They had no guidance from others about clinical priorities or clinical triage. The trust’s access policy was lengthy, out of date and under review.
- Each clinical group in the service had different arrangements for booking appointments. The booking process had multiple steps, which were the responsibility of service managers, team leaders, rota coordinators and clinic clerks from the bookings teams.
- Workload pressures and loss of staff meant there was a lack of robust and timely validation of the follow-up position for outpatients’ appointments. The on-going ‘clinical admin review’ meant many band 3 staff across the trust left, including medical secretaries. Fewer staff in the central data quality team meant they could not monitor follow-up in outpatients.
- There were significant backlogs of OP appointments at the trust; on the 30 September 2015, 30,667 patients who needed a follow up appointment did not have a date. A significant number of patients were waiting a long time for follow up appointments, or not getting a follow up appointment when they needed one. This meant there was a risk of delays in patients receiving the care and treatment they required. The trust had identified some of the issues in March 2015 and actions to improve the backlog were in progress at the time of the inspection. However, at the time of the inspection these had not been effective in significantly improving the position.
- Following the inspection, we asked the trust to act on this immediately. They provided weekly updates and in

Outpatients and diagnostic imaging

January 2016 told us that all patients in this backlog had now been validated and either discharged, given an appointment or were identified as waiting for an appointment in the future.

- Referral to treatment (RTT) performance for non-admitted patients had fallen since April 2013, but had remained above the 95% standard and the England average throughout this period.
- Referral to treatment performance for incomplete pathways had been between 96- 98% since April 2013, above the standard of 92% and the England average.
- All cancer waiting time measures had been consistently higher than the England average since Q1 2013/14. This meant patients waited less than the national average for their appointments.
- During this inspection visit, we found the did not attend rates and cancellation rates in outpatients had not improved since the last inspection in April 2014.
- We reviewed the trust's 'Referral to treatment access policy' and found that the trust target for outpatient clinic cancellation and did not attend rates was 6%.
- Between September 2014 and August 2015, the did not attend rate was 10.2%. The level of list cancellations in outpatients remained high and had increased since the 2014 inspection; the cancellation rate was 19% in 2014/2015 and continued at 19% between April and September 2015.
- In ophthalmology during the same period the did not attend rate 7.8%, this amounted to 1941 patients. The clinic cancellation figures in ophthalmology for September 2014 to August 2015 were 25.7%
- Waiting times for outpatient appointments at all three trust sites showed there were 116,535 first appointments between October 2014 and September 2015 and 28% (32930) of patients waited more than six weeks for their first appointment.
- Data provided by the trust showed 67.97% of OP referrals had been seen within six weeks in August 2015, against the national target of 90%.
- The admitted RTT was 76.57% against the national target of 90% and the non-admitted RTT and incomplete pathway targets were both being met.
- In outpatients, the manager recorded changed OP clinics (cancelled, reduced or extra activity); these showed there had been 44 changed clinics on the week of the inspection (12-17 October), 42 for the week following the inspection (19-24 October) and 53 for the week 26 October to 1 November.
- We spoke with eight patients in ophthalmology and one in urology, all nine told us their appointments had either been changed or cancelled at least once, prior to attending on the day we spoke with them. Two patients in ophthalmology told us it was their first appointment, and they had both received letters telling them the time and date had changed.
- The OP nurse manager told us "Surgery and medicine both have huge capacity issues (in meeting the demand in outpatients)."
- Signs indicated how late clinics were running and these were updated regularly by the nursing staff. When we asked patients about waiting times within the departments one male patient in urology told us, "It's very poor from a time-keeping point of view." They added, "My last appointment was in August 2015 and that was postponed until today without any explanation."
- We saw displayed that ophthalmology appointments were running 35 minutes behind time during our time spent in that waiting area. One patient told us they were not happy about the long waiting times in the ophthalmology department.
- Nursing staff told us the number of patients booked into urology clinics did not comply with BMA the guidelines of 20 patients in total comprising of six new and 14 follow up. The clinical nurse specialist on duty told us the afternoon before our visit there had been 65 patients for three consultants. The clinics had been due to finish at 5pm but did not finish until 5.45pm.
- Staff in OP told us patient appointments and clinic bookings were not the responsibility of the OPD.
- CAST booking staff told us they made the decisions about who to cancel from clinic lists. One band 2 clinic clerk related a recent clinic, which had to be reduced from 36 patients to 18 because the consultant was going to be in theatre. They told us they had selected the patients to cancel at random and stopped when they had managed to get through on the phone to 18 patients. This meant there was no clinical triage of clinic appointment cancellations. They said the consultant secretaries decided which clinics to cancel; this might be due to annual leave, sickness or study leave.
- When we looked at the trust's 'Referral to treatment access policy,' we saw it stated that when the hospital cancelled appointments, this should be undertaken in accordance with clinical guidance.

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- Nursing staff in urology told us, “Administrative staff cancel patients’ appointments.” They added that the consultants did not have time to look through multiple sets of notes when clinics were cancelled.
- When we asked the service manager for ophthalmology who decided which patients were cancelled they told us, “The clinician does not look at it; the CAST team member cancels the appointment and phones the patient.” When we asked them how many clinics were cancelled in ophthalmology they did not know and were unsure of who would know.
- The OP nurse manager told us appointment errors happened frequently, they said they often did not know which doctors would be attending the OP clinics.
- We saw evidence of overbooked clinics in ophthalmology was recorded in the department’s ‘Clinic problem log’ For example, on 18 May 2015, the morning clinic was overbooked and five consultants had 15 patients each to see. One consultant had a list of ten follow up and eight new patients to see. Appointment time slots were overbooked, between 0845 and 1040 there were three time slots with seven patients, one time slot with nine patients, two time slots with eight patients, one time slot with five patients and two time slots with two patients.
- We also saw examples of consultants being on annual leave and their clinics not being cancelled and overrunning clinics. Records showed, and staff confirmed, that afternoon clinics regularly ran over until between 6.30 and 7pm. Afternoon clinics were due to finish at 5pm.
- Staff told us there were problems with the recently installed ‘self-check in’ stations. They said that if the reception staff forgot to ‘refresh their computer screens’ on a regular basis then the fact that patients had arrived in the waiting room could get missed. One HCA in ophthalmology told us of a recent clinic where seven out of 10 patients were left waiting because they had used the self-check in machines. Other staff said the self-check in machines often sent patients to the wrong zone.
- Reception staff told us there were, “Issues with phone calls.” Patients calling to change or discuss their appointments cannot get through to the bookings team.” We also saw incidents recorded that patients had been unable to get through on the phone to discuss or change their appointments.

Ophthalmology

- Ophthalmology staff told us patients regularly came in to the department who had been cancelled six or seven times. They suggested it would be useful if the system flagged patients that had already had an appointment cancelled, so that it did not keep happening to the same patients.
- A member of staff in ophthalmology told us they were, “So short staffed.” They said the eye clinics were one of the worst for running over. They explained that every patient needed a vision test and there were only two rooms where these could be done, feeding between three and five other clinics. They said this contributed to everything running late, affecting the flow of patients through the department.
- Staff in ophthalmology told us they needed more non-medical staff to support the patient flow through the system. One said, “Sometimes the doctors are sat waiting!”
- There were ongoing capacity and demand pressures in ophthalmology resulting in:
 - Failure to meet 18 week targets
 - Delays between follow up appointments, resulting in patient incidents
 - Unable to meet national standards and guidance required
 - Cancelled appointments
 - Poor patient experience evidenced through high numbers of complaints
 - Ophthalmology outpatient referrals numbers increasing
- Progress had been made to reduce new to review ratio and increase patients through theatre. In 2012/13, the new to review ratio was 4.0, decreasing to 3.7 in 2013/14 and 3.3 in 2014/15. However, increasing number of new patients meant the numbers of patients requiring follow-ups was increasing. As there was no more physical space in ophthalmology to see patients, this was proving impossible to achieve.
- There were high numbers of on the day patient cancellations and on the day hospital on the day cancellations. There had been no significant improvement in follow up appointments being timely.
- Of 3032 letters, which had been identified as a backlog in ophthalmology, 1187 letters were outstanding as at August 2015 trust wide with 1483 patients remaining to be seen.

Outpatients and diagnostic imaging

- The ophthalmology OP follow up position in August 2015 was:-
 - 3601 overdue not booked
 - 2133 Unknown not booked
 - 2179 booked and overdue
 - 1340 booked and unknown
- Previous growth trends identified an increase in inpatient activity and a decrease in outpatient new appointments and this was expected to continue in 2015/16. However, patients remaining in the follow up system due to chronic disease were increasing. Additionally, growth on the 18-week waiting list had increased substantially year on year since 2012/13 and continued to create pressures on service delivery.
- Trend analysis demonstrated that the ophthalmology service received an additional 250 new referrals extra each year, and there has not been an increase in established posts or physical footprint to meet this increased demand for a number of years
- Ophthalmology saw 1100 patients per week on average and each patient was typically seen for four review appointments before going on to be discharged or reviewed for life due to the nature of their condition.
- Nursing staff in ophthalmology told us five or six patients who had attended A&E over the weekend were regularly added on to ophthalmology clinic lists that were already busy or full.
- The service manager told us recent capacity and demand work for ophthalmology had shown the service was 18 clinics a week short and they were not aware of any plans that would ensure the service would make up this shortfall. The trust provided evidence that there were plans for a further two clinics and DPoW and Scunthorpe hospital sites.

Diagnostic Imaging

Between 1 October 2014 and 30 September 2015 radiology at the DPoWH site undertook; 17,587 Computed Tomography (CT) scans; 3,658 fluoroscopy; 10,332 Magnetic Resonance Imaging (MRI) scans; 36,370 ultrasound and 69,489 X-rays. There were four days a week when MRI scans were done on an on-site van; the staff reported their own scans and these were uploaded to PACS every week.

- We visited ultrasound and spoke with sonographers; they told us there was no backlog of reporting in

ultrasound, as sonographers reported on their own work immediately. Ultrasound covered obstetrics and gynaecology, early pregnancy unit and terminations of pregnancy.

- Waiting times for radiology appointments were good; between October 2014 and September 2015 0.07% (74) of patients waited more than six weeks for their appointment, out of 103,991 appointments.
- We reviewed waiting turnaround times and reporting times for examinations performed at all three sites. Waiting turnaround times / examinations for radioisotopes was 26 days and the reporting time was just over 200 hours. When we discussed this with the managers, they were aware of the issues.
- The service had trigger points for outsourcing work when a backlog was identified; the trust had systems and processes in place to monitor any radiology backlogs. Radiology work was outsourced to an external company. We reviewed their turnaround time report for July 2015; this showed 98.2% of reports were processed in hours and 1.8% out of hours.
- We spoke with five patients in the radiology waiting areas. Four out of five told us their appointments had been on time and one told us they had a 40-minute delay for their ultrasound appointment.
- One patient was an inpatient who told us they had been waiting four days for their abdominal CT scan, which medical staff on the ward had requested the previous Saturday. They told us this was following a CT scan of their chest, which had shown abnormalities.
- Data submitted by the trust showed performance against the eight national and local cancer targets was compliant in six out of the eight categories in July 2015. The two categories which were not compliant were:-
 - 62-day wait urgent GP referral to treatment was 80.42% against the national standard of 85%
 - 62-day wait consultant screening service was 84.62% against the national standard of 90%.

Meeting people's individual needs

Outpatients

- The OP service did not have reliable systems and processes in place to meet the needs of different patient groups, including those in vulnerable circumstances or with additional needs, such as those living with dementia or a learning disability.

Outpatients and diagnostic imaging

- Staff told us if they knew that a patient had dementia or special needs then this was written in the notes. There was no visual check on the outside of the patients' notes to indicate this to staff. There had been a recent complaint from a relative of a patient with autism; they said their autistic relative waited four hours in the ophthalmology outpatient's clinic and had not been seen as a priority. This meant there was no system or process in place to ensure patients with special needs were fast tracked or given priority. Staff told us the hospital /trust had a lead nurse for dementia
- Staff in ophthalmology showed us pictorial cards, which they used for patients with literacy or understanding problems. Staff said they would give priority to patients with dementia or complex needs if they were aware of them. They told us the clinic ran a separate refraction list for children.
- The planned care manager was not aware of any systems for meeting people's individual needs, apart from booking interpreters. For example, they did not know what could be provided for patients that were hard of hearing.
- Nursing staff in urology told us clinic slots were 15 minutes long. They said 15 minutes was never long enough for appointments where you were breaking bad news, such as telling a patient they had cancer. The OP nurse manager also told us no additional appointment time was allowed for cancer patients.

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- Staff we spoke with were aware of the procedures when dealing with patients with special needs; they told us patients with learning disabilities or dementia and children would be fast-tracked. Ultrasound staff told us people with learning disabilities or dementia would require a chaperone and radiography staff were able to describe how they would manage patients with special needs.
- We asked staff about interpretation services; staff in sonography and radiology were aware of how to access these.

Learning from complaints and concerns

Outpatients

- Between the 1 April and the end of October 2014, 154 complaints received by the trust via the patient advice and liaison service (PALS) complaints, the vast majority

related to the administration of appointments. This was consistently high in comparison to other specialties and higher at this site. In the same period, there had been nine formal complaints, the majority related to the administration of appointments.

- Information provided by the trust dated July 2015, showed between 1 April and 31 July there had been 198 complaints received via PALS, 14 formal complaints and 5 SIs in ophthalmology.
- Two formal complaints had been received in outpatients at the DPoWH site between 1 October 2014 and 6 October 2015.
- Staff in ophthalmology told us they would deal with concerns and complaint 'as they arose' in the clinics, they said they were not involved or aware of any complaints. Managers also said complaints and concerns "would be dealt with there and then" but did not say how they would record this.

Diagnostic Imaging

- Complaints were handled in line with the trust policy. The trust had received ten formal complaints relating to radiology at the DPoWH site between 1 October 2014 and 6 October 2015. Nine related to the standard of care and one related to waiting times. Sonographers we spoke with were not aware of any complaints received in their department.

Are outpatient and diagnostic imaging services well-led?

Inadequate



At the last inspection in April 2014, we rated outpatients as 'good' for being well led. During this focussed inspection, we identified significant concerns in outpatients, which the trust had failed to recognise, monitor and address.

We rated the core service as 'inadequate' for being well-led because:

- The delivery of high quality patient care was not assured by the leadership, governance or culture in place. The trust did not have effective arrangements to monitor, recognise and act on the issues we found with

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outpatients appointments. Patients had been harmed and there was a continuing risk that patients would not receive good quality care. There was no effective system for identifying, capturing and managing risks.

- Following our inspection, we wrote to the trust on 25 October 2015 detailing the significant concerns we found in outpatients services during the visit. The concerns related specifically to the OPD follow-up backlog, the high level of cancelled appointments, appointments cancelled on the day and evidence of appointments being cancelled without clinical input in to decision making.
- The trust acknowledged that the management and monitoring of OP waiting lists urgently required improvement, especially in ophthalmology.
- The trust assured us they would take urgent action to clear the backlog of OP appointments, and monitor clinic cancellations and unanswered phone calls going forward. The ongoing clinical admin review was part of the trust's action plans and this was due to be completed by the end November 2015.
- There was not a culture of continuous evaluation and quality improvement. There was a lack of evidence to show staff and patient involvement and feedback on the improvement of services.
- Leaders were out of touch with what was happening on the front line. The trust did not communicate effectively with the staff working in outpatients. For example, they told us about their visions and plans but staff we spoke with in the service did not know about these, when we asked. Staff heard about work to improve capacity and demand but the trust did not involve them in this work or share their plans.

However,

- Staff in both outpatients and radiology told us their local line managers supported them. They said local managers were visible and provided leadership. Staff and managers told us there was an open culture. They felt empowered to express their opinions and felt that they were listened to.

Vision and strategy for this service

Outpatients

- Senior managers in CSS and the executive team talked about visions and plans, but had not communicated these to staff working in the OPD.

- The trust was working closely with the commissioners to address the significant capacity and demand issues within ophthalmology. The trust Governance and assurance committee (TGAC) update from July 2015 showed all 11,500 ophthalmology patients had been validated, with just over 3000 patients requiring a follow up appointment.
- There had been an 'Ophthalmology deep dive' in February 2015. The main findings showed unbalanced job plans against pay budget, high did not attend rates, opportunities to complete more elective cases and high on day cancellation rates.
- Assurance and overview of the entire ophthalmology improvement plan, including equipment, workforce changes, and pathway design was being undertaken through the monthly business meetings with the entire ophthalmology team led by the clinical leader and the CSS assistant general manager (a medical consultant). The 'ophthalmology backlog action plan' included surgery and outpatient follow up clinics.
- The clinical admin review was ongoing at the time of the inspection and band 2 and band 3 staff were expecting to hear where their new roles were allocated to within the following two weeks.
- Nursing staff in ophthalmology told us there were plans to have dedicated clinics to manage stable long-term conditions, such as glaucoma and diabetes, in the future.
- The clinical nurse specialist in urology told us they were developing an erectile dysfunction service for patients. They said consultants currently saw these patients, so a nurse led clinic would help in managing the department's workload. They said the service was planning to increase the number of consultant nurse specialists across the three trust sites.
- The OP nurse manager told us they were aware there was some work being done around OP sustainability, capacity, and demand. However, they said, "It's never been explained to us." A urology consultant also told us they were aware there was some work being done around capacity and demand but they had not been involved. This showed the executive team were not sharing their high-level plans with the staff providing the services.

Diagnostic Imaging

- Diagnostic imaging was part of the clinical support services (CSS), which managed radiology services across

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the three hospital sites. The head of radiology services was accountable to the associate medical director and associate chief operating officer. Clinical support service also had a business manager and two business support managers.

Governance, risk management and quality measurement

- There was no system in place to monitor and manage effectively the patients who were on the non-referral to treatment (non-RTT) pathways. This appeared to have been the case for some years.
- Staff told us that every now and again someone goes through the lists and highlights which patients need a follow up and checks whether they have had it. If patients need an appointment further than six weeks ahead it is not booked. There did not appear to be anyone within the management structure taking responsibility for the patients on the non-RTT pathways.

Letter to the trust following the inspection

- Following our inspection, we wrote to the trust on 25 October 2015 detailing the significant concerns we found in outpatients services during the visit:- The concerns related specifically to the OPD follow-up backlog (non RTT) and specifically the high level of cancelled appointments, appointments cancelled on the day and evidence of appointments being cancelled without clinical input in to decision making:-

The inspection team found:-

1. There was no monitoring of patients with multiple cancellations and no audit of clinic cancellations.
2. Significant gaps in the assurance process and assessment of managing clinical risk. For example, another SI was identified during the inspection week of a patient post corneal graft.
3. Systems and processes to provide information to booking staff as to whether patients have had previous cancellations were not robust.
4. Systems for booking clinics were multi-step and fell between different specialties and administration groups. This meant no one had ownership or responsibility for the process.
5. Lack of administration staff in the CAST (bookings) team at both the DPoWH and SGH sites meant phone calls were not answered.

6. From interviewing staff there appeared to be confusion about accurate waiting list figures and what actions were being taken to address these. Figures presented to the inspection team included 30,000 in June 2015 and 13,000 in September 2015.

7. The numbers by speciality of all patients within the non-RTT backlog and how these will be tracked going forward.

- The trust response addressed these points and assured the commission that action would be taken to:-
 - audit patients on the follow-up lists
 - strengthen the monitoring arrangements in place in relation to OPD follow-ups
 - strengthen arrangements for monitoring of short notice clinic cancellations
 - appoint a senior over-arching lead to drive the required improvements in OPD booking systems
 - Include call abandon rates as part of the key performance indicators to be monitored monthly
 - Provide waiting list information in a more 'user friendly' dashboard
- In June and August 2015, the executive team (ET) had acknowledged there was no national reporting or benchmarking available and there was no historical position about the OP backlogs known within the trust.
- The ET had agreed the focus on validation would remain within ophthalmology but that once complete the trust's data quality team would explore additional validation resources required to look at other OP specialty areas.
- Since 6 October 2015, the trust has been providing weekly progress reports on the validation of the OP waiting lists. These had shown sustained progress towards meeting the targets set.

Outpatients

- Following the reporting of two SIs in ophthalmology in March 2015, a validation exercise was undertaken to identify and prioritise those ophthalmology patients who may still require an appointment. The ET subsequently agreed a similar high-level validation exercise for all of the specialties where the system indicated patients still needed an appointment still needed. This validation, which included all follow-up patients not on an active 18-week pathway, was due to be completed and all patients to have appointments booked by no later than 31 December 2015.

Outpatients and diagnostic imaging

- In 2014, an external company carried out an 'Out Patients Diagnostic Review' reviewed the systems and processes within the OPD, and looked at data between January and December 2014. Their findings showed:-
 - High levels of unused clinic slots, for example 13,000 in ophthalmology and 8,000 in urology
 - Local booking rules used in many specialties
 - High levels of overbooking or inflated templates to compensate for large did not attend rates
 - High administration costs (£197k) related to overbooking and cancellations
 - The top 13 specialties had a capacity opportunity of £15.2m
 - The systemic problems with outpatients clinic bookings and cancellations meant the service:-
 - was unable to meet quality standards by NICE regarding frequency or reviews
 - received continued high numbers of complaints and incidents
 - had low staff morale
 - For example, in April 2009 NICE issued guidelines on the diagnosis, monitoring and treatment of glaucoma. These guidelines recommend that certain areas of glaucoma-related work should be undertaken only by an optometrist with a specialist qualification or who is working under the supervision of a consultant ophthalmologist. The Royal College of Ophthalmologists together with the College of Optometrists published supplementary guidance on supervision in relation to glaucoma-related care by optometrists. Discussions had taken place between the CCG, the hospital and the local eye health network but compliance with these guidelines had not been achieved.
 - The trust's ophthalmology business case (dated March 2015) contained information showing how the trust planned to achieve compliance with the glaucoma NICE guidelines. However, at the time of the inspection none of the actions identified in this business case had been completed. These included developing technicians to perform work currently carried out by medical staff. There were weekly meetings between the central data quality teams and the business groups to manage and monitor waiting lists and patient tracker lists (PTLs) and the executive team had oversight of the 18-week targets and outpatient follow-ups.
 - We reviewed minutes from weekly clinic utilisation group between 17 September and 8 October 2015. We saw these minutes identified that clinic change forms were not being completed.
 - The planned care manager told us they felt, "Processes (within OP bookings) had failed and collapsed." They said the situation had been the same for the past two years. They also said the processes used, such as bookings and patient tracker lists, "Used to be tight." When we asked them what they were going to do about it they said they would have more meetings with the OP nurse managers to look at clinic utilisation, did not attend rates and cancellations.
 - They confirmed what staff had told us about not knowing which clinics were on, which doctors were coming and clinic change forms not being completed. They confirmed that this was not audited they said this would be monitored in the future.
 - When we asked the OP nurse manager whether the location of the resuscitation trolley in the Amethyst ward had been risk assessed, or whether it was on the risk register. They said they were not aware of what was on the risk register for the OPD and they did not know whether the planned care manager was aware that it could be an issue in the event of an emergency. This showed there was a lack of involvement and awareness of risk management within the senior staff at clinic level.
- ## Pathology
- All of the on-site pathology departments were accredited with the clinical pathology accreditation. They were awaiting notification of their first inspection by the United Kingdom Accreditation Service. The Human Tissue Authority had inspected the mortuary by the in 2014; no issues were raised. This showed governance, risk management and quality measurement within pathology was good.
 - The Path Links pathology general manager told us the service delivery within pathology was working to meet all of the key performance indicators of the Royal College of Pathologists.
- ## Diagnostic Imaging
- Governance arrangements were in place, which staff were aware of. The clinical support services (CSS)

Outpatients and diagnostic imaging

division held monthly governance meetings and business meetings. Radiology held medical exposures committee meetings and radiation protection committee meetings.

- The service held monthly team briefing meetings at the DPoWH site. Staff told us any changes to risk assessments, policies and procedures were discussed at these meetings.
- Staff confirmed managers gave them feedback about incidents and lessons learned the team meetings. Comments, compliments, complaints, audits and quality improvement were also discussed.
- The service had a risk register in place and managers updated this accordingly. Managers were aware of the risks within their departments and were managing them appropriately.
- Staff told us the radiologists gave feedback to the radiographers about the quality of the images. Quality assurance systems and feedback was made via the departmental computer system.
- We reviewed the trust's radiation safety guidance and organisational structure document. This showed the structure for overall radiation safety across all sites, including reporting structures and responsibilities.
- Meetings were held with the Radiation Protection Advisor (RPA) and Radiation Protection Supervisor (RPS), which were recorded. The RPA was based at the local trust and an SLA was in place. The RPS was a radiographer based on site.
- Diagnostic imaging was part of the clinical support services (CSS), which managed radiology services across the three hospital sites. The head of radiology services was accountable to the associate medical director and associate chief operating officer. Clinical support service also had a business manager and two business support managers.
- We interviewed the management team during the inspection. No significant issues were identified within radiology during the inspection. The managers were aware of the need to recruit more radiologists and this work was ongoing.

Leadership of service

Outpatients

- We found there were management responsibility and accountability structures in place within the outpatient's services.

- However, there was no matron for outpatients and there was no line manager between the band 7 OP nurse manager at each site and the planned care manager. The planned care manager was responsible for a large number of areas within the trust, across all three sites. These included cancer service, endoscopy, health records, outpatients and the nurse practitioners in immunology and transfusion.
- The OP nurse managers used a matron in one of the other services for clinical supervisions and clinical advice. The OP nurse manager told us they line managed 45 staff in OP and had recently taken on managing the nursing staff in X-ray. They said X-ray had two new staff starting on the 1 November, and then they would be line managing 52 staff members. They said a large proportion of staff worked part time. This meant there was a lack of management support for the staff and managers working within the OPD.
- Staff we spoke with understood the departmental structure, and who their line manager was.
- The trust submitted emails showing service managers had declined requests for time off from medical staff rostered for outpatient clinics were being declined. These included requests for annual leave and time off to carry out appraisals
- These were submitted to demonstrate that the trust was managing the clinics effectively. However, these emails showed several medical staff not happy with the system for approval of annual leave. One consultant wanted time off for Eid and had requested this several months previously and another had requested time off to complete appraisal with junior medical staff. This showed the problems with bookings and clinic capacities in the OPD were affecting the work life balance and professional responsibilities of medical staff working in the OP clinics.

Diagnostic Imaging

- We found there were clear lines of management responsibility and accountability within the diagnostic imaging services. Staff we spoke with understood the departmental structure and who their line manager was.
- All staff within radiology spoke positively about their local line managers; they said they were supportive and that there was regular contact with them.

Outpatients and diagnostic imaging

- Staff told us the radiologists were supportive of the local staff and gave good feedback to the radiographers. One radiologist told us there were, “No issues here apart from staffing.”
- We interviewed the management team during the inspection. No significant issues were identified within radiology during the inspection. The managers were aware of the need to recruit more radiologists and this work was ongoing.

Culture within the service

Outpatients

- Staff feedback about the culture within the OPD was mixed, mainly because of workload pressures and the ongoing clinical admin review for band 2 and band 3 staff.
- When we asked staff about the clinical admin review comments included:-, “Morale is a bit low”, “Absolutely heartbroken” and “Very distressing for all concerned.”
- The planned care manager told us staff working in OP were, “Very tired, frustrated and fed up.” They said they had a, “Good and open relationship” with the three OP nurse managers. When we asked them about communication they told us they had identified that there were, “Some blockages in sharing information with all staff groups.”
- The OP nurse manager told us there were problems with communication about OP clinics from the service managers.
- Staff told us the OP team worked well together, the OP managers and service managers were supportive and approachable and communication was good. Negative comments included:-
 - “Stressful”
 - “Good at sharing information.”
 - “The staff are really helpful; I can’t fault them.”
 - “A lovely team.”
 - “Happy working here
- Reception staff told us it, having to deal with patients whose clinics had been cancelled was stressful. They said patients should be informed by phone when their appointments were cancelled but this often did not happen.

Diagnostic Imaging

- Staff spoke positively about the service they provided for patients. Staff were aware of the importance of providing a quality service with a positive patient experience
- Staff worked well together and there was obvious respect between different staff groups within the department. Radiologists told us they had good working relationships with their colleagues and other staff told us morale was good and there was a positive culture in the teams with good teamwork, and good team support.
- Staff also gave positive feedback about their local line managers, and said they were supportive
- One ultra-sonographer told us they, “Enjoyed working for the trust.”

Public engagement

Outpatients

- We asked the planned care manager about feedback from the friends and family test (FFT), as we had seen in departmental minutes that these had been discontinued. They confirmed these meetings had been discontinued but were going to “be realigned to another meeting.” They said there was no analysis of FFT comments received, “We just get a list of comments.” They said these were shared at the governance meetings and, “Any negative comments are usually about the doctors.”
- They confirmed the FFT results were ‘a few months behind.’ We asked what happened to the results of the FFT, they said they were fed through to the governance facilitator and they did not get any further feedback. They said the comments went back to the specialties involved, and not to the OPD.

Diagnostic Imaging

- We reviewed the nuclear medicine patient satisfaction survey for 2015; we saw 55 patients had responded between 1 February and 18 March 2015. The feedback was all positive, with 13 people making comments 12 of which were positive; one negative comment related to the distance to travel to the hospital.
- Ninety-three percent of the patients (51 out of 55) who completed the surveys thought that their nuclear medicine examination could not have been improved

Staff engagement

Outpatients and diagnostic imaging

Outpatients

- Staff told us there was good engagement with their local teams but not with the wider organisation. Nursing staff in ophthalmology told us the monthly team meeting within ophthalmology was good and communication was good. However, they said communication with the business team was not so good. They said they communicated things upwards but did not get feedback. One nurse gave an example of a cancelled clinic due to consultant sickness on the day of the inspection. They said the business team advised them to cancel the clinic, however staff did not receive confirmation that this had happened. One nurse said, “Nothing is ever fed back to us.”
- Staff in ophthalmology told us a staff nurse had been completing a ‘Daily clinic information form’ every day for the past nine years. They said they did not know why they completed this form and they never got any feedback about the information submitted.
- In urology, the consultant urologist told us, “The staff here are exemplary.” Urology nursing staff said their challenge was to have more autonomy over patients being cancelled booked and rebooked. They said the current booking system was, “annoying and frustrating.” They related a recent incident of a patient whose appointments had been cancelled twice and when they came to their appointment they said, “No-one has checked my prostate blood levels for nine months. They said they carried out an audit to check 800 male patients to ensure no other patients had been missed, they said, “Luckily none had.”

Diagnostic Imaging

- Staff feedback about the local line management support was extremely positive; staff told us they felt, “Consulted and involved.”

- Staff told us they knew how to contact the executive team, but they were not visible in the departments. Staff felt consulted about issues that affected them.
- Radiology held a team-briefing meeting once a month, which included a verbal synopsis of contents of trust-wide team brief. Trust and local issues, including incidents, were discussed.
- Radiographers told us they received positive mentoring by senior radiographers

Innovation, improvement and sustainability

Outpatients

- When we asked the planned care manager about innovation and they gave the example of the self-check in kiosks. They were unaware of the staff feedback we had received, that the system did not work reliably and patient’s arrival in the department was often not recorded or patients were sent to the wrong clinic areas. This meant patients missed their appointment slots, as the reception staff were not aware of their arrival.
- The OP nurse manager told us they were training HCAs to support in the laser clinics.

Pathology

- The Path Links pathology general manager told us cell pathology was planning to introduce whole slide imaging and digital pathology. They explained this would have massive benefits for patient safety and turnaround times, and staff would be able to read slides remotely.
- They also told us pathology staff had developed the WebV touch books, which had recently been rolled out across the trust.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels. This must include but not be limited to: medical staff within ED and critical care, nursing staff within medicine and surgery and midwives. It must also include a review of dedicated management time allocated to ward co-ordinators and managers. It must ensure adequate out of hours anaesthetic staffing to avoid delays in treatment. The trust must ensure there are always sufficient numbers of radiologists to meet the needs of people using the radiology service.
- The trust must ensure that staff at core service/divisional level understand and are able to communicate the key priorities, strategies and implementation plans for their areas. The trust must improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform.
- The trust must ensure that the significant outpatient backlog is promptly addressed and prioritised according to clinical need. Ensure that the governance and monitoring of outpatients' appointment bookings are operated effectively, reducing the numbers of cancelled clinics and patients who did not attend, and ensuring identification, assessment and action is taken to prevent any potential system failures, thus protecting patients from the risks of inappropriate or unsafe care and treatment.
- The trust must ensure equipment is checked, in date and fit for purpose including checking maternity resuscitation equipment and critical care equipment is reviewed and where required included in the trust replacement plan
- The trust must ensure that action is taken to address the mortality outliers and improve patient outcomes in these areas.
- The trust must ensure it acts upon its own gap analysis of maternity services across the trust to deliver effective management of clinical risk and practice development.
- The trust must ensure the safe storage and administration of medicines. The trust must ensure staff check drug fridge temperatures daily and record minimum and maximum temperatures. Additionally it must ensure staff know that the correct fridge temperatures to preserve the safety and efficacy of drugs and what action they need to take if the temperature recording goes outside of this range. The trust must ensure the DPoW hospital discharge lounge has a facility and process for safe storage for medicines.
- The trust must review the validation of mixed sex accommodation occurrences, especially within the acute medical unit, to ensure patients are cared for in appropriate environment and report any breaches.
- The trust must ensure there is an effective process for providing consistent feedback and learning from incidents.
- The trust must ensure the reasons for do not attempt cardio respiratory resuscitation (DNACPR) decisions are recorded and in line with good practice within surgical services.
- The trust must ensure the five steps for safer surgery including the World Health Organisation Safety Checklist (WHO) is consistently applied and practice is audited in theatres.
- The trust must review the effectiveness of the patient pathway from pre-assessment, through to timeliness of going to theatre and the number of on the day cancellations for patients awaiting operation.

Outstanding practice and areas for improvement

- The trust must ensure policies and guidelines in use within clinical areas are compliant with NICE guidance or guidance from other similar bodies and that staff are aware of the updated policies, especially within maternity, ED and surgery.
 - The trust must have a process in place to obtain and record consent from patients and/or their families for the use of the baby monitors in ITU and CCTV cameras in CCU.
 - The trust must ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation, especially in relation to: staffing; critical care and ensuring the essential equipment is included in the trust replacement plan.
 - The trust must ensure there are adequate specialist staff, training and systems in place to care for vulnerable people specifically those with learning disabilities and dementia.
 - The trust must stop using newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses on duty.
 - The trust must ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours The trust must continue to improve against the target of all staff receiving an annual appraisal and supervision, especially in surgery, and that actions identified in the appraisals are acted upon.
 - The hospital must ensure the safe storage of medicines within fridges. The trust must ensure staff check drug fridge temperatures daily and record minimum and maximum temperatures. Additionally it must ensure staff know that the correct fridge temperatures to preserve the safety and efficacy of drugs and what action they need to take if the temperature recording goes outside of this range
- Action the hospital SHOULD take to improve**
- The trust should evaluate the medical review of outlying medical patients on surgical wards to improve consistency of cover arrangements and prevent unnecessarily delayed discharges.
 - The trust should evaluate the arrangements for consultant cover of the AMU to ensure a consultant reviews all patients daily, irrespective of length of stay.
 - The trust should as a matter of urgency address the continuing gap in clinical education in critical care.
 - The trust should review patient flow and reduce the number of delayed discharges from ITU.
 - The trust should introduce critical care specific morbidity and mortality meetings.
 - The trust should continue to improve on its mandatory training targets to achieve its own compliance level of 95% and specifically ensure that staff have a better understanding of the assessment of mental capacity and the use of restraint (including chemical restraint).The trust should continue to work towards delivering care and treatment that is in line with national guidance and Core Standards for Intensive Care.
 - The trust should review the use of pressure relieving equipment and preventative blood clot equipment within theatres.
 - The trust should ensure that within maternity services multiple use equipment and devices are cleaned or decontaminated between uses; that all areas are kept clean and records of cleaning are maintained.
 - The trust should ensure that there is a standard operating procedure for the use of the second theatre (anaesthetic room) to maintain patient safety within maternity.
 - The trust should ensure the premises and location of the ophthalmology department is suitable for the purpose for which it is being used.
 - The trust should ensure there is sufficient space and seating for patients and their supporters in the outpatients departments.
 - The trust should strengthen the support provided to nuclear medicine technologists by the ARSAC licence holder.
 - The trust should ensure IR(ME)R training is mandatory for radiology staff.

Outstanding practice and areas for improvement

- The trust should ensure that all staff within outpatients are aware of their responsibilities in relation to the Duty of Candour .

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>How the regulation was not being met: there were breaches of the national policy for mixed sex accommodation which compromised a person's right to privacy and dignity. Patients privacy and dignity was compromised by the use of baby monitors and CCTV on critical care and CCU at DPoW hospital.</p> <p>The trust must:</p> <ul style="list-style-type: none">• review the validation of mixed sex accommodation occurrences, to ensure patients are cared for in appropriate environment and report any breaches.Reg 10(1)• ensure that patients' privacy and dignity is maintained if the baby monitors and CCTV and in useReg 10(1)
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>How the regulation was not being met: There was no review of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions post-operatively when the emergency situation may have changed or when patients were diagnosed medically fit, or transferred between hospitals. Consent was not been obtained/recorded from patients and/or their families for the use of the baby monitors in critical care and for the use of CCTV in CCU at DPoWhospital.</p> <p>The trust must:</p>

Requirement notices

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

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

How the regulation was not being met: care was not always provided in a safe way as policies and guidelines were not all compliant with national guidance;not all equipment was checked or where required included in the trust's replacement plan; fridge temperatures were not effectively monitored to preserve the safety and efficacy of drugs; there were not suitable arrangements in place in order to ensure the proper and safe management of medicines in people's homes.

The trust must:

- ensure policies and guidelines in use within clinical areas are compliant with NICE guidance or guidance from other similar bodies and that staff are aware of the updated policies, especially within maternity, ED and surgery.Reg 12 (1)
- ensure equipment is checked, in date and fit for purpose including checking maternity resuscitation equipment and critical care equipment is reviewed and where required included in the trust replacement plan.Reg 12(2)(e) & (f)
- ensure the safe storage of medicines within fridges, specifically with regard to temperature and stock control.Reg 12(2)(g)

Regulated activity

Regulation

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met: systems and processes were not operated effectively to: assess, monitor and improve the quality and safety of services; assess, monitor and mitigate risks relating to the health and safety of patients; maintain some community records in line with recognised guidance and; seek and act on feedback from relevant persons.

The trust must:

- ensure that staff at core service/divisional level understand and are able to communicate the key priorities, strategies and implementation plans for their areas.Reg 17 (2)(a)
- ensure the five steps for safer surgery including the World Health Organisation Safety Checklist (WHO) is consistently applied and practice is audited in theatres.Reg 17 (2)(a)
- review the effectiveness of the patient pathway from pre-assessment, through to timeliness of going to theatre and the number of on the day cancellations for patients awaiting operation.Reg 17 (2)(a)
- ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours.Reg 17(2)(a)
- ensure that the significant outpatient backlog is promptly addressed and prioritised according to clinical need, ensure that the governance and monitoring of outpatients' appointment bookings are operated effectively, reducing the numbers of cancelled clinics and patients who did not attend, and ensuring identification, assessment and action is taken to prevent any potential system failures, thus protecting patients from the risks of inappropriate or unsafe care and treatment.Reg 17(2)(a)&(b)
- ensure it acts upon its own gap analysis of maternity services across the trust to deliver effective management of clinical risk and practice development.Reg 17(2)(a)&(b)
- ensure that action is taken to address the mortality outliers and improve patient outcomes in these areas.Reg 17(2)(a)&(b)

Requirement notices

- ensure there is an effective process for providing consistent feedback and learning from incidents.Reg 17(2)(b)
- ensure there are timely and effective governance processes in place to identify and actively manage risks throughout the organisation, especially in relation to: staffing; critical care and ensuring the essential equipment is included in the trust replacement plan.Reg 17(2)(b)
- improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform.Reg 17(2)(e)

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met: there were not always sufficient numbers of suitably skilled, qualified and experienced staff deployed and not all staff received appropriate training, supervision and appraisal necessary to enable them to carry out the duties they were employed to perform.

The trust must:

- ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patients' dependency levels. This must include but not be limited to: medical staff within ED and critical care, nursing staff within ED, medicine and surgery. It must also include a review of dedicated management time allocated to ward co-ordinators and managers. It must ensure adequate out of hours anaesthetic staffing to avoid delays in treatment. The trust must ensure there are always sufficient numbers of radiologists to meet the needs of people using the radiology service. The trust must stop including newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses on duty.Reg 18(1)

This section is primarily information for the provider

Requirement notices

- ensure there are adequate specialist staff, training and systems in place to care for vulnerable people specifically those with learning disabilities and dementia.Reg 18(1)
- continue to improve against the target of all staff receiving an annual appraisal and supervision, especially in surgery, and that actions identified in the appraisals are acted upon. Reg18(2)(a)