Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust

Scunthorpe General Hospital

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a follow-up inspection of Northern Lincolnshire and Goole NHS Foundation Trust from 22 to 25 November 2016 to confirm whether the trust had made improvements to its services since our last inspection in October 2015. We also undertook an unannounced inspection on 17 October 2016 and 08 December 2016.

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

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

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

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

In November 2016 we inspected:

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

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

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

We rated Scunthorpe General Hospital as inadequate overall.

Key Findings:

- Nursing and medical staffing had improved in some areas since the last inspection. However, there were still a number of nursing and medical staffing vacancies throughout the trust. Staff turnover in some areas were particularly high especially in medical care, emergency departments, surgical services, and services for children and young people.
- The trust had systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care. However, a number of registered nurse shifts remained unfilled, despite these escalation processes and we saw examples of wards not meeting planned staffing levels and high patient acuity not identified appropriately.

Summary of findings

- There had been a lack of improvement since the inspection in 2015, areas of concern had not been fully addressed in a sustained way and there had been deterioration in a number of services. Safety processes were not always adhered to in some services.
- In 2015, we said that the trust must ensure there is an effective process for providing consistent feedback and learning from incidents. During this inspection, learning from incidents remained inconsistent and variable between directorates. Staff we spoke to reported a varying standard of feedback and learning from incidents.
- Assessing and responding to patient risk was inconsistent and did not support early identification of deterioration in maternity, surgery and urgent and emergency services. This was particularly evident in the Emergency Department (ED) at Scunthorpe General Hospital (SGH), where the national early warning scores (NEWS) were not recorded in the majority of records we reviewed.
- A Paediatric Early Warning Score (PEWS) was not used in the Emergency Department, so we were unable to be sure that the identification and escalation of deterioration in a child's condition would be recognised.
- The trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) checklist. However, from a review of records and observations of procedures, it was apparent that this was not an embedded consistent process.
- The standard of documentation was variable, for example in the ED at SGH; documentation was variable and at times inadequate to ensure delivery of safe care.
- During our inspection, the ED at SGH was overcrowded with no resuscitation bays or trolleys available. Patients were queuing with paramedics waiting for a cubicle and we saw and heard evidence of patients put at risk due to unavailable space.
- There were poor infection prevention and control processes and standards of cleanliness in the ED at SGH. Mandatory training rates in infection control were variable across the hospital with low rates in the areas where concerns were identified.
- We found inconsistent practice with regard to resuscitation trolley checks, fridge temperature checks and medication checks across the hospital.
- We were not assured patients had adequate nutrition and hydration whilst they were in the Emergency Department for a long period of time.
- Patient flow through the hospital remained an issue with a significant number of patients cared for on non-medical or non-speciality wards. A 'buddy' ward system was in place, however there was still confusion regarding which consultant should review which patient. Patients who were moved more than once could be under the care of different consultants during their stay in hospital.
- There was a high number of black breaches (ambulances waiting for over one hour) at this trust between December 2015 and September 2016, there were 694 black breaches.
- Patients requiring pre-assessment prior to surgery were not always assessed according to an effective patient pathway. There remained a large number of 'on the day' cancellations for clinical reasons.
- Referral to treatment times across a number of services showed a deteriorating position and was significantly below the national indicator and slightly below the England average. Patients were not always able to access services for assessment, diagnosis or treatment when they needed them. There were long wait times within surgical services and overall the service was not meeting the national referral to treatment times (RTT) or all cancer performance standards.
- Emergency Department performance was variable and between August 2015 and July 2016 the department did not achieve the target for 95% of patients to be treated, discharged or admitted within four hours.
- In 2015, we raised concerns regarding the numbers and reporting processes of mixed sex accommodation breaches. The trust had updated the policy for eliminating mixed sex accommodation, which was in line with Department of Health guidance (November 2010). However, the trust has continued to report mixed sex breaches in a number of core services. For example in medicine at SGH, 14 mixed sex breaches had been reported.

Summary of findings

- The trust participated in national and local audit programmes however, trust performance against national performance was mixed across most of the core services with many showing performance that was worse than England averages. There was also variation in patient outcomes between the two hospital sites. Patient outcomes were overall worse at SGH than DPoW.
- Mandatory training and appraisal targets had not been met by some staff groups. This included safeguarding training targets and not all staff had the required level of safeguarding training in place.
- At the 2015 inspection we were told that were plans to introduce a seven day 24 hour gastro-intestinal (GI) bleed rota. At this inspection we found that this was still not in place. Agreement had been reached for consultant rota cover however further work was being undertaken to agree the nursing rota.
- The endoscopy unit had lost their Joint Accreditation Group (JAG) accreditation in August 2016 due to an audit that was not submitted within the necessary timescales and communication issues.
- In maternity services we had concerns regarding the completion of the K2 training package (an interactive computer based training system that covered CTG interpretation and fetal monitoring) for midwives and medical staff in maternity.
- We found poor leadership and oversight in a number of services, notably maternity services, outpatients, surgery and urgent and emergency care. In these services leaders had not led and managed required service improvements effectively or in a timely manner. In addition service leads had tolerated high levels of risks to quality and safety without taking appropriate and timely action to address them.
- There was variability in the quality of risk registers, not all risk registers accurately reflected the risks in the service and were not always updated and reviewed effectively.
- Concerns remained regarding the organisational culture. There were a number of themes that emerged from discussions with staff relating to a disconnection still between the executive team and staff, there was a sense of fear amongst some staff groups regarding repercussions of raising concerns and bullying and harassment. Feedback from management teams had a more positive focus.

However:

- The trust had taken action in some areas since the 2015 inspection, for example, the trust had stopped using Band 4 nurses, awaiting professional registration numbers, within the registered nurse establishment.
- There were improvements in critical care services, the management team were able to articulate a clear vision and governance processes were effective.
- There was a new management team in surgery that were able to demonstrate an understanding of the challenges and the areas that required further improvement. They had only recently come into post and had not had sufficient time to implement the changes required to address the ongoing concerns.
- At SGH the Ambulatory Care Unit (ACU), which opened in September 2015, had a positive impact on patient flow.
- There was evidence of good multidisciplinary working in most of the services. A frail elderly assessment team (FEAST) attended ED liaising with the community teams and the service offered hyper acute stroke services with acute stroke nurses attending ED.
- In critical care patient outcomes, for example, mortality, early readmissions, delayed and out of hours discharges had improved and were in line with similar units.
- There were improvements in the ophthalmology service specifically with regard to the cancellation of clinics and clinical oversight of this process
- All radiology staff had received training regarding the ionising radiation (medical exposure) regulations (IR (ME) R 2000).
- Overall we observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way..

We saw several areas of good practice including:

Summary of findings

- An ambulance handover team, to see ambulance patients and provide an initial assessment, had been introduced and was providing a positive impact on the ambulance turnaround times.
- There was a new initiative called the virtual ward. Two health care assistants were available all day Sunday to Friday and half days on Saturdays. They were deployed to an elderly medical ward at the start of their shift, and then re-deployed to any area with short notice absence or where one to one patient care was required.
- The Ambulatory Care Unit (ACU) opened in September 2015 and had a positive impact on patient flow at the Scunthorpe General Hospital site. This had resulted in a significant reduction in length of stay of almost 2 days, an increase in zero length of stay patients and a significant reduction in medical outliers.
- A online call service run by the infant feeding co-ordinator was being offered to support breast feeding mothers within the community setting.
- The trust had held 'Dying Matters' roadshows at a number of local venues in May 2016, including supermarkets and community centres. These had been advertised as events to provide advice and sign-posting to members of the public on all aspects of planning end of life care, bereavement, dying, organ donation, and will-writing.
- The Macmillan end of life care clinical coordinator had been in post for ten months. During that time, 400 staff had attended educational sessions and the new end of life care plan had been implemented on 11 wards. An end of life care facilitator had also been appointed recently.
- The diagnostic imaging departments had begun a pilot in conjunction with primary care for radiologists to refer patients straight to CT following an abnormal chest x-ray. When patients were seen in clinic as a two-week wait, they already had CT scans and results available for the clinician at their first appointments. This potentially reduces lung cancer patients' length of pathway.

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

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

Emergency and Urgent Care

Summary of findings

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

Critical Care

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

Maternity

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

Children and Young People's Service

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

Outpatients and Diagnostic Imaging

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

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

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

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Urgent and emergency services	Inadequate

Why have we given this rating?

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

- There had been no significant improvement since our last inspection in October 2015.
- The department was not meeting the department of health standard, which states that 95% of patients should be treated and discharged or admitted within four hours of arrival. They showed mixed performance against the England average.
- There was a disparity between the nationally published data for the time to initial assessment and what we found on inspection.
- Between September 2015 and August 2016, Scunthorpe General Hospital median percentage of patients that left the hospital before being seen for treatment was worse than the England average for six of the 10 months.
- Between September 2015 and August 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally worse than the England average.
- Between November 2015 and October 2016 there was a fluctuating trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In November 2015 61.7% of ambulance journeys had turnaround times over 30 minutes; in October 2016 the figure was 63.7%. However, since the introduction of the ambulance handover team there had been an improvement.
- There was a high number of black breaches (ambulances waiting for over one hour). At this trust between December 2015 and September 2016, there were 694 black breaches.
- When the department was busy, ambulance staff waited at least 15 minutes prior to booking the patient in at reception. This therefore, affected

Summary of findings

the figures for the length of time patients were in A&E, as patients were up to 15 minutes longer in the department before they were registered as arriving.

- During our inspection, the department was overcrowded with no resuscitation bays or trolleys available. Patients were queuing with paramedics waiting for a cubicle and we saw and heard evidence of patients put at risk due to unavailable space. Although there were escalation procedures in place, the nurse co-ordinator several times referred to the department as being unsafe.
- Nurse leadership was weak. Quality and safety was not the top priority for leadership. New processes were put in place following our inspection, but on our unannounced inspection, these had not been consistently completed and leaders had not checked they were effective.
- Governance meetings were attended by the senior team however; departmental meetings did not take place. Therefore, staff were not actively engaged or empowered.
- The department was not meeting the trust target for staff completing mandatory training. There was no clear system for medical device training and no assurance staff were competent to use each piece of equipment.
- We saw evidence that the department did not always meet the planned nurse staffing numbers. Medical staffing and children's nurse staffing did not meet national guidance. We observed the lack of nurses and the impact this had on patient care.
- The target for appraisal rates was not being met.
- There was poor monitoring of infection control practices.
- Emergency equipment was not checked regularly in line with trust policies.
- Safeguarding vulnerable adults and children were not given sufficient priority.
- Nursing documentation and assessments were not consistently completed.

Summary of findings

- There was lack of recording of the National Early Warning Scores (NEWS) therefore we could not be assured that the patients were having the appropriate level of monitoring whilst in the ED.
- We found medicines and intravenous fluids were not always stored safely and securely. Controlled drugs daily balance checks were not always performed and fridge temperatures were out of range and not acted upon.
- There was little evidence of basic nursing care being carried out, such as, assessment of pressure areas, pressure relief, offering of toilet facilities regularly and offering food and drink.
- Patients were not always well informed of what was happening or what they were waiting for.
- Privacy and dignity was not always respected.
- There was no specific support for patients who attended whilst living with dementia.
- Patients who attended with mental health problems were nursed in a specific cubicle that should be ligature free; however, we found ligature points in the room.
- There was a lack of health and safety assessments of the ongoing building work taking place to construct the children's waiting room.
- The general public had unsupervised access to the equipment and supplies in the resuscitation room because it was not secure.
- The risk register did not include all risks identified during the inspection and it was not clear who had responsibility for each risk and if any action plans were in place and being monitored.
- We did not see robust evidence of actions completed from action plans of audits.
- Clinical pathways were not reviewed regularly.
- The vision and strategy created since our last inspection in July 2015 was still in its infancy. The vision did not encompass key elements such as compassion, nursing care, patient safety and quality. Not all staff were aware of, or understood, the vision and strategy for the department.

Summary of findings

Medical care (including older people's care)

Requires improvement

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

- We had concerns about the safety of medical care services, which required improvement. The number of nursing staff on duty was below the minimum agreed level in order to provide safe care and there was minimal medical cover at night with one registrar and two junior doctors covering the stroke unit, the clinical decisions unit and all medical wards.
- There were mixed results in national audits and the endoscopy unit was no longer meeting the requirements for JAG accreditation and had lost this is in July 2016.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England overall performance. Patient flow through the hospital remained an issue with a significant number of patients cared for on non-medical or non-speciality wards. We also found two week breaches were still occurring in endoscopy.
- There was no action plan to demonstrate how the medicine group were going to meet their business objectives. We found staff engagement varied. Although staff appeared dedicated to patient care and worked well with colleagues, morale was low because of staff shortages, ward moves and working additional shifts. Ward managers had limited time to carry out their management duties as they were counted in the nursing numbers four days out of five.

However:

- We found the monitoring and reporting of medicine fridge temperatures had improved and nurses awaiting their PIN were no longer counted in the nursing numbers.
- Staff were caring and patients were treated with respect and compassion.
- On the Scunthorpe General Hospital site, the Ambulatory Care Unit (ACU), which opened in September 2015, had a positive impact on patient flow.

Summary of findings

Surgery

Requires improvement

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

- Skill mix and experience of staff remained an issue even though, when staff shortages existed, the trust did try to fill the vacancy.
- Access to emergency theatres was not consistent or in conjunction with national guidelines. Staff we spoke with said that clinicians held discussions in accordance with the National confidential enquiry into patient outcome and death (NCEPOD) guidelines. However, data we reviewed showed that patients were not consistently booked to accord with NCEPOD classifications.
- Patients requiring pre-assessment prior to surgery were not always assessed according to an effective patient pathway. There remained a large number of 'on the day' cancellations for clinical reasons. The senior management team were aware of the issues and had been working with the pre-assessment team to develop a business case for improvements in the pre-assessment pathway, but this work was still to be approved.
- Services did not always meet patients' needs. Patients were not always able to access services for assessment, diagnosis or treatment when they needed them. There were long wait times within surgical services and overall the service was not meeting the national referral to treatment times (RTT) or all cancer performance standards. Since June 2016 the trust performance of meeting referral to treatment standards for patients admitted for treatment within 18 weeks of referral has been worse than the England overall performance. Data for October 2016 showed 73.7% of patients were treated within 18 weeks (national standard of 92%) against an England performance of 75.5%. Trust performance over the period showed a deteriorating trend. Patients also experienced

cancellations of operations and procedures for clinical reasons. A number of medical patients were cared for in surgical beds which limited the availability of beds for elective surgical patients.

- Performance in national audits was variable with the majority of indicators in the national emergency laparotomy, bowel cancer and national hip fracture audits being worse than national averages for a number of performance measures, including the time taken for a patient with a fractured neck of femur to access theatre. This had been a concern since our 2014 inspection, and although performance had improved slightly year on year, it still remained below national performance.
- The surgical directorate had a clinical strategy for surgical services, and while it did make detailed reference to national reports and recommendations, it did not reference the trust values and strategy or have deadlines for actions identified. We discussed this with the senior management team who explained that they were new in post and so required further time to populate and embed all of the actions required but they said they were aware of the issues and said that this document was a list of immediate priorities to focus on.
- The trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) checklist. However, from a review of records and observations of procedures, it was apparent that this was not an embedded consistent process. In one case we observed that the checklist was completed slightly prior to the end of the operation.
- The trust used the national early warning score (NEWS) tool to identify deteriorating patients; surgical areas used an electronic based system to record the early warning score. From seven sets of notes we reviewed we did not see consistent effective escalation of all deteriorating patients. Four patients we reviewed had deteriorating early warning scores; however, documentation of escalation and review was not available. For three patients, escalation and action was documented as being taken.

Summary of findings

Critical care

Good

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

- The service had taken action on most of the issues raised in the 2015 inspection. There was an effective governance process in place with a clear structure for escalation in the directorate and there was evidence of regular review of the risk register and controls in place for the risks.
- Staff were positive about the recent changes to the senior management team, morale had improved, staff were happy in their work and felt supported and valued.
- There was a clear critical care strategy and staff understood the vision for the service.
- Patient outcomes, for example, mortality, early readmissions, delayed and out of hours discharges had improved and were in line with similar units.
- There was a good track record in safety. There had been no never events, or serious incidents and staff understood their responsibilities to raise concerns and report incidents. The incidents staff reported mainly resulted in low or no harm.
- Staffing levels and skill mix were planned and reviewed to keep people safe.
- Staff were supported to maintain and develop their professional skills and the number of nurses that had an up to date appraisal was better than the trust target. A clinical educator had been appointed and was due to commence in post.
- Seventy-two percent of nurses had a post registration qualification in critical care; this was better than the minimum recommendation of 50% in the Guidelines for the Provision of Intensive Care Services 2015 (GPICS).
- There had been no complaints about the service in the last 12 months and feedback from patients and relatives was positive about the way staff treated them.

However:

Summary of findings

- Some of the issues raised at the 2015 inspection remained a concern. For example, medical and nurse staffing was still not yet in line with the GPICS. The critical care strategy had plans in place to address this.
- The rehabilitation after critical illness service was very limited and not in line with GPICS.
- The number of non-clinical transfers was not in line with national guidance and was worse than similar units and the service did not formally monitor the number of patients ventilated outside of critical care.
- Reporting of mixed sex occurrences had improved, but there was evidence of nine mixed sex accommodation breaches in two months where patients had not been discharged in line with trust policy.

Maternity and gynaecology

Requires improvement

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

- The services had not provided assurance that lessons had been learned and embedded following a serious incident or from serious incidents.
- Midwifery staffing levels were having an impact of patient care. A number of incidents had been reported in relation to midwifery staffing including delays in inductions and elective caesarean sections and coordinators taking clinical caseloads.
- Access to emergency theatres was not consistent or in conjunction with national guidelines. The service did not have a standard operating procedure for obstetric patients accessing theatres out of hours.
- The trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) checklist. From a review of clinical records it was apparent that this was not consistently embedded.
- The trust used the modified early obstetric warning score (MEOWS) tool to identify

Summary of findings

deteriorating patients. Results of an audit by the trust found, if women required escalation, only 58% of records had evidence of an appropriate referral and management plan.
- We found gaps in daily checking of fridge temperatures and no action taken when temperatures went out of range.
- Governance arrangements did not always allow for identification of risk, for example accessing theatre out of hours.

However:

- Clinical areas were visibly clean and tidy.
- The implementation of care bundles had reduced the number of stillbirths.
- Staff were aware of the procedures for safeguarding vulnerable adults and children.
- Women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- We saw strong leadership at a ward level. Staff felt supported by their ward managers and felt they could raise concerns.

Services for children and young people

Requires improvement

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

- There was a shortage of qualified nursing and medical staff available within the service. Staffing levels did not meet professional guidance and had resulted in services being closed at times of peak demand. There was a lack of senior nursing or medical cover available out of hours and at weekends.
- Mandatory training and appraisal targets had not been met by all staff groups. This included safeguarding training targets and not all staff had the required level of safeguarding training in place.
- We were not assured that staff had received the necessary paediatric life support training. This

was because data provided by the trust suggested low rates of compliance. However, staff we spoke with told us that they had training in place.
- The Neonatal Intensive Care Unit had been closed to admissions on a number of occasions due to capacity or staffing concerns.
- Identified risks to the service were not always appropriately recorded or monitored via the risk register.

However:

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

End of life care

Good

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

- There were low numbers of incidents involving end of life care patients. Staff we spoke with were aware of the duty of candour. All areas appeared clean and well maintained. The trust had policies and procedures in place for the safe handling and administration of medicines. There were also specific policies available to support staff caring for patients at the end of their life. Nurse staffing was appropriate, patient records were stored securely and record keeping was of a good standard.
- We saw that trust polices referenced national best practice guidance such as the National Institute for Health & Clinical Excellence (NICE). This included policies relating to care at the end of life, such as anticipatory drug prescribing for end of life care and the pain and symptom management guidance in the last days of life. We saw evidence of local and national audit

participation. We saw that patient's pain levels and nutrition and hydration needs were assessed and managed effectively. Staff had effective clinical supervision. The trust had been involved in the development of a Northern Lincolnshire multi-agency end of life care strategy; from this, the trust had identified seven work streams, each of which had developed key performance indicators to measure the trust performance and patient outcomes.

- We observed staff being compassionate and caring to patients and their families without exception. Patients and relatives we spoke with described staff as 'brilliant' and 'excellent'. They said staff could not do enough for them. We saw that staff provided emotional support to patients and their families.
- Staff on the wards told us that the SPCT were visible, available and that they regularly reviewed end of life patients and had discussions with patients and their families. Information received from the trust indicated that 86.5% of patients referred to the SPCT were seen within 48 hours. The bereavement team had developed robust processes to help and support bereaved relatives. 82% of patients audited were asked about and 71% achieved their preferred place of death.
- The trust had been involved in the development of a multi-agency end of life strategy that encompassed the whole of the local health economy. The trust was collating and monitoring quality measures such as patient outcomes through seven strategy sub-working groups. There was a non-executive director, at board level. Staff reported a positive culture and good working relationships between teams. The trust were supporting the development of staff that were caring for patients at the end of life and we saw good examples of innovation and staff whose purpose was to maintain and improve the services provided to patients and their loved ones.

However:

Summary of findings

- We found that mandatory training compliance was less than the trust target of 95% for all teams providing end of life care. There was limited use of the trusts last days of life documentation however the SPCT were progressing the roll out of the document across the trust. The trust employed less than the National Council for Palliative Care guidance of two whole time equivalent consultants per 250,000 population however, there had been no specialist palliative care medical staff in place during our previous inspection therefore this was an improvement. Chaplaincy support was minimal.
- The trust did not meet the NICE guidance for palliative care provision because it did not provide a seven-day service or any out of hours advice and support system. Low numbers of staff had received a yearly appraisal. The trust did not use an electronic palliative care co-ordination system however; the development of this was part of the strategy action plan. We were concerned that consent to care and treatment was not always obtained in line with legislation and guidance, including the Mental Capacity Act 2005, for patients who lacked capacity.
- Not all risks for the service were identified on the risk register for the end of life care service. For example, the lack of seven-day service provision, delayed roll out of the last days of life document and completion of the deceased patient audit tool were not on the risk register.

Outpatients and diagnostic imaging

Inadequate

In the previous CQC inspection in October 2015, we rated this service as inadequate. At this inspection we rated outpatient and diagnostic services as inadequate because

- The trust had failed to address a number of actions, from the October 2015 inspection, in a timely manner
- The trust had been slow to implement clinical validation and assessment of risk within waiting lists, across all specialities.
- The trust had been slow to get to the bottom of waiting list issues and was still discovering patients in unmonitored systems in August 2016.

Summary of findings

- Referral to treatment times were worsening and the trust told us they were unlikely to recover a good position until March 2018.
- There continued to be large numbers of patients' overdue follow up appointments or with no due date on the patient administration system.
- The trust had a continuing high number of cancelled clinics.
- Effective oversight, monitoring and management of booking patient appointments and waiting list was not evident in all specialities.
- There was evidence of actual harm and ongoing significant risk of potential harm to patients waiting long periods of time for first and follow up appointments.
- Safeguarding training compliance for the outpatient staff was below the trust target.
- There was mixed feedback from staff in a number of roles regarding leadership and an expressed reluctance to raise concerns regarding management or services, for fear of reprisals.

However:

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

Summary of findings

- The trust performed well against cancer waiting time operational standards.
- The diagnostic imaging department had a five-year strategy in place to ensure that the department was future proof and had governance processes in place to ensure that risks were mitigated.

Scunthorpe General Hospital

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people;End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Scunthorpe General Hospital

The trust provides acute hospital services and community services to a population of more than 350,000 people across North and North East Lincolnshire and the East Riding of Yorkshire. Its annual budget is around £330 million, and it has 843 beds across three hospitals: Diana Princess of Wales (DPoW) Hospital in Grimsby, Scunthorpe General Hospital (SGH) and Goole & District Hospital (based in the East Riding of Yorkshire). The trust employs around 5,364 members of staff.

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

We inspected the trust from 13 – 16 October 2015 and performed an unannounced inspection on 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. We did not inspect children and young people's services or end of life services within the hospitals. Additionally not all of the five domains: safe, effective, caring, responsive and well led were reviewed for each of the core services we inspected.

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

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

Detailed findings

trust was also one of 14 trusts, which were subject to a Sir Bruce Keogh (the Medical Director for NHS England) investigation in June 2013, as part of the review of high mortality figures across trusts in England. Overall, Scunthorpe hospital was found to require improvement, although CQC rated it as good in terms of having caring staff.

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

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Consultant, Chair of Inspection

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included: CQC inspectors and a variety of specialists, namely, Chief Executive, Director of Nursing, Deputy Medical Director, Community Matron, Health Visitor, Physiotherapist, District Nurse, Consultant Paediatrician, Paediatric Nurse, Children and Young People's Nurse, End of Life Care Nurse Specialist, Critical Care Doctor, Critical Care Nurse, A&E Matron, A&E Sister, A&E Nurse, Medicine Doctor, Medical Doctor in Training, Consultant Surgeon, Surgery Nurse, Theatre Nurse, Outpatients Nurse, Outpatients Manager, Midwife Matron, Obstetrician, Adult Safeguarding Named Nurse, , Safeguarding Specialist, Equality and Diversity Specialist, Mental Health Act Reviewer, Consultant Radiologist, and experts by experience (people, or carers or relatives of such people, who have had experience of care).

How we carried out this inspection

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

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

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

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

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

We held two local focus groups, prior to the inspection to hear people's views about care and treatment received at the hospital and in community services. We held a focus group especially for people with learning difficulties. We also held two similar focus groups, especially for people

living with dementia, their families and carers. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the focus groups, Mencap Scunthorpe Gateway, Care4All Ltd and Alzheimer Society in Scunthorpe and Grimsby.

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

We carried out an announced inspection on 22 to 25 November 2016 and an unannounced inspection on 17 October and 08 December 2016. The inspection team inspected services at Scunthorpe General Hospital, Diana Princess of Wales Hospital and in the community at Scunthorpe.

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

Facts and data about Scunthorpe General Hospital

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

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

This trust has three hospital locations:

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

The trust has a total of 886 beds including:

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

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

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

The trust has:

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

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

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

Detailed findings

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

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

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We will rate effectiveness where we have sufficient, robust information which answer the KLOEs and reflect the prompts.

Urgent and emergency services

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

Information about the service

Urgent and Emergency Care services were delivered by the Emergency Departments (ED) at the Diana, Princess of Wales Hospital and Scunthorpe General Hospital, which provide a 24-hour, seven-day a week service to the local population. Goole and District Hospital has a minor injuries department. Between April 2015 and March 2016 Scunthorpe General Hospital had 66,449 attendances at its urgent and emergency care services. This equates to an average of 182 patients each day. Children aged zero to 16 years old accounted for 19% of emergency department attendances between April 2015 and March 2016. This percentage has been 19% – 20% for the last three years.

The emergency department was a designated trauma unit. However, the most severely injured trauma patients, if their condition allowed them to travel directly, were taken by ambulance or helicopter to the nearest major trauma centre. If not, they were stabilised within the emergency department and as their condition dictated, either treated or transferred. There was a protocol to inform the medical team which patient injuries required treatment at a major trauma centre.

In order to make our judgements we spoke with 12 patients, 5 carers and 28 staff from different disciplines including nurses, doctors, managers, support staff and ambulance staff. We observed daily practice and viewed 30 sets of records. Prior to and following our inspection, we reviewed performance information about the trust and reviewed information provided to us from the trust.

Summary of findings

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

In this inspection we rated the emergency and urgent care service as inadequate because:

- There had been no significant improvement since our last inspection in October 2015.
- The department was not meeting the department of health standard, which states that 95% of patients should be treated and discharged or admitted within four hours of arrival. They showed mixed performance against the England average.
- There was a disparity between the nationally published data for the time to initial assessment and what we found on inspection.
- Between September 2015 and August 2016, the Scunthorpe General Hospital median percentage of patients that left the hospital before being seen for treatment was worse than the England average for six of the 10 months.
- Between September 2015 and August 2016, the trust's unplanned re-attendance rate to ED within seven days was generally worse than the national standard of 5% and generally worse than the England average.
- Between November 2015 and October 2016 there was a fluctuating trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In November 2015 61.7% of ambulance

journeys had turnaround times over 30 minutes; in October 2016 the figure was 63.7%. However, since the introduction of the ambulance handover team there had been an improvement.
- There was a high number of black breaches (ambulances waiting for over one hour). At this trust between December 2015 and September 2016, there were 694 black breaches.
- When the department was busy, ambulance staff waited at least 15 minutes prior to booking the patient in at reception. This therefore affected the figures for the length of time patients were in ED, as patients were up to 15 minutes longer in the department before they were registered as arriving.
- During our inspection, the department was overcrowded with no resuscitation bays or trolleys available. Patients were queuing with paramedics waiting for a cubicle and we saw and heard evidence of patients put at risk due to unavailable space. Although there were escalation procedures in place, the nurse co-ordinator several times referred to the department as being unsafe.
- Nurse leadership was weak. Quality and safety was not the top priority for leadership. New processes were put in place following our inspection, but on our unannounced inspection, these had not been consistently completed and leaders had not checked they were effective.
- The senior team attended governance meetings; however, departmental meetings did not take place. Therefore, staff were not actively engaged or empowered.
- The department was not meeting the trust target for staff completing mandatory training. There was no clear system for medical device training and no assurance staff were competent to use each piece of equipment.
- We saw evidence that the department did not always meet the planned nurse staffing numbers. Medical staffing and children's nurse staffing did not meet national guidance. We observed the lack of nurses and the impact this had on patient care.
- The target for appraisal rates was not being met.
- There was poor monitoring of infection control practices.
- Emergency equipment was not checked regularly in line with trust policies.
- Safeguarding vulnerable adults and children were not given sufficient priority.
- Nursing documentation and assessments were not consistently completed.
- There was a lack of recording of the National Early Warning Scores (NEWS) therefore we could not be assured that the patients were having the appropriate level of monitoring whilst in the ED.
- We found medicines and intravenous fluids were not always stored safely and securely. Controlled drugs daily balance checks were not always performed and fridge temperatures were out of range and not acted upon.
- There was little evidence of basic nursing care being carried out, such as, assessment of pressure areas, pressure relief, offering of toilet facilities regularly and offering food and drink.
- Patients were not always well informed of what was happening or what they were waiting for.
- Privacy and dignity was not always respected.
- There was no specific support for patients who attended whilst living with dementia.
- Patients who attended with mental health problems were nursed in a specific cubicle that should be ligature free; however, we found ligature points in the room.
- There was a lack of health and safety assessments of the ongoing building work taking place to construct the children's waiting room.
- The general public had unsupervised access to the equipment and supplies in the resuscitation room because it was not secure.
- The risk register did not include all risks identified during the inspection and it was not clear who had responsibility for each risk and if any action plans were in place and being monitored.
- We did not see robust evidence of actions completed from action plans of audits.
- Clinical pathways were not reviewed regularly.
- The vision and strategy created since our last inspection in July 2015 was still in its infancy. The

Urgent and emergency services

vision did not encompass key elements such as compassion, nursing care, patient safety and quality. Not all staff were aware of, or understood the vision and strategy for the department.

Are urgent and emergency services safe?

Inadequate

In the previous inspection, we rated the safe domain as requires improvement. During this inspection we rated it as inadequate because:

- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The trust was not meeting the 15-minute standard. There was disparity on the recording times for the time of arrival to initial assessment. The trust reported one minute however, different figures were supplied on inspection.
- Ambulance staff had to wait at least 15 minutes prior to booking the patient in at reception. This therefore affected the figures for the hospital, as patients were up to 15 minutes longer in the department before they were registered as arriving.
- Between November 2015 and October 2016 there was a fluctuating trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In November 2015 61.7% of ambulance journeys had turnaround times over 30 minutes; in October 2016 the figure was 63.7%.
- There was a high number of black breaches (ambulances waiting for over one hour). At this trust between December 2015 and September 2016, there were 694 black breaches.
- We saw evidence that the department did not always meet the planned nurse staffing numbers and medical staffing and children's nurse staffing did not meet national guidance. We observed the lack of nurses and the impact this had on patient care.
- We observed the department full, with no resuscitation bays or other trolleys available. Patients were queuing with paramedics waiting for a cubicle and we saw and heard evidence of patients put at risk due to unavailable space.
- The assessment of the risk of patients whose condition may deteriorate was not completed consistently. National Early Warning Score (NEWS) scores were not always completed. We were concerned the lack of NEWS scores means you cannot be assured that the patients were having the appropriate level of monitoring.

- A Paediatric Early Warning Score was not used, so we were unable to be sure that the identification and escalation of deterioration in a child's condition would be recognised.
- We found medicines and intravenous fluids were not always stored safely and securely. Controlled drugs daily balance checks were not always performed and fridge temperatures were out of range and not acted upon.
- Safeguarding vulnerable adults and children were not given sufficient priority. The assessment for safeguarding adults and children was not robust. There were no clear systems and processes in place to protect children and vulnerable adults from abuse.
- The department were not meeting the trust's target for staff completing mandatory training. There was no clear system for medical device training and no assurance staff were competent to use each piece of equipment.
- The general public had unsupervised access to the equipment and supplies in the resuscitation room because the room had no lock or keypad and was in an area near the waiting room which was not always occupied.
- Record keeping was variable. In any of the records we reviewed, although observation and triage was documented, there was no other nursing documentation regarding nursing care and assessments completed. At the unannounced visit, new nursing documentation had been introduced but not completed regularly.
- We had concerns regarding the lack of effective infection prevention and control processes. We found parts of the department and equipment to be dirty and dusty and there was poor monitoring of infection control practices. Ongoing building work had not been screened off and in the waiting room there were high levels of sawdust.
- Emergency equipment was not checked regularly in line with trust policies. When we returned for our unannounced inspection, a process had been put in place but had not been followed consistently.
- New processes had been put in place following our inspection, such as, the new ED trolley passport and the shift lead handover sheet. However, since commencing these new processes, they had not been checked to see if staff were doing these. On our unannounced inspection, we found these were not consistently completed.

However:

- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for 10 months over the 12-month period.
- The new process of the ambulance handover team had improved the ambulance handover times.

Incidents

- There was a culture of reporting and investigating incidents however, we found that learning from incidents was not consistent in the department.
- To report incidents, staff used an electronic system. Staff were confident about using the system and were encouraged to report incidents. Incidents were appropriately graded in severity from low or no harm to moderate or major harm. The most common reported incidents were patients attending ED with community acquired pressure ulcers.
- Between September 2015 and October 2016, the trust reported no incidents which were classified as Never Events for urgent and emergency care.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between September 2015 and October 2015, in accordance with the Serious Incident Framework 2015, the trust reported four serious incidents RTT in urgent and emergency care which met the reporting criteria set by NHS England. Two incidents were a maternity/ obstetric incident (one a mother and baby and one a baby only); one was a treatment delay; and the last was a medication incident.
- Following investigations of incidents of harm or risk of harm, staff told us they did not always receive feedback. The matron told us learning from incidents was discussed and cascaded through several forums including: discussion in the morning 'huddle', ward manager meetings for medicine and the cross-site monthly governance meetings. We saw evidence from the minutes of these meetings that some incidents were discussed.
- Not all staff were aware of the statutory duty of candour principles. Senior staff told us the department had a system in place to ensure patients were informed and

given an apology when something went wrong and were told of any actions taken as a result. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The senior team gave examples of duty of candour and we saw staff were open and honest with the patient and their family.

- We saw evidence in the mortality performance and assurance committee minutes that any unexpected deaths or potentially avoidable deaths that occurred in ED were reviewed within this meeting and a reflection of a case review was shared.

Mandatory training

- The completion rate for mandatory training for nursing staff in the department was 76% which was below the trust target of 95%.
- There were 13 mandatory training modules, these included: bullying and harassment, conflict resolution, medicines management, moving and handling, slips, trips and falls, equality and diversity, mental capacity act, deprivation of liberty, information governance, infection control, fire and resuscitation.
- We looked at a training diary of training sessions for staff which was kept, however, there was no documentation to show who had attended each session and it had not been kept up-to-date.
- The majority of mandatory training sessions were face to face and time was allocated in the rota.
- A week prior to starting in the department, newly qualified staff attend 'care camp'. They were given training which included cannulation, catheterisation, dementia training plus all mandatory training.
- New staff we spoke with said they had at least a two-week supernumerary period, depending on experience, and a training booklet to work through that contained competency assessments.
- Each new member of staff was given a preceptor who supported them and signed off competencies.
- Medical device training was not planned but delivered on an unplanned basis. Nurses were not assessed on competencies for each piece of equipment and there was no clear record of medical device training or assurances staff were competent to use each piece of equipment.
- Training figures for adult resuscitation showed 11% of medical staff and 32% of nursing staff had completed adult resuscitation training and 11% of medical staff and 36% of nursing staff had completed paediatric resuscitation training.

Safeguarding

- The department had a system and process in place for the identification and management of adults and children at risk of abuse (including domestic violence). However, this was not robust. The emergency department card only had a small one-line section which contained a tick box for either child protection, or cause for concern or no further action.
- We reviewed 12 sets of paediatric records. According to their records, only two children had been assessed regarding safeguarding. We reviewed one record of an adult who had a mental health problem and a safeguarding assessment was not completed.
- The IT system had a flag that identified any person with a previous safeguarding concern.
- The child protection team was in the hospital between 9am and 5pm Monday to Friday to advise the staff if they had any concerns. Out of hours, there was an on call contact.
- There was a health visitor referral book. Nurses could refer to the health visitor if they had any concerns regarding a child. The liaison health visitor visited the department daily on weekdays.
- We spoke with nursing, medical and administration staff who were able to explain the process of safeguarding a patient and provide us with specific examples of when they would do this.
- Staff said they knew how to recognise and report both adult and children safeguarding concerns.
- We observed staff accessing the trust safeguarding guidelines, which were readily available on the trust's IT system. This provided information of how to make referrals when staff had concerns about the safety of a child or adult.
- Staff told us if they had safeguarding concerns they would escalate these to the senior nurse and doctor.
- We did not see any evidence of any safeguarding audits which had taken place and staff were not aware of any.
- Staff were aware of the assessment for child exploitation and female genital mutilation (FGM). There was a FGM policy in place and this was easily accessible.

- The intercollegiate document 'Safeguarding Children – Roles and competencies for healthcare staff' published by the Royal College of Paediatrics and Child Health (RCPCH) 2014, states that: 'All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns should be trained in safeguarding for children levels one, two and three'.
- The overall safeguarding training completion rate was 60% for medical staff and 100% for nursing staff having received adult safeguarding training. For children safeguarding level 3 training, the rate was 63% for medical staff and 88% for nursing staff.

Cleanliness, infection control and hygiene

- The emergency department was visibly dirty and dusty. When we visited in the afternoon, we saw that the floors had debris and dust on them. There was no cleaning in progress during the afternoon visit, which was from 3pm to 7pm. We were told the hospital support assistants (domestics) worked from 6am to 2pm in the department. At 4pm one hospital support assistant cleaned the toilets and emptied the bins. We performed an unannounced inspection on the 8th December 2016 and observed cleaning in progress in the afternoon. We were told that since our inspection, an additional hospital support assistant was allocated to ED in the afternoons.
- We checked several equipment trolleys and found them to be dirty and dusty.
- We checked 10 patient trolleys and they were very dirty. There was no evidence cleaning had taken place of any of the patient equipment or patient bays. During the unannounced visit on the 9th December 2016, we were shown a new ED 'trolley passport'; this had been put in place following the announced inspection to ensure trolleys were cleaned daily. This was a sheet of paper for each trolley and dates that staff signed to state the trolley had been cleaned. This had been introduced on the 2nd December 2016. On the day it was introduced every trolley was signed to have been cleaned, however, there were following days where the passport had not been signed to state that the trolleys had been cleaned. Out of the seven days since the introduction of the ED trolley passport, the trolleys were documented as cleaned between one and four days only.
- Staff did not routinely carry out mattress audits. We were told they were checked and cleaned between patients. On inspection, we checked three mattresses and found one was split and had holes in it, leading to the inside foam being contaminated.
- We reviewed areas including the sluice, the clean utility room and administration stations. These areas were cluttered and not clean.
- Needle sharp bins were over full in some areas (more than ¾ full). The bins were dated and signed by a member of staff, (as required by the trust's policy). These remained over full on the unannounced inspection.
- Infection prevention and control training was completed for 53% of all staff. Hand hygiene was audited on a monthly basis. The audit results for November 2015 to August 2016 showed between 72% and 100% compliance. In February 2016 there was no audit performed. During our inspection, we observed staff not washing their hands following contact with patients which is poor hand hygiene.
- There were adequate hand washing facilities throughout the department and hand gel dispensers were available either in or outside each cubicle.
- We viewed monthly cleaning audits from November 2015 to August 2016 and they scored between 0% and 100%. The cleaning audit in June 2016 had the lowest overall score of 67%.
- The kitchen cleanliness scored 0% in July 2016 and 2% in June 2016. The kitchen was used to make drinks for patients and staff, and sandwiches and toast could be prepared for patients. Staff prepared/stored their own food in the kitchen.
- The department had appropriate facilities for patients who required isolation. Three cubicles had doors rather than curtains and we viewed isolation notices.
- We spoke with a hospital support assistants (domestic staff) whose main role was to assist with the hygiene and cleanliness of the department and they spoke of the importance of infection control and how they contributed to patient safety by ensuring that they followed trust infection control policy. We looked at the cleaning stock room and saw that equipment such as

coloured mops and buckets were available and stored correctly. The cleaning chemicals had the appropriate instructions for storage and usage in line with Control of Substances Hazardous to Health national guidelines.

- Notices on the wall of the cleaning cupboard contained a 'scrubbing plan'. The plan was a list of each area to be cleaned and the hospital support assistant signed when each area was cleaned. There was a gap since April 2016 on the cleaning of the resuscitation bays. We were told that the domestic staff were not allowed in the resuscitation room when patients were in; therefore cleaning was missed at times. However, it was not documented on the scrubbing plan if they used the I-mop. There was no clear evidence of when the resuscitation bays were last cleaned.
- On viewing the resuscitation bays, there was high and low level dust, debris on the floor and dirty equipment. There were wooden boards behind each trolley which contained equipment needed to manage a patient's airway. Some of this equipment was unwrapped therefore a potential infection risk. This was pointed out to staff on the inspection and remained the same when we returned for the unannounced inspection.
- On the unannounced inspection, we found that building work was taking place to create a children's waiting room next to the main waiting room. This work was not screened off and a large amount of sawdust was coming into the main waiting room. The doors into the work area were left open with cones and a plastic barrier in place; however, access could be gained therefore presenting a health and safety risk to both the public and staff. We called the infection prevention nurse to the department to discuss our concerns and these were also discussed with the associate chief nurse who assured us they would take immediate action. We later saw a workman in the department who was looking into screening the work area.
- Waste was managed in line with effective infection control practices; however, we found the sluice full of several bags of dirty linen.

Environment and equipment

- The hospital department pre-dated current national guidance for compliance in facilities for accident and emergency departments (HBN 15-01: Accident and Emergency Departments).
- Emergency department patients received care and treatment in three main areas: 'minors', 'majors' and 'resuscitation bays'. Self-presenting patients with minor illnesses or injuries were assessed and treated in the 'minors' bays.
- Patients checked in at the main reception and at the time of the inspection all patients including those who arrived by ambulance came through the same entrance. However, a separate ambulance entrance was under construction and was due to open in the following few weeks.
- There was a main waiting room, which was used for adults and children. A separate children's waiting room was under construction and was due to open in January 2017.
- Off the waiting room was a triage room and three further treatment rooms. There was a separate room for assessing and treating a patient with an eye injury.
- There were 15 majors' cubicles. One was designed for the assessment of a patient with a mental health illness.
- The resuscitation room had three bays, one of which was equipped for children. The resuscitation bays were similarly set up which helped staff care and treat patients in a timely and efficient manner. This room had two large sliding doors leading into it from a corridor near the waiting area. The public could access this room as there were no electronic card entry systems or keypad on the door. This risk was highlighted to staff.
- There was an assessment room, known as a 'pit stop', used for patients who had arrived by ambulance. This had six bays and a small nurses' station.
- There was an area, known as a 'holding area', which was used if there was no space in the department and patients who arrived by ambulance were queuing to be allocated a cubicle. This area was a small holding area and patients' dignity and privacy could not be respected, as patients were able to see each other as they waited with the ambulance crews. During our inspection, we saw up to five patients waiting in this area at any one time.
- The main waiting room had 40 loose lightweight plastic seats facing a glass partition. The loose chairs could be a safety risk as they could easily be picked up and thrown. The patients were not facing the reception desk and had their backs to staff as they walked through from majors to reception. Therefore, they were not easily observed.

- There were display boards with information of what the department was proud of. Also a board stating 'what are we working to improve'. This had information regarding the new children's waiting room. There was no display of staff on duty.
- The department was located adjacent to the x-ray department and CT scanner. However, the department was a distance from theatre which was in the main hospital approximately 10 minutes' walk away.
- Access to some areas in the department was controlled by electronic card entry systems. Staff ID badges acted as their access control. This enabled the hospital to restrict access to some sensitive areas to particular groups of staff. The card access system could be audited if required to show which staff had used their card to enter a specific area. However, access to the resuscitation room was not secure.
- Some equipment trolleys were clearly labelled. Although some had checklists, there was no evidence of regular checks. There were separate checklists but these were not in order and it was difficult to ascertain how often the trolleys were checked. This was highlighted to the matron.
- According to the trust's policy, the resuscitation trolleys in each bay should be checked daily. However, we found significant gaps. For example, one had not been checked for 12 days in October 2016. In addition, we found expired defibrillator pads in the paediatric resuscitation trolley and there was no way of sealing the trolley to make it tamper evident. On the unannounced visit, we rechecked the checking of resuscitation equipment and equipment trolleys and found that the trolleys were still not checked daily.
- On the unannounced inspection on 9th December 2016, we were told that the department had introduced a shift lead handover sheet which was used to record who had been allocated to check the resuscitation equipment, drug fridges and drugs cupboard. Once equipment was checked, the member of staff allocated to do the checks was to sign the shift lead handover sheet. On reviewing these sheets, we found from the introduction of this on the 3rd December, on two days all jobs were allocated and signed for, two days jobs were allocated and not all signed for, and on three days, no jobs were allocated or signed for.
- There were adequate stocks of equipment and we saw evidence of good stock rotation to ensure that equipment was used before its expiry date.
- Safety testing of electrical equipment had been carried out in the department. All equipment was serviced by the medical engineering department on a rolling programme basis. Stickers on the equipment confirmed servicing and maintenance had been completed.
- Security arrangements were in place 24 hours a day within the hospital. Closed circuit television (CCTV) was also in operation.

Medicines

- We found medicines and intravenous fluids were not always stored safely and securely. In majors, it was custom and practice to leave the door to the medicines room unlocked. This meant unauthorised persons had access to intravenous fluids and some medicines.
- Controlled drugs were appropriately stored and accurate records were maintained however, we found daily balance checks were not always carried out. For example, checks had not been carried out on five days in October and six days in November 2016. Emergency medicines and equipment were readily available throughout the emergency department.
- We checked medicines requiring cold storage and found the fridge temperatures in majors had been outside of the recommended range between 1st November and 10th November 2016, and no action had been recorded in response to this. We raised this with the ward sister who was unaware the fridge had been out of temperature range.
- Patient Group Directives (PGDs) were in use and there was a robust system in place to ensure they were managed appropriately. PGDs are written instructions that allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked PGDs used by the nursing team and found they were being used effectively to support patient access to medicines in a timely way.
- We observed staff giving a controlled drug and following the correct procedures in accord with the trust's policy.
- We observed an allergy name band given to a patient who was allergic to penicillin.
- Prescription pads were stored securely and appropriate records maintained in accordance with national guidance.
- Medicine prescribing was done on paper records.

Records

- Paper records (ED cards) were used within the department and these were scanned onto the IT system following discharge or transfer to a ward. The paper copy was sent to the ward, or if the patient was sent home from ED, their records were kept on site, until they were archived.
- A discharge letter was automatically generated and emailed to the GP within 24 hours. If the patient was from out of area, a paper copy was posted to their GP.
- Access to patients' previous notes was timely and could be accessed through the medical records department 24 hours, seven days a week.
- We initially fully reviewed 30 sets of patients' records (18 adults and 12 children's) and found completion of documentation was inconsistent and inadequate. For example, there was no record of nursing care in any of the 30 records reviewed. This included no record of pressure ulcer assessment or pressure care given, no risk assessment for falls, and no documentation if the patient had been offered or given food or drinks whilst in ED.
- We were told on the unannounced inspection that the trust had introduced care rounds documentation. This was a document with a list of checks the nurse makes on a patient including checking pressure areas, changing their position, offering the toilet, offering drinks and food, and assessing if they have pain.
- During the unannounced inspection we checked a further 10 records and found that since the new care round documentation, six out of ten patients had the documentation in their notes. However, of those completed they were not always completed fully or regularly.
- There was a high number of incidents reported of patients attending ED with a community acquired pressure ulcer(s) however, assessment of pressure ulcer(s) were not recorded in the patient's notes.
- Writing was legible in 29 out of 30 patients' records.
- Records were dated and timed in 23 out of the 30 records.
- The recording of the patients' allergy status was in all the records we checked.
- The electronic system alerted staff to any patient specific concerns or risks. For example, if a patient had a previous infection or a safeguarding concern.
- Reception staff collated and filed the patient notes at the end of the visit and arranged for safe storage of notes.

Assessing and responding to patient risk

- All patients booked into the ED received triage based upon their presentation, which was undertaken by an appropriately qualified nurse 24 hours a day, seven days a week. The triage system used within the ED was based on the Manchester triage system. The triage system was in line with all Royal College of Emergency Medicine (RCEM) Guidance.
- A National Early Warning Score (NEWS) system for acutely ill patients was used, which supported the process for early recognition of those patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff. We checked adult records and found NEWS scores were not recorded in 10 out of 18 records checked. We were concerned that the lack of NEWS scores meant that it was difficult to be assured that the patients were having the appropriate level of monitoring.
- A similar paediatric early warning score (PEWS) was used in the process for early recognition of those children who were becoming unwell. Out of the 12 paediatric records we checked none had a PEWS score recorded. Due to the lack of PEWS we were not assured that there would be timely recognition and escalation of deterioration. An action as a result of the RCEM audit for vital signs in children (July 2016) was for all children to have vital signs recorded unless seen for an injury and the recording of the paediatric early warning scores (PEWS).
- We observed a patient with a mental health problem and at risk of suicide, nursed in another cubicle (as the mental health assessment room was occupied). This patient was not observed as the curtains were drawn around the trolley space. There were ligature points within the cubicle. This patient required cardiac monitoring due to an overdose of a drug which caused cardiac arrhythmias however, the patient's monitor was not observed.
- During the unannounced inspection, we observed the paramedics arrive in ED with a patient who had a provisional diagnosis of sepsis. The paramedics had pre-alerted the department however, they were stood in the corridor for 50 minutes with the patient not receiving any treatment. This was in contradiction to the RCEM Sepsis recommendations. The patient was at serious

risk of rapid deterioration. When we noticed the patient and the long delay, we intervened. The patient was very ill and needed to be in the resuscitation bay requiring active treatment.

- Patients who walked into the department were registered by the receptionist and directed to the waiting room where a nurse triaged them.
- Patients arriving by ambulance entered through the same entrance (however, a dedicated entrance specifically for ambulances was in the process of being constructed). They were directed in an opposite direction avoiding the waiting room. There were six bays available where patients had an initial assessment by a nurse. The initial assessment included commencing investigations that would assist with diagnosis and treatment. For example, bloods were taken, electrocardiograms (ECG) carried out, analgesia prescribed and x-rays ordered. A nurse then triaged the patient into the appropriate area (unless the patient required immediate access to the resuscitation bay).
- The trust used a recognised triage system in the 'minors' area which categorised the severity of the patient's condition and level of risk. This reflected the order in which patients were seen.
- Once triaged, the walk-in patients received an initial assessment by a doctor or nurse.
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration.
- The published data for the median time from arrival to initial assessment for patients arriving by ambulance was better than the overall England median for the whole of the 12-month period. In May 2016, the median time to initial assessment for this service was reported as one minute compared to the England average of seven minutes. The trust had consistently reported a median time of one minute each month. However, we looked at the records of 30 patients who had been discharged from ED at SGH (12 paediatric and 18 adults), and found that the time to initial assessment was, on average, 20 minutes. During the inspection, we tracked seven patients who had walked into the department and the average time to initial assessment was 65 minutes. We tracked five patients who arrived by ambulance and the average time to initial assessment was 25 minutes.
- The trust provided us with median waiting times from arrival to initial assessment, from January 2016 to October 2016 which averaged 16 minutes. Therefore, there was disparity between the initial assessment time published, the times the trust submitted to us and our findings during the inspection. We spoke with senior management staff during our inspection and raised the issue of recording and reporting the time to initial assessment. We were told that they were unaware of the publication of time to initial assessment of one minute. There was no evidence of auditing of time to initial assessment to provide assurance of compliance with the nationally reported performance figures.
- We spoke with ambulance staff during the inspections and were told that they could not book the patients in until they had handed over. Therefore, during the unannounced inspection, we spoke with 13 ambulance staff. Ten ambulance staff told us they had to wait 15 minutes before they could book the patients in. Two told us that they had to wait longer, and could not book the patients in until they had handed them over. This practice would not provide an accurate record of the actual length of time patients were in the department. We spoke with senior management staff who informed us they were aware of this practice but were of the understanding this had been stopped 20 months previously. There had been no ongoing monitoring or audit to assure us that this practice had been stopped.
- Between November 2015 and October 2016 there was a fluctuating trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes. In November 2015 61.7% of ambulance journeys had turnaround times over 30 minutes; in October 2016 the figure was 63.7%.
- A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. Between December 2015 and September 2016, the Scunthorpe General Hospital had 694. There was an improving trend in the monthly number of "black breaches" reported. An ambulance handover team was introduced in May 2016 which saw the trust improve their handover times significantly. Between December 2015 and April 2016 Scunthorpe General Hospital was averaging 123 black breaches a month however since the introduction of the ambulance handover team they had reduced to 15 black breaches a month.

- There was an area with six trolleys, called a 'pit stop', where ambulance staff could handover their patient to the ambulance handover team which was a registered nurse and a healthcare assistant.
- The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. Between September 2015 and August 2016, the trust met the RCEM standard for 10 of the 12-month period. Trust performance against this standard showed a declining trend. In September 2015, the median time to treatment was 47 minutes compared to the England average of 55 minutes. There has been a steady increase in time to treatment which has seen the median time rise to 56 minutes compared to the England average of 55 minutes.
- The emergency department was a designated trauma unit and provided care for all trauma patients. However, if their condition allowed them to travel directly, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre. If not, they were stabilised at SGH and either treated or transferred as their condition dictated. There was a protocol to inform the medical team which patient injuries would require treatment at a major trauma centre
- A handover process known as SBAR was used when patients were transferred to the wards. (This is used to describe the patients' medical Situation, Background, Assessment and Recommendations). This allowed staff to communicate effectively, ensuring key information was passed to relevant staff and reducing the need for repetition. We observed a nurse handing a patient over to the ward staff using SBAR.

Nursing staffing

- The trust reported there were 54.55 whole time equivalent nursing staff budgeted within the ED. In September 2016, there was 45.95 staff in post. There was a vacancy rate of 20.14%. When we spoke with the matron and department manager at the time of the inspection there was a vacancy rate of eight registered nurses, of which 4.68 had recently been recruited (and were awaiting start dates) and four were due to be interviewed the following week. The trust were unsure of the health care assistant vacancies.
- As at September 2016, the trust reported an average nursing turnover rate of 14.65% in ED.
- The senior team told us that staffing rotas had been reviewed and matched to peak times, allowing more staff on duty at busy periods.
- We reviewed four weeks of nursing rotas between 24th October 2016 and 20th November 2016. We found only four out of the 28 day shifts had met planned staffing numbers of registered nurses and/or health care assistants. Ten out of the 28 night/twilight shifts had the planned staffing numbers.
- Bank and agency nurses were used and these were included in the above numbers. Often the same bank and agency nurses were used, providing familiarity to the department and many of the bank nurses were substantive staff working extra shifts. We were told the agency nurses were experienced emergency department nurses.
- Between August 2015 and July 2016, the trust reported a bank and agency usage rate of 4.06% in urgent and emergency care. In October 2015, bank usage was at 5.2% and reached its lowest usage in March 2016 with 2.5%. Since March, it had increased to 4.1% in July 2016.
- During the inspection on the 22nd November, there were six out of a planned nine registered nurses on duty. This allowed only one nurse to look after three patients in the resuscitation bays, two nurses looking after 15 major's patients, one nurse triaging and caring for patients with minor injury/illness, one nurse looking after patients arriving by ambulance and one nurse co-ordinating.
- At the unannounced inspection we checked the staffing levels, all registered nurse shifts were filled and there was one healthcare assistant shift unfilled on the day shift.
- As at September 2016, the trust reported an average sickness rate of 5% in urgent and emergency care. There was no specific figure supplied to us by the trust for the department at Scunthorpe General Hospital.
- In accordance with the safer staffing initiative put in place as part of the NHS response to the Francis enquiry, wards and departments should display for each shift the actual against planned numbers of nursing staff on duty. We did not see this displayed.
- The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department, however, the staffing numbers did not always allow this.
- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in

Emergency settings (2012) identifies that there should always be a registered children's nurse in the emergency department, or trusts should be working towards this. Staff told us that there was one registered children's nurse who worked 24 hours each week. Therefore staffing was not in line with national guidelines.

- When trusts cannot provide a registered children's nurse on duty the RCPCH guidelines state there should be a plan in place to ensure that nurses access more detailed education in the care of children and young people, to be able to offer advice and support to other staff. None of the nursing staff in the ED at SGH had received additional training during their induction regarding the care of children to mitigate the risk of only having one registered children's nurse.
- Nurses from the paediatric ward would attend a paediatric cardiac arrest if their ward staffing allowed them to.
- There was an overall consultant lead for children's care in the department.
- The department was overseen by a modern matron who provided managerial support, and clinical support when necessary. However, the matron had only been in post since October 2016. There were trust wide operational and quality matrons. The medical division had an associate chief nurse.
- Nursing and medical handover occurred separately at the beginning of each shift and there was a huddle in the morning where staff discussed incidents, complaints and other recent relevant issues. We observed a huddle which included both nursing and medical staff.

Medical staffing

- We looked at four weeks of medical staffing rotas between 7th November and 28th November. Consultant rotas demonstrated that a consultant presence in the department was between 8am and 8.30pm Monday to Friday.
- According to the Royal College of Emergency Medicine (RCEM, 2015), the service must ensure there is 16 hours of consultant presence, 16 hours a day, except in Major Trauma Centres which should have 24 hour cover. Therefore, the department did not meet these recommendations.
- According to the Royal College of Emergency Medicine (RCEM, 2015), an emergency department should have at least 10 whole time equivalent consultants to provide a sustainable service during extended weekdays and over the weekend. The department had six consultants.
- On Saturday and Sunday there was consultant cover provided for 6 hours in the department. This was flexible and consultants attended as needed. Outside of these hours, a consultant was available on call and attended the department if there was a clinical need to do so. In the absence of a consultant, middle grade cover was available in the department. This does comply with RCEM guidance that states a minimum of a middle grade doctor should be present in an ED.
- There was an average of 60% of shifts covered by locum doctors. There were four regular locums; two consultants and two registrar locums who did permanent night shifts.
- The staffing aim was seven middle grade doctors working a variety of shifts and five juniors. When reviewing the rota there was only one shift which was not fully covered.
- In September 2016, the trust reported an average vacancy rate of 34% in urgent and emergency care for medical staff. The ED at SGH has the highest vacancy rate with 37.16%.
- As at September 2016, the trust reported a turnover rate of 52.29% of medical staff in ED at SGH.
- As at September 2016, the trust reported an average sickness rate of 0.14% for medical staff in ED at SGH.
- As at September 2016, the trust reported an average sickness rate of 1% in urgent and emergency care. Scunthorpe General Hospital had a sickness rate of 0.14%.
- Between August 2015 and July 2016, the trust reported a bank and locum usage rate of 5.92% in urgent and emergency care. Scunthorpe General Hospital had the highest locum usage with 10%.
- The proportions of consultant and junior (foundation year 1-2) medical staff reported to be working at the trust were about the same as the England average.
- A paediatric consultant provided paediatric cover if needed and was on site 24 hours a day, 7 days each week.
- Medical staffing was not on the risk register.

Major incident awareness and training

Urgent and emergency services

- The trust had a major incident policy; this was accessible to staff on the trust intranet.
- Not all staff we spoke with had an understanding of their roles and responsibilities with regard to any major incidents. On our inspection, staff were unsure where the major incident equipment was kept however, on the following unannounced inspection staff were aware where the store was and their role in a major incident.
- We spoke with the trauma nurse co-ordinator who was responsible for checking the equipment. There was a designated store for major incident equipment that contained specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials.
- The trauma nurse co-ordinator could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- In August 2016, 15 members of staff had undertaken training and practice that included rehearsal in wearing the protective suits.
- Major incident training was mandatory.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

In the previous inspection in 2015, we rated the effective domain as good. During this inspection we rated it as requires improvement because:

- Outcomes of RCEM audits were below expectations compared with similar services.
- The department had an ongoing audit programme, where performance was noted below national standards. The department had implemented action plans to improve the care and treatment of patients but we did not see evidence of the completed actions.
- The last sepsis audit we saw was the RCEM severe sepsis shock in adults in 2013 to 2014.Five standards were below 70%. We saw no evidence of a re-audit. When we asked, we were told it was not re-audited as it was already embedded. However, we saw an example that this was not the case during our inspection of the department.
- In September 2016, two months prior to our inspection, the trust was recognised as being an outlier for deaths from septicaemia (except in labour).
- Pathways were not reviewed regularly.
- Between September 2015 and August 2016, the trust's unplanned re-attendance rate to ED within seven days was generally worse than the national standard of 5% and generally worse than the England average.
- The documentation of patients' pain scores was not consistent.
- The target for appraisal rates was not being met however; the department had plans in place to address this issue.
- There was no evidence to support whether patients had adequate nutrition and hydration.

However:

- There was evidence of good multidisciplinary working. A frail elderly assessment team attended ED liaising with the community teams and the service offered hyper acute stroke services with acute stroke nurses attending ED.
- The department offered a 24-hour seven-day service however; some services were available out of hours as an on call service.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment.

Evidence-based care and treatment

- We saw pathways in place that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) clinical standards for emergency departments. These were a stoke pathway, sepsis pathway, paracetamol overdose pathway, community acquired pneumonia pathway, chronic constructive pulmonary disease pathway, diabetes keto-acidosis pathway and a fractured femur fast track pathway. Some of these pathways had not been regularly reviewed.

- Care and treatment was not always delivered in line with national guidance and best practice. We reviewed the notes of two patients following a head injury and NICE guidance was not followed.
- The last sepsis audit we saw was the RCEM severe sepsis shock in adults in 2013 to 2014. Five standards were below 70%. We saw no evidence of a re-audit. When we asked, we were told it was not re-audited as it was already embedded. However, we saw an example that this was not the case during our inspection of the department when we saw a patient with sepsis queuing in the corridor for 50 minutes, without an assessment, even though the paramedics had pre-alerted the department. We raised this with the staff in the department.
- From the notes we reviewed, we saw evidence of the sepsis and community acquired pneumonia pathway being used. These aimed to promote early treatment and improve patient outcomes.
- The ED provided a hyper acute service for patients who had a stroke. Patients who attended ED following a stroke were seen in ED by the stroke nurse and doctor and were given appropriate investigations and treatment in ED prior to being transferred to a specialist stroke unit.
- Clinical pathways were available in paper copy and could be accessed on the intranet.
- The nursing and medical staff we spoke with had a good understanding of the Mental Health Act (MHA) and code of practice. Staff were able to explain how patients detained under the MHA were being treated for their mental disorder; if they required treatment for physical illness consent would still have to be sought in line with current legislation. We observed the care of a patient who was detained under the MHA.

Nutrition and hydration

- During our inspection, we did not see patients routinely offered food and drinks. Patients could be waiting for prolonged periods of time in the department. We raised this with the senior team and at the unannounced inspection; we saw that this had not significantly improved. We asked 10 patients if they had been offered food or a drink; five had not been offered food or drink and one patient could not have food or drink.
- We saw evidence on patients' records that fluid and food intake had not been monitored effectively. There was nothing documented in the nursing notes that patients had been offered food or drinks. At the unannounced visit, the trust had introduced the care rounds documentation. We checked ten patients' notes who had attended ED in the last week. It was documented in five out of the ten records that the nurse had recorded whether adequate nutrition and hydration was maintained.
- Sandwiches were provided for patients and there were facilities for making toast and drinks.
- Baby food could be accessed from the children's ward if needed.

Pain relief

- Staff used a pain score tool to assess if a patient had pain. Pain was scored as zero for no pain, up to 10 for severe pain.
- We reviewed 18 sets of adult patients' notes for the completion of pain scores.13 did not have a pain score recorded, and ten of the 18 patients' records indicated pain relief had been administered. It was not possible, from the records, to determine if the remaining eight patients required pain relief. This means that in the adult records, five patients were given analgesia but who had not had a pain score recorded.
- All the patients we asked were happy with the pain relief they had received.
- Of the 11 paediatric records we reviewed, 10 had no pain score recorded, and six had a record of analgesia being administered. In one record, there was a pain score documented as a level eight but there was no record that analgesia had been administered. In the paediatric records six paediatric patients had no pain score but had analgesia administered.
- From the 11 paediatric notes we checked, six children were offered pain relief within 20 minutes of arrival and those in severe pain reassessed every hour (RCEM management of pain in children 2013).

Patient outcomes

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

measures and was between the upper and lower quartiles for two of the six measures. The site was not rated for three indicators. The site did not meet the fundamental standard of having an Early Warning Score documented. The measure for which the site performed in the lower quartile was about whether cognitive assessment took place (0%).

- In the 2015 RCEM audit for initial management of the fitting child, the site was in between the upper and lower quartiles for all five of the measures. The site met the fundamental standard of checking and documenting blood glucose for the fitting child.
- In the 2015 RCEM audit for mental health in the ED, the site was in the lower quartile for five of the eight measures and between the upper and lower quartiles for the other three. Of the two fundamental standards included in the audit, the site did not meet the fundamental standard of having a documented risk assessment taken. The site did not meet the fundamental standard of having a dedicated assessment room for mental health patients. The measures for which the site performed in the lower quartile were History of patient's previous mental health issues taken and recorded (58%); Mental state examination taken and recorded (6%); Provisional diagnosis documented (26%); Assessed by MHP within 1 hour (0%); Details of any referral or follow-up arrangements documented (62%).
- In the 2015/16 RCEM audit for Procedural Sedation in Adults, Scunthorpe General Hospital was in the top 20% compared to other hospitals for two of the seven standards and was in the middle 50% for the remaining five standards. Of the fundamental standards, the hospital only met one which states that procedural sedation should be undertaken in a resuscitation room or one with dedicated resuscitation facilities.
- In the 2015/16 RCEM audit for VTE Risk in Lower Limb Immobilisation in Plaster Cast, Scunthorpe General Hospital was in the bottom 20% compared to other hospitals in the one of the two standards. The trust did not submit data for the remaining standard, which was fundamental.
- In the 2015/16 RCEM audit for Vital Signs in Children, Scunthorpe General Hospital was in the bottom 20% compared to other hospitals for two of the six standards and in the middle 50% for the remaining four. The hospital did not meet either of the two fundamental standards set by RCEM.
- As a result of audit findings we saw action plans in place to improve. However, we did not see evidence that actions were completed. For example, the action for the RCEM audit for vital signs in children (July 2016) was for all children to have vital signs recorded using the paediatric early warning scores (PEWS), unless seen for an injury. On reviewing the notes, no PEWS scores were completed.
- The Commissioning and Quality Innovation (CQUIN) framework supports improvements in quality and patterns of care in specific identified areas of care and treatment. In order to achieve CQUINS, the service provider must submit evidence that they are meeting the requirements on a quarterly basis. Screening for sepsis CQUIN from April 2015 to March 2016 showed an average of 62% of patients were adequately screened. The percentage of patients given timely antibiotic treatment was an average 48%.
- In September 2016, two months prior to our inspection, the trust was recognised as being an outlier for deaths from septicaemia (except in labour). The trust provided a detailed action plan to investigate and address this.
- The department had joined the North Yorkshire and Humber Trauma Network. Within a specified geographical area, trauma networks are set up to deliver specialist treatment to patients with major trauma, such as, severe head injuries. A requirement of being part of the network is to improve and share best practice. The department submit data to the Trauma Audit and Research Network (TARN) on an annual basis. We saw evidence of improvements made. For example, as a result of the audit it was noted there was no documentation to suggest if tranexamic acid was considered, (This is a drug used in major trauma to help stop bleeding). To improve, a sticker was placed on each set of ED trauma documentation where a doctor could document if this was considered.
- Between September 2015 and August 2016, the trust's unplanned re-attendance rate to ED within seven days was generally worse than the national standard of 5% and generally worse than the England average. In the latest reporting period, trust performance was 9.7% compared to an England average of 8.1%.
- A current RCEM audit was ongoing for consultant review prior to discharge for adults with non-traumatic chest

pain, febrile children under 12 months, unplanned re-admissions within 72 hours, and unplanned re-attendances within 7 days. The trust was unable to supply us audit results as this was an ongoing audit.

Competent staff

- We were told 54% of nursing staff had received an appraisal. There was a new department manager who had recently started in post. We were told that there was a plan to allocate the appraisals to senior members of staff and all to be completed by April 2017. We were told 71% of medical staff had received an appraisal.
- We were told all new staff received a trust induction.
- There was an emergency department competencies booklet, which new nursing staff worked through. A preceptor supported their learning, and they had a supernumerary period of time that varied depending on their previous experience and learning needs.
- Medical device training was not planned but delivered on an unplanned basis. Nurses were not assessed on competencies for each piece of equipment and there was no clear record of medical device training or assurances staff were competent to use each piece of equipment.
- Revalidation is the process that all nurses and midwives in the UK will need to follow from April 2016 to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practicing. Nursing staff were aware of the revalidation process.
- We were told that any new doctor who worked at the trust completed an induction checklist. This covered orientation, equipment, infection control and fire procedures.
- Medical staff have been required to undergo a revalidation process with the General Medical Council (GMC).The trust had a process in place to support medical staff in revalidation procedures. We had no concerns about the medical revalidation process.

Multidisciplinary working

- We observed good working relationships between medical and nursing staff in the department. Staff appeared to communicate and work co-operatively between all areas of the emergency department.
- We observed effective communication between nursing and medical teams at their daily huddle. Staff discussed how to manage patients with percutaneous endoscopic gastrostomy (PEG) feed, (if people are unable to swallow or eat a (PEG), tube may enable long-term feeding). Within the huddle, the co-ordinator reminded staff to complete documentation and they discussed the new streaming nurse role which had been introduced that day. We saw staff at all levels within both nursing and medical teams were encouraged to contribute.
- We observed a board round where the nurse co-ordinator, two consultants and the patient flow co-ordinator talked through the plan of treatment for patients who were in the majors' part of the department.
- Clinical nurse specialists came to the department to provide clinical expertise and review patients if needed, for example stroke specialist nurses.
- The critical care outreach team attended the department to help care for patients who were critically ill and offer advice and support to nursing staff.
- The mental health team came to the hospital site to provide assessment to patients with mental health needs.
- A frail elderly assessment team (FEAST) was a multi-disciplinary team that attended ED seven days each week (Monday to Friday 8am -8pm and 8am – 4pm at weekends). This team reviewed patients and supported safe discharge, liaising with the community teams.

Seven-day services

- The adults and children's ED was operational 24 hours a day, seven days a week.
- There was seven days a week cover from the acute stroke specialist nurses available to provide care and support to patients admitted with a stroke.
- The emergency department had x-ray facilities within the department, which could be accessed 24 hours, seven days a week.
- CT scans were available from 7.30am to 8.30pm seven days a week. There was on site radiographers providing 24 hours a day seven days a week cover for CT patients with a stroke and an on call radiographer with a 30-minute response time for all non-stroke CT patients.
- There was availability of physiotherapy services seven days a week and out of hours, an on call service was provided.
- Pharmacy services were provided seven days a week and an on call service was available out of hours.
- There was seven-day access to pathology services.

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

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are urgent and emergency services caring?

Requires improvement

In the previous inspection, we did not rate the caring domain. In this inspection we rated caring as requires improvement because:

- Patients' basic nursing care was not always met in relation to pressure area care and offering of toilet facilities regularly.
- When patients experienced pain and discomfort staff did not always respond in a compassionate, timely and appropriate way.
- Patients were not always offered food and drinks when they had been in the department over several hours.
- Patients were not always well informed about what was happening or what they were waiting for.
- Privacy and dignity was not always respected.
- The trusts urgent and emergency care Friends and Family Test performance (% recommended) was generally worse than the England average between November 2015 and October 2016.

Compassionate care

- We saw examples of patients who did not always receive the care and compassion they deserved.
- Staff did not always show an encouraging, sensitive and supportive attitude to people.
- We observed patients in the department for up to 10 hours and no evidence of any pressure relief given. If they were waiting a long time, no patients were put onto beds from trolleys.
- We observed a patient who had earlier attended the hospital for investigations in the morning and was telephoned on their return home to attend ED as there were problems with the results. The patient was in the ED for over 3.5 hours and had not eaten since early morning. The patient, despite being frail, received no food or drink, no pressure relief and no explanation of what they were waiting for.

Urgent and emergency services

- We spoke with a patient who had requested a commode three times before one was brought to her.
- However, some patients spoke highly of the staff. They said they understood they were busy and used comments such as friendly, courteous and they were happy with their care and treatment.
- Privacy was not always respected particularly when patients were waiting in the ambulance holding bay. They were all able to see and hear each other and staff were unable to separate them.
- The trusts urgent and emergency care Friends and Family Test performance (% recommended) was generally worse than the England average between November 2015 and October 2016. In latest period, October 2016 trust performance was 74.2% compared to an England average of 86.0%. The trust had seen a fluctuating trend over the last year, with a steady decline in performance over the last 6 months.

Understanding and involvement of patients and those close to them

- Four patients told us they were kept informed of what was happening or what they were waiting for. One patient commented they 'felt they were in the dark about what was happening'.
- When explanations were given patients told us staff ensured they understood medical terminology.
- Staff generally communicated in a way that people could understand.

Emotional support

- There was a room for relatives to use if needed. Access to a telephone and drinks were available.
- There was support available for the bereaved from the multi-faith chaplaincy service.
- The spiritual needs of patients were provided by a 24-hour chaplaincy support that provided sacramental care in the trust chapel and at the bedside and through supporting patients at the end of life.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

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

- The care of patients with mental health problems was highlighted in the last inspection. To nurse patients who were a suicide risk, the trust had created a specific ligature free cubicle. During the inspection, we observed patients who were a suicide risk in cubicles with ligature points.
- During our inspection, we saw the department was crowded and it had reached capacity because there was no available space. We saw and heard of examples were patients' safety was at risk. Although there were escalation procedures in place, we witnessed the crowding for several hours. The nurse co-ordinator several times referred to the department as being unsafe.
- The department was not meeting the department of health standard which states that 95% of patients should be treated and discharged or admitted within four hours of arrival.
- Between September 2015 and August 2016, the Scunthorpe General Hospital median percentage of patients that left the hospital before being seen for treatment was worse than the England average for six of the 10 months.
- There was no specific support for patients who attended with dementia.

However:

- Between November 2015 and October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average.
- The percentage of ED attendances at this trust that resulted in an admission was lower than the England average 2015/16.

- Between September 2015 and August 2016, the trust's monthly median total time in ED for admitted patients was consistently lower than the England average.
- Patients' complaints were managed in line with the trust's policy and feedback was given to staff.

Service planning and delivery to meet the needs of local people

- To meet the needs of local people, planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities. For example, the trust was working with external partners to provide access to primary care services through the ED. This was in line with RCEM guidance on how to achieve safe, sustainable care in emergency departments.
- The department had developed networks with external providers to deliver increased mental health provisions for the local population.
- Due to the patient flow throughout the hospital being poor, during our visit we saw the department was overcrowded, there were insufficient numbers of treatment rooms and cubicles available and patients waited a long time in ED for a bed on the wards. We saw patients queuing in the ambulance holding area and in the corridor. We saw an example of how this impacted on patient care. For example, a child needed emergency treatment and there was no available trolley. The child was placed on a 'pat slide' which is a hard board used to transfer patients from trolleys to a bed. This pat slide was held between two chairs. We observed a full department and full resuscitation bays, consequently, if a patient came in by ambulance requiring resuscitation there was no available resuscitation bay or other cubicles to provide care for them.
- A separate children's waiting room was in the progress of being constructed and was planned to open in January 2017 but pending opening there was no good segregation for children away from the adults waiting area.

Meeting people's individual needs

- The department was constructing a separate entrance for ambulance patients and walk-in patients. This was due to open shortly following our inspection. This would provide improved privacy and confidentiality for patients arriving by ambulance.
- Separate male, female and disabled toilets and baby change facilities were available in the waiting room. The department was accessible for people with limited mobility and people who used a wheelchair.
- The reception area had a designated hearing loop.
- Within the waiting room there were no toys or books for children to keep them occupied.
- Within the waiting room there were vending machines which contained cold and hot drinks, chocolate and crisps.
- There was a digital display on the wall of waiting times but this was switched off throughout our inspections.
- The IT system had a flagging system. This included identifying patients with dementia or a learning disability, to allow staff to put in place support and ensure they are nursed in a suitable place.
- Staff told us if they had a patient with a learning disability they would encourage their carer to stay with the patient to help alleviate any anxieties and try and see the patient as soon as possible
- There was no specific 'dementia friendly' cubicle. We were told special distraction equipment was available for patients with dementia.
- All the trolleys were able to be used for patients with a weight up to 35 stone. Within the hospital, a hoist and bariatric wheelchair were available if needed. Bariatric equipment could be hired from an outside company who would deliver within four hours.
- A range of information leaflets were available for patients to help them manage their condition after discharge however, leaflets were available in English only.
- Interpreting and translation services were available. These could be either face to face or by telephone. During the unannounced inspection, a distressed relative approached us who needed translation services for a patient. This was organised by staff.
- There was a relatives' room and on request, relatives could access a telephone. Hot and cold drinks were offered and available on request. The relatives' room was next to a viewing room for deceased patients providing direct access to people who wished to see their loved one.
- There was a separate mental health assessment room used for patients with mental health problems. This was near the nurses' station so patients could be observed and equipment could be removed to provide a ligature free safe environment. However, during our visit, we

found the room was occupied by a patient who had been sectioned under the Mental Health Act but the room had a trolley with suction tubing in it, which was a ligature risk. We found another occasion where a patient at risk had access to an intravenous drip. This patient was not observed and the patient's cannula had dislodged. The room had a plastic chair in which could also be a potential risk.

- We observed a patient with a mental health problem and identified as a suicide risk nursed in another cubicle (as the mental health assessment room was occupied). This patient was not observed due to the curtains being drawn around the trolley space. There were ligature points within the cubicle which posed a risk to the patient.
- The mental health team was based out of the hospital providing a service seven days a week 24 hours a day. Staff told us there could be a delay in the mental health team attending the ED and we observed a nurse trying for 90 minutes to contact the crisis team.

Access and flow

- The bed management team observed flow within the emergency department and at least four meetings took place a day (more frequently if needed) to understand the bed situation to enable planning for expected admissions and discharges, ensuring patient flow throughout the hospital was timely.
- An escalation process was in place that gave staff actions for how to manage the department during periods of extreme pressure. This involved help from the wider hospital teams, including bed managers and senior managers improving the patient flow throughout the hospital and specialist teams reviewing patients in the ED. At the time of the inspection, we observed the department full and under extreme pressure with no empty cubicles and patients queuing in the holding bay. This was a risk to incoming patients as the resuscitation bays were also full. This lasted for approximately 3 hours. We spoke with nursing staff who told us of recent incidents that had occurred which impacted on patient safety due to the lack of cubicles. This concern is discussed elsewhere within this report.
- Patient flow co-ordinators were introduced, although these did not cover seven days a week. This was an administration role to help co-ordinate patients transferring to the wards.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. Between August 2015 and July 2016 the department breached the standard in all months except September 2015, May 2016 and June 2016.
- Between November 2015 and October 2016, the monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was better than the England average. Between January 2016 and July 2016, performance against this metric showed a trend of improvement. January 2016 was when the Scunthorpe General Hospital had the highest percentage of patients waiting between four and 12 hours from the decision to admit until being admitted with 9.4% and in July 2016, it was 1.4%. The trust has followed national trends for the whole period.
- Between September 2015 and August 2016, the Scunthorpe General Hospital median percentage of patients that left the hospital before being seen for treatment was worse than the England average for six of the 10 months.
- The percentage of A&E attendances at this trust that resulted in an admission was lower than the England average 2015/16. The England average had slightly decreased from 2014/15 to 2015/16 however, the trust's attendances resulting in admission has remained consistent.
- Between September 2015 and August 2016, the trust's monthly median total time in ED for admitted patients was consistently lower than the England average. Performance against this metric showed a trend of decline from 125 minutes in September 2015 to 134 minutes in August 2016.
- Patients who were referred by their GP with a medical problem went straight to the acute medical unit for assessment. This reduced the number of patients attending ED. However, during the inspection, because the acute medical unit was full patients admitted by their GP came to ED until a bed was available.
- The department had admissions pathways to ambulatory care. Patients who presented to ED were assessed by a clinician and if their symptoms suggested that they had specific conditions including cellulitis, deep vein thrombosis (DVT) and pulmonary embolisms (PE), they were directed to the ambulatory care centre.

Urgent and emergency services

Learning from complaints and concerns

- The department had a complaints response process that addressed both formal and informal complaints, which were raised through the Patient Advice and Liaison Service (PALS). All complaints were answered fully with an assessment of root causes made.
- Between September 2015 and August 2016 there were 81 complaints about urgent and emergency care services, 32 were for Scunthorpe General Hospital. The trust took an average of 56.2 days to investigate and close complaints, which was in line with their complaints policy, which states complaints should be responded to within an agreed timescale with the complainant but no longer than six months. 84% of complaints were due to clinical treatment.
- Response letters to complainants included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectation that services operate under a duty of candour.
- Staff told us they were aware of how to deal with complaints. Feedback was given in the huddle and we saw evidence of discussion of complaints in minutes of governance meetings.
- Patients and relatives we spoke with were confident about how to make a complaint to the trust. One patient we spoke with had put in a formal complaint.

Are urgent and emergency services well-led?

Inadequate

In the previous inspection, we rated the well-led domain as inadequate. During this inspection we rated it as inadequate because:

- There had been no significant improvement since our last inspection in October 2015. The areas of improvement identified in the last inspection, such as, ensuring the sufficient numbers of staff, ensuring staff received an annual appraisal and the removal of ligature risks were not seen.
- We were not assured that leadership was effective. Quality and safety was not the top priority, nurse leaders were not clear about their roles and accountability for quality.
- There was a lack of effective governance processes in the department that enable concerns to be identified and addressed.
- Nurse leaders were out of touch with what was happening on the front line. They were not clear about their roles and their accountability for quality. New processes had been put in place following our inspection such as the new ED trolley passport, the shift lead handover sheet and care rounds. However, since commencing these processes, they were not audited or checked to ensure they were being used.
- There was no matron dashboard to monitor patient safety and quality.
- NEWS and PEWS scores were not recorded regularly therefore we could not be assured that the patients were having the appropriate level of monitoring whilst in the ED.
- Outcomes of RCEM audits were below expectations compared with similar services.
- The risk register did not include all risks identified during the inspection and it was not clear who had responsibility for each risk and if any action plans were in place and being monitored.
- The vision and strategy created since our last inspection was still in its infancy. For example, the introduction of the streaming nurse had been trialled for a few hours during our inspection with a view to implementation when staffing numbers would allow.
- The vision did not encompass key elements such as compassion, nursing care, patient safety and quality. Not all staff were aware of or understood the vision and strategy for the department.
- There was disparity in the published time to initial assessment, the information provided by the trust and our findings on inspection. The published data for the median time from arrival to initial assessment for patients arriving by ambulance was one minute compared to the England average of seven minutes. The trust has consistently had a median time of one minute each month. This did not correspond to the data the trust provided us with median waiting times from arrival to initial assessment which averaged 13 minutes. When we raised this with senior managers on the inspection they could not tell us why the published data was one minute and how that figure had been derived.

- The department took part in locally agreed audits and they took part in Royal College of Emergency Medicine (RCEM) audits in 2016. Although actions from these audits were in place, we did not see evidence actions were completed.
- Although there were governance meetings which were attended by the senior team, departmental meetings did not take place. Therefore, staff were not actively engaged or empowered.
- There was lack of health and safety assessments of the ongoing building work taking place to construct the children's waiting room. Senior leaders failed to recognise the risks regarding this.
- There was minimal engagement with people who use services.

However:

- A frail elderly assessment support team visited the ED and staff spoke about how this had a positive impact for patients.
- An ambulance handover team, to see ambulance patients and provide an initial assessment, had been introduced and was providing a positive impact on the ambulance turnaround times.
- During the inspection, they had trialled for one day, with a plan to continue with the model, of streaming at the ED reception. This involved working with the external providers, and GP out of hours, to create an impact on reducing avoidable admissions and give timely assessment and pain relief. This was not yet in place as nurse staffing was an issue.
- An acute physician model had been introduced on the acute admissions ward, short stay ward and ambulatory care. One of the benefits of this was to improve the four-hour standard in ED by improving patient flow.

Leadership of service

- The emergency department was part of the medical directorate. The leadership of the directorate consisted of a team of three people, composed of an associate medical director, an associate chief operating officer and an associate chief nurse.
- The nursing leadership had changed regularly over the past few years, creating inconsistency of nurse managers and matrons. At the time of inspection, a new nurse manager had started in post two weeks before and a new matron started in October 2016.
- The trust had an operational matron and a quality matron who had oversight of certain aspects of the department. However, there was a lack of processes around infection prevention and control, checking of emergency equipment, basic nursing care, nursing documentation, mandatory training, staff appraisals and quality measures.
- Nursing staff spoke of the lack of nurse leadership and inconsistency.
- There was a high use of locum doctors and consultant cover was below the RCEM recommendations.

Vision and strategy for this service

- The emergency department was part of the medical services directorate.
- The senior management team had a clear vision of an urgent care floor model although this was in its infancy. They described an acute physician model on the acute assessment ward; however, we did not see the impact of this on ED at the time of the inspection.
- The introduction of streaming for walk-in patients was trialled for a short period during our visit. The senior team were keen to introduce this following recruitment.
- Not all staff we asked were aware of the trust vision and strategy or the department's vision or strategy.

Governance, risk management and quality measurement

- A governance system was in place and the agenda items of the monthly emergency care business and governance meeting included discussions of incidents, complaints and lessons to be learned.
- A monthly medicine group governance meeting took place which had representatives from across site. Discussions included ratifying operational group policies and procedures, NICE recommendations, audit programmes, risk register and incidents, lessons learned and complaints.
- There was no emergency department meeting which included staff from the ED. Therefore, information did not always cascade to the staff working in the ED. A staff huddle had been introduced daily where some information was passed on. We observed a huddle and staff discussed how to manage patients with PEG feed, reminding staff regarding documentation and the new streaming nurse role which had been introduced that day.

- The ED risk register was sent to us prior to the inspection. This had a total of six risks recorded at the time of our inspection. Each risk was graded, dependent on severity. There was one graded as high, which was relating to performance against the 95% standard. One was graded as moderate risk, which the recruitment of acute care practitioners. These were all locums and they incurred a higher cost. Four were recorded as low risk. One of the low risks was regarding the risk of ligature points in the rooms where patients with a suicide risk were nursed. It states the trust must ensure that all risks to the health and safety of patients with a mental health condition are removed in Scunthorpe emergency department (ED). This must include the removal of all ligature risks. However, during our inspection we found ligature risks present where patients who were a high suicide risk were nursed.
- The risks on the risk register did not match the risks identified during the inspection. For example, overcrowding of the department or medical and nurse staffing was not on the risk register.
- There was no lead identified on the risk register therefore it was not clear with regard to who was taking responsibility for each risk and if any action plans were in place and being monitored.
- The department took part in locally agreed audits and they took part in Royal College of Emergency Medicine (RCEM) audits in 2016. Although actions from these audits were in place we did not see evidence actions were completed. For example, the action for the RCEM audit for vital signs in children (July 2016) was for all children to have vital signs recorded unless seen for an injury and the recording of the paediatric early warning scores (PEWS). On reviewing the notes, no PEWS scores were completed.
- There was disparity in the published time to initial assessment, the information provided by the trust and our findings on inspection. The published data for the median time from arrival to initial assessment for patients arriving by ambulance was one minute compared to the England average of seven minutes. The trust has consistently had a median time of one minute each month. This did not correspond to the data the trust provided us with where median waiting times from arrival to initial assessment averaged 13 minutes. During the inspection, the records we examined informed us that the target was met for 12 out of 30 patients' notes we checked. These times were between two and 58 minutes, averaging 20 minutes. When we raised this with senior managers on the inspection, they could not tell us why the published data was one minute and how that figure had been derived.
- A trust wide monthly accident and emergency activity dashboard measured the number of attendances and the four-hour performance against the 95% standard.
- There was no matron dashboard used to monitor quality and safety performance.
- There was a sepsis lead for the trust. The last sepsis audit we saw was the RCEM severe sepsis shock in adults in 2013 to 2014. Five standards were below 70%. We saw no evidence of a re-audit. When we asked we were told it was not re-audited as it was already embedded. However, we saw an example that this was not the case during our inspection of the department.
- On the unannounced inspection we found a health and safety risk. Building work was taking place on the paediatric waiting room and this work was not screened off. Children from the waiting room could have easily entered the work place and there was a variety of hazards. No documented health and safety assessment had been carried out. The cones caused a trip hazard in the waiting room and the high level of sawdust was an infection prevention and control hazard. Anyone could have accessed the workplace, where various hazardous materials were around, such as, metal wires, nails and tools. Senior leaders failed to recognise the risks regarding this.
- New processes had been put in place following our inspection such as the new ED trolley passport, the shift lead handover sheet and the ED care rounds. However, since commencing these new processes, they had not been checked to see if staff were completing them. On our unannounced inspection, we found these were not consistently completed.

Culture within the service

- Staff told us they enjoyed working in the department and although it was very busy they felt supported in their work by their colleagues the majority of time.
- We observed staff working well together and there were positive working relationships with the multidisciplinary teams.
- We observed staff being flexible and helping in the different parts of the department which were busy to provide a better and more responsive service for patients.

- We asked staff at all levels about the morale of the department; there was a consensus that morale was lower during busy shifts due to increased activity within the department.
- Staff at all levels also told us that although achieving targets was important they were not afraid of breaching a target if it meant that the patient was safe and received the correct care including admission to an appropriate speciality.

Public engagement

- The trust took part in the friends and family test.
- There was no evidence of any further public engagement regarding the emergency department.

Staff engagement

- We were told that at Scunthorpe ED there was a monthly minor works / alterations meeting since August 2016 which involved nursing, medical and administration staff. This group was set up due to staff concerns about the environment.
- We saw evidence trust wide of staff receiving recognition for their contribution to the service through internal annual awards ceremonies.

Innovation, improvement and sustainability

- A frail elderly assessment support team visited the ED and staff spoke about how this had a positive impact for patients.
- Patient flow co-ordinators were introduced although these did not provide cover seven days a week.
- An ambulance handover team, to see ambulance patients and provide an initial assessment, had been introduced and was providing a positive impact on the ambulance turnaround times.
- During the inspection, they had trialled for one day, with a plan to continue with the model, of streaming at the ED reception. This involved working with the external providers, and GP out of hours, to create an impact on reducing avoidable admissions and give timely assessment and pain relief. This was not yet in place as nurse staffing was an issue.
- An acute physician model had been introduced on the acute admissions ward, short stay ward and ambulatory care. One of the benefits of this was to improve the four-hour standard in ED by improving patient flow.

Medical care (including older people's care)

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

Information about the service

Scunthorpe General Hospital is part of Northern Lincolnshire and Goole NHS Foundation Trust and provides medical care services for NHS patients across North and North East Lincolnshire and the Goole area. Medical care is provided across three sites in the trust, Scunthorpe General Hospital, Goole District Hospital and Diana Princess of Wales Hospital in Grimsby.

Between April 2015 and March 2016, there were approximately 46,741 medical episodes of care carried out in this trust with approximately 23,541 at this hospital. Day cases accounted for 49% of all episodes, emergency admissions 48% and elective admissions 3%. 18,189 admissions were general medicine, 7,716 were gastroenterology and 6,418 medical oncology.

Medical services across the trust were managed within the medicine group. The group was operationally divided into three care groups: acute care (which included emergency and general medicine); specialist medicine; and planned care. Scunthorpe General Hospital provided medical care in 11 medical wards, and covered a number of different specialties, which included general medicine, care of the elderly, respiratory medicine, diabetes/ endocrinology, gastroenterology, neurology and stroke care.

During the inspection, we looked at 16 patient records and 16 prescription charts. We spoke with 20 patients and relatives, and approximately 50 staff including doctors, nurses, therapists, health care assistants, ward managers, matrons, administrative assistants and student nurses.

We visited 10 medical wards, which included the Clinical Decisions Unit (CDU), the Planned Investigation Unit (PIU), and the Stroke Unit. We also visited the Cardiac Catheter Laboratory and the Endoscopy Unit.

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

Scunthorpe General Hospital was previously inspected in October 2015. All five domains were inspected for medical care services. Safe and responsive were rated as requires improvement and effective, caring and well-led were rated as good. The service was rated requires improvement overall. The main issues of concern from the last inspection were: nurse staffing levels were often below the minimum agreed to provide safe care and medical cover at night was minimal; feedback and learning was inconsistent across the trust and there were issues with the storage of drugs in fridges; we found issues with flow across the hospital and there were delays and cancellations of patients in the cardiac catheterisation laboratory; and the endoscopy unit was breaching the two week wait standard.

Medical care (including older people's care)

Summary of findings

At the previous inspection in 2015, we rated medical care services overall as requires improvement. At this inspection we rated this service as requires improvement because:

- We had concerns about the safety of medical care services, which required improvement. The number of nursing staff on duty was below the minimum agreed level in order to provide safe care and there was minimal medical cover at night with one registrar and two junior doctors covering the stroke unit, the clinical decisions unit and all medical wards.
- There were mixed results in national audits and the endoscopy unit was no longer meeting the requirements for JAG accreditation and had lost this is in July 2016.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England overall performance and patient flow through the hospital remained an issue with a significant number of patients cared for on non-medical or non-speciality wards. We also found two-week breaches were still occurring in endoscopy.
- There was no action plan to demonstrate how the medicine group were going to meet their business objectives. We found staff engagement varied. Although staff appeared dedicated to patient care and worked well with colleagues, morale was low because of staff shortages, ward moves and working additional shifts. Ward managers had limited time to carry out their management duties as they were counted in the nursing numbers four days out of five.

However:

- We found the monitoring and reporting of medicines fridge temperature had improved and nurses awaiting their PIN were no longer counted in the nursing numbers.
- Staff were caring and patients were treated with respect and compassion.

The Ambulatory Care Unit (ACU) opened in September 2015 and had a positive impact on patient flow at the Scunthorpe General Hospital site.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

At the previous inspection in 2015, we rated medical care services as requires improvement for safe. At this inspection we rated safe as requires improvement because:

- Although there had been some recent recruitment of newly qualified nurses, nurse vacancies were still high. Nurse staffing fill rates were low and we saw examples of staffing levels on wards that were below the safe level.
- Medical staffing at night had not improved and several medical staff told us that this did not feel safe.
- There had been some improvement in learning from incidents, however further improvement was needed to ensure feedback to staff was consistent.

However:

- With one exception, we found the monitoring and reporting of medicine fridge temperatures had improved.
- Nurses awaiting their PIN were no longer counted in the nursing numbers.

Incidents

- Between August 2015 and August 2016, there were 4,215 reported incidents in the medical care service across the trust. The majority of these (99.4%) resulted in no harm or low harm however, 19 caused moderate harm, two caused severe harm and four resulted in patient death.
- The most frequently reported incident category, which accounted for 1,478 of the reported incidents, was implementation of care and ongoing monitoring or review followed by patient accident with 1,102 incidents.
- Most of the incidents (96%) were reported within the expected timescale of 60 days. There were 55 incidents, which took longer than 90 days to report which was 1.3%.
- There were 11 serious incidents reported in medical care services for between August 2015 and August 2016, and 10 of these related to Scunthorpe General Hospital. The most common cause was pressure ulcers (five), treatment delay (four), slips, trips and falls (1). Serious incidents are incidents that require further investigation and reporting.
- There were no never events reported in medical care services between August 2015 and August 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff knew how to report incidents using an electronic reporting system. Feedback and learning from incidents had improved since our last inspection. There was a tick box on the electronic incident reporting form, which staff could select if they wished to receive feedback. Staff told us they sometimes received verbal feedback and received a monthly newsletter, which contained information on lessons learned from incidents. Some wards had developed secure social media pages to share learning from incidents with staff. However, some staff on the planned investigation unit and ward 24 said they rarely received feedback and one nurse on the clinical decisions unit said she had given up asking for feedback.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood the principles of the duty of candour and the importance of being open and honest with patients. We reviewed a serious incident investigation and saw that duty of candour was included in the content of the report.
- Mortality and Morbidity meetings were held every six to eight weeks. We reviewed minutes from the stroke, cardiology and gastroenterology department's mortality and morbidity meetings, which showed discussion and learning points from the review of mortality cases. Within the stroke mortality meeting, it identified how many deaths had occurred within the period, and the care every patient received was reviewed and summarised. The meetings also showed wider learning from other forms of feedback such as complaints, PALS and serious incidents.

Medical care (including older people's care)

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). Between October 2015 and October 2016, staff reported 116 pressure ulcers, 24 falls with harm and 34 catheter urinary tract infections in the medical care services across both hospital sites.
- All wards displayed their safety thermometer information for patients and visitors to see. For example, the stroke ward information showed they had zero pressure ulcers, two falls, no urinary tract infections, four catheters in place and zero blood clots.

Cleanliness, infection control and hygiene

- The areas we visited appeared organised and clean. Hand washing facilities were available at the entrance to and throughout the wards we visited. Personal protective equipment including aprons and gloves, and sanitising hand gel were also available.
- We observed good infection prevention and control practice on all wards we visited. Staff used appropriate personal protective equipment when completing clinical tasks. They complied with bare below the elbows policy, correct handwashing technique and use of sanitising hand gels.
- Staff observed the uniform policy and had clear name badges. The matrons audited compliance with the uniform policy monthly.
- One patient who was a health care professional told us that he thought the ward cleaning and infection control practice he observed was excellent.
- Staff completed infection prevention and control training as part of their mandatory training programme. The overall compliance with this training for medical care staff at this hospital was 76% against a target of 95%.
- We observed clinical waste and domestic waste were appropriately segregated and disposed of correctly in accordance with the trust's policy. Separate bins for clinical and domestic waste were evident throughout all wards visited. Sharps bins were correctly labelled and dated and sharps disposed of safely.
- Equipment we inspected appeared clean and was identified as being recently cleaned using cleaning assurance stickers.
- We observed a colour coded cleaning checklist in the endoscopy unit, which made it clear to all staff their responsibilities for cleaning clinical areas and equipment.
- Trolley beds in endoscopy were deep cleaned weekly. We saw a chart that had been signed and dated to record when cleaning had taken place and was next due.
- Clinical areas participated in monthly environmental audits, which were carried out by the quality matrons. The audits focused on 12 key elements; these included infection control practice and observation of hand hygiene, environment, waste disposal and sharps safety and decontamination. We looked at a random sample of these and found compliance was good in most areas. Actions were documented if compliance fell below the required level.
- Decontamination of endoscopy equipment was carried out in a new decontamination unit adjacent to the new build. The equipment was transported between the two areas on a trolley by a member of staff. This would no longer be necessary once services had been relocated to the newly built unit. We saw that equipment was clearly identified as clean or dirty and there was a track and trace system in place.
- The trust carried out audits of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile. There had been no incidences of MRSA reported. We observed from the clostridium difficile audits that specific questions were asked to identify: if the patient was isolated and were risk assessments in place, such as, bowel charts. Key themes were identified and other comments provided to be able to give feedback. In June 2016, wards 17 and 18 had been audited by the infection control nurses and both scored 100%.

Environment and equipment

- The trust had an electronic medical device register, which identified where equipment was stored and the frequency of the service required. We saw that the register logged when the equipment was last serviced along with the asset and serial number identification labels. The trust had a policy for maintaining equipment, which outlined the process to follow when repairs to equipment were needed. We checked

equipment such as hoists and infusion pumps and found them to be serviced correctly and the dates recorded appropriately. Electronic equipment had been safety tested within the last 12 months and had test labels attached.

- Staff said equipment was available to meet patients' needs. This included pressure relieving equipment and equipment to prevent falls such as sensor pads and low-level beds.
- Resuscitation equipment was available on all wards. Records indicated these were checked on a daily basis and ready for use.
- Staff told us that the bleed trolley in the endoscopy unit was checked daily and if any items were used, they would be replaced straight away. There was no checklist in place to demonstrate this however staff told us one had been developed and they were about to start using it. We saw a copy of the new checklist.
- The endoscopy unit appeared more organised and less cluttered since our last inspection. Drying units were no longer in the corridors. There were separate areas for male and female patients to provide privacy and dignity. A new purpose built unit was near to completion and staff informed us they would be moving services there soon.

Medicines

- Medicines were appropriately stored, prescribed, administered and recorded. Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained. Regular balance checks were performed in line with the trust policy.
- We looked at 16 prescription charts and found they had been fully completed and were legibly written, signed and dated. Allergies were recorded and VTE prophylaxis was documented. Start and stop dates were recorded and where medicines were omitted, a corresponding code was entered detailing the reason for this.
- We saw an example of one patient who was managing their own medicines, however their ability to self-medicate had not been assessed and no documentation had been completed. This meant we could not be sure they were adequately supported to take their own medicines safely and that staff were not following the trust policy on self-administration.
- We checked the arrangements for medicines requiring refrigeration. This had improved since our last visit, however, on the Clinical Decisions Unit (CDU) we found fridge temperatures had been above the recommended range on nine days in November 2016. No action had been recorded by ward staff on any of these occasions. The ward manager was aware there had been problems with the fridge but had not escalated or reported the issue in accordance with trust policy.
- The chief pharmacist told us about a new remote temperature monitoring system, which was being trialled to improve the management of refrigerated medicines; however, this was not fully rolled out across the trust at the time of our inspection.
- We checked medicines for emergency use and found that they were readily available, stored appropriately, and that regular checks had been performed to ensure that they were fit for use.
- Oxygen was stored safely in a trolley endoscopy unit and in date.
- Medicines management training was part of the trust mandatory training programme. Information supplied by the trust showed that compliance with this training for medical care services at this hospital was 87%.

Records

- Medical records and part of the nursing records were stored securely in lockable units and trolleys. Part of the nursing record was by the patient's bedside to allow for easy access for staff to complete patients care records. Other assessments were completed on the trust electronic system, which could be viewed behind the nurses' station.
- We reviewed 16 sets of patients' records, which included care plans. Care plans were divided into care bundles, which related to certain risks such as falls, nutrition and hydration, pressure areas, pain and venous thromboembolism. We found these were completed appropriately in line with trust and professional standards and included relevant risk assessments and descriptions of staff interaction with the patient.
- Intentional rounding documentation was in place and completed in all but two of the records we reviewed.
- Information supplied by the trust showed that compliance with information governance training for medical care services at this hospital was 79%.

Safeguarding

- The trust had policies and procedures in place for safeguarding children and adults. Both policies were in date and provided staff with flowcharts to aid decision making and to ensure the correct processes were followed.
- Staff we spoke with knew how to access safeguarding policies and were clear about their safeguarding responsibilities. They were aware of the safeguarding team and confident they could access the team for support and advice. Contact details for the safeguarding team were available to patients, visitors and staff on a notice board at the entrance to each ward.
- Overall compliance with safeguarding training for staff providing medical care services at this hospital was 84%. Safeguarding adults training was 82%, safeguarding children level one, two and three was 84%, 87% and 67% respectively.

Mandatory training

- The trusts mandatory training programme included information governance, moving and handling, safeguarding adults and children, infection control and resuscitation. The trust target for mandatory training was 95%. Training could be completed either face-to-face or online. Staff were also required to complete statutory training such as fire safety training.
- Information provided by the trust showed that overall compliance with mandatory training at this hospital in medical care services was 80%. This was a slight improvement on the previous inspection, which was 79%.
- The highest areas of compliance were in safeguarding and medicines management both at 87% and the lowest were resuscitation and infection control at 67% and 76% respectively.
- Staff we spoke with were clear on their responsibility to complete mandatory training and most told us they were up to date. If any outstanding training needed to be completed, staff said they were booked on to complete this.
- Two junior doctors we spoke with said cover was not always arranged for them to attend mandatory training therefore it was difficult to keep up to date with this.
- Newly qualified and overseas nurses attended a two-week intensive course called care camp, which included most of their mandatory training. Ward managers told us that the training figures did not always reflect this as it took a long time for the care camp training to be updated on the system.
- Staff on the ambulatory care unit told us they were 100% up to date with their mandatory training. They said the ward manager was keen to ensure that they completed all their training and followed this up with all staff on the unit.

Assessing and responding to patient risk

- The trust used a National Early Warning Score (NEWS) to measure whether a patient's condition was improving, stable or deteriorating and indicated when a patient might require a higher level of care and medical review. Nurses and care support workers recorded patient observations and entered them onto an electronic device that displayed the NEWS score on the electronic display board. The colour changed automatically dependant on the score, for example, if the score was seven and above it would turn red, a score of five or six would turn amber and a score of four and below would remain green. This enabled staff to identify if a patient was deteriorating and required escalating.
- The electronic display board could also be viewed by staff at the hospital's operational centre and was used at medical handover to identify patients at risk of deteriorating.
- We saw from the Nursing Audits Interim Report (Quarter 1 2016), the trust audited 62 patient records on medical wards at Scunthorpe General Hospital against compliance with NEWS. The report identified that in all ward areas there was 100% compliance with vital signs being recorded in accordance with the NEWS; 100% compliance in documenting if observations were outside of the NEWS in all wards with the exceptions of ward 16 and ward 23; 100% compliance in actions taken being fully documented and all wards had 100% compliance with documenting the management plan with the exception of ward 16 which scored 75%.
- Patient risk assessment documentation for falls, pressure areas, nutrition and venous thromboembolism were included in care records. These were completed thoroughly in the sample of records we looked at.
- The trust was an outlier for septicaemia (except in labour). A nurse consultant for the deteriorating patient and a sepsis specialist nurse were in post. The sepsis specialist nurse had been in post since January 2016

and told us that the trust was working towards compliance with sepsis pathway and rolling out education to staff on the wards. Medical staff we spoke with knew about the sepsis six bundle.

- The critical care outreach team was available 12 hours a day, seven days a week. Outside of these hours, the hospital at night team managed patients. The team supported patients stepped down from critical care and reviewed deteriorating patients alerted to them by ward staff. The team also delivered non-invasive ventilation outside of critical care in line with the trust's policy.

Nursing staffing

- Nurse staffing at this hospital had been identified as an issue at the last inspection and we found this was still an issue.
- As of July 2016, the trust reported a vacancy rate of 14% for nursing staff in medical care services. Out of the three hospital sites, Scunthorpe General Hospital had the highest at 17.5%. There were 46.5 whole time equivalent nurse vacancies. The trust turnover rate for nursing staff was 17% overall in medical care services and 22.4% at this hospital. Between August 2015 and July 2016, the trust reported a bank and agency usage rate of 2% for nursing staff at Scunthorpe General Hospital.
- The trust used the safer nursing care tool as recommended by the National Institute of Clinical Excellence (NICE) to calculate safe nurse staffing levels based on patients' level of sickness and dependency.
- The trust had recently recruited newly qualified nursing staff however, more had chosen to work at Diana Princess of Wales Hospital and there was still a high level of nurse vacancies at Scunthorpe General Hospital.
- We looked at nurse and health care assistant fill rates on medical wards for the period January 2016 to September 2016. Figures for June or August 2016 were not included. Fill rates for registered nurses were poor on some wards. Those rated red had a fill rate of below 80%, those rated amber 80 - 85% and those rated as green 85 – 114%. Out of seven months we reviewed, all were rated red for ward 17, four red and two amber for ward 23, four red and one amber for ward 18 and one red and one amber for ward 2. The lowest fill rates were for the day shifts. All night shifts were filled and rated green. Health care assistant fill rates were generally good at 100% or above.
- Twice daily safety brief meetings took place at the operational centre every day. The aim of this meeting was to ensure that minimum safe staffing levels were achieved in all areas. Senior staff attended safety briefings and each ward was given a rag rating of red, amber or green depending on their staffing levels. There was an escalation process in the event of vulnerable staffing levels. For any areas rated as red, bank or agency staff would be requested. Permission to do this would be escalated to director level for approval. Another option was to move staff from their substantive area to other areas to make this safe. Despite this process, we visited some wards where staffing levels were extremely low.
- Managers told us that due to nurse staffing shortages, they had taken the decision to close the short stay ward (ward 2). Staff from ward 2 had been distributed to other wards. We spoke to one nurse who had been relocated to CDU from Ward 2. The nurse had already completed a rotation on CDU prior to relocation so was familiar with working on the unit.
- At the time of our inspection, the respiratory ward (ward 22) was closed for refurbishment. We were told the refurbishment would include a high observation bay for respiratory patients requiring a higher level of care, for example patients on non-invasive ventilation. Patients from this ward had been temporarily relocated to the empty ward 2. Staff from ward 22 had moved over with their patients. The ward sister told us that ward 22 had 10 whole time equivalent registered nurse vacancies.
- Ward 2 had 23 beds. When we visited ward 2 all beds where full and there were patients with a high level of need. Five patients were receiving non-invasive ventilation. We saw planned and actual staffing levels for the ward displayed on a staffing notice board at the nurses' station. Planned nurse staffing was six nurses in the morning, five in the afternoon and three at night with four health care assistants on all shifts. On the day of our visit actual staffing was three nurses in the morning, two in the afternoon and three at night with four health care assistants on all shifts. This included the ward sister counted in the numbers on the early shift. A risk rating of amber was displayed. A ward round was occurring whilst we were there and the ward appeared chaotic. We felt the staffing levels were unsafe given the acuity of the patients. We looked back at staffing rotas for the previous 24 dates and saw that actual staffing

met planned levels on only three dates. On all other dates nurse staffing was short by either one or two registered nurses. Night time nurse cover was better than day time.

- Female patients from ward 22 were relocated to beds on the Planned Investigation Unit (PIU). Staff on PIU told us the unit had been well staffed prior to this; however, they now had additional patients to care for and staffing had not been increased to reflect this. Staff told us this often led to delays in providing care for the day care patients on the unit. The unit normally accommodated short stay patients Monday to Friday and closed at the weekend but was now remaining open to care for medical outliers from ward 22. When we visited the unit on 25 November, there were 13 inpatients and the ward sister did not yet know which staff would be looking after these patients at the weekend. The ward sister said this was a regular occurrence. Information provided by the trust showed there were no planned staffing levels for PIU at weekends.
- The stroke ward had 15 beds. The ward sister informed us that they had 1.6 whole time equivalent (wte) nurse vacancies, one wte health care assistant vacancies and three wte staff on maternity leave. We were told staff on the stroke ward were helping on ward 24. All trained nurses were rotating to ward 24 for a two-week period until February 2017 when new staff were due to start. Planned staffing on the stroke unit was two registered nurses and one health care assistant on all shifts. We looked back at staffing rotas and found that staffing levels met planned on only 11 dates out of 25. On all other dates, there was only one registered nurse and one health care assistant on the ward for at least one shift giving a nurse to patient ratio of 1:15. On one occasion, there were no nurses present on the early shift. This meant nurses from the adjacent hyper acute stroke unit needed to look after these patients as well as their own.
- We visited the Hyper Acute Stroke Unit (HASU), which had six beds. Planned staffing for the HASU was two registered nurses, one health care assistant and one stroke responder, 24 hours a day, giving a nurse to patient to ratio of 1:3. Staff told us they were concerned about the staffing levels on the HASU as there had been occasions when the unit was full and there was only one nurse to care for six patients. The stroke responder would go to the emergency department to start thrombolysis. We looked back at staffing rotas and found that staffing levels met planned on only six dates out of 25. On 17 dates, there was only one registered nurse on the unit for either part or the whole of the 24 hour period. We checked bed occupancy data for the unit provided by the trust for this period, which gave a snapshot position at midday each day. The average occupancy for November was 73.9% and there were four occasions were occupancy was 100% with only one registered nurse on duty. Staff told us that if the HASU was fully occupied, with only one registered nurse on duty, this would be reported as an incident.
- Ward 23 (Gastroenterology) had 30 beds. The ward manager told us the ward had approximately six registered nurse vacancies and there were plans to reduce the number of beds on the ward to 24 due to staffing issues. The planned staffing levels for ward 23 were five registered nurses and four health care assistants in the morning, four nurses and three assistants in the afternoon and three nurses and two assistants at night. We looked at staffing rotas for the previous 24 days and found that the planned staffing levels were achieved on only five days and staff were moved to other wards on nine occasions within this period.
- The Clinical Decisions Unit (CDU) had 22 beds with four bays and six side rooms. Nurse staffing had improved on the CDU. There were five band 5 nurse vacancies compared to 10 vacancies at the last inspection. Staff from ward 2 had been moved to the unit and there were two newly qualified nurses who were in their last week of being supernumerary. We looked at staffing rotas and saw that there was always a designated shift leader for every shift.
- Due to recent recruitment, there were several newly qualified nurses working on medical wards. Two newly qualified nurses worked on the Coronary Care Unit (CCU). The ward manager told us she ensured that new staff were not working on the same shifts together. This meant they had the support of working alongside more experienced staff.
- Newly qualified nurses who were awaiting their registration PIN number worked as band 4 health care assistants until their PIN numbers came through. They were not counted in the nursing numbers. This was identified as an issue at the last inspection and was no longer happening.

- Staff told us that it was difficult to recruit to some wards. Registered nurse vacancies on medical wards were being advertised as general medicine nursing posts rather than ward specific to try to overcome this problem.
- Nurse staffing handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover on wards 16 and 17. All staff coming on duty attended. One registered nurse handed over all patients. The nurse circulated a printed sheet of information and discussed each patient individually. The discussion included patient demographics, admission details, progress, risks and levels of support needed by the patient.

AHP staffing

- Allied Health Professionals (AHPs) we spoke with said their staffing levels fluctuated. They had been successful in recruiting newly qualified staff but said it was difficult to recruit experienced staff. Retention of staff was also an issue as once newly qualified staff had gained experience they often moved onto other trusts.

Medical staffing

- The percentage of consultants working at the trust in July 2016 was about the same as the England average and the proportion of middle career doctors was slightly higher. There was a lower proportion of registrars and higher proportion of junior doctors than the England average.
- As of July 2016, the trust reported a vacancy rate of 25.8% for medical staff in medical care services at Scunthorpe General Hospital. The turnover rate for medical staff was 29.6%. The trust used locums to provide continuity of care to patients. Between August 2015 and July 2016, the trust reported a bank and locum usage rate of 2% for medical staff at Scunthorpe General Hospital.
- The Clinical Decisions Unit (CDU) was led by two Acute Care Physicians (ACPs) who were present on the unit from 8.30am to 4.30pm Monday to Friday. From 2pm to 8pm, there was on call physician of the day present and from 8pm to 8.30am, the on call physician of the day was accessible using on call. At weekends, a physician was present from 8am to 8.00pm and on call from 8pm to 8am. A registrar and two junior doctors were available over the 24 hour period seven days a week.
- A discharge team was available at the weekend, which consisted of a junior doctor working 9am to 5pm and an additional consultant working from 8am to 12pm to review patients who may have been fit for discharge.
- Medical cover at night at this hospital was one registrar and two junior doctors (one Foundation Year One and one senior house officer), supported by an on call consultant. This was to cover the CDU, CCU, the stroke unit and all medical wards. The registrar could also be called to the emergency department. Four doctors we spoke with said they thought the overnight medical cover rota was not sufficient, it felt unsafe and one said it was not good enough. Junior doctors told us they did not have enough support on nights with the current staffing levels. We saw that in August 2016 an incident was reported relating to this. The incident reported that there had been no doctor present in the clinical decisions unit at 10.30pm and five patients had waited to be clerked in with some waiting for nine hours. This was because the registrar was attending a patient in the coronary care unit and the senior house officer was attending patients in the stroke unit.
- This issue was raised at our last inspection. Some measures to strengthen medical staffing out of hours had been put in place; however, the trust recognised that there was still more to do. Mondays and Fridays were particularly busy therefore since August 2016 the trust had put two consultants on site to receive acutely ill patients until 8.00pm. Between June 2016 and February 2017 there was an additional core medical trainee working between 9.00pm and 1.00pm on Mondays and Fridays.
- Junior doctors we spoke with said they were aware of gaps in medical staffing rotas, but they said that these were covered by locum medical staff. We checked the medical rotas provided by the trust from January to August 2016 and found gaps both day and night due to vacancies and these were covered with locum staff.
- Medical handovers took place at the operational centre twice daily at 8.30am and 9pm. Handover on CDU was at 9am and 4.30pm. Patients could be handed over to the Ambulatory Care Unit (ACU) if appropriate. We attended a medical handover on CDU, which was led by the day consultant and night time registrar. The handover was comprehensive and included all patients with details of concerns, patient transfers and patients waiting to be seen. Relevant documents were available in the room and access to systems for checking test results.

Medical care (including older people's care)

- A junior doctor worked in the ACU from 9.00am to 4.30pm Monday to Friday and was supported by the senior nurse, middle grade physician and the Acute Care Physician (ACP). The junior doctor would call an ACP to complete the final sign off for investigations or to make the decision to admit a patient.
- Staff working on the coronary care unit told us that medical staff were consistent within the unit, which was good for patient care.
- The endoscopy unit had five consultants/trained endoscopists on duty on the day of our visit. This was in line with their planned numbers.

Major incident awareness and training

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

Are medical care services effective?

Requires improvement

At the previous inspection in 2015, we rated medical care services as good for effective. At this inspection we rated effective as requires improvement because:

- There were mixed results in national audits. Whilst there was good performance in the Sentinel Stroke National Audit Programme, performance in the Heart Failure Audit and the Myocardial Ischaemia National Audit Programme were poor.
- The endoscopy unit was no longer meeting the requirements for JAG accreditation and had lost this is in July 2016. JAG identified that they were not meeting the standards in clinical leadership, training, timeliness, capacity and booking.
- The trust did not have a seven day, 24 hour, gastrointestinal bleed rota. At our last inspection we were told that the trust was working towards this, however, it was still not in place.
- Between April 2016 and August 2016, 64% of staff within medical care services at this trust had received an appraisal compared to a trust target of 95%. Compared to 2015/16, appraisal rates for medical staff had decreased by 11%, although they showed an improvement for nurses and administrative and clerical staff.

However:

- We observed good multidisciplinary working on all the wards we visited and observed multidisciplinary team reviews recorded in patients' records.
- Staff had a good understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and acted in accordance with the act.

Evidence-based care and treatment

- We saw policies and care pathways based on Royal College of Physicians guidelines and National Institute for Health and Care Excellence (NICE) guidance. The Ambulatory Care Unit (ACU) followed standardised algorithm pathways for patients with conditions such as suspected pulmonary embolus, cellulitis and deep vein thrombosis.
- The trust policy for non-invasive ventilation was in line with national / British Thoracic Society (BTS) guidance. During our inspection, we saw care was delivered and staff worked in line with the policy.
- Staff had access to policies and procedures and other evidence-based guidance through the trust intranet. They knew how to access the information and were notified when new policies were released. All polices we reviewed had identified the author/owner and all had review dates. One policy we reviewed was out of date.
- The trust carried out quarterly nursing audits across medical wards to monitor standards in documentation (which included risk assessments for falls, pressure areas and nutrition and hydration), NEWS and patient identification. These audits were combined into one report; previous to this, they were carried out separately. We looked at the Nursing Audits Interim Report (Quarter 1 2016) and saw variable performance across medical wards, however, there were no actions at the end of the report to improve these standards.

Pain relief

- We observed staff responding to patients requests for pain relief promptly and effectively and patients we spoke with told us that they received pain medication when they needed it.

- Nursing staff used and documented an evidence based pain score to assess patients' needs. We saw from patients' care plans that pain was assessed on a regular basis. Pain was recorded as part of the intentional rounding.
- We saw pain relief had been prescribed on 14 out of 16 prescription charts we reviewed.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patients' nutritional risk. MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition), or obese. We saw in patients' notes that their nutritional needs were assessed. The MUST score was recorded on an electronic system which automatically triggered a referral to the dietitian. It also identified when a reassessment was required.
- Protected meal times were observed on the wards we visited and we saw that patients were provided with their meals promptly with assistance if needed. Drinks were provided at meal times and between meals; we saw that drinks were placed within patients' reach.
- Patients had access to additional supplements as well as their meals, which consisted of drinks or dessert based products. Soft diets were also available and small meals with a high calorific value.
- Patients receiving care on the Ambulatory Care Unit (ACU) told us staff offered them drinks and snacks and they felt very well looked after.

Patient outcomes

- Scunthorpe General Hospital took part in the Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E where A is best, this hospital achieved grade A in latest audit for January 2016 to March 2016. Overall performance was high. The discharge processes had deteriorated in both team and patient centred indicators (dropping from A to C) and thrombolysis remained consistently low compared to the other indicators.
- In the 2015 Heart Failure Audit this hospital's performance was worse than the England and Wales average in all four of the standards relating to in-hospital care and worse than the England and Wales average for four of the seven standards relating to discharge. Performance in the discharge indicators relating to onward referrals and discharge planning were notably poorer than the England and Wales average with the poorest being in discharge planning where the site scored 34.2% compared to the national average of 87%.
- In the National Diabetes Inpatient Audit 2015, this hospital scored better than the England average in six metrics and worse in 11 metrics. The indicator regarding "All or most staff know enough about diabetes" had the largest difference against the England average (37.1% compared to the England score of 65.5%).
- In August 2016 the endoscopy unit had been unsuccessful in retaining their Joint Advisory Group accreditation on Gastrointestinal Endoscopy (JAG).The unit had not met the required standards in clinical leadership, training, timeliness, capacity and booking. A trust wide JAG action plan was in place to address issues in endoscopy. Weekly meetings were held to discuss progress with the action plan.
- There was poor performance in the Myocardial Ischaemia National Audit Programme 2013/14 for this hospital. Compared to the England average for Non-ST-elevation myocardial infarction, a lower proportion of patients were admitted to cardiac unit or ward (15.9% compared to 55.6%) and a lower proportion were referred for or had angiography (38.3% compared to 77.9%). Compared to the 2012/13 audit, Scunthorpe General Hospital showed improvement on one of the three metrics.
- Between March 2015 and February 2016, patients at this site had a similar expected risk of re-admission for both non-elective and elective admissions. Elective admissions in medical oncology and gastroenterology both had a higher than expected risk, while clinical haematology was notably lower. In non-elective admissions, risk of re-admission in cardiology was markedly higher than expected.
- We saw evidence in the minutes of meetings that there were ongoing action plans to improve the outcomes from national audits.
- In 2015, the trust was identified as a CQC outlier for patients dying from acute bronchitis and cardiac dysrhythmias. The trust provided a comprehensive report about the work they had undertaken to act upon the findings of the data. No further concerns relating to these conditions have arisen.

Medical care (including older people's care)

- In September 2016, two months prior to our inspection, the trust was recognised as being an outlier for deaths from septicaemia (except in labour). The trust provided a detailed action plan to investigate and address this.
- The Summary Hospital-level Mortality Indicator (SHMI) statistics from July 2015 to June 2016 showed that the SHMI remained in the 'as expected' banding with a figure of 110. It showed that the trust was ranked 117 out of 136 NHS trusts nationally. The previous SHIMI results showed that the trust was ranked 106 out of 136 and had declined by 11 places. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there.
- The Hospital Standardised Mortality Ratio (HSMR) was107.5 as at June 2016, which was within the expected range.
- Therapists in the stoke unit used several outcome measures to monitor their patient's progress. For example, speech and language therapists used therapy outcome measures (TOMS) and physiotherapy staff used the modified Rivermead mobility index.

Competent staff

- Between April 2016 and August 2016, 64% of staff within medical care services at this trust had received an appraisal compared to a trust target of 95%. The appraisal rate for the majority of staff groups showed an improvement compared to 2015/16. For example appraisal rates for nurses and administrative and clerical staff increased by 26% and 39% respectively. Appraisal rates for medical staff during this period had decreased by 11%.
- Appraisal completion rates reported by the trust for Allied Health Professionals (AHPs) were 0% for April-August 2016 and not reported for the previous financial year.
- Most staff we spoke to told us they had completed their annual appraisal. At the time of our inspection appraisal rates were 89% on CCU. Therapists on the stroke unit told us they had all completed appraisals and had regular supervision.
- Newly qualified staff and overseas nurses attended a two-week intensive induction course called care camp. The course includes topics, such as, patient centred care, ward rounds, providing personal care, recognising deteriorating patients and care associated with death and dying. Following this, they are supernumerary on the wards, until they have been assessed as competent.
- Following induction, newly qualified nurses followed a preceptorship programme. This included monthly supervision for three hours a month, for a six-month period.
- Following completion of the trust preceptorship programme, newly qualified nurses working on the Coronary Care Unit (CCU) completed further training specific to CCU before they were fully competent in coronary care. A clinical sister on the unit developed the training packages with competencies for CCU staff. We observed nine folders containing comprehensive training packages.
- Critical care outreach nurses provided training and updates on non-invasive ventilation (NIV) for nurses on CDU and the respiratory ward. We checked the training records and found that all qualified nurses on CDU and Ward 22 had received this training. All new nurses on ward 22 attended a respiratory study day.
- The ward sister of the temporary respiratory ward (ward 2) told us that when staff were moved to help on the ward, they were not allocated patients on non-invasive ventilation (NIV) unless they had received training. If bank or agency staff were used, the trust tried to book staff that were already trained in NIV.
- Junior doctors we spoke with said they felt well supported and had regular educational supervision. They spoke highly of the acute care physicians in CDU in educating and improving practice.
- Locum medical staff told us they had a brief induction and were given access to the relevant IT systems. They said compared to other organisations they had worked at, the induction was about the same.
- Therapists on the stoke unit told us there were opportunities for training and development available, for example advanced dysphagia training.
- Medical wards provided placements for student nurses. Trained mentors were allocated to both student nurses and newly qualified nurses to provide support.

Multidisciplinary working

- We observed good multidisciplinary working (MDT) working on all the wards we visited and observed multidisciplinary team reviews recorded in patients' records.

- Therapists in the stroke service attended twice-weekly MDT meetings, which were also attended by the ward sister, consultant, clinical psychologist, and the social worker. They said these meetings were very useful for discharge planning.
- The dietitians visited wards daily to review patients' nutritional needs. The pharmacy team visited the wards daily during the week to check patients' medication charts and complete drug reconciliation.
- Clinical nurse specialists attended wards to provide clinical expertise and review patients if needed.
- Staff spoke positively about close MDT working and felt they had good working relationships between professional groups.

Seven-day services

- At our last inspection, we were told that there were plans to introduce a seven day, 24 hour, gastrointestinal bleed rota. At this inspection, we found this was still not in place. Agreement had been reached for consultant rota cover, however, further work was being undertaken to agree the nurses rota.
- A gastroenterologist was available for endoscopy Monday to Friday 8.am – 6.pm and from 11.00am to 1.00pm on Saturday and Sunday for urgent endoscopy (within 24 hours). If a patient needed an emergency endoscopy (within two hours) outside of this period, we were told there was an agreement with the tertiary site in Hull to transfer the patient there. However, we saw in the minutes of the June 2016 general surgery business meeting that Hull did not agree with the pathway and therefore it was necessary to produce and agree a new one. It was also identified that patients with an emergency gastrointestinal bleed were too unstable to transfer to Hull.
- Ward rounds were in place every day and a discharge team was available at weekends to identify any patients fit for discharge.
- The Ambulatory Care Unit (ACU) was located within the Clinical Decisions Unit (CDU) and provided services between the hours of 8am to 8pm on Mondays, 8am to 6pm Tuesday to Friday and 8am to 4pm at weekends. Referrals were accepted from the wards, GPs and the emergency department for patients meeting a specific set of criteria. Patients with conditions such as cellulitis, deep vein thrombosis (DVT) or non-cardiac chest pains could be assessed, treated and discharged home on the same day. Any patients not ready for discharge when the unit was closing would be handed over to the CDU.
- Imagining and pathology services were accessible 24 hours a day, seven days a week.
- Pharmacy services were available seven days a week including bank holidays. The service did not visit all the wards at weekends; they targeted wards with new patient admissions. An on call service was available out of hours.
- Physiotherapy staff worked in the stoke service Monday to Friday with a reduced service over the weekend. Other therapists such as occupational therapists and speech and language therapists worked in the stroke service five days a week. However, the therapy team were looking at the possibility of working on Saturday and Sunday mornings and taking their time back during the week.

Access to information

- Staff were able to access an electronic patient board on each ward; this allowed up to date information to be stored and viewed on the system. The system held useful patient information with icons linked to the patient record. Icons included nutritional status, isolation requirements, DNACPR, dementia and falls risk.
- Nursing staff in the discharge lounge were able to view the electronic system which showed when discharge letters were completed and when patients medication was organised to take home. This was very helpful in managing patients being discharged from the lounge.
- Staff had access to relevant guidance and policies on the trust intranet. Staff we spoke with were aware of how to access policies and were advised to look on the intranet for the latest version. All staff had access to an email account.
- Staff were able to access blood results and x-rays using electronic results services.
- Medical and nursing records were accessible on all wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated a good understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

- DoLS applications could be made over the telephone. There was a dedicated number through to the local authority who assisted staff to complete the relevant paperwork. Staff said this was very helpful as they found the paperwork difficult to complete.
- Although we were told that currently the trust had no patients subject to a DoLS authorisation at Scunthorpe General Hospital, two DoLS applications and subsequent urgent or standard authorisations were noted in the files scrutinised at this hospital. These had not been flagged up on the electronic patient system and the internal database did not routinely flag up applications waiting for assessment or those authorisations about to expire.
- We observed staff obtaining verbal consent and giving explanation prior to completing procedures. Patients we spoke with also said that staff asked for consent prior to delivering care.
- Staff had attended best interest meetings for patients who lacked capacity to make decisions themselves.
- Training records provided by the trust showed that the overall, compliance with Mental Capacity Training for medical care staff at this hospital was 82%. Trust wide, 80% of staff in medical care services had completed DoLS training.

Are medical care services caring?

Good

At the previous inspection in 2015, we rated medical care services as good for caring. At this inspection we rated caring as good because:

- We observed staff maintaining the privacy and dignity of patients when providing care.
- Patients and families told us that staff had empathy and provided good care.
- Patients were treated with respect and compassion.
- We saw evidence that patients and families were involved in care planning.
- There were good results in the Friends and Family Test. The majority of medical wards had recommendation rates between 90-100%.
- Emotional support was available to meet patients' needs.

However:

- Survey results on CCU showed negative comments about males and females sharing the unit. We spoke to the ward manager about this who explained that this was inevitable as they were the only unit to provide cardiac monitoring however, every effort was made to maintain privacy and dignity on the unit.

Compassionate care

- We spoke with 20 patients and relatives who told us that staff were friendly, helpful and had a good attitude. They told us that staff had empathy and provided good care.
- A patient told us he observed that staff always went out of their way to maintain patients' dignity. Although he thought they were short staffed, he did not feel that this had an impact on his care.
- During the unannounced inspection, we carried out short observational framework for inspections (SOFI) on ward 16 and ward 17. We observed good interactions between staff and patients. Patients responded positively to staff and it was clear from the patient's facial expressions that they enjoyed this interaction. Staff talked to patients regularly to see if there was anything they needed.
- Patients on the stroke ward told us that the nursing staff treated them with respect. They said the nurses were quick to answer call bells and requests for an extra blanket or to have a fan on were responded to quickly.
- Relatives of a patient being cared for on ward 24 told us they had no worries about staff and thought some were exceptionally good. They could see staff were under pressure and that this sometimes led to delays in care.
- We saw results of the Percutaneous Coronary Intervention (PCI) quality survey displayed on a notice board in the Coronary Care Unit (CCU). This contained many positive comments from patients about how caring staff were. Negative comments were around males and females sharing the unit. We spoke to the ward manager about this who explained that this was inevitable as they were the only unit to provide cardiac monitoring however, every effort was made to maintain privacy and dignity on the unit.
- We observed staff looking after patients in the discharge lounge and noted they were very kind to patients. They offered patients drinks and made them feel very welcome as well as organising and preparing them for leaving the hospital.

Medical care (including older people's care)

- On ward 17, staff had organised a celebratory party for a patient and her husband who were celebrating their golden wedding anniversary.
- The Friends and Family Test response rate for medical care services between September 2015 and August 2016 at this trust was 52% which was better than the England average of 25%. The response rate at this hospital was 47% and the majority of wards had recommendation rates between 90-100%. We found excellent Friends and Family test results on the Ambulatory Care Unit (ACU), which often scored 100% in all areas. The stroke ward displayed their friends and family test results, which showed that for the month of October 100% of patients completing the survey said their needs were met.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with told us that staff answered their questions fully or if they did not know, they would go and find out the answer. For example, the relative of a patient told us that staff were good at sharing information. When she asked to speak with the consultant, their discussion had taken place in a private room.
- The relative of a patient on the stroke ward told us that the ward sister had made time to sit down and talk to her and explained what was happening with her relatives care.
- We saw patients and relatives involvement in care decisions clearly documented in patients' case notes.

Emotional support

- Clinical psychologists were available to provide care and support for patients adjusting to a new diagnosis or a health issue affecting their quality of life, for example, following a stroke.
- A chaplaincy service, which included chaplains and volunteers, was available to support patients, their families and carers during their time in hospital. There was a chapel and a multi-faith prayer room available within the hospital.
- Nurse specialists provided psychological support to patients with new and ongoing diagnoses.

Are medical care services responsive?

Requires improvement

At the previous inspection in 2015, we rated medical care services as requires improvement for responsive. At this inspection we also rated responsive as requires improvement because:

- The trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England overall performance. Figures for October 2016 showed 74.9% of this group of patients were treated within 18 weeks. Over the time period, RTT performance had deteriorated ranging between 80-89% to between 70-79% while the England average has remained fairly consistent at 91-93%.This was worse than at the last inspection.
- Patient flow through the hospital remained an issue with a significant number of patients cared for on non-medical or non-speciality wards. A buddy ward system was in place however, there was still confusion regarding which consultant should review which patient.
- Two week breaches were still occurring in endoscopy. We reviewed the endoscopy activity report and found between April 2016 and November 2016 there were 387 breaches in urgent and two week waits for endoscopy. There were also 2,194 patients waiting for a follow-up appointment.
- High numbers of patients were moved to wards late at night and into the early hours of the morning.
- Staff in the cardiac catheter laboratory told us that procedures were often cancelled on the day. This was an issue at the previous inspection and had not improved.

However:

- The Ambulatory Care Unit (ACU) opened in September 2015 and had a positive impact on patient flow at the Scunthorpe General Hospital site.
- We saw some good examples of patients' individual needs being met in particular patients living with dementia.

Service planning and delivery to meet the needs of local people

- The trust worked with local commissioners to set up the Ambulatory Care Unit (ACU). Staff on the unit told us they had specific key performance indicators to meet which commissioners monitored.

Access and flow

- The trust's referral to treatment time (RTT) for admitted pathways for medical services was worse than the England overall performance. Figures for October 2016 showed 74.9% of this group of patients were treated within 18 weeks. Over the time period, RTT performance had deteriorated ranging between 80-89% to between 70-79% while the England average has remained fairly consistent at 91-93%.
- Three speciality areas were above the England average for admitted referral to treat times; these were general medicine was 100%, rheumatology 100% and thoracic medicine at 96.2%. Three speciality areas were below the England average for admitted referral to treatment times; these were dermatology at 25%, cardiology 69.7% and gastroenterology 86.7%. No figures were available for geriatric medicine and neurology.
- The trust had updated the policy for eliminating mixed sex accommodation, which was in line with Department of Health guidance (November 2010). No mixed sex breaches had been declared by the trust for this hospital in the 12 month period prior to our visit, however in November 2016, there were 14 mixed sex breaches at this hospital.
- We reviewed waiting times for endoscopy at this hospital and found there were long waiting lists and breaches in waiting times. Waiting lists were kept on an electronic system. On the day of our visit, we saw the total numbers of patients waiting at this site were 2,194. This figure included patients on surveillance who were due for an appointment. The target to see urgent referrals including suspected cancer was two weeks and for routine referrals six weeks. Staff told us that timescales for surveillance patients were often extended in order to prevent two week and six week breaches. We reviewed the endoscopy activity report and found between April 2016 and November 2016 there were 387 breaches in urgent and two week waits for endoscopy; the highest number was 118 in April and the lowest was 14 in July. There were 51 breaches in November 2016. The number of new referrals for endoscopy within this period ranged from 695 in July to 834 in November.
- We saw in the JAG action plan actions to address the two and six week breaches in endoscopy. Actions included providing additional capacity at weekends and weekly monitoring of activity. The target date for completion was December 2016 and this was amber on the action plan indicating they were on target to achieve this. During the inspection, we were told that there was overuse internally of referrals into the two-week pathway and they were taking action to address this.
- The management team had taken the decision to close ward 2 (short stay ward) due to staffing shortages. Staff we spoke with in the Clinical Decisions Unit (CDU) told us that since the ward 2 had closed, some short stay beds had been made available on ward 23 and ward 24. However, there were fewer beds and these were not always available. This caused difficulties with the flow in and out of CDU and meant that patients had to wait longer in the emergency department.
- Patients were admitted directly to CDU through their GPs or through the emergency department. They could be clerked in either the emergency department or CDU.
- The Ambulatory Care Unit (ACU) opened in September 2015 and it had made a positive impact on patient flow at the Scunthorpe General Hospital site. This resulted in a significant reduction in length of stay of almost two days, an increase in the number of patients staying less than one day in hospital following an emergency admission, and a significant reduction in medical outliers. Staff working on the unit told us they had good access to diagnostics, as pre-agreed scanning slots were available for their patients.
- Staff in the cardiac catheter laboratory told us that procedures were often cancelled on the day. Sometimes this was because emergency procedures had taken priority, however often this was because clinics ran late and they ran out of time. Staff recorded how often cancellations occurred and from 4 November to 23 November 2016, 17 procedures had been cancelled on the day; of these 11 were due to no time. Information supplied by the trust showed that between 1 June 2016 and 1 December 2016, 225 patients had their procedure cancelled on the day of the planned procedure. We were told there was an action plan in place to understand and address the issue of cancellations.
- Information provided to us by the trust showed that between April and September 2016 there were 38

medical outliers on non-medical wards. This figure does not include patients outlying on non-speciality medical wards, for example a patient with an endocrine problem being cared for on a stroke ward.

- The majority of surgical wards had medical patients (medical outliers) located on them. Staff we spoke with and records we reviewed showed that medical outliers were not always allocated to the most appropriate medical consultant for their care. For example, patients with diabetes or respiratory conditions did not always receive care from a medical consultant from these specialities. If patients remained unstable, they were referred to the appropriate medical consultant however; this could lead to delays in treatment and discharge plans.
- A buddy ward system had been agreed for medical outliers. However, we found that patients did not always go to the buddy ward and this caused confusion about which consultant was looking after which patient. A doctor we spoke with on ward 24 told us they were concerned because nurses on the ward were not always clear on which doctors covered which patients. We were given an example of a patient missing a medical review on this ward because of confusion and poor communication between nursing and medical staff.
- On surgical wards 28 and 25, the medical team assessed the majority of medical outliers regularly. However, staff we spoke with were not clear about a buddy system with a nearby medical ward. Some staff said they were buddied with ward 23 and other staff said they were not. One member of staff provided an example of a delay in review of a medical outlier patient due to not being able to get access to junior medical staff. Staff had escalated this to the consultant who had attended and reviewed the patient.
- At the time of our visit, there were four outlying patients on the stroke ward. The ward sister told us they were regularly reviewed by the stroke consultant.
- Staff told us there were issues with the repatriation of stroke patients to Diana Princess of Wales Hospital because beds on the stroke rehabilitation unit were taken up with medical outliers. We identified this as an issue at the last inspection and there had been no improvement.
- Between April 2015 and March 2016, the average length of stay for medical elective patients at this hospital was 2.5 days, which is lower than the England average of 3.9 days. For medical non-elective patients, the average length of stay was 6.5 days, which is slightly better than England average of 6.6 days. Elective clinical haematology had a markedly shorter average length of stay than the England average with 3.3 days at this site compared to 5.6 days nationally.
- Information regarding bed moves between August 2015 and July 2016, indicated that across medical services for Scunthorpe General Hospital, 33% of patients had no moves, 57% were moved once during their stay, 7% were moved twice, 2% three times and 1% of patients were moved four or more times. This was very similar to the previous year.
- Information provided by the trust showed that during the six month period of February to July 2016 682 medical patients had been internally transferred between 10pm and 8am. The ward with the highest number of bed moves at night over this period was ward 22 with 154.
- A patient on the Planned Investigation Unit (PIU) told us they had remained on the unit for one week; however, they had been moved several times to different parts of the unit. This sometimes happened whilst they were asleep which made them feel confused when they woke up.

Meeting people's individual needs

- A quality matron led on dementia and informed us that dementia training was on the trust's essential training list. The training was based on the Health Education England framework. The trust were recruiting two new dementia nurses and the matron hoped they would be able to provide higher-level dementia training to staff. Training records provided by the trust showed 75% of staff in medical care services had completed dementia training.
- Relatives of a patient living with dementia told us they had been asked to complete a 'My Life' document on behalf of their relative. This documented patients' likes and dislikes. Relatives thought this was a good idea to help staff provide individualised care.
- The husband of a patient with dementia had open visiting because his wife was more settled when he was present.
- Staff could tell us which patients on the wards were living with dementia and this was identified within their record. Dementia screening was completed for patients

over 75 years old. Wards had access to activities and special distraction equipment for patients living with dementia. We also observed on the ward, information regarding dementia and contact numbers for support.
- A wedding box was available on ward 18 to support patients nearing end of life who wished to marry in hospital.
- One patient told us he had been offered Halal food.
- Staff used a telephone interpreting service to communicate with patients who did not speak English. Staff said the system worked well. Face to face interpreters were also available and there was access to British Sign Language (BSL) interpreters.
- Staff on the coronary care unit said they sometimes used relatives or other staff to interpret for general conversations with patients but always used interpreting services for important conversations such as consenting to a procedure.
- Earplugs were provided to a patient on CCU who said the equipment was noisy and it was difficult to sleep.
- The dedicated post for a specialist learning disability nurse was vacant and was in the process of being advertised at the time of our inspection. However, staff informed us that the quality matron visited all patients with a learning disability. Prior to the inspection, we held focus groups for patients with a learning disability and their carers who were positive about the care they had received at this hospital.
- Therapists on the stroke ward worked with patients to set their short and long-term goals. They told us about a picture based tool they were developing for patients who could not verbally articulate their goals.

Learning from complaints and concerns

- The trust had a process for addressing both formal and informal complaints that were raised through the Patient Advocacy and Liaison Service (PALS).
- Between September 2015 and August 2016, there were 124 complaints about medical care services across the trust. There were 60 complaints for medical care services at Scunthorpe General Hospital. The most common themes for complaints were clinical treatment followed by communication. Complaints took an average of 50 days to investigate and close at this site.
- Information for patients on how to make a complaint was evident within ward areas.
- Staff we spoke with understood the process for managing concerns and how patients or relatives could make a formal complaint.
- The ward sister on the stroke unit said staff always tried to manage concerns before they escalated into a formal complaint. Formal complaints were investigated by ward managers who told us they would share the complaint with appropriate members of staff. Any learning from complaints would be shared with all staff on the ward.

Are medical care services well-led?

Requires improvement

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

- The medicine risk register was not regularly updated and some risks were not graded.
- There was no action plan to demonstrate how the medicine group were going to meet their business objectives.
- Staff engagement varied. Although staff appeared dedicated to patient care and worked well with colleagues, morale was low because of staff shortages, ward moves and working additional shifts.
- There was little evidence of engaging with patient representatives to improve services.
- Ward managers had limited time to carry out their management duties as they were counted in the nursing numbers four days out of five.

However:

- Staff working on the Ambulatory Care Unit (ACU) were very proud of their unit and the services they provided to patients.

Leadership of service

- The medicine group was led by an associate medical director, associate chief operating officer and an associate chief nurse.
- Staff spoke highly of the chief nurse. They said the chief nurse was accessible, approachable and listened to them. Staff gave an example of how they had taken action following staff sharing concerns about being moved to different wards at short notice without the

necessary skills and experience in that specialist area. The chief nurse had written a procedure, which set out the standards for moving staff to cover other wards. We found several staff that were aware of this policy.

- The senior leadership team and executives had a scheme to adopt a ward. They were allocated a clinical area to visit on a monthly basis. Staff on the stroke unit and the planned investigation unit told us they visited once a month to help with a number of tasks including serving meals to patients.
- Poor leadership issues had contributed to the loss of JAG accreditation in endoscopy at both the Scunthorpe General and Diana Princess of Wales Hospitals. However, there had been learning from this, which resulted in the appointment of new clinical leads for endoscopy, the introduction of business support managers (since August 2016) and a clinical lead nurse post for endoscopy.
- Ward managers had limited time to carry out their management duties as they were counted in the nursing numbers four days out of five. We found on some wards junior nurses were in charge as part of their development; however, they were not confident in this role and their knowledge was limited.
- Some staff we spoke with did not always feel that information was effectively disseminated to them. They felt communication between senior managers of the service and ward staff was poor.
- Staff on the stroke ward said they regularly saw the matron but rarely saw managers from the medicine group.
- Newly qualified staff we spoke with on CCU told us that the ward manager was supportive and recognised the difficulties newly qualified staff had working on the unit.

Vision and strategy for this service

- We saw the medicine group business objectives for 2016/17, which had five main headings; however, there were no details of how these objectives were going to be achieved.
- The medicine group management team had a vision and plan of an urgent care floor development. This was in its infancy at the time of the inspection. Good practice from the Scunthorpe General Hospital site was being mirrored at the Diana Princess of Wales site and further developments at the Scunthorpe site were planned. These included further development of the acute care model with the expansion of Ambulatory Care and increasing the number of Acute Care Physicians (ACPs).

Governance, risk management and quality measurement

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

Culture within the service

- Staff on Coronary Care Unit (CCU) told us there were good working relationships between medical and nursing staff on the unit.
- Therapists we spoke with on the stroke unit said they felt the culture was supportive with good teamwork. They thought the organisational culture was improving and felt listened to.
- Staff were required to complete harassment and bullying awareness training. Information provided by the trust showed that 87% of staff working in medical care services at this hospital had completed this training.

- Staff we spoke with described the culture as hardworking and committed but very stressed, especially about staffing levels and pressure.
- Several staff we spoke with said they felt pressure to work additional shifts. Some had caring responsibilities outside of work so were not prepared to do this but they still felt pressured.

Public engagement

- Wards displayed improvements they had made based on feedback from patients and relatives. This was in a 'you said, we did' format. For example the stroke ward had provided a hot drinks machine in response to relatives saying they would like hot drinks facilities.
- As part of the JAG action plan, patient focus groups were set up. Issues identified within the focus group were waiting times and communication, these were included within the action plan.
- The trust participated in the friends and family test.

Staff engagement

- Staff engagement varied on the Planned Investigation Unit (PIU). Most staff told us they liked working on the unit and it felt like a big family.
- Nursing staff told us they did not like being constantly moved to work on different wards. They aimed to give good care but felt this was often not possible due to staff shortages.
- Staff in the stroke unit said they liked their job but did not like being moved to another ward and being asked to take charge of the ward. They did not feel this was safe.
- The trust held an annual 'our stars' award ceremony to recognise and reward achievements. We spoke to several staff and teams who were proud to have received awards.
- Staff working on the Ambulatory Care Unit (ACU) were very proud of their unit and the services they provided to patients.
- Between April 2015 and March 2016, the trust reported a sickness rate for nurse staffing of 5.6% in medical care services. The rate at Scunthorpe General Hospital was 6.2%.The sickness rate for medical staff at this site was 2.2%.

Innovation, improvement and sustainability

- There was a new initiative called the virtual ward. Two health care assistants were available all day Sunday to Friday and half days on Saturdays. They were deployed to an elderly medical ward at the start of their shift, and then re-deployed to any area with short notice absence or where one to one patient care was required.
- The Ambulatory Care Unit (ACU) opened in September 2015 and had a positive impact on patient flow at the Scunthorpe General Hospital site. This had resulted in a significant reduction in length of stay of almost 2 days, an increase in zero length of stay patients and a significant reduction in medical outliers.
- The two week intensive care camp for newly qualified staff and overseas nurses was innovative. It gave staff a good grounding in the behaviours and values the trust expected and highlighted differences in practices between other countries and the UK. Central to the training were the six Cs of nursing: compassion, care, communication, competence, commitment and courage.

Surgery

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

Information about the service

Scunthorpe General Hospital (SGH) is part of the Northern Lincolnshire and Goole NHS Trust. The surgical directorate provides a range of surgical services for the population of Scunthorpe and surrounding areas.

The trust has 19 main operating theatres and 13 surgical wards covering general surgery, head and neck, ophthalmology, urology and trauma and orthopaedics across the three sites of Grimsby, Scunthorpe and Goole. Overall, the trust has 38-day case beds and 250 inpatient beds.

On this site, the surgical directorate provides elective and non-elective (acute) treatments for different specialities such as ear, nose and throat, gastroenterology, general surgery, ophthalmology, orthopaedic and urology. The surgical service had four surgical wards with 87 inpatient beds. The hospital has eight operating theatres.

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

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

During our inspection, we spoke with 36 members of staff including nursing, medical, and allied health professionals as well as 16 patients and four relatives. We visited all surgical wards, theatres and day surgical units. We reviewed 25 sets of patient records. We observed care and treatment of patients and reviewed a range of performance information about the surgical health group.

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

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

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

Surgery

Summary of findings

The overall surgery rating from the 2015 inspection was 'requires improvement'.

During the 2016 inspection, we rated surgical services at SGH as 'requires improvement' overall because:

- The directorate did not consistently learn from incidents, when things go wrong, or when things could be improved and take appropriate action to improve safety standards as a result. Repeat incidents had been reported and lessons learned had not consistently been implemented to prevent the incident from re-occurring.
- The service did not follow national guidelines when assessing patients. Staff did not always book patients needing emergency surgery into theatres in accordance with the National confidential enquiry into patient outcome and death (NCEPOD) guidelines. No formal emergency theatre booking policy or protocol was available to enable staff to comply with the guidelines.
- The directorate did not have in place processes to ensure that capacity of services was sufficient to meet the demands. Patients could not always access services for assessment, diagnosis or treatment in a timely manner.
- The service had a high number of clinical and non-clinical cancellations. From April to June 2016, 102 operations were cancelled for non-clinical reasons. The high number of outlying patients (patients nursed in a different speciality areas) often caused non-clinical cancellations. In the same reporting period, 184 operations were cancelled on the day for clinical reasons. Staff did not assess elective surgery patients, who needed pre-assessment before surgery, using an effective patient pathway.
- The service did not consistently have enough qualified, experienced and skilled staff. Ward managers and co-ordinators had to care for one cohort of patients and supervise another as well as their managerial role. Staff shortages affected staff morale. Staff spoke about a lack of support from the site co-ordination team, in relation to movement of staff, staff shortages and moving patients.
- Patient information was not shared with GP's in an effective way. Data we reviewed showed that there were 1964 letters requiring review, approval, distribution and completion (September 2016), 266 of these letters being urgent cancer patient letters. Delays in the system have the potential to lead to treatment delays in the patient pathway.
- Performance in national audits was variable. The majority of indicators in the national emergency laparotomy, bowel cancer and national hip fracture audits continued to be below national performance. National audit action plans we reviewed did not always reflect the actions required by the audit performance.
- Surgical services did not use patient safety tools consistently. The five steps to safer surgery procedures, including the World Health Organisation (WHO) checklist, was not an embedded consistent process. Staff did not complete formal risk assessments for each day case patient for blood clots (Venous thrombosis). Staff did not always complete nutritional assessments and we did not see consistent effective escalation of all deteriorating patients.
- The directorate did not hold specific surgical mortality and morbidity meetings. Although the senior management team said that individual specialities discussed mortality as part of audit meetings, this information was not collated centrally within the directorate.
- Policies and guidelines in use within clinical areas were not all compliant with NICE or other clinical bodies. Data we reviewed from June 2016 showed that policies within the directorate were 69% compliant with NICE guidance.
- The majority of fluid balance charts we reviewed were not completed accurately; this had been previously highlighted on the matron dashboards.
- The clinical strategy for surgical services did not make detailed reference to national reports and recommendations, the trust values and strategy, or have clear deadlines for actions.
- The service had a high number of out of hours transfers, after 8pm. On two occasions, we saw

Surgery

records, which showed patients being transferred into surgical beds at 1am. This disrupted surgical patient sleep and decreased the number of beds available for elective surgical inpatients.
- We saw no evidence of the service engaging with patient representatives or staff to improve services.
- Surgery did not meet the trust target for individual mandatory training modules, such as resuscitation, at 67% compliance.

However:

- The trust had taken action since the 2015 inspection, and had stopped using Band 4 nurses awaiting professional registration numbers within the registered nurse establishment.
- We observed positive interactions between patients and staff. The majority of patients we spoke with were happy with the care they received.
- Appraisal rates had improved since the 2015 inspection, however they remained below internal compliance targets.
- The senior management team were aware of the challenges within the directorate and spoke with us about their commitment to improving these.

Are surgery services safe?

Requires improvement

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

- The directorate did not consistently learn from incidents, when things go wrong, or when things could be improved and take appropriate action to improve safety standards as a result. Repeat incidents had been reported and lessons learned had not consistently been implemented to prevent the incident from re-occurring.
- The service did not consistently have enough qualified, experienced and skilled staff. Ward managers and co-ordinators had to care for one cohort of patients and supervise another as well as their managerial role.
- Patients requiring surgery were not assessed in accord with effective pre-assessment pathways.
- Surgical services did not use patient safety tools consistently. The five steps to safer surgery procedures, including the World Health Organisation (WHO) checklist, was not an embedded consistent process. In one case, we observed that the checklist was completed slightly prior to the end of the operation.
- The trust used the national early warning score (NEWS) tool to identify deteriorating patients. From seven sets of notes we reviewed we did not see consistent effective escalation of all deteriorating patients. Four patients we reviewed had deteriorating early warning scores; however, documentation of escalation and review was not available.
- Surgery did not meet the trust target for individual mandatory training modules such as resuscitation, at 67% compliance.
- Staff did not complete formal risk assessments for each day case patient for blood clots (Venous thrombosis). Day case admissions had no formal risk assessments for VTE completed during the admission. In three out of four cases we reviewed patients did not receive Venous thrombolysis (VTE), (blood clot) assessments nor preventative treatments pre-operatively. In one case, this was rectified and the correct actions were carried out in theatre, but in the other three cases no actions were completed despite equipment being available. Staff did not always complete nutritional assessments.

- The directorate did not hold specific surgical mortality and morbidity meetings. We reviewed the critical care morbidity and mortality meeting minutes where shared critical care/surgical patients were discussed. However we did not see evidence that discussion was held specifically for surgical only patients. Although the senior management team said that individual specialities discussed mortality as part of audit meetings, this information was not collated centrally within the directorate.

However:

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

Incidents

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

in relation to the need to report, provide evidence, take action or investigate as required. Junior medical staff we spoke with said they were encouraged to attended directorate audit meetings where staff discussed incidents.

- Staff we spoke with said they did not always report all incidents; they said they did not always report late transfers of patients, incorrect paperwork errors or staffing issues.
- In 2015, we said that the trust must ensure there is an effective process for providing consistent feedback and learning from incidents. The majority of staff we spoke with said that they received feedback following completion of incident forms. Staff investigating incidents were aware of what action needed to be taken to provide staff with feedback.
- Staff we spoke with said that the directorate shared learning from incidents internally through safety briefs during shift handovers, ward meetings, communication books, quality and safety bulletins and lessons learned newsletters. Themes within the directorate newsletters and bulletins we reviewed included medication issues.
- Bimonthly quality and safety days were held within the directorate to improve communication and sharing learning across both sites.
- There was evidence of changes in practice from incidents: for example, staff had been asked to improve written communication about abdominal drain devices in patients following the never event. Following a series of medication issues, staff had received further training and skills assessments in relation to medication competencies and knowledge.
- In 2015, we said that the trust must ensure that action is taken to address the mortality outliers and improve patient outcomes. No specific surgical mortality and morbidity meetings were held within the directorate. We reviewed the critical care morbidity and mortality meeting minutes where shared critical care/surgical patients were discussed. However we did not see evidence that discussion was held specifically for surgical only patients. The senior management team said that individual specialities discussed mortality as part of audit meetings. However, this information was not collated centrally within the directorate.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were aware of duty of candour requirements and described it as being open and honest; they provided examples of its use in relation to patient accidents and cancellation.
- Responses to complaint letters included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectations of the service under duty of candour requirements.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harm and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots) and catheter and urinary tract infections (CAUTI's).
- Information from the safety thermometer data were displayed in wards and departments we visited; however, on ward 28 the data displayed was not up-to-date.
- During the reporting period, October 2015 to October 2016 the trust reported there had been 62 pressure ulcers, 14 falls with harm and 14 catheter urinary tract infections (CAUTI's). There was an increase in the reports of pressure ulcer and CAUTIs acquisition from the 2015 inspection report when 77 incidents of harm were reported, 54 pressure ulcers and 7 CAUTIs. The number of falls was slightly lower than the 2015 rate of 16 falls in the reporting period July 2014 to July 2015.
- During the reporting period October 2015 to October 2016, the rate of new pressure ulcers reported and falls showed a decreasing trend. The rate of urinary tract infections reported in patients with a catheter showed a variable trend.
- Venous thrombosis (blood clot) assessments were carried out in the trust for overnight admissions and trust data we reviewed for August 2016 showed 94.2% of patients received the appropriate assessment of risk. Staff we spoke with said that they received a list of patients every week highlighting outstanding VTE assessments.

Cleanliness, infection control and hygiene

- The infection, prevention and control team delivered training face to face and through e learning. IPC training compliance rates for the hospital were 83% lower than the trust's own compliance rate of 95%. However, this rate had improved from the 2015 rate of 79%.
- Infection prevention and control information was visible on all wards we visited; this information included information on preventing infections.
- The trust reported no cases of hospital acquired Methicillin resistant staphylococcus aureus (MRSA) April to August 2016. The trust reported seven cases of hospital acquired Clostridium difficile (C.Difficile) in the same reporting period but this was lower than the agreed threshold.
- Wards and departments we visited were visibly clean and we saw ward cleanliness scores displayed in public corridors.
- We reviewed sixteen pieces of clinical equipment including commodes, and noted these to be clean. Staff also used labels to provide assurance to patients that they were clean. The bath on ward 28 was visibly stained.
- On the majority of occasions, we observed staff washing their hands, using hand gel between patients and staff complying with 'bare below the elbows' (BBE) policies. However, staff working in the theatre department and on ward 28 did not always comply with hand hygiene, standard precautions policies and the use of personal protective clothing or BBE policies. We saw: staff not removing gloves following use; used gloves placed in a non-clinical waste bin; and a member of staff wearing a stoned ring whilst in a room being used for isolating an infected patient.
- Hand hygiene audit data we reviewed showed 96.6% compliance in the reporting period January 2016 to October 2016. The infection prevention and control team validated the data on a monthly basis at a reported rate of 86.1% in the same reporting period. Data we reviewed showed compliance ranged from 17% to 100%.
- During the inspection, we saw hand hygiene compliance data displayed on the wards and departments we visited.
- The hospital carried out surgical site infection surveillance. They participated in national surgical site infection surveillance through Public Health England. The hospitals participated in the knee replacement module.

Environment and equipment

- Sixteen pieces of equipment we reviewed had been electrically safety tested. However two pieces of equipment (two beds) had not been serviced and staff we spoke with said that some electric beds did not work appropriately.
- In the majority of occasions, for the resuscitation equipment we checked, staff had recorded that checks were completed. On ward 28, there were no tamper proof tags on the resuscitation trolley, so stock could be removed following safety checks.
- Staff we spoke with said there were adequate stocks of equipment and we saw evidence of good stock rotation.
- Equipment for bariatric patients was available and staff we spoke with were aware of how to access this.

Medicines

- In 2015, we said that the trust must ensure the safe storage of medicines within fridges, specifically with regard to temperature and stock control. During this inspection, we saw that on the majority of occasions medicine fridges were secured and temperature records were completed in accordance with national guidance and trust policy.
- On surgical wards we visited, medicines were appropriately stored and prescribed, and access to medicines was restricted to authorised staff. However, we found evidence of a number of gaps inpatient records where staff had not signed to say they had administered medicines. On ward 28 intravenous medications were stored in a separate room, located on a main corridor, but the door was left open even though it had a keypad lock.
- Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained. Regular balance checks were performed in line with the trust policy.
- We reviewed the prescription charts and medicine administration records for patients on the ward. We saw on the majority of occasions arrangements were in place for recording the administration of medicines. On the majority of occasions, these records were clear and fully completed. The records showed patients were receiving their medicines when they needed them and as prescribed. Records of patients' allergies were recorded on the prescription chart.

- We observed nurses following the hospital policy when administering medicines to ensure the safety of patients. This included checking the patient's identity.
- Newly qualified registered nurses had to undertake competency assessments prior to them administering medications.
- Patient group directives (documents allowing nursing staff to administer specific treatments) were in date, however, on ward 28 not all staff had signed the PGD.
- Emergency medicines were readily available and there was a robust procedure in place to ensure that they were fit for use.
- We found evidence that some patients receiving anticoagulant therapy had not had a venous thromboembolism (VTE) risk assessment completed.

Records

- Paper records were available for each patient that attended the wards or department; the trust also used a computerised patient administration system, and an integrated computerised patient assessment and bed management system.
- Electronic boards were available on all wards visited, which provided easy access for staff to key information, for example, flags for dementia, post-operative confusion, patient acuity and discharge plans. This system had expanded since our last inspection and now included the theatre management system.
- We reviewed 25 sets of medical and nursing care records whilst on site. The majority records showed that staff used staff used black ink, legible handwriting and documentation was completed at the time of the review or administration of medication in accordance with trust policy and professional standards.
- Patient records were stored in notes trollies that could be locked, or were stored in secure areas.
- Patient records were multidisciplinary and we saw where physiotherapy staff had made entries.
- The wards and departments used risk assessments records that we reviewed. They showed that on the majority of occasions documentation for falls, nutrition and completion of pressure damage pathways were completed accurately. These were audited as part of the quality assurance audit and reported monthly by the matrons.

Safeguarding

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

Mandatory training

- Mandatory training was delivered as face-to-face training sessions or through the e-learning programme.
- The trust target for mandatory training completion was 95% compliance; training data we reviewed showed an overall training compliance rate for the directorate of 82%. This was the same as the 2015 data, when 82% of staff received mandatory training. All training modules were below the target for medical and dental staff, while nursing and midwifery staff met or exceeded the target in three out of the 13 modules. Resuscitation, moving and handling and fire training had the lowest completion rates across both staff groups. Resus training had only been completed by 67% of the staff. Staff we spoke with in the physiotherapy team was aware that a number of resuscitation sessions had been cancelled and that staff were not able to access new sessions in a timely manner.
- New staff received a corporate and a ward based induction, which included some aspects of their mandatory training.
- New or junior medical staff received a corporate induction and departmental induction training programme.

Surgery

Assessing and responding to patient risk

- In 2015, we said that the trust must ensure the five steps for safer surgery including the World Health Organisation (WHO) safety checklist is consistently applied and practice is audited in theatres. The hospital used the five steps for safer surgery procedures including the World Health Organisation (WHO) safety checklist. The hospital reviewed compliance with the safety checklist through audit; the internal audit had audited the emergency team brief. Results we reviewed showed moderate levels of assurance (70-89%), but improvements were required in the sign in checks, (86-89% compliance). The directorate had a plan to re-audit the WHO checklist in September 2016, however we were not provided with the results of this audit.
- During the inspection, we reviewed five sets of surgical notes containing WHO checklists; only one set of notes we reviewed contained a completed WHO checklist. We observed four patients operations and in the majority of occasions the checklist was completed; however, from our observations it was apparent that this was not a consistent and embedded process. In one case we reviewed, the checklist was completed slightly prior to the end of the operation.
- The trust used the national early warning score (NEWS) tool to identify deteriorating patients; surgical areas used an electronic based system to record the early warning score. Nursing staff identified deteriorating patients to medical staff by an internal bleep system. Nursing staff we spoke with were able to recognise the clinical condition of a deteriorating patient.
- The hospital reviewed compliance with completion of NEWS through audit; the internal audit department retrospectively reviewed 105 records (SGH and Goole) in October 2016. The results we reviewed showed good levels of performance, with 99% compliance for the outcome measure for vital signs being recorded; however, improvement was required with completion of a management plan including, treatment, parameters and escalation of care (70% compliance).
- From seven sets of notes we reviewed we did not see consistent effective escalation of all deteriorating patients. Four patients we reviewed had deteriorating early warning scores; however, we did not see documentation of escalation and review. For three patients, appropriate escalation and action was documented as being taken.
- In 2015, we said that the trust must review the effectiveness of the patient pathway from pre-assessment, through to timeliness of going to theatre and the number of on the day cancellations for patients awaiting an operation. Patients were assessed in pre- assessment clinics prior to surgery. Staff we spoke with provided examples of surgical elective patients being cancelled due to clinical reasons not been identified at pre-assessment. For example, blood thinning medication not being discontinued pre-operatively and patients having sleep apnoea and this not being highlighted at the time of the assessment. The senior management team were aware of the issues and had been working with the pre-assessment team to develop a business case for improvements in the pre-assessment pathway; this work was still to be approved.
- Ward 28 had a high observation bay (HOB); patients were nursed in the bay if they required higher levels of nursing care. Ward staff we spoke with said that they were able to move patients into the HOB if they deteriorated on the ward, following discussions and agreement with clinicians. However, during the inspection we saw two patients with high acuity both being nursed on ward 28 and 25 and not in the HOB.
- Access to a specialist critical care outreach team was available 12 hours a day seven days a week.
- Day case admissions had no formal risk assessments for VTE completed during the admission. In three out of four cases we reviewed patients did not receive VTE preventative treatments pre-operatively. In one case, this was rectified and the correct actions were carried out in theatre, but in the other three cases no actions were completed despite equipment being available.
- Venous thrombosis (blood clot) assessments were carried out in the trust and trust data we reviewed for August 2016 showed 94.2% of patients received the appropriate assessment of risk. Staff we spoke with said that they received a list of patients every week highlighting outstanding VTE assessments.

Nursing staffing

- In 2015, we said the trust must ensure that there are sufficient numbers of suitably skilled and experienced staff in line with best practice and national guidance taking into account patients' dependency levels. We also said that the trust must stop including newly qualified nurses awaiting professional registration (band

4 nurses) within the numbers for registered nurses. During this inspection, we did not see the trust using newly qualified nurses awaiting professional registration (band 4 nurses) within the numbers for registered nurses.

- At the time of the inspection, surgical wards and departments had 29 whole time equivalent (wte) registered nursing vacancies. We reviewed vacancy rates and this showed an 8.2 % vacancy rate. This was a similar figure to the vacancy rate seen in 2015. All surgical wards we visited had vacancies; ward 25 had 7.1 wte vacancies (41.9% of the total staffing establishment).
- Within theatres at this hospital, they had 39.7 wte operating department established posts, with 29.4 wte staff in post. They also had 10.3 vacancies.
- The trust used the safer nursing care tool (SNCT) to assess nursing staff requirements for each ward and department, on each shift. Nursing staff reviewed the acuity and inputted this into the computerised system three times a day to ensure the acuity, occupancy and dependencies were correct within the areas. The onsite co-ordination team used this information to aid decision making regarding the movement of staff to other areas.
- The surgical wards displayed planned and actual nurse staffing levels for each shift. The trusts planned nurse to patient ratios was based on one registered nurse for eight patients.
- Prior to the inspection, we reviewed the safer staffing report October 2016 for surgical wards. On all occasions the average fill rate for registered nursing (RN) staff each day and night shift was above the trust threshold of 85% for April- September 2016. For care staff the average fill rates were above 100% for the majority of day and night shifts. Data we reviewed ranged between 86.9% to 102.2% average fill rate for registered nurse RN day shifts and 97.1% to 145.3% average fill rate for night duties.
- We reviewed duty rosters for the previous three months and out of 189 registered nurse shifts reviewed, we saw that 26 shifts were staffed at below the established levels and 71 shifts had bank staff on duty.
- Staff we spoke with and records we reviewed showed that ward managers had difficulty ensuring the ward skill mix was correct; wards we visited had a high number of newly qualified nurses on the duty rota. This meant that senior staff nurses were expected to oversee and provide medication rounds for a large cohort of patients. Staff we spoke with also said that when combined with the number of agency staff working on the ward the ward co-ordinator often had to take a cohort of patients and oversee another cohort of patients being looked after by a junior member of staff. All staff we spoke with expressed concerns over the number of newly qualified staff on the wards. Senior staff were very supportive of the newly qualified staff, as they wanted to retain them and improve their skills.
- The surgical wards and departments used bank and agency staff to improve staffing levels; we reviewed use of bank and agency staff and noted 0.9% agency usage. Wards 25 and 28 had the highest bank and agency usage.
- The surgical directorate was actively recruiting to vacant posts; the trust had undertaken both local and international recruitment events, and an intake of new staff from the local university commenced employment in 2016.
- Daily safety brief reviews took place each day across the hospital. The purpose of this meeting was to ensure at least minimum safe staffing levels in all areas. Senior staff attended safety briefings. Staff were often moved from their substantive area to ensure minimum staffing levels in all areas.
- We saw that the senior management team had taken decisions to close beds on ward 25 to improve nurse to patient ratios. During the inspection, we did not see that any beds were reduced; staff we spoke with did have a clear understanding of when numbers of beds had to be reduced to meet available staffing levels.
- Formal handovers took place twice a day with informal handovers occurring during the shift when staff changed. We observed a formal handover and saw that comprehensive discussion of patients' clinical conditions were discussed and levels of support or risks were identified.

Surgical staffing

- For all surgical specialities a consultant was present on site 8am until 5pm Monday to Friday.
- On call cover was provided 24hours a day by foundation level one and two doctors; middle grade staff and consultants were available on an on call basis from 5pm until 8am. Whilst on call doctors covered general surgery and urology, Trauma and orthopaedics had a separate on call rota.

- The senior management team spoke with us about a new development of middle grade medical staff being resident within the hospital. This had commenced on the DPoW site, and it was due to commence on the SGH site from February 2017.
- At the time of the inspection, surgical wards and department had 35 wte surgical medical staff vacancies. We reviewed vacancy rates and this showed 15.4% wte vacancies. The ear, nose and throat unit had the highest vacancy rate at 34.4%.
- Junior doctors we spoke with said they were aware of gaps in medical staffing rotas, but they said that these were covered by locum medical staff. On occasions, these had not been covered and this had affected the workload of other medical staff. When on call the junior doctor covered two surgical wards and occasionally they covered the gynaecology ward. A separate rota was available for the trauma and orthopaedic wards.
- All junior medical staff we spoke with said that senior staff were supportive and senior medical staff could be accessed at all times.
- Junior medical staff we spoke with said that they received protective teaching time on a weekly basis; had good support from foundation level two staff and that consultants were accessible on an on call basis. They did say that continuity of care and peer support could be improved by changes in the staffing rota, such as, not having all the urology team on night shift at the same time.
- Between April 2015 and March 2016, the proportion of consultant staff reported to be working at the trust was lower than and the proportion of junior (foundation years 1 and 2) staff was higher than, the England average.
- The surgical wards and departments used locum staff to improve staffing levels; we reviewed use of locum staff during the reporting period of August 2015 to July 2016 and noted 1.5% agency usage. General surgery reported the highest bank and locum usage at 4.9%. Overall bank and locum usage had increased over the time-period from 1.3% to 2%.
- Formal medical handovers took place once a day with informal handovers occurring during the shift when staff changed.

Major incident awareness and training

- The trust delivered major incident training during induction for its entire staff. As of July 2016, 100% of staff had completed their training.
- The trust had a business continuity plan. This was available to staff on the trust intranet.
- We saw the major incident plan; this outlined the process for managing and co-ordinating the hospital's emergency response in the event of such an incident. Staff we spoke with were not familiar with these plans or been involved in any training exercises.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures were available; staff we spoke with were able to articulate these.

Are surgery services effective?

Requires improvement

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

- Staff did not always book patients needing emergency surgery into theatres in accordance with the National confidential enquiry into patient outcome and death (NCEPOD) guidelines. No formal emergency theatre booking policy or protocol was available to enable staff to comply with the guidelines.
- Performance in national audits was variable. The majority of indicators in the national emergency laparotomy, bowel cancer and national hip fracture audits continued to be below national performance. National audit action plans we reviewed did not always reflect the actions required by the audit performance.
- Patient information was not shared with GP's in an effective way. Data we reviewed showed that there were 1,964 letters requiring review, approval, distribution and completion (September 2016), 266 of these letters being urgent cancer patient letters. Delays in the system have the potential to lead to treatment delays in the patient pathway.
- Policies and guidelines in use within clinical areas were not all compliant with NICE or other clinical bodies. Data we reviewed from June 2016 showed that policies within the directorate were 69% compliant with NICE guidance.

- The trust had an internal appraisal target to achieve 95%. Appraisal records we reviewed showed that within surgery and critical care in the reporting period April 2016 to August 2016, 75% of staff had an up to date appraisal. This did not meet the trust compliance target but was an improvement on the 2015 compliance of 69%.
- Nurses, occupational therapist and physiotherapists held daily meetings on wards 10 and 11 (orthopaedic wards). Staff we spoke with said this improved discharge planning and flow within the orthopaedic department.
- Whilst on the wards we observed good communication and support between members of the medical, nursing, allied health professionals and specialist teams.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Two nurses were currently in training to allow them to insert specialist intravenous lines into patients requiring additional support.

Evidence-based care and treatment

- We saw patients' treatment was mainly based on national guidance, such as the National Institute for Health and Care Excellence (NICE), the Association of Anaesthetics, and from the Royal College of Surgeons.
- Policies were stored on the trust intranet and staff we spoke with said they were able to access them.
- In 2015, we said that the trust must ensure policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies and that staff must be aware of the policies within surgery. Data we reviewed from June 2016 showed that the directorate was 69% compliant with NICE guidance. Full compliance was available for 40 documents, partial compliance for 10 documents and 13 documents had yet to be assessed. This was a slight increase in the number of compliant policies seen in the 2015 inspection. However, within minutes of the October governance meeting, we noted concerns over a "deteriorating position" but the associate medical director was leading on this work.
- Access to emergency theatres was not consistent or in conjunction with national guidelines. Staff we spoke with said that clinicians held discussions in accordance with the National confidential enquiry into patient outcome and death (NCEPOD) guidelines. However, data we reviewed showed that patients were not consistently booked in accord with NCEPOD classifications. Staff we spoke with and records we reviewed showed that no physiological risk assessments were completed on cases, no formal planning meeting for cases to be discussed was held and no approved protocol or policy was available indicating how cases should be booked for theatres was available. A further emergency trauma list had received approval and had been granted. The list was due to commence in January 2016. At the unannounced inspection, we reviewed 47 booking forms. 22 forms were completed, six were incorrectly completed and four forms had no emergency theatre classification available. A further seven forms did not have time taken to theatre so we were unable to say whether these patients met emergency theatre booking guidance. The remaining patients were cancelled once booked as they no longer required emergency surgery. We were supplied with a draft protocol for emergency theatre booking, however this had not been approved and was not a cross-site document. We discussed this with the senior management team, who agreed to take action.
- We saw evidence of a range of standardised, documented pathways and agreed care plans across surgery, examples of these included hip fracture pathways.
- The directorate had a local audit programme and local audit meetings; the audit programme was also discussed during governance meetings.
- Wards and departments we visited took part in nursing audits, for example, infection prevention and control practices, medication and pressure area care. The matrons used the results in a matron dashboard report highlighting action required and actions requiring escalation.
- Staff we spoke with were knowledgeable about sepsis pathways and application of the protocol, however we did not see consistent recognition of sepsis in patients. In two out of two cases we reviewed, the sepsis pathway was not completed or instigated at the appropriate time.

Pain relief

- The hospital used a number of different medicines for relieving pain post-operatively dependent upon the surgery. Information about the medicine prescribed, including how to use it and any side effects was given to patients.

- We saw that patients were offered pain relief. Patients we spoke with said staff had offered pain relief regularly and staff had checked that pain relief administered had been effective.
- Staff used a pain-scoring tool to assess patients' pain levels; staff recorded the assessment on paper records. On the majority of occasions, pain assessments were completed. If a patient had pain, staff administered pain relief and checked this had the desired effect.
- The wards had access to a dedicated pain team.

Nutrition and hydration

- We saw staff offered patients regular drinks and food. Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Nutritional screening tools (MUST) were used, and nutritional risk assessment documentation we reviewed showed that on the majority of occasions this was complete.
- Staff referred patients to dietitian if this was required.
- We observed two meal services during the inspection. Staff working on the ward ensured that patients requiring support with eating received this within five minutes of being provided with warm food, and made sure that all patients had everything within easy reach.
- We reviewed five fluid balance charts and found that four of these were not completed accurately. Staff had not calculated the patients overall fluid intake or output. This had been previously highlighted on the matron dashboards.
- The trust staggered theatre fasting times, however, because of list overruns some patients we spoke with had fasted for longer times than planned. The trust did not undertake internal fasting audits.
- A snack menu was available on all surgical wards. This provided patients with additional food between meals such as crisps, yogurts and ice creams.

Patient outcomes

- In the reporting period March 2015 to April 2016, patients at this site had an overall lower expected risk of re-admission following elective and non-elective surgery than the England average. Elective general surgery had notably higher relative risk of re-admission than the England average. For non-elective admissions, trauma and orthopaedics had a higher relative risk of re-admission than the England average.
- The trust participated in the national bowel cancer audit 2015; the majority of measures fell within the expected range, however, the trust performed worse than the national aggregate for England and Wales on all measures. In the 2015 audit report, 83% of patients, undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate; this was similar to the 2014 figure of 81%. The risk-adjusted 90 days post-operative mortality rate was 6.1%, which was within expected range. This was worse than the 2014 rate of 5%. The risk-adjusted two-year post-operative mortality rate was 28.4%, which falls within the expected range. This was worse than the 2014 data of 24.8%. The risk-adjusted 90-day unplanned re-admission rate was 22.8%, which falls within the expected range. This was worse than the 2014 data of 18.3%. The risk-adjusted temporary stoma rate in rectal cancer patients undergoing major resection was 54%, which falls within expected range. This was better than the 2014 rate of 58%.
- In the national emergency laparotomy organisational audit (NELA) 2015, this site achieved a green rating (>70%) for three measures, an amber rating (50-79%) for one measures and a red rating (>49%) for six measures. The final case ascertainment rate was rated as green. The rating represents a score of between 70-100%. We reviewed the trust action plan. This was populated with deadlines and contained two actions, however, this did not contain actions required to consistently improve patient outcomes.
- In 2015, we said that the trust must continue to improve on the number of fractured neck of femur patients who receive surgery within 48 hours. Internal trust data we reviewed indicated that surgery was still not occurring consistently within 48 hours. Current compliance showed the proportion of patients having surgery on the day or day after admission was 62.5%, which does not meet the national standard of 85%.This had improved however on the 2015 result of 58.1%. Best practice guidance recommends that surgery is carried out on patients with a fractured neck of femur within 36 hours following attendance. The trust monitored this and performance was 47.4% for July 2016. The fractured neck of femur best practice action plan was all complete apart from one action. We discussed fractured neck of femur performance with clinicians, the senior management team and theatre staff and there did not appear to be an understanding of the reasons why

performance had not improved markedly in the previous two years. Each team provided examples of the other team having issues such as inappropriate scheduling and patient prioritisation, or patients not prepared pre-operatively correctly, or inadequate staffing numbers and availability of trauma lists. The senior management team agreed to take this forward for action.

- The trust participated in the national hip fracture audit. Findings from the 2015 and 2016 report showed performance in the Hip fracture audit remained mixed with three measures improving, two deteriorating and one remaining the same. The risk adjusted 30-day mortality rate was 6%, which is within expected levels; this had improved from the 2015 audit when it was 6.9 %. The perioperative surgical assessment rate was 77.5%, which does not meet the national standard of 100% and was below the national aggregate of 86.2%. This was a decrease on the 2015 rate of 87.6%.
- The proportion of patients not developing a pressure ulcer was 100%, which falls in the best 25% of all trusts. This was an improvement on the 2015 score of 99.5%.
- The length of stay was 12.6 days, which falls in the best 25% of trusts; the length of stay had remained the same from the 2015 audit.
- Trust patient reported outcome measures (PROMs) from April 2015 to March 2016, showed that for the majority of indicators the trust performed in line with the England average. Groin hernia indicators and knee replacement indicators showed more patients' health improved than the England averages. The hip replacement indicator showed fewer patients' health improved and more patients' health worsened than England averages.
- In the 2016, the trust participated in the Oesophago-Gastric cancer national audit (OGCNCA).The age and sex adjusted proportion of patients diagnosed after an emergency admission was 20.6%. This placed the trust within the highest 25% of all trusts for this measure. The 90-day post-operative mortality rate was not reported for this trust. Case ascertainment was better than the national aggregate at >90% in both the 2015 and 2016 audits. The proportion of patients treated with curative intent in the Yorkshire and Humber strategic clinical network was 34.3%, which was significantly lower than the national aggregate.
- The trust's quality assurance report reviewed and reported data on various nursing indicators to the chief nurse on a monthly basis.
- The hospital had local quality improvement projects identified and these were discussed at the quality and safety days.
- The trust monitored performance against a range of clinical indicators using a performance dashboard. This data included compliance with NICE guidance and performance in national audits.

Competent staff

- In 2015, we said that the trust must continue to improve against the target of all staff receiving an annual appraisal and supervision and that actions identified in the appraisals are acted upon.
- The trust had an internal appraisal target to achieve 95%. Appraisal records we reviewed showed that within surgery and critical care in the reporting period April 2016 to August 2016, 75% of staff had an up to date appraisal. This was an improvement on the 2015 compliance of 69%. Performance had improved from the previous financial year across all staff groups, particularly across administrative and clerical, which had improved to 53% from 17% in 2015/2016. Data for medical staff appraisal showed that within the directorate in the same reporting period, 74% of medical staff had an up to date appraisal. This was an improvement on the 2015/2016 data of 71%. All staff we spoke with said they had received an appraisal in the last year and the majority thought these had been beneficial.
- Newly qualified staff had a period of preceptorship following employment; during this period, staff were to complete specific competencies, for example, administration of medication. Staff we spoke with said that due to staffing levels and current skill mix on wards and departments, newly qualified staff found it difficult to have competencies signed off by senior staff.
- Specific ward based induction was undertaken on the surgical wards and departments. This involved training on specific issues and equipment used on the area. Agency and bank nurses told us they received an orientation and induction to the ward area. This included use of resuscitation equipment and medicines management.
- The majority of medical staff we spoke with said they had received time for specialist training, education and portfolio development.

- Nursing staff we spoke with were aware of and felt supported through the registered nurse revalidation requirements.
- Two nurses were currently in training to allow them to insert specialist intravenous lines into patients requiring additional support.
- The theatre department held bi-monthly staff development days for staff, which included simulation training.

Multidisciplinary working

- There were established multi-disciplinary team (MDT) meetings for discussions of patients on cancer pathways. MDT meetings included attendance from specialist nurses, surgeons, anaesthetists and radiologists. Consultants from the trust also attended specialist MDT at the local tertiary hospital when they had made referrals.
- Clinical nurse specialists attended wards to provide clinical expertise and review patients if needed. Whilst on the wards, we observed good communication between the tissue viability team and ward staff, and ward staff and the acute pain nurse.
- Whilst on the wards we observed good communication and support between members of the medical team.
- Nursing and medical staff referred patients to dietitians from the surgical wards. Dietitians attended wards daily Monday-Friday.
- Nurses, occupational therapists and physiotherapists held daily meetings on wards 10 and 11 (orthopaedic wards). Staff we spoke with said this improved discharge planning and flow within the orthopaedic department.
- Staff within the orthopaedic wards said that they had good working relationships within the multidisciplinary team. Physiotherapy staff said that they felt part of the ward team.
- Theatre managers from each site met regularly, however implementation of common policies, procedures and ways of working for theatres, for example, theatre-booking procedures, required improvement.
- Pre –assessment staff on the SGH site we spoke with said that they did not have any communication with the pre-assessment team on the DPoW site; this has the potential to hamper improvements in the pre-assessment service.

Seven-day services

- Onsite junior medical cover was available seven days a week; consultants out of hours (OOH) supported this.
- Middle grades or junior medical staff reviewed patients on admission.
- National audit performance showed that the trust did not consistently provide consultant review prior and post-surgery within the agreed timescales.
- Surgical inpatients had access to diagnostic and radiology services 24 hours, seven days a week to support clinical decision-making. The trust was compliant with this standard.
- Surgical inpatients had timely 24- hour access, seven days a week, to consultant-directed interventions for emergency general surgery these were available onsite and through formally agreed networked arrangements.
- When transferred from acute areas to general wards surgical patients were reviewed during a consultant-delivered ward rounds at least once every 24 hours, seven days a week.
- Access to occupational therapy and physiotherapy services were available Monday to Friday, with emergency cover on a Saturdays and Sundays.
- Pharmacy staff were available six days a week and an on call service was available out of hours.

Access to information

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are surgery services caring?

Good

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

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

Compassionate care

- We spoke with 16 patients and four relatives during the inspection. We observed positive interactions between patients and staff. The majority of patients we spoke with were happy with the care they received.
- The NHS Friends and Family test (FFT) is a national survey that measures satisfaction with the healthcare the patient has received. The response rate was 38% better than the England average of 29% in the reporting period August 2915 to July 2016. Ward level recommendation rates have been generally high, scoring between 90-100% across the majority of the reporting period. Wards and departments we visited displayed their friends and family results.
- During the unannounced inspection, we carried out on one ward a short observational framework for inspection (SOFI). Through our observations, we saw that on the majority of occasions, patient mood states were mainly positive or neutral and interactions with patients were positive. During the observation, all patients in the bay were treated with dignity and respect.
- The majority of patients we spoke with had drinks and call buzzers located within easy reach.

- On one occasion, a patient was asleep during meal service and staff decided not to wake them and to provide the patient with food once they awoke.
- In the majority of occasions we observed that patients were dressed, encouraged to eat out of bed and be independently mobile where possible.

Understanding and involvement of patients and those close to them

- Patients we spoke with said that they had been fully involved in their care decisions. This included discussion of the risks and benefits of treatment.
- Patients said they knew who to approach if they had issues regarding their care, and they felt able to ask questions.
- Patients we spoke with said that medical staff had explained things to them in a way they could understand and they provided an example of medical staff drawing pictures to explain issues to the patient.
- The majority of patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.
- We saw that ward managers were visible on the wards and relatives and patients were able to speak with them.

Emotional support

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

Are surgery services responsive?

Requires improvement

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

- The directorate did not have in place processes to ensure that capacity of services was sufficient to meet the demands. Patients could not always access services for assessment, diagnosis or treatment in a timely manner. The service had long wait times and overall it did not meet the national referral to treatment times (RTT) or all cancer performance indicators. Performance had been worse than the England overall performance since June 2016 and showed a deteriorating trend. Data for October 2016 showed 73.7% of patients were treated within 18 weeks (national standard of 92%) against an England performance of 75.5%. In November 2016, the trust reported that two surgical patients had waited over 52 weeks for treatment, one in general surgery and one in urology.
- The service had a high number of clinical and non-clinical cancellations. From April to June 2016, 102 operations were cancelled for non-clinical reasons. Non-clinical cancellations were often caused by the high number of outlying patients (patients nursed in a different speciality areas). In the same reporting period, 184 operations were cancelled on the day for clinical reasons. Staff did not assess elective surgery patients, who needed pre-assessment before surgery, using an effective patient pathway.
- Staff we spoke with also expressed concerns over the inappropriate times patients were transferred to surgical wards. Records we reviewed showed that a number of surgical and medical transfers happened past 8pm at night. On two occasions we saw records, (and patients we spoke with confirmed) that patients were being transferred into surgical beds at 23.47pm, 12.30pm and 3am. This disrupted surgical patient sleep and decreased the amount of beds available for elective surgical inpatients.

However:

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

Service planning and delivery to meet the needs of local people

- The surgical directorate provided non-elective (acute) treatments for different specialities such as ear, nose and throat, gastroenterology, general surgery, ophthalmology, orthopaedic and urology. The surgical service had four surgical wards with 87 inpatient beds. The hospital has eight operating theatres.
- The directorate did not have processes in place to ensure that capacity of services was sufficient to meet the demands. Patients could not always access services for assessment, diagnosis or treatment in a timely manner. The service was working closely with NHS improvement to identify current capacity and demand.
- The senior management team highlighted to us that current data collection issues were hampering progress, as they currently could not obtain all the relevant theatre utilisation data. Data we reviewed showed that 258 theatre sessions were cancelled during August to November 2016. These were cancelled for a variety of reasons including surgeons leave and no cases booked for the list.
- The directorate worked with the commissioning team when creating their strategy. They were also taking into account local transformation plans.
- Local agreements were available to provide services in the local tertiary hospital when the trust was unable to provide those services.

Access and flow

- NHS England published operational standards for the expected level of referral to treatment targets (RTT) for patients; incomplete pathways were set at (92%).
- The trust performance of meeting the referral to treatment indicator (RTT) for patients admitted for treatment within 18 weeks of referral had been worse than the England overall performance since June 2016. Data for October 2016 showed 73.7% of patients were treated within 18 weeks against an England performance of 75.5%. Trust performance over the period shows a deteriorating trend, having moved from being consistently above the England average to below from June 2016. Whilst the England average has also deteriorated over the time, it has stabilised somewhat from June while the trust has continued the downward trend.
- Trauma and orthopaedics and ophthalmology were performing below the national average with performance data at 67.8% (68.5% national) and 76.1% (80.1% national) respectively. Urology, ear nose and throat, general and oral surgery were all performing above the national average, with performance data ranging from 80.9% to 85.8% (national data ranged from 71.9% to 81%).
- We reviewed performance against the cancer standards and noted that one cancer standard was not achieved by the trust in August 2016.This was the 62 day standard. The senior management team were aware that they were short of approximately four clinics each week to allow them to meet cancer standards; they were discussing this issue with commissioners.
- The trust was working closely with NHS improvement (NHSi) to improve RTT and cancer standards performance.
- The trust had commenced working with outside partnership organisations to improve performance in key areas like ophthalmology and maxillofacial surgery.
- We requested to review recovery plans for individual specialities. However, we were only supplied with one of these documents for ophthalmology. We were not supplied with any other specialities to review.
- Theatre usage within the trust ranged from 0% to 95.4% during the period of May 2016 to July 2016. Data for this site was highest at 70.5% overall usage. The trust had a target for theatre utilisation of 93%.
- Elective theatre lists were available five days a week and emergency theatre lists were available seven days a week. Specialities shared access to theatres for emergencies overnight and at weekends. Trauma services for orthopaedics were only available six days a week; however, the directorate had approved a business plan for this to increase to seven days a week from January 2017.
- A last minute cancellation is a cancellation for non-clinical reasons on the day the patient is due to

arrive, after they have arrived or on the day of their appointment. Patients who are cancelled at the last minute must be relisted and treated within the next 28 days; otherwise, this is recorded as a breach in the standards. For the reporting period quarter three 2014/ 2015 to quarter two 2016/2017 the trust cancelled 1,220 surgeries, of these 1.3% were not treated within 28 days.

- All cancelled operations (not just last minute cancellations) as a percentage of elective admissions for the period quarter two 2014/15 to quarter one 2016/17 at the trust were generally greater than the England average although they have dropped below the England average during the last quarter.
- We reviewed on the day cancellation rates April 2016 to June 2016, at SGH for clinical and non- clinical reasons. 184 patients had their operation cancelled on the day for clinical reasons and 102 for non-clinical reasons. However, when both sites are added together and compared against last year's data this shows that the trust cancelled more patients in April 2016 to June 2016. 282 patients for clinical reasons against 240 patients in March 2015 to May 2015. This was reflected in cancellations for non-clinical reasons; 236 April 2016 to June 2016 against 180 March 2015 to May 2015. We discussed this with the senior management team who were aware of the number of cancellations, and said that a number of them were due to the industrial action by junior medical staff in April 2016.
- In November 2016, the trust reported that two surgical patients had waited over 52 weeks for treatment, one in general surgery and one in urology.
- At trust level, elective General Surgery admissions had a notably longer average length of stay than the England average at 4.7 days compared to 3.4 days for England. Average length of stay for non-elective admissions in Trauma and Orthopaedics was shorter for the trust at 6.3 days compared to the England average of 8.8 days. At SGH, the average length of stay for surgical elective patients was longer for elective patients and shorter for non-elective patients than the trust level.
- During the inspection, wards 25, 28 and 11 had medical patients (medical outliers) located on them. We discussed this with the staff working on the ward and reviewed medical records of patients located on surgical wards. Having medical patients in surgical wards had an impact on the availability of surgical beds. We saw an example of a surgical patient waiting in the day room for four hours until a bed became available.
- Staff we spoke with also expressed concerns over the inappropriate times patients were transferred to surgical wards and provided examples of disrupting patients' sleep. Records we reviewed showed that a large number of surgical and medical transfers happened past 8pm at night. On two occasions, we saw records, which showed patients being transferred into surgical beds at 1am. This disrupted surgical patient sleep and decreased the amount of beds available for elective surgical inpatients. Staff we spoke with provided a recent example of three orthopaedic patients moved between wards in the middle of the night. As a result, beds were not available for elective orthopaedics admissions and patients were cancelled.
- We reviewed data which showed the amount of time the recovery area was used to nurse critical care patients. Data we saw showed that this area was used less during 2016 than it was in 2015; however, staff we spoke with said this occurred on a frequent basis.
- Staff provided telephone access to patients for advice and guidance post-discharge following surgery.
- During the inspection, we saw a patient transferred from the accident and emergency department without a bed being available. This patient required isolation due to an infection. As no bed was available the matron was contacted to attend to the patient.

Meeting people's individual needs

- Patients with particular needs were identified to staff at the ward handovers, for example, learning disabilities, mental health and dementia.
- The wards and department used a butterfly symbol to support people living with dementia. We saw some areas that were decorated in a dementia friendly way, for example, coloured signs on toilet door or clocks in rooms.
- Directorate performance data for dementia and delirium screening for over 75's was 81.4% for July 2016 against a threshold of 90%.
- We saw 'This is my life' booklets used for patients as part of the disabilities passport.
- Healthcare assistants provided one to one observation and support for vulnerable patients.
- The high observation bay (HOB) on ward 28 admitted both female and male patients. Staff we spoke with said this occurred on a daily basis, however this was not classified as a mixed sex breach as the patients required care in this area. The protocol for admission into this

area indicated that these patients were level one-dependency patients. National guidance indicates that it is acceptable to have level two patients in mixed sex accommodation, however level 1 patients must not be mixed. Ward staff provided patients in the HOB unit with leaflets explaining mixed sex accommodation. However, staff we spoke with were unsure of which leaflet to use, as two similar leaflets were available. These leaflets were version controlled and had been recently updated. A sign was placed on the entrance to ward 28 indicating that male and female patients may be placed in bays together and asking patients to speak with staff if they had concerns.

- The wards and departments were accessible for people with limited mobility and people who used a wheelchair. Disabled toilets were available.
- The pre-assessment team or the admitting ward reviewed patients' needs on admission, in regards to hearing difficulties and specialist needs.
- Translation services were available for people whose first language was not English. Staff we spoke with said that this service was responsive. A welcome sign was in place on the entrance to ward 22 welcoming people in 22 different languages.
- There were links between specialist nurses and ward staff to ensure continuity of care and support for patients.
- Specialised equipment required for bariatric patients was available, and staff we spoke with were aware of how to access this.
- Relevant information to patients was displayed on the walls of corridors of wards we visited, such as, ward performance in safety audits.
- Ranges of leaflets were available for patients within surgical wards and departments, for example, prevention of pressure ulcers, carers information and condition related information.
- Patients we spoke with said that staff did not take long to answer call bells; during the inspection, we did not hear call bells ringing for long periods.

Learning from complaints and concerns

- The trust had a process that addressed both formal and informal complaints that were raised through the Patient Advocacy and Liaison Service (PALS).
- In the reporting period, September 2015 and August 2016, there were 35 (41.2% of total) complaints about surgical care. The trust took on average 54 days to investigate and close complaints. The most common theme of complaints was clinical treatment.
- We reviewed five complaints received by the surgical directorate and their responses and noted evidence of duty of candour requirements, an apology and acknowledgement when things did not go according to plan.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required. Senior staff we spoke with were aware of the number of complaints and the themes received for their area.
- Complaints were shared with staff through team meetings and individual conversations.

Are surgery services well-led?

Inadequate

At the previous inspection in 2015, we rated the surgical services at SGH for well-led as 'inadequate'. At this inspection we rated well-led as requires improvement because:

- We did not receive assurance that the surgical directorate had clear, up to date recovery plans to recover referral to treatment times (RTT) performance, and this was leading to increased waiting times for patients.
- The directorate had not fully implemented its pre-assessment and theatre sustainability programmes therefore the issues of high numbers of surgical procedure cancellations, increasing waiting times and a deteriorating RTT was not being addressed within the directorate.
- The clinical strategy for surgical services did not make detailed reference to national reports and recommendations, the trust values and strategy, or have clear deadlines for actions. The senior management team said that this document had been shared with the clinical team. However, staff we spoke with working in the clinical areas were not aware of the directorate vision and strategy, or their role within it.

- The service did not consistently have enough qualified, experienced and skilled staff. Staff shortages affected staff morale. Staff spoke about a lack of support from the site co-ordination team, in relation to movement of staff, staff shortages and moving patients.
- The service action plans in response to national audits did not always reflect the actions required by the trust to improve performance. Compliance on the number of fractured neck of femur patients who receive surgery within 48 hours had not improved significantly over the last two years and no clear reason for the lack of improved performance was identified.
- Staff we spoke with described the culture in wards and departments as variable. Staff we spoke with felt that staff morale had decreased recently due to staff shortages and staff having to work additional shifts.
- We did not see evidence of surgical wards and departments engaging with patient representatives to improve services.

However:

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

Leadership of service

- In the 2014 and 2015 inspection reports, it was noted that the senior management team was new and that it had not had time to identify and prioritise the issues and take action and implement change. During the 2016 inspection, there had been another recent change in the management team. The new management were aware of the issues that required action. However, they had not had time to implement or plan the changes effectively. The senior management team recognised that they needed more time to develop and become fully effective in their roles.
- A number of the senior nursing team had changed roles or were about to change roles in the days following the inspection. A number of the band 7/6 staff were new in post and required further time to be fully effective in the role.
- The directorate had not fully implemented its pre-assessment and theatre sustainability programmes therefore the issues of high numbers of surgical procedure cancellations, increasing waiting times and a deteriorating RTT was not being addressed within the directorate.
- In 2015, we said the trust must ensure it carries out a review of dedicated management time allocated to ward co-ordinators and managers. Whilst ward managers were allocated dedicated time, due to staffing and skill mix issues, it was difficult for them to protect this time. We saw that ward co-ordinators had to care for a cohort of patients whilst undertaken the co-ordinators role. This meant that the co-ordinator/ ward manager had to prioritise work to ensure patient care was not compromised.
- In 2015, we said that the trust must ensure it continues to improve on the number of fractured neck of femur patients who receive surgery within 48 hours. Compliance had not improved significantly over the last two years and no clear reason for performance was identified.
- The service action plans in response to national audits did not always reflect the actions required by the trust to improve performance.
- In 2015, we highlighted that improvements in staffing levels were required especially overnight on wards 10 and 11.During this inspection we saw that these had been implemented; however, they had only improved in August 2016.
- From our discussions with staff, the majority of nursing staff said that ward level senior leadership was supportive and staff felt listened too. Junior medical staff we spoke with felt supported in their roles and said there was an improvement in culture.

- Wards and departments we inspected had staff meetings. These were held at different frequencies due to staffing levels and vacancies.
- The majority of staff we spoke with said that some of the executive team were visible on the wards and departments, for example, the Chief Nurse. The Chief Executive was the executive 'buddy' for a surgical ward and attended the ward during the inspection.
- Nursing staff turnover rates in July 2016 for the trust reported a turnover of 16.2% within surgery. This rate was better at 10.5%, however, two wards reported a worse rate with greater than 30%.Ward 25 reported 35.1% (five wte staff) and ward 28 reported 31% (seven wte). Medical staff turnover (35.3%) was worse than the trust rate of 26.9%. Both urology and general surgery had the highest turnover for medical staff rates.
- Nursing staff sickness in the trust was 4% within surgery. The reported rate was better at 2.1% in July 2016. The ward with the highest sickness rates were theatres 7.1%. The trust report medical sickness staff rates of 0.6%.Surgical wards and departments reported higher than the trust rate at 1.9%.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- The surgical directorate had a clear management structure; the senior management team were new into post (July 2016). All management posts were filled with substantive staff. This new structure required further time to be established and embedded. However, we could see improvements in the new management team and they appeared to have an understanding of the issues facing the directorate.
- The directorate held governance meetings; we reviewed three sets of meeting minutes and noted multidisciplinary attendance, discussion of risks and incidents. There was no discussion recorded about complaints, mortality or performance data in the minutes we reviewed. We reviewed business minutes from breast, urology and ophthalmology from April 2016 to July 2016. Evidence of discussion in relation to incidents, performance and complaints and issues were identified for action and escalation.
- We reviewed two sets of the Matrons Quality assurance reports for surgery and critical care. Headlines and support required for improvement was identified. Data was reported on if the ward scored less than 80% on the nursing audits carried out. However, on reviewing the June and July 2016 report it was clear that actions required were not always documented if scores were below the expected level.
- There was a risk register in place. Risks for the directorate were discussed at governance meetings. Medical and nursing staff attended these meetings. Items requiring escalation to the trust governance and assurance committee were clearly identified. The risk register reflected most of the current risks relevant to the operational effectiveness of the health group. Data we reviewed from 2016 showed 28 risks with 14 rated as high risks, seven medium risks and seven low risks identified.
- The senior management team said the main risks for the directorate were workforce, performance and finance. These were all issues identified on the current risk

register and controls measures had been identified. A number of risks had remained on the risk register for a number of years; however, these had been regularly reviewed.
- The senior management team spoke with us about the computerised system used within theatres. It did not provide the senior management team with data required, for example, theatre start and finish times.

Culture within the service

- Staff we spoke with described the culture in wards and departments as variable. Staff we spoke with felt that staff morale had decreased recently due to staff shortages and staff having to work additional shifts. The majority of nursing staff we spoke with told us about issues of support offered from the site co-ordination team. When staff raised concerns in relation to movement of staff, staff shortages, and transferring patients, they did not always feel listened to.
- The senior management team said they were proud of the staff working within the directorate and staff working in the directorate spoke with us about feeling able to raise concerns and feeling listened to by their immediate senior team.
- Staff spoke about their immediate colleagues in a positive way.
- Staff were aware of escalation procedures for issues of concerns on their wards or departments.

Public engagement

- Surgical wards and departments participated in the NHS Friends and family test (FFT).
- Within the surgical directorate, no patient representative was available on key groups or committees.
- Wards we visited had clinical leadership boards in place. These had "You said, we did boards" which highlighted actions taken because of patient feedback, for example, patients being unsure of how to complain and staff writing a list of things to do. On ward 11 the 'you said', 'we did' board said the same information as last year. It was not clear if this had been highlighted as a new issue or had not been updated. These boards also detailed friends and family results, patient safety information, such as, pressure ulcers and falls on the ward.

Staff engagement

- In 2015, we said that the trust must improve its engagement with staff to ensure that staff are aware, understand and are involved in improvements to services and receive appropriate support to carry out the duties they are employed to perform. During the inspection, staff we spoke with working in the clinical areas were not aware of the directorate vision and strategy, or their role within it; however, this document was a recent development, and as such, it required further time to be implemented.
- In the 2015 staff survey, the surgical health group had scored joint second highest directorate for experiencing harassment, bullying or abuse from staff in the last 12 months with 32% of surgical staff completing the survey. 14% of surgical staff completing the survey said they had reported harassment, bullying or abuse. The surgical directorate also scored the second lowest score when asking staff what percentage reported good communication between senior management and staff. The directorate also scored lowest overall for the recommendation of staff that the organisation is a good place to work, or receive treatment. We discussed this with the senior management team who discussed with us their actions to improve staff morale.
- Senior staff had developed private social media groups to share important ward messages.

Innovation, improvement and sustainability

- The trust has recently started to use social media to recruit new members of staff.
- The trust held a yearly award ceremony to recognise great work from staff.
- During the inspection, we saw evidence of innovation within the directorate, especially in regards to breast care provision, ophthalmic surgery and information technology.

Critical care

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

Information about the service

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

There is one intensive care unit (ICU) at SGH. The unit is an eight bed combined facility for level three (patients who require advanced respiratory support or a minimum of two organ support) and level two (patients who require pre-operative optimisation, extended post-operative care or single organ support). There are six beds in an open bay and two side rooms. It is staffed to care for a maximum of seven level three patients.

Intensive Care National Audit and Research Centre (ICNARC) data showed that between 1 April 2015 and 31 March 2016 there were 460 admissions with an average age of 63 years. Sixty-seven percent of patients were non-surgical, 19% emergency or unplanned surgical and 14% planned surgical. The average (mean) length of stay on ICU was three days.

A critical care outreach team provided a supportive role to medical and nursing staff on the wards when they were caring for deteriorating patients or supporting patients discharged from critical care. The team was available12 hours a day, seven days a week.

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

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

During this inspection we visited ICU. We spoke with one patient and 17 members of staff. We observed staff delivering care, looked at three patient records and three medication charts. We reviewed trust policies and performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Critical care

Summary of findings

We rated this service as good because:

- The service had taken action on most of the issues raised in the 2015 inspection. There was an effective governance process in place with a clear structure for escalation in the directorate and there was evidence of regular review of the risk register and controls in place for the risks.
- Staff were positive about the recent changes to the senior management team, morale had improved, staff were happy in their work and felt supported and valued.
- There was a clear critical care strategy and staff understood the vision for the service.
- Patient outcomes, for example, mortality, early re-admissions, delayed and out of hours discharges had improved and were in line with similar units.
- There was a good track record in safety. There had been no never events, or serious incidents and staff understood their responsibilities to raise concerns and report incidents. The incidents staff reported mainly resulted in low or no harm.
- Staffing levels and skill mix were planned and reviewed to keep people safe.
- Staff were supported to maintain and develop their professional skills and the number of nurses that had an up to date appraisal was better than the trust target. A clinical educator had been appointed and was due to commence in post.
- Seventy-two percent of nurses had a post registration qualification in critical care; this was better than the minimum recommendation of 50% in the Guidelines for the Provision of Intensive Care Services 2015 (GPICS).
- There had been no complaints about the service in the last 12 months and feedback from patients and relatives was positive about the way staff treated them.

However:

- Some of the issues raised at the 2015 inspection remained a concern. For example, medical and nurse staffing was still not yet in line with the GPICS. The critical care strategy had plans in place to address this.
- The rehabilitation after critical illness service was very limited and not in line with GPICS.
- The number of non-clinical transfers was not in line with national guidance and was worse than similar units and the service did not formally monitor the number of patients ventilated outside of critical care.
- Reporting of mixed sex occurrences had improved, but there was evidence of nine mixed sex accommodation breaches in two months where patients had not been discharged in line with trust policy.

Critical care

Are critical care services safe?

Good

We rated safe as good because:

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

However:

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

Incidents

- Never events have the potential to cause serious patient harm or death. They are wholly preventable, where nationally available guidance or safety recommendations that provide strong systemic protective barriers have been implemented by healthcare providers. There were no never events reported in the service between October 2015 and October 2016.
- The service reported no serious incidents between September 2015 and August 2016.
- The service reported 193 incidents between September 2015 and August 2016. Of the incidents reported 69% were classed as no harm and 29% as low harm. Frequently reported incidents were pressure ulcers, the use of mittens for patient safety and out of hours discharges.
- All staff we spoke with understood what to report as an incident and how to report it using the electronic system. They gave us examples of incidents that staff reported on the unit; these matched the themes we saw on the incident report.
- Senior staff had completed training to investigate incidents and accessed support from managers and other clinicians as needed. They shared information from incidents at handover, team meetings, on the communication board in the staffroom and electronically using email and the unit's secure social media site.
- Learning from incidents was also shared at the bi-monthly cross-site directorate quality and safety day. Staff we spoke with were aware of learning from trust wide incidents, for example, a medication incident.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with demonstrated an awareness of the duty of candour and the importance of open and honest care.
- The trust included the process for duty of candour in the being open and duty of candour policy.
- The service had introduced monthly critical care specific mortality and morbidity meetings. The trust provided examples of two sets of minutes from the meeting. The minutes showed evidence of multidisciplinary attendance, review of two cases a month, (where the Intensive Care National Audit and Research Centre (ICNARC) expected mortality was less than 20%) and the learning from these cases.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- The unit displayed safety thermometer information visible to staff and visitors.

- Data for the unit from October 2015 to October 2016 showed between 63% to 100% harm free care on the day the data was recorded. The service did not report any falls with harm or new CUTIs during this period. New pressure ulcers were reported in three out of the 13 months and new VTEs were reported in three out of the 13 months.

Cleanliness, infection control and hygiene

- Infection prevention and control information was displayed to staff and visitors on the unit.
- All areas on the unit were clean and tidy.
- All the equipment we observed was visibly clean and all the disposable curtains around bed spaces were within date for replacement.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- The unit's records for flushing taps to prevent Legionella were up to date and complete.
- The unit had facilities for respiratory isolation.
- Ninety one percent of staff in the service had completed infection control training. The trust target was 95%.
- The trust provided methicillin resistant staphylococcus aureus infection (MRSA) and Clostridium difficile audits. There had been no incidences of MRSA or Clostridium difficile in critical care between January and August 2016.
- Senior staff completed monthly audits on compliance with central venous catheter care. Information provided by the trust showed the unit achieved 100% compliance between January and July 2016.
- Senior staff completed monthly audits on compliance with interventions to reduce the incidence of ventilator associated pneumonia. Information provided by the trust showed the unit achieved 100% compliance between January and July 2016.
- ICNARC data showed the unit had 2.5 unit acquired infections in blood for each 1000 patient bed days between 1 April 2015 and 31 March 2016. This was higher than similar units.
- Staff we spoke with told us they could access a microbiologist for telephone advice, however, due to capacity, the microbiologists did not visit the unit on a regular basis.

Environment and equipment

- The unit was secure; access was by an intercom with a security camera. There was an adjoining corridor from the unit to the operating theatres.
- The unit provided mixed sex accommodation for critically ill patients within the Department of Health guidance. To maintain patients' privacy the bed spaces were separated by curtains.
- Staff checked the defibrillator and other emergency equipment daily. The records for this were up to date and complete. The unit had a trolley containing equipment, which they used for difficult intubations and emergency equipment was available at every bed space.
- Disposable items of equipment were in date and stored appropriately.
- All electrical equipment we observed was clean and had been safety tested.
- The unit kept up to date equipment maintenance records.
- Cleaning equipment was stored appropriately and we observed staff following cleaning schedules and completing the appropriate documentation.
- The trust completed a monthly environmental audit. Information provided for ICU showed 94% and above compliance between January and August 2016.
- The unit had replaced the beds since our inspection in 2015. Staff we spoke with told us they no longer had incidents of beds breaking down. They also told us access to air mattresses for patients on the unit had improved from 2015.
- The trust provided details of a completed audit on difficult airway trolleys. One of the recommendations stated ICU needed a difficult airway trolley based on the unit. We saw this trolley was in place during our inspection.
- Nursing and medical staff were responsible for ensuring that equipment was fit for purpose and contacted medical engineering with any concerns. Staff we spoke with told us they did not experience delays in obtaining equipment or with equipment maintenance.
- The service did not have a critical care specific capital replacement programme. Equipment was considered as part of the trust wide capital replacement programme.

Medicines

- The unit had appropriate systems to ensure that medicines were handled safely and stored securely.

- Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- Staff monitored medication fridge temperatures in line with trust policy and national guidance. This meant that medications were stored at the appropriate temperature.
- The unit had made changes to the storage of oxygen since our 2015 inspection; this was now secured to the wall and stored appropriately.
- Ninety-nine percent of staff in the service had completed medicines management training. The trust target was 95%.
- We reviewed three medication charts. They had all been completed in line with national and trust guidance.
- We saw evidence in the records that staff had reviewed the use of medication such as sedation and antibiotics regularly.

Records

- Records were stored securely and all components of the record were in one place.
- Medical staff completed a daily critical care assessment form that met the National Institute for Health and Care Excellence (NICE) CG50 guidance (a tool for recognising and responding to deterioration in acute ill adults in hospitals).
- In the three records we reviewed, the nursing documentation included care bundles and risk assessments. Nursing records were accurate, complete and in line with trust and professional standards.
- In the three records we reviewed, the medical documentation did not record that care was delivered in line with GPICS. For example, staff did not print their name and grade when they signed the record; this was not in line with trust and professional standards and also meant there was no documented evidence of when a consultant review had taken place following admission to critical care.
- Ninety-three percent of staff in the service had completed information governance training. The trust target was 95%.

Safeguarding

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

Mandatory training

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

Assessing and responding to patient risk

- A consultant nurse managed the deteriorating patient team which included the critical care outreach nurses, vascular access nurse specialist and sepsis nurse specialist.
- A member of the critical care outreach team was available 12 hours a day, seven days a week. The hospital at night team managed patients outside of these hours.
- The critical care outreach team supported patients stepped down from critical care and reviewed patients alerted to them by emergency department (ED) and ward staff. The team also delivered non-invasive ventilation outside of ICU in line with the trust's policy.
- Information provided by the trust showed that, between November 2015 and November 2016, the critical care outreach team responded to 627 referrals from the wards and ED and followed-up all patients discharged from critical care.
- The trust used a nationally recognised early warning tool called NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care.
- The trust used a sepsis screening tool and pathway.

Critical care

- The patient records we reviewed all included completed risk assessments for VTE, pressure areas and nutrition.

Nursing staffing

- Nurse staffing met the GPICS minimum requirements of a one to one nurse to patient ratio for level three patients and one nurse to two patients ratio for level two patients.
- The unit's establishment for registered nurses was 41.4 wte. Information provided by the trust showed that in July 2016 there was 38 wte registered nurses in post. At the time of our inspection, senior staff told us there was currently one wte vacancy and recruitment was underway.
- The units displayed the planned and actual staffing figures.
- Information available on the trust's website showed the fill rates for registered nurses. The fill rates were 94% for day shifts and 92% for night shifts in July 2016, 94% for day shifts and 95% for night shifts in September 2016 and 97% for day shifts and 100% for night shifts in October 2016.
- The planned staffing figures included a supernumerary clinical co-ordinator for twelve hours during the day. At the time of the inspection, there was not a supernumerary clinical co-ordinator during the night shift. GPICS standards state the supernumerary clinical co-ordinator should be on duty 24 hours a day. Additional staffing was included in the unit's expansion plan to meet the GPICS standard.
- The unit did not have a ward clerk so clinical staff had to complete administration duties, for example, answering the telephone and door and filing patient notes. Nurses were supported by one health care assistant who worked Monday to Friday 8am until 4pm.
- Information provided by the trust showed the average bank usage for registered nurses between August 2015 and July 2016 was 0.9%. The unit did not use agency staff; bank staff that worked on the unit were the unit's own staff. This also met GPICS standards.
- The average sickness rate in the service between March 2015 and April 2016 was 3%. Senior staff managed sickness with support from the human resources and occupational health teams in line with the trust's policy.
- The critical care outreach team was staffed for one Band 6 nurse on site between 8am and 8pm seven days a week. Staff told us this was not always achieved with annual leave and sickness.

Medical staffing

- Critical care had a designated clinical lead consultant.
- The consultant establishment was 16 wte. Five of these consultants were intensivists and 11 were anaesthetists. The unit met GPICS requirements for medical staffing between Monday and Friday 8am to 9pm as care was led by a consultant in intensive care medicine. However, the work pattern did not deliver continuity of care as the consultant changed on a daily basis. The service was actively recruiting additional intensivists to meet GPICS standards 24 hours a day, seven days a week as part of the critical care strategy.
- There was no evidence that consultants completed twice-daily ward rounds which was not in line with GPICS.
- Two anaesthetic trainee doctors were on site overnight; one was based on the unit and was supported by the on call consultant. Between 6pm and 8:30am, the doctor had responsibility for critical care and maternity. This was not in line with GPICS or obstetric anaesthetic standards.
- Information provided by the trust showed the average sickness rate for March 2015 to April 2016 was 1% in critical care.
- Information provided by the trust showed the average vacancy rate for March 2015 to April 2016 was 10% in critical care.
- Information provided by the trust showed the average locum usage between August 2015 and July 2016 was 1.6% in critical care.

Major incident awareness and training

- Senior staff were able to clearly explain their continuity and major incident plans. The actions described were in line with the trust's business continuity policy and plans.
- Staff knew how to access the major incident and continuity plans on the intranet.

Are critical care services effective?

Good

We rated effective as good because:

- The service had taken action on the issues raised in the 2015 inspection. For example, patient outcomes, specifically mortality and early re-admissions, had

improved and were in line with similar units. A clinical educator had been appointed and was due to start in January 2017 and staff demonstrated an improved understanding of restraint and consent and worked in line with the trust's policy.
- Care and treatment was mostly planned and delivered in line with current evidence based guidance.
- The service participated in national and local audit.
- Staff were supported to maintain and develop their professional skills. The number of nursing staff who had an up-to-date appraisal was better than the trust's target.
- Seventy two percent of nurses had a post registration qualification in critical care. This was better than the national recommendation.
- We observed patient centred multidisciplinary team working.
- Staff assessed patients' nutritional and hydration needs and met these in a timely way.

However:

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

Evidence-based care and treatment

- The unit's policies, protocols and care bundles were based on guidance from the national institute for health and care excellence (NICE), the intensive care society (ICS) and the faculty of intensive care medicine (FICM). Staff we spoke with demonstrated awareness of the policies and how to access them on the electronic critical care hub.
- The admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.
- The critical care outreach team identified patients to invite to the follow-up clinic in line with recommendations from NICE CG83 rehabilitation after critical illness.
- The sepsis screening tool had been updated in line with NICE guidance, however, at the time of our inspection the trust did not have a planned launch date for the new tool.
- The unit had an up to date delirium policy, however, staff we spoke with were not routinely assessing patients for delirium and there was no evidence of delirium screening in the patient record.

Pain relief

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

Nutrition and hydration

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

Patient outcomes

- We reviewed the Intensive Care National Audit and Research Centre (ICNARC) data from 1 April 2015 to 31 March 2016; the risk adjusted acute hospital mortality ratio was 1.19. This was in line with similar units.
- The units had a 1.3% unplanned re-admission in 48 hours rate. This had improved from our 2015 inspection and was in line with similar units.
- The ICNARC data co-ordinators worked with clinical staff to collect additional information the service used for research and audit.
- The critical care outreach team collected patient outcomes in an electronic database.
- The clinical lead planned to audit the service's compliance with NICE CG83 rehabilitation after critical illness; however, this had not been completed at the time of our inspection.
- The trust provided titles of audits that had been undertaken in 2016. There was an ICU handover audit

and a re-admission and escalation to ICU audit on the list. We requested further details about the audits or the action plans, however, only the registration form for one of the audits was provided.

Competent staff

- Information provided by the trust showed that 98% of registered nurses on ICU had an up to date appraisal. This was better than the trust target of 95%. Staff we spoke with found their appraisal a useful process and gave examples of senior staff supporting their development through the appraisal process.
- Information provided by the trust showed that 100% of registered nurses in the critical care outreach team had an up to date appraisal. This was better than the trust target of 95%.
- Information provided by the trust showed that 79% of anaesthetists had an up to date appraisal. This was worse than the trust target of 95%.
- Information provided by the trust showed that 72% of nurses had a post-registration qualification in critical care. This was better than the GPICS minimum recommendation of 50%.
- The unit had successfully recruited a clinical educator who was due to commence their post in January 2017.
- New members of nursing staff received an induction onto the unit, were allocated two mentors and had a six-week supernumerary period.
- Nurses on ICU completed a local competency package; this was based on the national competency framework for adult critical care nurses.
- Nurses in the critical care outreach team completed local competencies for additional clinical skills, for example, arterial blood gas sampling and nasogastric tube insertion.
- Staff on the unit had link nurse roles, for example, tissue viability and infection control. They attended trust meetings and shared information with staff on ICU.
- The service kept records of staff training for specialist equipment. This training had been delivered by company representatives or senior staff in the absence of a clinical nurse educator.
- Staff in the deteriorating patient team delivered a large amount of education in the trust, for example, high dependency skills for ward based nurses, ALERT and BEACH courses (multi-professional courses that train staff in recognition of patient deterioration and actions to treat the acutely unwell) and tracheostomy training.
- Student nurses we spoke with felt supported by the staff on the unit, specifically by their mentors and they were able to access many learning opportunities.
- Junior medical staff told us they received a good level of training on the unit.
- Senior staff were confident to manage performance issues in line with the trust's policy and with support from occupational health and human resources.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit and at the bedside during our inspection.
- There was a lead physiotherapist, dietitian and pharmacist for ICU. Nursing staff told us they had access to occupational therapy and speech and language therapy when required.
- The unit had a full time and a part time ICNARC audit clerk.

Seven-day services

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

Access to information

- Staff could access guidelines, policies and protocols on the electronic critical care hub.
- Staff were able to access blood results and x-rays through electronic results services.
- Staff completed a discharge document for patients who were transferred to a ward in the trust. This was in line with NICE CG50 acutely ill patients in hospital standard and was due to be reviewed in 2018.

Critical care

- A standard critical care network out of hospital transfer form was completed for patients who were transferred to another trust.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.
- There was evidence in the patient record that staff reviewed sedation regularly. All patients had a sedation score completed where appropriate.
- Staff we spoke with demonstrated an understanding of consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS). They told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patient's capacity.
- Ninety-three percent of staff in the service had completed MCA training. The trust target was 95%.
- At our previous inspection in 2015, we found that two commercial baby monitors which had visual and sound capability, but no recording capacity, were in use in both of the side rooms. At this inspection the monitors were still in use, however, a notice was now on display outside both side rooms informing patients and their relatives about the monitors in line with the trust's policy. Staff we spoke with told us they informed patients and their relatives that the monitor was in use, the reasons for it and recorded this in the patient's notes.
- Staff we spoke with demonstrated an understanding of restraint. We did not see any evidence of restraint in use during our inspection, for example, chemical restraint or mittens. In information provided by the trust prior to the inspection we saw evidence that staff reported the use of mittens as an incident. This was in line with the trust's policy.

Are critical care services caring?

Good

We rated caring as good because:

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

However:

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

Compassionate care

- The unit did not carry out patient surveys. Thank you cards and feedback from patients and relatives were on display.
- We observed curtains being drawn around patients' beds when care and treatment was being delivered to maintain patient privacy and dignity.
- We observed all members of staff responding to patients' requests in a timely and respectful manner.
- During our inspection, we observed that all staff communicated with both conscious and unconscious patients in a kind and compassionate way.
- The patient we spoke with was very happy with the care they had received. They described the staff as 'angels and nothing was too much trouble for them'.

Understanding and involvement of patients and those close to them

- The patient we spoke with told us they had been kept informed of the treatment and progress and that they were involved in the decisions made by the medical team.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- We observed staff explaining to patients what was happening during care delivery. Staff we spoke with felt they were able to support patients and relatives and explain their care to them.
- Staff we spoke with knew the procedure for approaching relatives for organ donation when treatment was being withdrawn.

Emotional support

- 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.

Critical care

- Nursing staff we spoke with told us they felt they needed to provide additional emotional support to relatives at times due to the lack of continuity of consultant cover on the unit.
- The service did not have access to psychological support or counselling services. Staff could refer patients to their GP for support following discharge.

Are critical care services responsive?

Requires improvement

We rated responsive as requires improvement because:

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

However:

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

Service planning and delivery to meet the needs of local people

- The service was actively involved in the regional critical care network.
- Critical care provision was flexed to meet the differing needs of level two and three patients. A planned expansion for an additional four level two beds was due to start in January 2017.
- The rehabilitation after critical illness service was limited. Critical care outreach staff held a monthly follow-up clinic. There was no medical or multidisciplinary input to the follow-up clinic which was not in line with GPICS. If patients needed onward referrals from the follow-up clinic staff made these through the patients GP.
- The service did not have an ICU patient and relative support group.
- A visitors' waiting room was available on the unit which contained information for visitors and water. There was no overnight accommodation available for relatives.

Meeting people's individual needs

- Staff we spoke with knew how to access translation services for patients whose first language was not English.
- The unit had picture cards and aids available to assist with communication.
- Staff we spoke with felt able to support patients with dementia on the unit; they felt the experience they had of caring for patients with critical care confusion and delirium helped. Staff received training on dementia as part of the mandatory training programme.
- The unit had a link nurse for patients with a learning disability. Staff we spoke with felt confident to care for patients with a learning disability and told us of examples when carers had stayed with patients to assist staff to meet their needs.
- Staff could access equipment to care for bariatric patients through a hire company; they told us this arrived promptly and had not experienced delays to patient care.

Access and flow

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

  - There had been six elective cancelled operations between April and October 2016 due to a lack of critical care bed.
  - The service did not keep a record of the number of adult patients ventilated outside of critical care.
  - The ICNARC data from 1 April 2015 to 31 March 2016 showed the unit had transferred 3.5% of patients due to non-clinical reasons. This was not in line with GPICS and was worse than 0.9% in similar units. ICNARC data from 1 April to 30 June 2016 showed non-clinical transfers were 0.8%; this was the same as similar units.
- The ICNARC data from 1 April 2015 to 31 March 2016 showed the bed days of care post-eight hour delay rate was 5.8%. This was about the same as similar units' rate of 5%.
- The ICNARC data from 1 April to 30 June 2016 showed the bed days of care post-eight hour delay rate was 2.3% and the bed days of care post-24 hour delay rate was 0.9%. These were both better than similar units' rate of 5.7% and 3.5%.
- The ICNARC data from 1 April 2015 to 31 March 2016 showed the out of hours discharge to the ward rate was 3.9%. This was about the same as similar units' rate of 3.5%.
- The ICNARC data from 1 April to 30 June 2016 showed the out of hours discharge to the ward rate was 2.7%. This was about the same as similar units' rate of 2.8%.
- The trust had updated the policy for eliminating mixed sex accommodation. This was now in line with Department of Health guidance (November 2010) and stated that patients must be moved from specialist areas within four hours of the decision being made. Staff worked in line with the policy and completed the critical care mixed sex immediate occurrence reporting tool when appropriate.
- We reviewed 21 critical care mixed sex immediate occurrence reporting tool forms completed in the two months prior to our inspection. We found evidence of nine mixed sex accommodation breaches where patients had not been discharged in line with trust policy. Staff did not consistently record the time of discharge. The longest breach on the forms we reviewed was16.5 hours. On every form staff documented the measures taken to promote patients' dignity and that an explanation had been given to the patient.

Learning from complaints and concerns

- The unit had received no formal complaints in the 12 months prior to our inspection.
- Staff we spoke with understood the process for managing concerns and how patients or relatives could make a formal complaint.
- The unit displayed information on how to make a complaint.

Are critical care services well-led?

Good

We rated well-led as good because:

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

However:

- The service had limited formal processes to collect patient or relative feedback.
- Some staff raised concerns about the lack of continuity of care from the medical team and felt this could affect relatives' expectations and experience.

Leadership of service

- Leadership of the service was in line with GPICS standards. There was a Lead Consultant for Intensive Care and the unit had a Lead Nurse.
- Recent changes had been made to the directorate senior management team. All staff we spoke with were positive about the team and found them approachable and visible.
- The management team were very proud of all the staff and the quality of patient care they provided.

- It was clear that staff had confidence in the unit's leadership. All staff we spoke with reported feeling supported by their team and managers.
- Senior nursing staff attended directorate and trust wide ward manager meetings.
- Trainee medical staff told us they felt supported by consultants at all times.
- Senior staff had completed leadership and management courses, appraisal and root cause analysis training. They felt their development needs were met and supported by the senior management team.
- Staff we spoke with were unaware of the trust executive team's "adopt a ward" scheme. Staff we spoke with could not remember seeing a member of the executive team on the unit.

Vision and strategy for this service

- The directorate strategy and objectives were in line with the trust's strategy and objectives.
- There was a clear critical care strategy with focus on compliance with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) and additional obstetric anaesthetic guidance. The strategy recognised risks and focussed on staffing and the access and flow issues the service faced. By 2018/19 the service forecast to be compliant with 69 of the 80 standards; this was an improvement from compliance with 56 of the 80 standards in 2015/16.
- Staff we spoke with understood the vision for the unit was to increase capacity with an additional four level two beds. Senior staff were involved in planning the expansion.
- The senior management team were proud of the ICNARC data, such as reducing the number of out of hours and delayed discharges and the improvements this had made to patient care since the 2015 inspection.
- We observed staff delivering care and demonstrating behaviours in line with the trust's values.

Governance, risk management and quality measurement

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

Culture within the service

- Staff we spoke with told us they were happy in their work, felt supported and valued by their immediate and directorate managers. They felt able to raise concerns and that the culture on the unit was open and honest.
- Staff were proud of the team they worked in and of the care they were able to give to patients and their families. They were aware of the importance of being open and honest and the need to apologise to patients and relatives if there had been a mistake in their care.
- Staff morale had been affected by the movement of nurses from the unit to the wards to cover shortfalls in staffing. We reviewed the records kept of staff movement. In the three months prior to our inspection staff had been moved from the unit to the wards 26 times. This was for periods of two hours to the full shift. Staff had raised their concerns and spoke positively of the changes the new leadership had made, for example, ensuring the moves were fairly distributed and the change to expectations of nurses when moved to the wards, to ensure they were not working outside of their competency.
- Some of the nursing staff we spoke with raised concerns about the lack of continuity of care from the medical rota and felt this could affect relatives' expectations and experience.

Public engagement

- The unit did not complete a formal patient or relative survey.
- Patient comments and thank you cards were on display on the unit.
- Senior staff shared an example of a change made as a result of patient feedback about the noise at night. They ordered sound monitoring devices that attached to the end of patients' beds that visually alert staff when sound levels are too high.
- The unit displayed a "you said, we did" board. This gave an example of a new chair being ordered for the unit as a result of patient feedback.

Staff engagement

- The unit held twice-monthly staff meetings, but attendance could be variable. Senior staff recorded minutes of the meetings and shared them with all staff. Topics discussed at the meetings included incidents, equipment updates and issues staff raised.
- Staff shared information through a secure social media page, a communication book and noticeboard in the staff room. Urgent issues were communicated verbally by the ward manager and nurse in charge at handover.

Innovation, improvement and sustainability

- The service was actively involved in the regional critical care network.
- The unit was the first ward in the hospital that received gold accreditation. This was a new award in the trust in recognition that the unit had achieved and maintained all of the trust's quality standards for at least 12 months.
- The consultant nurse in the deteriorating patient team had developed a business proposal to bring the critical care outreach service in line with national outreach forum operational standards.
- A consultant nurse led the deteriorating patient team which included the sepsis specialist nurse, vascular access specialist nurse and critical care outreach team.

Maternity and gynaecology

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

Information about the service

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

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

The maternity service at SGH provided antenatal, intrapartum and postnatal care. Inpatient maternity care was provided on a mixed ante /post-natal ward (26 beds), an eight bed delivery suite (which had a birthing pool), and a dedicated obstetric theatre.

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

Women received care in the pregnancy assessment centre, where they had their first scan and any other tests required during pregnancy. The centre also dealt with complicated, high-risk pregnancies such as women with hypertension or diabetes. Clinics offered included: smoking cessation, teenage pregnancy, vaginal birth after caesarean section and pre-operative caesarean section clinics.

The maternity service at Scunthorpe and Goole hospital delivered 1,864 babies from November 2015 to October 2016.

Gynaecology services were available and there was a 12-bed ward. Gynaecological services offered medical and surgical terminations of pregnancies. From November 2015 to October 2016, the service carried out 454 medical terminations and 30 surgical terminations.

During our inspection, we spoke with ten patients and 38 staff including senior managers, and service leads, ward managers, midwives, consultants, doctors, nurses, anaesthetists, health care support workers, administrators and domestics. We reviewed 27 sets of maternity records.

In October 2015, the CQC carried out an announced comprehensive inspection. The overall rating of the service was good.

Maternity and gynaecology

Summary of findings

At the last inspection in October 2015, we rated maternity and gynaecology services as good in in all five domains. During this inspection, we identified some concerns that would now make maternity and gynaecology services at Scunthorpe General Hospital as require improvement because:

- The services had not provided assurance that lessons had been learned and embedded following a never event or from serious incidents.
- Midwifery staffing levels were having an impact on patient care and putting women and babies at risk. A number of incidents had been reported in relation to midwifery staffing including delays in inductions and elective caesarean sections and co-ordinators taking clinical caseloads.
- Access to emergency theatres was not consistent or in conjunction with national guidelines. The service did not have a standard operating procedure for obstetric patients accessing theatres out of hours.
- The trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) checklist. From a review of clinical records, it was apparent that this was not consistently embedded.
- The trust used the modified early obstetric warning score (MEOWS) tool to identify deteriorating patients. Results of an audit by the trust found, if a woman required escalation, only 58% of records had evidence of an appropriate referral and management plan.
- We found gaps in daily checking of fridge temperatures and no action taken when temperatures went out of range.
- The service had not addressed staff training on cardiotocography. Following a serious incident, one of the actions identified was additional CTG training (K2 training) for all midwifery and medical staff. This action was due for completion on the 30 October 2016. At the time of our inspection, 35% of medical staff and 38% of midwives had completed the training.
- The percentage of women experiencing third and fourth degree tears following assisted deliveries was above the regional average.
- Midwifery staffing levels were having a negative impact on staff morale and staff sickness levels.
- Governance arrangements did not always allow for identification of risk, for example, accessing theatre out of hours.

However:

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

Maternity and gynaecology

Are maternity and gynaecology services safe?

Inadequate

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

- The trust had not provided assurances of lessons learned following serious incidents that raised concerns around cardiotocography (used to record fetal heartbeat and uterine contraction during pregnancy).
- The service had not provided assurance that lessons had been embedded following a never event which related to a retained swab.
- Actual staffing levels were frequently below planned staffing levels within maternity putting women and babies at risk. A number of incidents had been reported in relation to midwifery staffing including delays in inductions and elective caesarean sections.
- We saw incidents of co-ordinators on the delivery suite taking clinical caseloads and therefore were not always free to support emergency situations and junior staff as they were providing care to women.
- The trust used the five steps to safer surgery procedures including the World Health Organisation (WHO) checklist. From a review of records we found that this was not consistently embedded.
- Access to emergency theatres was not consistent or in conjunction with national guidelines. The arrangements for obstetric patients accessing theatres out of hours were not robust.
- We found gaps in daily checking of fridge temperatures and no action taken when temperatures went out of range. We also found gaps in administration records where midwives had not signed when they had administered medicines.
- Out of hours anaesthetist cover was shared with the critical care unit. We saw evidence of two incidents that resulted in delays to patient treatment.
- Arrangements for assessing and responding to risk were not sufficient. There was a risk that patient safety needs may be overlooked because appropriate prompts were not included in the services escalation of clinical concern document.
- Maternity services used the modified early obstetric warning score (MEOWS) to identify deteriorating patients. The trust's audit found if a woman required escalation, only 58% of records had evidence of an appropriate referral and management plan.
- The service documentation audit showed that patient care records were not always completed in accordance with the trust's policy.

However:

- There were clear safeguarding processes in place and staff knew their responsibilities in reporting and monitoring safeguarding concerns.
- Clinical areas were clean and tidy.

Incidents

- The trust had a policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trust's electronic reporting system.
- The service had a maternity trigger list for incidents and near miss reporting. The list provided guidance to staff about incidents which required escalation to serious incidents.
- Staff were able to describe the process of incident reporting and understood their responsibilities to report safety incidents including near misses. This was reflected in the results of the 2015 National NHS staff survey. The trust scored higher (better) than the national average for staff reporting potentially harmful errors, near misses and incidents.
- A system was in place for staff to receive feedback. Once they had submitted an incident form, staff could tick a box if they wanted feedback.
- Staff said feedback from incidents was shared in a number of ways including team meetings, face to face feedback from managers, emails and a learning lessons newsletter. We saw posters displayed in the staff room summarising lessons learned following a never event and serious incident.
- Staff held weekly case review meetings to discuss incidents such as emergency caesarean sections, instrumental deliveries and shoulder dystocia (difficulty in delivering the baby's shoulders). The reviews were used to discuss cases and identify if any lessons could be learned.
- Incident data provided by the trust showed from September 2015 to November 2016 there were 1140

incidents reported within maternity and gynaecology services at SGH. 65.4% resulted in no harm, 32.8% resulted in low harm, 0.9% resulted in moderate harm and 0.2% resulted in severe harm/death. Analysis of the data showed commonly reported incidents related to be treatment and procedures, access, admission, transfer and discharge and implementation of care and ongoing monitoring and review.

- Serious incidents are incidents that require reporting and further investigation. There were three serious incidents reported to the Strategic Executive Information System (STEIS) between November 2015 and November 2016. One of the incidents related to a breach in confidentiality and two incidents related to unexpected neonatal deaths.
- For each serious incident the service completed a root cause analysis (RCA). An RCA is a structured method used to analyse serious incidents. We reviewed the three investigation reports which identified notable practice, key learning points, recommendations and action plans.
- Some of the RCA investigations did not identify all of the contributory factors that contributed to the root cause. This had an impact on the key learning points. For example, following an incident in May 2016, a category 1 caesarean section was delayed by approximately two hours, whereas the criteria was within 30 minutes from decision, the category 1 caesarean section was required to deliver. The investigation identified that there was no standard mechanism for opening a second obstetric theatre but this was not identified as a key learning point or included in the action plan.
- We had concerns that lessons learned from serious incidents were not embedded within the service or across hospital sites. These concerns were shared with other external stakeholders. Three serious incidents had resulted in an unexpected neonatal death (two were at DPoW and one was at SGH). The investigation reports identified delays in commencing cardiotocography (CTG), delays in recognising CTG abnormality and delays in escalating and responding to CTG abnormalities. (CTG is used to record fetal heartbeat and uterine contraction during pregnancy).
- The trust had arranged an assurance meeting with the local supervising authority (LSA) and head of midwifery to discuss concerns from the serious incidents investigations. The service had agreed to work with the LSA midwife to test out lessons learned. A meeting had been scheduled for 16 December 2016.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There was one never event reported at SGH from October 2015 to September 2016.
- The never event related to a retained vaginal swab in February 2016. We reviewed the RCA and subsequent recommendations. These included: reminding practitioners of their responsibilities for the counting of swabs; creation of a label for recording of fetal blood sampling swabs; and introducing plastic swab packs to aid with the identification and counting of swabs.
- With the exception of two midwives, staff we spoke with were aware of the never event and spoke about changes in practice in relation to swab counts.
- From reviewing clinical records, we were not assured that learning from the never event had been fully embedded. We reviewed 27 sets of records and found that swab counts were not correctly documented in 15 sets (55%).
- A re-audit of swab counts presented at the obstetrics and gynaecology clinical audit meeting in May 2016 provided limited assurance. At SGH 79% of records had both swab checks fully completed. This was below the trust standard of 100%.
- The multidisciplinary maternity documentation audit presented at the service clinical audit meeting in September 2016 reviewed swab counts. The audit found that swab counts were correctly recorded and countersigned in 85% of records for women who underwent suturing and in 79% of records for women who had an operative delivery. This was below the trust target of 100%.
- A simulation exercise to test the actions implemented following the never event was undertaken at SGH on the 24 October 2016. The drill found that the fetal blood sample stickers to record the swab counts were not available. Staff said this had been addressed.
- A further incident reported in October 2016 demonstrated that learning had not been embedded. A patient arrived in theatre and it was noted a swab was missing. This was later located on the central delivery suite. As an action, staff were reminded swabs must be counted before leaving the delivery room.
- The service held monthly perinatal mortality meetings (attended by gynaecology, obstetric and neonatal staff).

We reviewed minutes from May, June and August 2016 and found lessons to be learned were discussed, but no recommendation about how to improve care and treatment was recorded in the minutes.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff spoke about duty of candour and understood the importance of being open and honest with patients. We saw posters displayed raising awareness about the duty of candour on the central delivery suite.
- It was also evident in the serious incident investigations we reviewed that the duty of candour had been applied. Families were invited to attend a meeting with the trust to allow opportunities to discuss all aspects of care and interventions.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for monitoring, measuring and analysing patient harms and the percentage of harm free care. It looks at risks such as falls, venous thrombolysis (blood clots), pressure ulcers and catheter related urinary tract infections.
- We reviewed safety thermometer data for ward 19. Harm free care was reported at 100% from October 2015 to October 2016.
- The maternity safety thermometer allowed maternity teams to monitor and record the proportion of mothers who experienced harm free care. The maternity safety thermometer measured harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar (a check used by midwives and doctors to assess the health of a newborn) of less than seven at five minutes and those who are admitted to a neonatal unit. The service did not submit data to the maternity safety thermometer; however, it was due to commence submitting data in January 2017.
- The central delivery suite did display information on the number of deliveries, the percentage of caesarean sections compared to the national average and breastfeeding rates.

Cleanliness, infection control and hygiene

- From November 2015 up until the time of the inspection there were no cases of Methicillin-Resistant Staphylococcus Aureus (MRSA), no cases of Clostridium Difficile (C. difficile) and one case of Methicillin Sensitive Staphylococcus Aureus (MSSA) within maternity and gynaecology.
- The maternity unit and gynaecology ward were visibly clean. Cleaning records inspected on ward 26, showed evidence cleaning had taken place and satisfactory records were kept for the month of November.
- Staff cleaned equipment after use and used dated 'I am clean' stickers to indicate it was clean and ready for use. For example, on an infant resuscitaire and a breast pump stickers showed the equipment had been cleaned on 18 and 24 November 2016 respectively.
- Ward 26 had a process in place to ensure CTG belts were cleaned after use.
- Laminated cleaning rotas were displayed in all delivery rooms on the central delivery suite. We looked in two delivery rooms and the birthing pool room and saw the cleaning rotas were up to date.
- Hand washing facilities and antibacterial gel dispensers were available at the entrances of wards and there was signage encouraging visitors and staff to wash their hands.
- We observed most staff complying with bare below the elbows policy, correct handwashing technique and use of hand gels in most of the areas we visited. However, we did observe a midwife on ward 26 walking around the ward with gloves and an apron on.
- Results from hand hygiene audits showed that from February 2016 to October 2016 compliance with hand hygiene across all the wards within maternity and gynaecology ranged from 65% to 100%. No action plan was provided with the audit results.
- All clinical areas participated in monthly audits. The audit looked at ten elements including: hand hygiene facilities, the general environment, isolation of infected patients, dirty utility, sharps storage, treatment rooms and patient environment. We reviewed the audit results. In August 2016, the central delivery suite was 94% compliant and ward 26 was 100% compliant. Ward 19 had no results submitted for August 2016, however, results from July 2016 showed the ward was 100% compliant overall.

- Staff followed best practice with infection control and prevention principles in relation to management of clinical waste.
- In the 2015 CQC Maternity Survey, the service scored 9.1 out of 10 for the cleanliness of rooms and wards and 9.1 out of 10 for the cleanliness of toilets and bathroom facilities. Both results were similar scores to the England average.

Environment and equipment

- Access to the central delivery suite and ward 26 was by using an intercom system. Closed-circuit television (CCTV) cameras were installed at the entrances to the central delivery suite and ward 26. This complied with Health Building Note 09-02 – Maternity care facilities (2013).
- The central delivery suite was situated on the second floor and ward 26 was situated on the first floor. Both could be accessed using a lift or stairs. Midwives did not have a priority key for the lift to use in an emergency situation. Staff said they had run emergency drills and they would send a 'runner' to call for the lift.
- Equipment was available to meet people's needs. For example, piped oxygen, breast pumps, blood pressure monitoring machines, and CTG machines.
- Ward 26 was a 26-bedded combined antenatal, postnatal ward and had a combination of single rooms and bays. High-risk postnatal patients were cared for in the bay opposite the nurses' station. This enabled staff to monitor them closely. The ward also had four transitional care beds. This allowed babies to stay with their mothers rather than go to the Special Care Baby Unit.
- The central delivery suite had eight birthing rooms. One room, the butterfly room, had active birth equipment and was used for low risk women.
- A birthing pool was available on the central delivery suite; safety nets were stored in the room. Staff ran a yearly emergency pool evacuation simulation.
- The unit did not have a bereavement room for women and their family who were experiencing the loss of an infant.
- There was a dedicated obstetric theatre located just off the central delivery suite. The theatre was open Monday to Friday from 9am to 5pm. Outside of these hours the service used main theatre which was adjacent to the central delivery suite. The theatre was staffed by a theatre team 24 hours a day, 7 days a week and was used by other specialities. Staff said, if needed, a second theatre could also be opened.
- The service did not have a standard operating procedure to support the use of theatres out of hours. It was not clear how clinical cases were prioritised out of hours when the obstetric theatre was closed. We reviewed a serious incident in which a category 1 caesarean section was delayed because an orthopaedic case was in one theatre and another obstetric case was in a second theatre. The RCA found that the delay in performing the category 1 caesarean section was due to clinical decision making. There was no standard operating procedure (SOP) in place to support accessing theatre out of hours or the clinical decision making process.
- Further information provided by the trust showed from November 2015 to October 2016 there was one other case where a category one caesarean section was not undertaken within 30 minutes. The reason for the delay was not given.
- Staff were unable to tell us how many times the main theatre had been utilised for obstetric cases. The senior management team said they were developing a business case to have a dedicated obstetrics theatre open 24 hours a day.
- We were supplied with a draft protocol for emergency theatre booking during our unannounced inspection; however, this had not been approved and was not a cross-site document.
- The neonatal unit was situated in close proximity to the labour ward. Staff we spoke with informed us that paediatric staff could attend emergencies quickly.
- Adult resuscitation trolleys were easily located on the main corridors in each of the areas we visited. We checked the adult resuscitation trolleys and found with the exception of three dates, 4 June, 7 November and 21 November 2016, daily checks had been completed in line with best practice.
- Paediatric resuscitaires were available and daily checks had been completed however, we saw when equipment was not available, staff had not recorded the action they had taken. For example, for three days in November the stethoscope and stoma adhesive were not on the trolley. We discussed this with staff at the time of the

inspection and it had been reported to the person in charge. This information had not been recorded in the daily record. This could have meant in an emergency situation the equipment would not have been available.
- Ward 19 had twelve inpatient gynaecology beds, two chairs for day case procedures and a treatment room. The ward had four side rooms with en-suite bathrooms.
- We checked 13 pieces of equipment including observation machines, CTG machines, ultrasound machines, bladder scanners and suction machines. We found all equipment had visible evidence of electrical testing indicating safety checks and when it was next due for servicing.

Medicines

- We checked the storage of medications on the wards we visited. We found that the majority of medications were stored securely in appropriately locked rooms and fridges.
- On our previous inspection we found intravenous fluids stored in an unlocked cupboard on the central delivery suite. During our inspection we found intravenous fluids were stored securely with access restricted to authorised staff.
- Controlled drugs were appropriately stored with access restricted to authorised staff. Accurate records were maintained and we found balance checks were carried out regularly in accordance with the trust's policy.
- In the majority of areas medications that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures in accordance with national guidance. We saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range.
- However, on ward 26 records showed fridge temperatures had been outside of the recommended range on four occasions in November and six occasions in October 2016. No action had been recorded in response to this. We raised this with the nurse in charge who was unaware the fridge temperature had been out of the recommended range.
- We reviewed five prescription charts and found a number of gaps in administration records where midwives had not signed when they had administered medicines. In addition, two patients had not received an injection used to thin the blood as it had been prescribed. This increases the risk of blood clots following surgical procedures. We raised this with the ward manager at the time.
- We reviewed a further three prescription charts. Allergies were clearly recorded on the prescribing documentation used. On two of the charts patients were receiving intravenous fluids. The intravenous fluid batch numbers had not been recorded on both records. If the patient had a reaction to the infusion, without the batch number of the fluid used, the investigation as to the cause could be delayed.
- On ward 26 the Entonox and oxygen cylinders were stored inappropriately in a linen room which was unlocked.
- Patients were routinely encouraged to manage their own medicines. We saw appropriate risk assessments were completed; however staff did not always record self-administered medicines on drug cards.
- On the central delivery suite we found guidance for staff administering medication under patient group directions (PGD's) had expired. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a pre-defined group of patients without them having to see a doctor. Staff were unaware of the process for PGD's.
- From September 2015 to August 2016, Women's and Children's group reported one serious incident relating to medication errors. We reviewed the incident and found this came under the paediatric speciality.

Records

- Women had a complete record of antenatal test results in their hand-held maternity records in accordance with NICE quality standard 22.
- Maternity records included appropriate antenatal risk assessment to identify any medical, obstetric, or psychological risk factors including venous thromboembolism (VTE) risk assessment.
- The 'fresh eyes' approach was used to review CTG's. Fresh eyes involved a second person reviewing the trace and aimed to improve the accuracy of CTG interpretation. The service had introduced antenatal and intrapartum stickers to allow midwives to record the minimum data set.
- The trust's guidelines on CTG for continuous electric fetal monitoring states an hourly systematic assessment

of the CTG trace must be recorded and that every two hours the practitioner providing care must seek the assistance of a colleague to systematically review the CTG trace.

- We reviewed 15 sets of records to review CTG's and found in 6 (40%) sets there was no evidence of hourly CTG review or that fresh eyes had been completed.
- A review of fetal monitoring was included in the service's multidisciplinary maternity documentation audit, which was presented at the service clinical audit meeting in September 2016. In relation to fresh eyes the audit found that in only 58% of cases fresh eyes were provided and recorded at least two hourly. An action plan was not included in the audit.
- The service had introduced situation, background, assessment, recommendation (SBAR) stickers to document when handing care over between staff.
- On the central delivery suite we found some patient records left on a trolley in an open room. This room could be easily accessed and there was a risk that confidential information could be accessed. We informed the ward manager who moved the records.
- We reviewed the multidisciplinary maternity documentation audit presented at the service clinical audit meeting in September 2016. The audit reviewed 247 sets of records of women who had delivered from March 2015 to July 2016. The aim of the audit was to assess compliance against basic record keeping standards and assess care provided during the antenatal, intrapartum and postnatal periods.
- In relation to general record keeping the audit found eight out of the 13 standards scored below 90%. For example, 64% of records had the clinicians/midwives designation documented.
- In relation to antenatal care, 14 out of the 29 standards scored below 90%. For example, 88% of records had a birth plan completed and only 71% of records had a completed antenatal risk assessment tool with a review at each appointment.
- In relation to intrapartum records, including electronic fetal monitoring, 32 out of 68 standards were highlighted as non-compliant. For example, recording observations during the second stage of labour.
- The audit also reviewed swab counts. For women who underwent suturing, swab counts were correctly recorded and countersigned in 85% of records. For women who had an operative delivery swab counts were correctly recorded and countersigned in 79% of records.
- In relation to postnatal care records, 16 out of the 20 standards scored below 90%. For example, in 50% of records the breast feeding assessment page was fully completed and in 58% of records there was evidence that care plans were reviewed at each appointment.
- The action plan and recommendation from the audit were still to be agreed. Further information provided by the trust included a copy of the services action plan.

Safeguarding

- There were processes in place to safeguard women and babies. The service had a named safeguarding midwife who supported staff with the safeguarding process.
- The trust's safeguarding policy provided a framework for all staff when identifying, responding to and reporting any aspects of safeguarding.
- Staff we spoke to knew how to escalate safeguarding concerns. Staff could articulate what they would escalate and what types of things they would look for.
- Information was displayed in ward areas with a contact number for people if they had a safeguarding concern.
- Community midwives had 1:1 safeguarding supervision with the safeguarding midwife. All community midwives attended monthly safeguarding meetings with the safeguarding midwife. Compliance with safeguarding supervision for community midwives was 44%.
- We saw a screening tool used in the antenatal period, for identifying domestic abuse. The female toilet in the antenatal day unit had a poster about domestic violence and a contact number for women if they had concerns.
- Safeguarding level 3 training included FGM training and training on child sexual exploitation (CSE).
- We saw a poster displayed on the entrance to the central delivery suite about CSE and included a number to contact if people had concerns.
- Training data provided by the trust showed 74.5% of staff had completed safeguarding adults level 1 training, 91% had completed safeguarding children level 1 and level 2 training and 86.4% had completed safeguarding children level 3 training. The trust target was 95%.

- Staff were aware of the trust's abduction policy, which detailed actions to be taken in the event of a baby being taken. However, neither ward 26 nor the central delivery suite ran any live drills of the abduction policy.
- Teenagers who presented to the pregnancy advisory service were referred to the safeguarding team.

Mandatory training

- The trusts mandatory training consisted of 13 topics and included fire safety, infection and prevention control, moving and handling, information governance, conflict resolution and resuscitation. Overall compliance within the Women's and Children's group for maternity was 87%; this was below the trust target of 95%.
- We reviewed training data for staff groups and found compliance rates ranged from 69% to 100%. Training percentages for medical staff within obstetrics and gynaecology were 78% and 69% respectively. This was below the trust target of 95%.
- Midwives of ward 26 achieved 86% compliance, community midwifery teams achieved 87% and midwives on the central delivery suite were 93% compliant with training. Specialist gynaecology nurses were 100% compliant.
- Staff said they could access the trust's mandatory training either through an electronic learning system or could attend face to face training. Staff said it was challenging completing mandatory training due to staffing levels. Information provided from the trust following the inspection stated that staff had been 'pulled away' from mandatory training to work on the unit to mitigate short staffing issues.
- All staff could access their mandatory training record and received alerts to indicate when training was due. Ward managers could monitor mandatory training compliance.
- Midwives, medical staff and healthcare assistants (HCA) attended an annual obstetric skills and drills training session. This covered topics such as cord prolapse, pre-eclampsia and post-partum haemorrhage.

Assessing and responding to patient risk

- Within maternity and gynaecology services staff used the modified early obstetric warning score (MEOWS) and the national early warning score (NEWS) respectively to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient's clinical condition was changing and prompted staff to get medical support if a patient's condition deteriorated.
- We reviewed the services process for escalation of clinical concern and found this was not robust. There was insufficient guidance on the documentation as to what constituted a clinical concern.
- The trust audited MEOWS as part of their maternity documentation audit which was presented at the service clinical audit meeting in September 2016. The audit reviewed 247 sets of records and found 79% of women had a MEOWS completed immediately after delivery, and 73% had a MEOWS completed between six and 12 hours post-delivery. The audit found if a woman required escalation, only 58% of records had evidence of appropriate referral and a management plan. The audit did not include an action plan.
- We reviewed MEOWS charts in 13 sets of records and found that that MEOWS scored had been calculated correctly and patients had been escalated when appropriate.
- The hospital used the five steps for safer surgery procedures including the World Health Organisation (WHO) safety checklist. The surgical safety checklist is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications.
- The service completed an audit to assess compliance with the safety checklist for women undergoing surgical procedures and presented it to the clinical audit group in August 2016. 12 maternity cases and 10 gynaecology cases were reviewed at SGH. Within gynaecology the audit found 80% compliance in all areas of the checklist. Within obstetrics, 58% of records were compliant with all aspects of the checklist. The audit stated that recommendations and an action plan were still to be agreed.
- We reviewed the safer surgery checklist in 24 sets of records and found it was not fully completed in 13 sets (54%).
- Findings of three serious incidents (two at DPoW and one at SGH) that resulted in unexpected neonatal deaths found delays in commencing CTG's, delays in recognising CTG abnormality and delays in escalating and responding to CTG abnormalities.
- Following the serious incidents, actions taken by the trust included a review of the guidelines for continuous electrical fetal monitoring in labour, the development of

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

- The trust's guidelines on CTG for continuous electrical fetal monitoring stated an hourly systematic assessment of the CTG trace must be recorded and that every two hours the practitioner providing care must seek the assistance of a colleague to systematically review the CTG trace.
- We reviewed 16 sets of records to review CTG's and found in 5 (31%) sets there was no evidence of hourly CTG review or that the 'fresh eyes' process had been completed.
- A review of fetal monitoring was included in the services multidisciplinary maternity documentation audit, which was presented at the service clinical audit meeting in September 2016. In relation to fresh eyes the audit found that in only 58% of cases fresh eyes were provided and recorded at least two hourly. 53% of records had evidence of hourly reviews and annotation of events and if a CTG trace was suspicious, action taken was recorded on the trace in 82% of records.
- A further audit provided by the trust reviewed 66 cases and found 55 (83%) cases had fresh eyes reviews recorded every 2 hours.
- We reviewed information relating to post-delivery suturing. We reviewed the trust's guideline and definition of perineal trauma and repair and it stated 'repair perineal trauma as soon as possible after birth to minimise blood loss and the risk of infection.' Data provided by the trust showed one patient had experienced a delay however, when we reviewed the services incident data, from September 2015 and October 2016, there had been seven incidents reported at SGH. For example, on the 27 May 2016 a patient waited one hour and forty-five minutes and subsequently experienced 1800 ml estimated blood loss. In June 2016, we saw an incident where a patient waited over four hours for the repair of a third degree tear, but the incident was reported as no harm.
- Staff said consultant obstetricians were available out of hours for emergency caesarean section and if a patient's condition gave rise for concern.
- Midwives completed risk assessments at booking to identify women with any medical, obstetric, psychological or lifestyle risk factors, to help determine if an individual was high or low risk.
- The central delivery suite was responsible for triaging women who contacted the service. A standard operating procedure for telephone triage was in use and a call screening maternity assessment record was completed. Women were booked in for assessment either on the antenatal day unit or, outside of their opening hours, on ward 26.
- Women could contact the central delivery suite out of hours for advice and reassurance.
- The trust had a policy for the emergency transfer of women from a community setting to the hospital.

Midwifery staffing

- The Royal College of Obstetricians and Gynaecologists (RCOG) standards for The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour recommend a ratio of one midwife to 28 births (1:28). Information on the Women's and Children's reporting dashboard showed the midwife to birth ratio was 1:32. Information provided by the trust following the inspection stated that following interviews on the 28 October 2016, (and if the service had no short-term sickness) the midwife to birth ratio would be 1:25.
- Staffing of the maternity service was reviewed using the Birthrate Plus® midwifery workforce planning tool in accordance with the recommendations and procedures outlined in the National Institute for Health and Care Excellence (NICE) safe staffing guidelines. The maternity service undertook A Birth Rate establishment review in 2014 based on 2013 data.
- Following consultation with staff, on the 10 October 2016, maternity services introduced a new midwifery staffing model. The model aimed to increase continuity of care for women and involved midwives on ward 26 moving onto the central delivery suite, and remaining with the woman until she delivered.
- The establishment following the introduction of the new staffing model included a team of core midwives based on the central delivery suite, consisting of one co-ordinator, a healthcare assistant and a midwife. Ward

26 had six midwives and a healthcare assistant on early, late and night shifts. They also had an additional midwife working from 9am to 5pm to support the increased daytime activity.

- The policy for safe staffing levels for obstetricians, midwifery and support staff had not been updated to reflect the new staffing model. Following our unannounced inspection, we received a copy of the policy that reflected the changes to the service. However, the version number, date approved and date of version remained unchanged.
- As part of the new staffing model and escalation process, it was accepted that ward 26 could go down to two midwives. This was not reflected in the services policy for safe staffing levels.
- Staff said when ward 26 was reduced to two midwives it could feel unsafe due to the ward caring for high risk postnatal ladies and high risk antenatal ladies undergoing induction of labour.
- Staff gave an example of a near miss when the ward was reduced to two midwives. Staff were delayed in commencing CTG's (used to monitor fetal heart rate) on a woman who was admitted for an induction of labour. When this was commenced the trace was non-reassuring and the woman was taken to theatre for an emergency caesarean section.
- Staff said staffing levels had been a challenge since the introduction of the new staffing model. Issues with staff sickness, increased activity, vacancies and patient acuity had led to challenges maintaining planned staffing levels.
- We found planned and actual staffing levels were displayed on the entrance to all wards. During our inspection, actual staffing levels did not match planned staffing levels on ward 26 or the central delivery suite. The unit had pulled in midwifery staff from the community as part of their escalation policy.
- We reviewed planned and actual midwifery staffing levels from 01 August 2016 to 31 October 2016. On ward 26, out of 92 days, 27 days had above the planned staffing level and 65 days had below the planned staffing level. On the central delivery suite, out of 92 days, 43 days had above the planned staffing levels and 49 days had below the planned staffing levels.
- Staff we spoke with had concerns about staffing levels and felt that they were impacting on patient care. We reviewed incident data from August 2016 to November 2016 and found 47 incidents relating to staffing had been reported. 20 of these incidents were since the new staffing model had been implemented.
- As part of the escalation policy inductions of labour and elective caesarean sections were delayed at times of short staffing. We reviewed incident data from the trust and found from August 2016 and November 2016 there had been seven delays in elective caesarean sections (6 following changes to the staffing model) and 20 delayed inductions of labour (16 of these were following the changes to the staffing model).
- We saw examples of high risk women having their induction delayed. For example, on 16 October 2016 an incident was reported that stated a woman with two episodes of reduced fetal movements and raised blood pressure was delayed. Staff had monitored the woman using CTG to mitigate the risk. Another incident reported on the 26 October 2016 stated two high risk women were admitted for inductions of labour but due to a lack of midwives only one could be induced.
- RCOG guidelines state that co-ordinators should be supernumerary. Incident data from August 2016 and November 2016 showed six occasions when co-ordinators had to take a clinical caseload and were unable to carry out reviews and 'fresh eyes'.
- Staff felt that staffing levels were having a negative impact on staff morale and that the reliance on bank staff was having an effect on staff sickness. Data provided by the trust showed staff sickness on ward 26 had increased from 7.5% in November 2015 to 13.3% in October 2016. Staff sickness on the central delivery suite had increased from 0.7% on November 2015 to 4.1% in October 2016.
- As part of the maternity staffing escalation policy, community midwives covered the acute hospital at times of short staffing. We reviewed incident data and found there had been 16 occasions where community midwives had been called in from August 2016 to November 2016. This had impacted on the service and information provided by the trust showed six women were unable to have a home birth due to suspension of the service from December 2015 to November 2016.
- We reviewed planned and actual staffing hours for community midwifery teams. In May, June, July and August 2016 the total actual hours for both registered midwives and healthcare assistants were below the planned staffing hours. For example, in August 2016, the

planned hours for registered midwives was 2595 and the actual hours were 2284.33.The fill rates for this month were 88%. The planned hours for Healthcare assistants were 825 and the actual hours were 615.The fill rates were 74.6%.
- From August 2015 to July 2016, the trust reported bank and agency usage rate at Scunthorpe General Hospital as ranging from 0.1% to 1.6%.
- Staff said within maternity they had 1.95 wte permanent vacancies and 3.65 wte temporary vacancies.
- Ward managers said they had escalated their concerns about staffing levels within maternity to the senior leadership team. Staff felt they were listened to but had not taken on board suggestions to improve staffing levels.
- Following the inspection the service provided further information to outline some of the actions taken to mitigate short term staffing issues. These included, pulling staff away from mandatory training, daily staffing reviews, covering long term sickness with temporary posts and the recruitment of three new midwives.
- Following our inspection, due to further deterioration in staffing levels, short term staffing issues were added to the services risk register.
- Despite challenges around staffing, data provided by the trust showed that from November 2015 to October 2016, 97.6% of women received 1:1 care in labour.
- The 2015 maternity survey asked women if they felt a member of staff helped them in a reasonable amount of time during labour and birth. The trust scored 9.1/10 which was about the same as other trusts.
- We observed a morning handover on the central delivery suite. It was well-attended and there was a sign in book to ensure that appropriate staff attended. The handover was detailed and concise.

Medical staffing

- The average number of hours a week consultant cover on labour ward was 60 hours. This was in line with recommendations by the Royal College of Obstetricians and Gynaecologists for the number of deliveries.
- There was dedicated consultant presence on the labour ward Monday to Friday 9:00am to 7pm and from 9am to 2pm on a weekend. There was a resident on call consultant outside of these hours.
- Staff reported the consultant obstetricians were available when needed and patients said they received consultant and medical care which met their needs.
- There was no designated medical cover for the antenatal day unit. When a doctor was required staff would contact the registrar for obstetrics or gynaecology.
- From April 2015 to April 2016, the proportion of consultant staff working at the trust was lower than the England average. The proportion of junior (foundation year 1-2) staff reported to be working at the trust was higher than the England average.
- From October 2015 to September 2016, the trust reported a vacancy rate of 1.8% in gynaecology and of 5.6% in maternity at SGH.
- From August 2015 to July 2016, the trust reported a bank and locum usage rate of 0.9% in maternity and 1% gynaecology.
- We saw evidence of an induction checklist for locum staff.
- Dedicated anaesthetic cover was available on the labour ward during the day. From 6pm to 8:30am, anaesthetic cover was available with the anaesthetist also providing a service to the critical care unit and theatres. There was an additional on call anaesthetist if required.
- RCOG guidelines state that there must be a 'duty anaesthetist' immediately available for the obstetric unit 24 hours a day.
- Staff said out of hours anaesthetists responded in a timely manner however, we did see two incidents reported at SGH in September and December 2015 resulted in delays to patient. One patient was unable to have an epidural and another patient with a retained placenta was delayed going to theatre.
- A multidisciplinary handover took place on the central delivery suite. We observed the handover and saw this was well-attended. There was a sign in book to ensure that appropriate staff attended. The handover was detailed and concise.

Major incident awareness and training

- The trust had appropriate policies with regard to major incident planning. These policies detailed actions to be taken and key contact information to assist staff in dealing with a major incident.
- Staff we spoke with knew how to access the major incident policy.

Maternity and gynaecology

- Medical staff and midwives attended yearly skills and drills training in neonatal and obstetric emergencies. These enabled staff to maintain skills in a range of emergency situations, for example, maternal collapse, neonatal resuscitation and haemorrhage.
- Escalation plans for maternity services were in place to manage staff shortages and potential closures of the unit. We found that the service had not updated the policy for safe staffing levels for obstetricians, midwifery and support staff to reflect the changes to the staffing model.

Are maternity and gynaecology services effective?

Requires improvement

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

- The service had not addressed staff training on cardiotocography. Following a serious incident, one of the actions identified was additional CTG training (K2 training) for all midwifery and medical staff. This action was due for completion on the 30 October 2016. At the time of our inspection, 35% of medical staff and 38% of midwives had completed the training.
- The percentage of women experiencing third and fourth degree tears following assisted deliveries was above the regional average.
- Only 45% of medical staff were up to date with obstetric skills and drills training.
- Due to lack of scanning capacity, the service was unable to implement Royal College of Gynaecology Guidelines – Small for Gestational Age Fetus, Investigation and Management.

However:

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

Evidence-based care and treatment

- Policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Examples of guidelines we reviewed included bladder care guidelines and major obstetric haemorrhage guidelines. All guidelines had a review date with version control and the author was clearly identified.
- All staff could access guidelines, policies and procedures on the trust's intranet website.
- Policies and guidelines for ratification were discussed at the obstetrics and gynaecology clinical governance meeting.
- The service reviewed its compliance against thirteen NICE quality standards. Of the thirteen standards the service declared itself fully compliant with four of the standards and partially compliant with seven of the standards. The service had not yet assessed itself against two of the standards. Quality standards that the service were partially compliant with included: QS109: Diabetes in pregnancy, QS35: Hypertension in pregnancy, QS22: Antenatal care, QS46: Multiple Pregnancy: Twin and Triplet Pregnancies and QS69: Ectopic pregnancy and miscarriage.
- The trust had implemented changes to practice following the saving babies lives in Northern England (SABINE) study. The midwifery teams had implemented standardised fundal height measurements and plotting on a customised growth chart.
- The service had introduced carbon monoxide (CO) monitoring in line with NICE PH26, smoking: stopping in pregnancy.
- A sepsis care bundle and sepsis management guidelines were available.
- The services risk register identified that they did not have adequate resources to implement RCOG

Guidelines – Small for Gestational Age Fetus, Investigation and Management. The service did not have enough capacity to offer women the required number of scans. The trust had completed a business case to recruit additional sonographers and for midwives to be trained in scanning.
- The service audited compliance with The Abortion Act 1967. This included the completion of Certificate HSA1 forms. The trust reviewed the health records of 40 women who were admitted for a medical termination of pregnancy or a surgical termination of pregnancy during a one month period in 2015. The audit found 100% of women received an outpatient appointment within five working days, a data scan was performed in 100% of cases and HSA1 forms were completed and signed by two registered medical professionals prior to treatment commencing in 100% of cases.
- Women attending the antenatal day unit were provided with information relating to fetal movements in line with national recommendations.

Pain relief

- There were several methods of pain relief available to women in labour. Women said they were provided with information about pain relief during their pregnancy.
- A birthing pool was available on the labour ward.
- Nitrous oxide and oxygen (Entonox®) was piped directly into all delivery rooms and opiates were also available. A 24 hour epidural service was provided.
- Written information about epidurals was available for women on the central delivery suite. The information was also available in different languages.
- All women said they were able to access pain relief in a timely way, analgesia was offered regularly and their pain was well managed.
- Educational childbirth preparation classes were available for expectant parents. One of the topics covered was stages of labour including pain relief options.
- Women who had undergone gynaecological procedures said they received sufficient pain relief and nursing staff responded to requests for pain relief promptly.
- Clinical records showed staff assessed patients' pain throughout labour. On the gynaecology ward, pain scores were recorded on the NEWS charts.

Nutrition and hydration

- The trust's dashboard figures showing the breastfeeding initiation rates had been combined with the Goole Midwife led unit. From November 2015 to October 2016, the rate ranged from 54.2% and 66.5%. This was below the trust target of 74.4% and the England average of 76%.
- The United Nations Children's Fund (UNICEF) baby friendly initiative is a global accreditation programme developed to support breast feeding and promote parent/infant relationships. The service was level two accredited and was due to be reassessed for level three accreditation in January 2017.
- Ward 26 had educational information about breast feeding displayed. There was an infant feeding room that new mums could use to prepare feeds.
- Healthcare assistants were trained to support new mums breastfeeding, using expression pumps and bottle feeding. The North Lincolnshire breastfeeding and babies extra support team also worked on ward 26 and provided additional support to new mums.
- Women said they felt well supported and educated about feeding. Women said staff had shown them how to make up formulas and felt supported with breastfeeding.
- The service had an infant feeding co-ordinator who was responsible for the co-ordination of infant feeding practices and provided educational sessions to women and their partners.
- Women had no concerns about the food and told us that different dietary and religious requirements were catered for.
- Maternity services had a dedicated area on the trust website. There was a wide range of information and videos available on the website about breastfeeding including maximising breast milk and hand expression.

Patient outcomes

- The trust did not have any active maternity outlier alerts. 'Outlier alerts' are a description used to describe when a service lies outside the expected range of performance. However, the trust had reported a number of serious incidents resulting in poor outcomes including unexpected neonatal deaths.
- The trust's Women's and Children's reporting dashboard provided information on a range of clinical indicators. The dashboard for SGH was combined with Goole hospital.

Maternity and gynaecology

- The maternity service at Scunthorpe and Goole hospital delivered 1,864 babies from November 2015 to October 2016.
- We reviewed the dashboard and saw from November 2015 to October 2016 the average rate for normal vaginal deliveries was 68.5%. This was better than the trust target of 60.9%. The average rate of instrumental deliveries was 5.9%; this was better than the trust target of 12.7%.
- For the same reporting period, the hospital had an average elective caesarean section rate of 7.9%; this was better than the trust target of 11% and an average emergency caesarean section rate of 14.6%. This was better than the trust target of 15.2%.
- From November 2015 to October 2016, the rate of 3rd and 4th degree tears at SGH and Goole ranged from 0.9% to 6.1% for normal deliveries and 0% to 28.6% for assisted deliveries. The service had no set targets on their dashboard for this clinical indicator.
- The percentage of postpartum haemorrhages above 1500mls ranged from 0.6% to 2.3%. There was no target set by the trust for this clinical indicator.
- The trust participated in the Yorkshire and Humber regional performance dashboard; this allowed comparison with other hospitals in the region and help identify trends and patient safety issues. This was in accordance with recommendations of the Royal College of Obstetricians and Gynaecology 2008.
- The Yorkshire and Humber maternity dashboard RAG rated the service as red for 3rd and 4th degree tears in assisted births, and amber for 3rd and 4th degree tears in normal births. Third and fourth degree tears following an assisted birth was 12.5% compared to a regional average of 5.4% and in normal births was 3.1% compared to a regional average of 2.5%.
- In November 2016 the service audited 3rd and 4th degree tears. Recommendations from the audit included: episiotomies with instrumental deliveries, continuing with daytime consultant supervision of trainee doctors during assisted deliveries and to include a demonstration of the instrumental delivery procedure during trainee doctor's inductions. The service planned to repeat the audit in 12 months.
- From January 2016 to October 2016, the number of unexpected admissions to NICU was 52. The data did not state the number of full term babies.
- The National Neonatal Audit Programme (NNAP) included two questions that applied to maternity services. The 2015 report indicated that the hospital was achieving 95% compliance with recording babies' temperature within an hour of birth; this was below the target of 98%. The hospital achieved 95% compliance for the percentage of mothers receiving a dose of antenatal steroids; this was above the target of 85%.
- Data provided by the trust showed the stillbirth rate for each 1000 births had reduced from 6.5% in 2013, to 3.5% in 2016 which was below the threshold of 4.7%. This reduction was felt to be as a direct response to the implementation of the SaBiNE care bundles.
- Maternal deaths, re-admissions rates or unplanned admissions to ICU were not recorded on the trust's dashboard. We requested this data from the trust. They reported no maternal deaths but did not provide information on the number of unplanned admissions to ICU or re-admission rate.
- The trust's target for home delivery rate was 2.2%. From November 2015 to October 2016, the hospital achieved this rate in February 2015 (5.1%), June 2016 (2.2%), August 2016 (2.8%), September 2016 (3.1%) and October 2016 (2.2%).
- From April 2015 to March 2016 across the whole service, 283 births were to mothers under the age of 20. This equated to 6.5% of all births and was higher than the England average of 3.4%. There were 3,517 births to mothers aged 20-24, this equated to 80.6% of all births and was higher than the England average of 75.4%.
- The Yorkshire and Humber maternity dashboard RAG rated smoking at booking and smoking at time of delivery as red. The percentage of women smoking at the time of booking was 22.3% compared to a regional average of 17.3% and the percentage of women smoking at time of delivery was 21.5% compared to a regional average of 14.6%. Carbon monoxide monitoring was offered by community midwives and women were referred to a stop smoking practitioner.
- In November 2015, the service audits compliance with six different screening programmes including: infectious diseases, Down syndrome/fetal anomaly, sickle cell and thalassaemia, newborn hearing, newborn blood spot and newborn physical examination screening. The audit reviewed 26 sets of records and carried out a patient survey. The audit found good compliance; 98% of women were offered each of the screening programmes, 97% of women had the offer for screening within the

agreed timescale, 96% of women had the results documented and 100% of women who had a positive screening result were referred for treatment in the appropriate timescale.

Competent staff

- At the time of our inspection, 86.2% of midwives and healthcare assistants and 66.7% of medical staff had completed an appraisal. 100% of medical staff within gynaecology had completed an appraisal.
- The majority of staff we spoke with said they had completed an appraisal or were expecting one in the future. Staff said the appraisal process was valuable and allowed them to discuss their development and learning needs.
- Midwives, medical staff and healthcare assistants attended an annual obstetric skills and drills training session. This enabled staff to maintain skills in a range of emergency situations and covered topics such as cord prolapse, pre-eclampsia and post-partum haemorrhage. Training data showed 82% of midwives had completed the training, however only 45% of medical staff had completed the update.
- All midwives must have a supervisor of midwives (SOM). Their role is to provide support and guidance for all practicing midwives. National recommendations for the number of SOM to midwives is 1:15. At the time of our inspection the ratio of supervisors to midwives was 1:11.
- All midwives said they had a designated SOM. Staff confirmed they had access to a supervisor of midwives for advice and support 24 hours a day.
- The LSA report complied in January 2016 confirmed that for the practice year five or more midwives had not completed their annual review. The report found that statutory supervision was very effective but the SOM needed to ensure all midwives were up to date with their annual reviews.
- The service had a clinical skills and governance midwife in post.
- The trust offered two types of CTG training, one of which was mandatory and the other was additional training known as a K2 training package (an interactive computer based training system that covered CTG interpretation and fetal monitoring). At the time of the inspection, 72% of midwives and 37.5% of medical staff had completed the mandatory training.
- One of the themes identified following a serious incident was CTG misinterpretation. One of the recommendations was for all medical and midwifery staff to complete the K2 training package. The timescale for completion was 30 October 2016. Training data provided by the trust showed 35% of medical staff and 38% of midwifery staff had completed the training at the time of inspection.
- Medical staff could attend obstetrics and gynaecology training sessions. We saw a poster displayed informing staff of the training dates.
- The trust had a preceptorship programme for newly registered staff. The midwifery preceptorship document outlined specific competencies and training for midwives.
- We spoke to midwives who were working through their preceptorship programme and they said they had a mentor to support them through the process. Some midwives said at times it was challenging to get the support due to staffing levels. Staff said they were supernumerary for three weeks and spent time in different clinical areas, however, some staff reported not always feeling supernumerary due to staffing levels on ward 26.
- Maternity services had a number of new band 7 co-ordinators in post. Staff said they did not have a formal documented competency programme but they felt supported in their new role.
- The previous inspection identified gynaecology patients had been receiving care and treatment on the antenatal ward, staff reported that gynaecology patients were no longer cared for on the ward with the exception of women with hyperemesis.
- Nursing staff said they felt supported in the revalidation process.

Multidisciplinary working

- We saw evidence of multidisciplinary working within clinical areas. All necessary staff and teams were involved in assessing, planning and delivering patients care and treatment.
- Staff described good working relationships with the medical staff in the care of patients and said they worked well together as a team.
- Systems were in place to ensure communication between the hospital-based midwives and community-based midwives on discharge. Communications with GPs, community midwives and health visitors included summaries of antenatal, intrapartum and postnatal care.

- At the previous inspection, co-ordinators were rotating across sites to share practice and promote a trust approach to service provision. During the inspection staff said this was no longer taking place.
- Anaesthetists attended the multidisciplinary team handover on the central delivery suite and were made aware of any high risk women.
- Midwives used the SBAR tool (situation, background, assessment, recommendation) when handing over the care of women. SBAR stickers were used in patients' records to document the handover.
- Following the introduction of the seamless model of care, staff reported closer working relationships between the midwives on ward 26 and the central delivery suite.
- Staff said they could access support and advice from specialist nurses and confirmed there were systems in place to request support from other specialities such as pharmacy and the critical care outreach team.
- Staff worked closely with children's services to care for babies admitted to the transitional care unit. (Transitional care is where babies who need a little more nursing care and monitoring can stay).

Seven-day services

- There was a consultant presence on the central delivery suite from 9:00am until 7:00pm on weekdays. There was designated consultant on call cover outside of these hours.
- Access to a dedicated obstetric theatre team was available Monday to Friday from 9:00am until 5:00pm. Outside of these times the service utilised main theatres. Out of hours anaesthetists were available and they had shared responsibilities with critical care and theatres. A second anaesthetist was available on call if required.
- There was an on call rota of Supervisors of Midwives (SOM). They were available 24 hours a day, seven days a week and provided midwives with support. Staff did not report a problem contacting a SOM.
- The antenatal day unit was open from 9:00am to 5pm Monday to Friday, and if staffing allowed the unit would remain open until 8pm. On a Saturday the unit was open from 8:00am to 4pm and was closed on a Sunday. Out of hours women were seen on ward 26.
- An on call pharmacy service was available.
- Maternity and gynaecology services had access to diagnostics and imaging services out of hours.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

Maternity and gynaecology

- Maternity and gynaecology services were caring. The NHS Maternity Friends and Family Test for September 2016 showed the number of women who would recommend maternity service was similar to or better than the national average.
- We observed staff interacting with women and their relatives in a polite, friendly and respectful way. There were arrangements to ensure privacy and dignity in clinical areas.
- Women spoke positively about their treatment by clinical staff and the standard of care they had received. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Women felt involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care. The service scored similar to other trusts in the CQC's survey of women's experiences of maternity service 2015 when asked about involvement in decisions about their care.

Compassionate care

- The trust received 103 responses to the CQC Survey of Women's Experiences of Maternity Services 2015. Results were similar to other trusts for 15 out of the 16 indicators relating to care received during labour and birth, staff during labour and birth and care in hospital after birth. The other indicator was better than other trusts (raising concerns and having it taken seriously).
- Friends and Family maternity test results from July 2016 to September 2016 showed the percentage of people recommending the hospital was consistently above the England average with the exception of patients who would recommend antenatal care. Results for September 2016 confirmed that 90%, 100%, and 100% of women would recommend the antenatal care, birth, postnatal ward and postnatal community care respectively.
- In September 2016, the response rate to the Friends and Family test for ward 19 was 61.4%. Of these respondents, 100% were either extremely likely or likely to recommend ward 19.
- During the inspection, we spoke with ten women and their relatives across maternity and gynaecology services. Overall, people spoke positively about their experience and the care and treatment they had received.
- On ward 26 we spoke to seven women. All women spoke positively about the care they had received. Positive comments from patients included: "the midwives were helpful, friendly and really seemed to care" and "staff on the delivery suite were brilliant".
- However, three women commented on the staffing levels on the ward and felt that midwives did not always have the time to spend with women. We heard one example of staff not returning to support a woman with breast feeding.
- The delivery rooms on the central delivery suite had 'do not disturb' signs displayed to ensure women in labour were not unnecessarily disturbed.
- We observed staff interacting positively with women and their partners. Women who were concerned about their pregnancy could contact the central delivery suite and the co-ordinator would triage the patient. We heard staff providing encouragement and reassurance to women who were anxious and worried.
- Single rooms were available for women experiencing pregnancy loss or medical management of pregnancy.

Understanding and involvement of patients and those close to them

- CQC's Survey of Women's Experiences of Maternity Service 2015 showed results similar to other trusts for questions relating to involvement in decisions about care. The trust scored 8.5/10 for being involved in decisions about their care during labour and birth and 8.1/10 for the partner being involved as much as they wanted.
- Women said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby.
- One woman whose elective caesarean section had been delayed expressed concern about not being kept informed.
- Vaginal birth after caesarean section (VBAC) clinics were held to discuss birth plans for women who had previously had a caesarean section.
- Partners said that they felt involved in their partners care and treatment and had things explained appropriately.

Emotional support

- The chaplaincy service was available and could provide support to women if requested.

- Staff said perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period.
- There were no specific counselling services for women who had experienced pregnancy loss. However, staff said women were given a contact number and could contact the clinic at any time for support and advice.
- Patients undergoing surgical terminations of pregnancies were admitted onto the surgical day unit. Following the procedure staff said they would pull the curtains around patients but the environment did not always offer patients privacy.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good because:

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

However:

- The impact of midwifery staffing levels often resulted in women having inductions of labour and elective caesarean sections delayed.
- The service did not have a bereavement midwife or a bereavement room on the central delivery suite. The service had produced a business case to recruit a bereavement midwife.

Service planning and delivery to meet the needs of local people

- Women had the option to either deliver at home, in the midwifery led unit at Goole or at SGH or DPoW.
- Community midwives carried out routine antenatal care. Hospital antenatal clinics were available for higher risk women. Midwives could refer expectant mums to the hospital antenatal clinic if she developed any problems.
- Maternity and gynaecology services worked with the local commissioners of services, the local authority, other providers, GP's and patients to co-ordinate care pathways.
- The maternity services liaison committee (MSLC) had an active role in maternity services and minutes from July 2016 showed a good representation from service users.
- Clinics were held within the antenatal clinic to support women, such as smoking cessation clinics and diabetic clinics.
- Ward 26 had an area dedicated for transitional care. This was an area where babies who needed a little more support could stay with their mum rather than go to the Special Care Baby Unit. This meant mum and baby did not have to be separated.
- The service had acted on feedback from women and implemented a seamless care model. This allowed a midwife to go with a women from ward 26 up to the central delivery suite and care for her throughout labour. The aim was to increase continuity for women.
- The service offered educational childbirth preparation classes run by midwives. Topics included: comfort, back pain and exercise in late pregnancy, signs of labour and when to come into hospital, natural coping strategies, stages of labour including pain relief options, assisting your partner in labour, variations of normal delivery including caesarean section, introduction to breastfeeding and life after birth.

Access and flow

- From July 2015 to October 2016, the bed occupancy levels for maternity across the trust were generally lower than the England average, with the trust having 84.2% occupancy compared to the England average of 89%.
- From November 2015 to October 2016, the service had achieved 96.1% of antenatal booking appointments at gestation less than 13 weeks. This was above the regional average and the England average for the same reporting period.
- From February 2015 to July 2016, there were no maternity unit closures.

- As part of the staffing escalation plan, maternity service would go on internal divert and transfer women to DPoW. From 01 November 2015 to the 31 October 2016, 29 women were transferred to DPoW.
- The central delivery suite was responsible for triaging any women who contacted the service. A standard operating procedure for telephone triage was in use and a call screening maternity assessment record was completed. Women were booked in for assessment either on the antenatal day unit or, outside of their opening hours, on ward 26.
- Staff said that the lack of capacity on NICU was increasing the number of women been transferred to neighbouring trusts to deliver their babies. Data provided by the trust showed 19 women had been transferred due to the closure of NICU in the past 12 months.
- In the event of shortages in staffing, the maternity services policy for safe staffing levels stated that elective admissions such as caesarean sections and inductions of labour were to be delayed wherever safe to do so. Staff said that delays in inductions were a regular occurrence due to midwifery staffing levels. We reviewed incident data and found from August 2016 and November 2016 there had been 7 delays in elective caesarean sections and 20 delayed inductions of labour.
- The service did not collect data about the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. However, staff told us all women were seen immediately on transfer to the labour ward by a midwife. Consultants reviewed patients in accordance to need, for example, a low risk woman would not need to be reviewed by an obstetric consultant.
- The services performance of meeting referral to treatment times (RTT) for gynaecology patients admitted for treatment within 18 weeks of referral was 94%.
- The service audited compliance with The Abortion Act 1967. The audit found 100% of women received an outpatient appointment within five working days.
- The gynaecology ward (ward 19) said they occasionally had surgical patients outlying on the ward. Staff said this did not have an impact on the service and data provided by the trust showed from September 2015 to June 2016, three elective gynaecology procedures were cancelled due to a lack of capacity on ward 19.

Meeting people's individual needs

- Women told us they felt their individual needs were met and they felt listened to and able to participate in decisions about their care.
- There were specialist midwives in place including a teenage pregnancy midwife and a safeguarding midwife who specialised in substance misuse. However, the service did not have midwives who specialised perinatal mental health, bereavement, or diabetes.
- Women carried their own records and had contact numbers for the central delivery suite should they need advice.
- Maternity services had a dedicated area on the trust website. Pregnant women and their families could access the site and view information about the service, the facilities at the trust and advice about breastfeeding.
- Information leaflets were available on the ward and in antenatal clinic areas on a variety of subjects such as, smoking in pregnancy, induction of labour, breech deliveries and 'Kicks count' providing information about feeling babies movements in pregnancy.
- We saw information leaflets were available on ward 19 about recovery from surgical management of miscarriages and miscarriage in early pregnancy.
- In all areas we visited staff described how to access interpretation services through a telephone system called 'the big word'. We reviewed the records of a patient on ward 26 whose first language was not English. We saw an interpreter had been used throughout their antenatal care.
- Staff said they could access written information in different languages on request. The antenatal day unit had leaflets in Polish about reduced fetal movements and the central delivery suite had written information about epidurals available in different languages.
- The trust did not have a specialist midwife for bereavement in post or a bereavement room. The service had produced a business case to recruit one wte bereavement midwife. It was not clear from the business case if funding had been approved.
- Maternity staff said they had not completed bereavement training. The service's strategic plan had identified that the trust should provide training and two bereavement study days were scheduled for March 2017.

- At handover, we observed staff organising bariatric equipment for a patient undergoing an elective caesarean section. This had not been pre-arranged for the patient but staff said they could access equipment in a timely manner..
- Support was given to families for the sensitive disposal of fetal/placental tissue. Staff supported families and enabled them to make an informed choice with burial and funeral arrangements.

Learning from complaints and concerns

- The trust had a policy in place for the management of complaints, concerns, comments and compliments. The policy was dated September 2016 and was in line with recognised guidance.
- The service had a system in place for handling complaints and concerns. Staff said they would try and resolve complaints at a local level and were aware of the procedure to follow.
- From September 2015 to July 2016, maternity and gynaecology services received 34 complaints. Fourteen of these complaints related to Scunthorpe General Hospital. Themes of complaints included clinical treatment, communication, staff behaviours and patient care.
- The service held monthly obstetrics and gynaecology operational meetings. Complaints were a standing agenda item. Meeting minutes from 11 May 2016 noted an increasing trend in the number of complaints to the Patient Advice and Liaison Service (PALS) relating to the behaviour of staff.
- Minutes from the quality risk profile on the 24 August 2016 stated the number of complaints regarding Women's and Children's group had doubled since last year.
- We reviewed two response letters following complaints. The responses included an acknowledgement when care fell below the expected standard, an apology and actions to be taken.

Are maternity and gynaecology services well-led?

Requires improvement

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

We rated well-led as requires improvement because:

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

However:

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

Leadership of service

- Maternity and gynaecology services formed part of the Women's and Children's group. An associate chief operating officer, a clinical lead for obstetrics and gynaecology and the head of midwifery led the service. Each hospital site had an operational matron. There was no nominated clinical director, with consultants instead operating as a forum and providing representation through a nominated representative.
- Senior staff told us that they felt that they lacked a representative at board level to lead and champion issues within the service. Staff felt that this impacted on the priority given to the service within the trust.
- Staff said that ward managers were supportive and approachable.

- Staff said there had been some instability in the leadership within maternity due to long-term sickness. Staff were hoping this would improve moving forward.
- Nursing and midwifery staff we spoke with at ward level spoke about the visibility of the matron. We heard the matron attended morning handover and carried out a daily walk round.
- Five midwives told us that the head of midwifery was not visible; however, they understood the challenges of having to cover different hospital sites.
- We saw information and contact details for the head of midwifery displayed in the staff room on the central delivery suite.
- Staff said they felt able to raise concerns but did not always feel they were acted on. We heard examples of staff that raised concerns about staffing levels and offered suggestions that were not implemented.
- Staff said they held twice monthly cross-site meetings with the ward managers, head of midwifery and matrons, to discuss any concerns and share learning.
- On the central delivery suite we saw evidence of team briefs. Topics discussed were documented on a white board and included celebrating success.
- The trust offered an in-house leadership training course.

Vision and strategy for this service

- Maternity and gynaecology services were part of the Women's and Children's health group.
- The vision for the group was, 'every woman and child in our locality is healthy and happy' and the mission statement was 'to provide safe, effective and leading edge care to the population we cover through nurturing high performing teams that prioritise patient experience'.
- The service had strategic objectives and an action plan to implement the services strategy. The actions were timed, assessed against an assurance framework and RAG rated.
- The strategic action plan was based on regional and National recommendation. For example, the Kirkup report, saving babies' lives and recommendation for improving stillbirth and bereavement care in Yorkshire.
- Key prioritise identified by the service included: working towards opening a dedicated obstetric theatre to enable 24/7 access, improving the patient experience, support following bereavement (including a dedicated bereavement room), a bereavement midwife and implementing RCOG guidelines for small gestational age.

Governance, risk management and quality measurement

- Following our previous inspection the trust had recruited a clinical skills and governance midwife who had commenced in post in April 2016.
- The risk register was a standing item on the monthly governance meetings.
- Local risk registers assisted the service in identifying and understanding the risks. There were 11 risks, of which four 'high risk' were identified for maternity and gynaecology services. All had risk scores attached to them, review dates and existing controls to mitigate the risks. Examples of risks identified by the service included suturing and swab checks and CTG archiving.
- Midwifery staffing was not contained in the service risk register. There was also no consideration of the risk posed to obstetric patients accessing theatre out of hours. Information provided by the trust following the inspection stated that the midwifery staffing level was now registered as a risk on the group risk register.
- A range of governance meetings took place within the service and the wider women and children division. This included monthly team meetings, operations meetings, clinical review meetings, a clinical audit group and morbidity and perinatal mortality meetings.
- These meetings then fed into a monthly care group wide clinical governance meeting. This worked to a set agenda and included dashboard and trend monitoring.
- We reviewed minutes of these meetings from August 2016 and saw complaints, incidents including lessons learned, audits, RCOG guidelines and policies were discussed. Previous actions were reviewed and monitored.
- There had been a gap analysis undertaken following the publication of the Kirkup report (2015). There was an action plan to address areas of improvement with clear timescales and responsibilities. The action plan fed into the services strategic plan.
- We reviewed the services women's and children's reporting dashboard and saw not all the maternity clinical indicators had targets. For example, the number

of 3rd and 4th degree tears and postpartum haemorrhage rate above 1500mls. Therefore it was unclear if the service was achieving above or below their target.
- One of the RCA investigations did not identify all of the contributory factors that contributed to the root cause. This then had an impact on the key learning points
- Lessons learned from serious incidents were not embedded within the service or across both hospital sites. These concerns were shared with other external stakeholders. We reviewed three serious incidents that had resulted in unexpected neonatal deaths (one at DPoW and two at SGH). All three incidents identified delays in commencing CTG's, delays in recognising CTG abnormality and delays in escalating and responding to CTG abnormalities.
- Following our inspection the trust had arranged an assurance meeting with the local supervising authority (LSA), deputy chief nurse and senior maternity team. The trust had produced an action plan and this was to be monitored through both the group and trust governance structures. The service had agreed to work with the LSA midwife and a meeting had been scheduled for 16 December 2016.

Culture within the service

- The introduction of the new staffing model within maternity meant there was a mixed feeling amongst staff. All staff we spoke with said staffing levels had made it challenging to implement the new model.
- Staffing levels within maternity were having a negative impact on staff morale. Midwives we spoke with felt morale was low.
- Staff within maternity reported high levels of short-term and long-term sick. We requested data from the trust and found in October 2016 sickness rates on ward 26 were 13.3% and on the central delivery suite were 4.1%. This had increased from 7.5% in November 2015 on ward 26 and 0.7% in November 2015 on the central delivery suite.
- Staff said they were encouraged to be open and honest. Staff were aware of reporting incidents and were aware of the duty of candour.
- The trust had worked hard to enable the different hospital sites to work more collaboratively. Cross-sites senior meeting were held to share practice amongst teams. However, ward staff rarely worked across site.

Public engagement

- Ward areas displayed 'you said, we did'. An example displayed on the central delivery suite included women said 'we would like more continuity of care from midwives' and in response; the service introduced a seamless model of midwifery care in October.
- The maternity service had some links to the local Maternity Services Liaison Committee (MSLC). The MSLC was run by a group of patient representatives who worked with staff and commissioners to develop maternity services. We reviewed meeting minutes from the 15 July 2016 and saw good attendance. The agenda for the next meeting included an open meeting to discuss bereavement support.
- Maternity service collected friends and family data. Between July 2016 and September 2016 the percentage of people recommending the hospital was consistently above the England average with the exception of patients who would recommend antenatal care.

Staff engagement

- Midwifery staff had been engaged in the new seamless care model. The service had implemented a task and finish group and consulted staff on the new model. The service was planning on reviewing the model and seeking feedback from staff.
- Posters on the central delivery suite showed 'what we are proud of' and 'what we are working towards'. Staff were proud of providing 1:1 care, friends and family results and MDT working and were working towards continuity of care, provision of a bereavement suite and normality.
- There was no service specific data from the 2015 NHS staff survey in relation to staff engagement. However, the overall score for staff engagement was 3.69.This was below the national average (3.8).

Innovation, improvement and sustainability

- A online call service run by the infant feeding co-ordinator was being offered to support breast feeding mothers within the community setting.
- The trust had secured funding to deliver CTG masterclass training to all labour ward co-ordinators and obstetric consultants. The training provided staff with advanced skills in CTG interpretation.

Maternity and gynaecology

- The trust had secured funding to purchase new equipment to deliver effective and realistic simulation training for obstetric emergencies.
- A leadership/management programme had been developed to support new of aspiring leaders.

Services for children and young people

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

Information about the service

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

Disney ward consists of 18 beds, plus an additional two high dependency beds. Of the 18 beds, there was one six bedded bay, with the remaining rooms being single occupancy. There was an additional six-bedded bay that was not in use at the time of our inspection. The neonatal intensive care unit (NICU) had ten cot spaces available and the PAOU had use of a bay for the assessment and observation of up to six children and young people. The outpatient department consists of five outpatient clinic rooms and was located within the main hospital building.

During our inspection, we spoke with 14 members of staff. 8 parents of young children receiving care and reviewed 15 sets of medical records. We also met with the service leadership team.

Summary of findings

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

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

Services for children and young people

- There was a shortage of qualified nursing and medical staff available within the service. Staffing levels did not meet professional guidance and had resulted in services being closed at times of peak demand. There was a lack of senior nursing or medical cover available out of hours and at weekends. Healthcare staff were required to care for patients without completing appropriate training.
- The NICU had been closed to admissions on a number of occasions due to capacity or staffing concerns.
- No specific safe room was used to assess or treat CAMHs patients and no wider ward based risk assessment had taken place.
- Complaints were not always responded to in line with the trust's target timescales and appropriate action plans were not in place.
- Identified risks to the service were not always appropriately recorded or monitored. We saw that staffing, CAMHs, and access issues were not specifically addressed in the service or trust risk register.
- Staffing shortages and workload pressures had impacted on morale and senior staff told us that there was a lack of support for children's services at board level. Ward based leaders had limited time dedicated to management duties.
- There were limited examples of staff and public engagement to drive improvements in the service.

However:

- Governance and reporting structures were in place and incidents were appropriately reported and investigated.
- The ward environments were clean and we observed good infection prevention and control techniques.
- Medicines were stored securely and managed appropriately.
- We saw that children and their families told us that they received compassionate and dignified care. Parents told us that they understood the care provided to their child and had been involved in decision making. Parents told us that they would be confident in seeking emotional support from staff.
- Play specialists were available to help provide support to children using services.
- Staff spoke positively about their immediate line management and felt that they were working better cross-site with Grimsby.

Services for children and young people

Are services for children and young people safe?

Requires improvement

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

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

However:

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

Incidents

- Between September 2015 and August 2016, the trust reported no incidents which were classified as Never Events for children's services. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in children's services which met the reporting criteria set by NHS England between September 2015 and August 2016. All incidents occurred at Scunthorpe General Hospital.
- Data from the Patient Safety Thermometer showed that the trust reported no pressure ulcers, no falls with harm and no catheter urinary tract infections between August 2015 and August 2016 in children's services. The NHS safety thermometer is used to record the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Disney ward reported 105 incidents across the ward and assessment area between September 2015 and August 2016. The majority of these (88) were reported as no harm, with 16 low harm, and one moderate harm. We saw that incidents we reviewed were appropriately graded.
- The NICU reported 61 incidents. Of these, all incidents were graded as low or no harm. We saw that incidents we reviewed were appropriately graded.
- There was a trust wide target to increase incidents reported by medical staff. This was to ensure that incidents were reported in a timely way by the appropriate person and were not delegated to other staff to report. The service reported that it had met this target, with average reporting above around 6% at the time of our inspection.
- Management staff told us that they had identified a number of cases of mis-identification within the children service. This had not caused harm to patients, but had resulted in confusion and on one occasion breast milk being provided to the wrong child. As a result, a decision had been taken for a concise root cause analysis investigation to take place into every mis-identification incident. We reviewed a copy of one of these RCAs. This included appropriate detail on the cause of the mis-identification and set out appropriate actions to resolve these concerns.
- Staff told us that incidents were shared and discussed at team meetings. However, many staff told us that they were not always able to attend meetings due to work pressures. Meeting minutes were circulated and displayed in staff areas. However, there was no way for staff to sign or confirm that they had read the minutes in order to learn about the incidents that had been shared.

- The service participated in monthly perinatal morbidity and mortality meetings with maternity services to discuss the deaths of neonates. In addition, paediatric mortality was also discussed at a monthly paediatric morbidity and mortality meeting and a quarterly meeting with colleagues from the hospital's emergency department, EMBRACE (a transport service for critically ill children) and the regional critical care network.
- Staff we spoke with were broadly aware of the duty of candour and requirements to be 'open and honest' with patients when things went wrong. However, the majority of staff were unfamiliar with the legal duties and processes under the duty of candour regulation.

Cleanliness, infection control and hygiene

- Ward based nursing and medical staff had attained 68% and 90% compliance with mandatory infection prevention and control training. Outpatient staff had attained 43% compliance.
- The trust conducted monthly infection control audits. The Disney ward performed consistently well between December 2015 and August 2016 with average scores between 98 and 99%. The average score for the NICU was between 94% and 98%.
- Admissions to the NICU had been restricted between 28 April 2016 and 4 May 2016 following an MRSA outbreak where four babies had become infected. We reviewed the root cause analysis into the outbreak and found that no root cause for the infection outbreak was found. Recommendations were put in place and an action plan was completed in regard to further improving general infection prevention and control measures.
- It was acknowledged in the report that screening of staff was delayed owing to work pressures on the occupational health team. We also noted that there was a delay in the unit being closed, with admissions continuing following the unit being aware that three children had developed MRSA, and no cause for this being identified. The hospital explained that this was because of different MRSA strains being identified. However, once the same strain was found in a second child the unit was closed.
- Hand washing basins and gel were available in clinical areas. Hand gel was also available outside of patient rooms and on entry to the ward. Signs were in place to encourage staff and visitors to sanitise their hands.
- We observed the majority of staff complying with the arms bare below the elbow policy when entering clinical areas.
- We observed the majority of staff that interacted with patients adopted appropriate hand hygiene techniques.
- At the time of our inspection, a number of children on the ward were suffering from bronchiolitis. These children had been isolated in side rooms and appropriate notices were in place to advise staff of the precautions that needed to be taken in interacting with these patients. We saw staff using appropriate personal protective equipment and hand hygiene techniques when interacting with these children.
- In the latest CQC children's survey in 2014, the trust scored 9.09 for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts. Site level data was not available.

Environment and equipment

- Matron conducted a monthly environmental assessment of the ward areas. This incorporated observations around areas such as general environment, equipment, and waste disposal. In the latest audit in August 2016, Disney ward scored 94% overall. However, there were red rated (lower than 84% scores) for questions around toilets, showers, baths and sinks (80%), and waste (67%). Actions were identified as a result of the audit to improve compliance. During our inspection, we saw no concerns in regard to these areas.
- The wards had conducted an activity risk assessment to consider how children and adolescents accessing mental health services (CAMHS) could be protected from harm. This included guidance on use of a risk assessment tool on admission and ensuring ligature risks and equipment that could cause harm were minimised. However, the residual risk rating was still noted to be moderate. This meant that there was a risk that the environment in which CAMHS patients were cared for may not be suitable.
- The August 2016 governance meeting identified that two side rooms on Disney ward had a damp leak on the back walls. It was anticipated that this could leave the rooms out of use for many weeks. We did not see any works taking place at the time of our inspection and were not informed of any concerns about these rooms by nursing staff.

- We saw that resuscitation equipment was available on Disney. In addition, cot side resuscitation equipment was available at each cot area within the NICU. Resuscitation equipment on Disney had not been consistently checked in the previous three months; it had not been checked on 12 days in September, but had been checked on every day in October 2016 and 21 from 23 days in November 2016. At the time of our inspection, we saw that the trolleys and cot sides had appropriate stocks of medicines and equipment.
- Access to the NICU and Disney ward was by using a swipe card or buzzer system. CCTV was available to staff to monitor access and identify visitors before being allowed in. We were appropriately challenged by staff when allowing colleagues to enter the unit to ensure that only appropriate persons were on the NICU.
- There was a fridge on NICU for expressed breast milk to be stored. Milk was labelled to show which baby it was to be used for. The fridge and room it was in were not locked. This meant that there was a risk that milk could be tampered with. However, no such incidents had been reported at the time of our inspection.
- We saw that children and young people were placed on adult theatre lists. They were anaesthetised in the same area as adults, and were recovered in shared recovery bays with adults, with a curtain separating them. However, there was a risk that children in recovery would be able to see adult patients being transported and recovered. This process was not in line with Royal College on Anaesthetist standards (Standards for Children's Surgery, 2013) or Royal College of Nursing guidance.
- We observed a trip hazard when inspecting the NICU. A parent was on the phone to translation services in a side room. The telephone from the desk had been used and the phone cord was trailed from the desk and into the side room. The cord was on the floor across the entrance to the intensive care room. A patient was being nursed in this room and the cord presented a trip hazard. Staff told us that this was the normal arrangement for parents needing to speak to a translator.
- In the latest CQC children's survey in 2014, the trust scored 9.46 for the question 'Did you feel safe on the hospital ward?' The trust scored 9.5 for the question 'Did you feel that your child was safe on the hospital ward?'. The trust scored 8.8 for the question 'Did the ward where your child stayed have appropriate equipment or adaptions for your child?' These scores were about the same as other trusts.

Medicines

- Medical and outpatient staff were 95% compliant with mandatory medicines management training. Ward based nursing staff were 100% compliant with this training at the time of our inspection.
- Medication charts were appropriately completed and signed in the records we reviewed. This was in line with professional guidance and trust policies.
- The temperature of medication fridges on the NICU and Disney was recorded to ensure that medications were stored at appropriate refrigerated temperatures. We saw only one gap in the checking of medication fridges in NICU and no omissions on the ward. These were locked to maintain security.
- Staff told us that the ambient temperature of the room where other medicines were stored was not routinely recorded. There was a thermometer in the room and staff told us that they would report any temperature they thought was excessively high to the pharmacy team in case this impacted on the drugs stored in the room.
- Controlled drugs and medication prescription pads were securely locked away in a separate cabinet to maintain their security. We saw that controlled drugs books were up to date to show medicines received and given out.
- Staff told us that they received a daily visit from pharmacy staff during week days. Weekend discharges were planned in advance so that any medications to take home could be ordered and checked by pharmacy during the week.
- Staff used an electronic key system to activate the controlled drugs cupboard. This meant that there was a log of which key had been used to access the cupboard. The key also deactivated if not used within a certain period. This prevented access from keys which could have been lost/misplaced without the need to replace locks.
- We checked the patient group directives (PGDs) in place. PGDs are documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions. These had not been completed at the time of our inspection. Management

staff told us that this had been due to staffing issues meaning training could not take place. Instead, doctors were signing to allow the administration of all medicines.

Records

- Ward based nursing staff were 85% compliant with mandatory information governance training. Outpatient staff were 86% compliant and medical staff were 100% compliant.
- We reviewed 15 sets of records across Disney and NICU. In general, we saw that the documentation was of a good quality in regard to the recording of clinical interactions by nursing and multidisciplinary staff, with appropriate entries being recorded in the records and few gaps in planned observations.
- However, the majority of records did contain detailed entries from middle grade doctors to record the medical management plan or interventions. Also, these did not contain a legible signature from medical staff or their GMC number. This meant that it was not always possible to identify which member of medical staff had made an entry in the records. This was not in line with General Medical Council guidance on record keeping.
- We saw that records entered by student nursing staff and healthcare assistants were not always appropriately countersigned in line with professional guidance.
- Staff on NICU told us that standard observations charts had been introduced between Grimsby and Scunthorpe in the past six months to ensure there was a consistent approach to the monitoring and recording of observations. The charts we reviewed had been fully completed by staff.
- Multidisciplinary staff and medical staff wrote in black ink. On the ward and NICU we saw that nursing staff wrote in the medical records in red pen. Staff told us that this was custom and practice within the trust. No concerns had been identified by staff around the legibility of records that required photocopying.

Safeguarding

- The trust set a target of 95% for completion of the relevant level of safeguarding children training by staff. Intercollegiate guidance (Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, March 2014) states that all clinical staff working with children, young people and/or their parents should undergo appropriate safeguarding training. The required levels of safeguarding training had not been achieved throughout the service. This meant that there was a risk that staff looking after children did not have appropriate training to identify and address safeguarding concerns.
- At the time of our inspection, the hospital medical staff had met training targets for level one and level two safeguarding. However, only 62% of staff had completed relevant level three training.
- Ward based nursing staff had narrowly failed to meet training targets for level one and level two safeguarding training (94% for each). Ninety one percent of staff had completed relevant level three training.
- Surgical staff in theatres operated on and cared for children and young people. However, data we received showed that no staff received level three safeguarding training. This meant that there was a risk that staff in theatres and recovery were not appropriately trained to identify or act on any safeguarding concerns.
- Nursing staff were also required to undergo level one training in safeguarding adults. At the time of our inspection, ward based nursing staff had failed to meet a target of 95% with 68% of staff having received this training.
- Although some safeguarding children training was above target levels, level three training and safeguarding adults training was below the trust target across the service. This meant that there was a risk that staff had not received appropriate training in safeguarding children and adults at the appropriate level. The risk around level three safeguarding was recorded on the corporate risk register and monthly compliance reporting was taking place.
- An up to date safeguarding policy was in place. This provided guidance to staff when identifying, responding to and reporting safeguarding concerns. The policy included reference to child sexual exploitation, but did not specifically set out guidance on cases of female genital mutilation. A separate policy was in place to provide staff with guidance on female genital mutilation.
- Staff told us that they were confident in identifying safeguarding issues and reporting. Staff provided practical examples of things that would raise concern and how they would report this.
- Designated nurses and medical staff were available at both hospital sites for staff to contact should they wish to discuss any safeguarding concerns.

- The 'failure to be brought' policy for outpatient consultations set out safeguarding concerns that could be raised due to parents or carers not bringing children and young people to planned appointments. It provided guidance on how to escalate and act on these concerns.

Mandatory training

- The trust set a target of 95% for completion of mandatory training. This included 13 modules across a range of subjects.
- At the time of our inspection, medical staff had achieved 69% compliance with mandatory training. Only four of 19 modules had made completed by more than 95% of staff.
- Ward based nursing staff had achieved 79% compliance with mandatory training. Four of the 19 modules had been completed by more than 95% of staff, with two modules at 94%.
- Training was available online and through some face to face sessions.
- Staff told us that they did not routinely have time to attend for mandatory training or complete this within working hours. This meant that training was often completed in their own time.

Assessing and responding to patient risk

- Mandatory training data provided by the trust showed that staff needed to undergo a yearly resuscitation training course. For the yearly course, 43% of ward based nursing staff, 65% of outpatient staff, and 25% of medical staff were shown as being compliant with this training. In addition, medical staff were expected to undergo additional training every two years. At the time of our inspection, 60% of medical staff were compliant with this additional training.
- Additional data provided by the trust showed that 28% of medical staff and 63% of nursing staff had undergone training in paediatric intermediate life support. This meant that there was a risk that there may be a lack of staff on duty with appropriate resuscitation training.
- However, nursing and medical staff we spoke to told us that their resuscitation training was up to date. This did not correlate with the data provided to us by the trust.
- Cross-site data provided by the trust showed that there had been 24 paediatric resuscitation or trauma calls in the emergency department that had been attended by ward staff between September and November 2016. Staff told us that they carried an emergency bleep to attend these calls due to a shortage of paediatric trained staff in the emergency department. Staff said that attending calls could leave ward staffing levels at unsafe levels.
- The trust paediatric early warning scoring (PEWS) system comprised of a traffic light alert system, with observations set out in normal (green) abnormal (amber) and very abnormal (red) on age dependant paper observation charts. Management staff told us that efforts had been made to move to an electronic system, but that this was found to be unable to show the trends involved if a patient's condition was changing.
- At the time of our inspection, management staff told us that consultation work was ongoing in the local region with other NHS trusts to develop a new regional numerical scoring tool.
- An audit of nursing documentation in July 2016 considered the PEWS scoring in two case files from Disney ward. This identified no concerns with the use of the PEWS tool.
- We saw that PEWS scoring had not been appropriately completed or escalated in three of the records we reviewed. This included no evidence of escalation being followed when a 'yellow' indicator was noted, observations not being recorded, and a PEWS chart for the wrong age range being used.
- The NICU had developed a neonatal early warning scoring system (NEWTT) and observation charts. We saw that these were used effectively to monitor and assess risk.
- The service undertook a gap analysis against the UK Sepsis trust's standards for the emergency management of sepsis in children. This identified that paediatric patients presenting to the service may not be screened for sepsis. In response to this, laminated PEWS charts for all ages, and NICE Guidance for 'Clinical assessment of children with Fever' had been placed in the emergency department and Disney triage areas for guidance and reference. However, the gap analysis also noted that specific training on sepsis was not available to paediatric staff.
- The service was able to access support and guidance on the transfer of critically ill patients using the local EMBRACE network. Staff reported good working relationships with EMBRACE and knew how to contact them for support if required.

Nursing and other staffing

- As at July 2016, the trust reported that it had an establishment level of 21.3 whole time equivalent nursing staff on Disney and 22 on the NICU. Staffing was below establishment levels on Disney (19.3) and the NICU (20.9).
- Between August 2015 and July 2016, the trust reported no vacancies at the hospital. The staff turnover rate was noted to be 0.8%. Sickness levels at the hospital were 4.8%.
- The hospital reported on the usage of bank or agency staff in the reporting period, with 0.1% of shifts being covered.
- Staff worked a two shift system, from 7am-7.30pm and 7.30pm-7am. There had recently been a move to introduce a further additional nurse on an 8am-4pm shift on Disney ward. However, ward staff told us that it was not always possible to cover this additional shift.
- Data provided by the trust showed that for the last reported three month period (June to August 2016) the average fill rate for nursing shifts on Disney was below establishment levels. Average fill rates for nursing staff on Disney were 69.4% for day shifts and 95.5% for night shifts. Average fill rates for nursing staff on the NICU were at 97.1% for day shifts and 100.5% for night shifts.
- Data provided by the trust showed that for the last reported three month period (June to August 2016) the average fill rate for daytime healthcare assistant shifts on Disney and the NICU, and night shifts on the NICU, were below establishment levels. Fill rates for healthcare assistant staff on Disney were 81.1% for day shifts and 100% for night shifts. Fill rates for healthcare assistant staff on the NICU were 74.8% for day shifts and 57.1% for night shifts.
- Data from November 2016 showed that 82.46% of shifts on the NICU had been filled in accordance with British Association of Perinatal Medicine guidance on staffing numbers. This was greater than the national average of 57.91%. The service also identified that 90.19% of shifts had been staffed with appropriate 'qualified in specialty' nurses. This was also above the national average of 72.44%. Nought point one percent of shifts had been covered by a designated supernumerary team leader. This was below the national average of 22.91% and was not in line with the BAPM guidance.
- The service told us that it used a recognised staffing acuity tool to measure the acuity and dependency of patients. The acuity and dependency of patients was measured three times a day and used to measure the safety of staffing in the clinical area, in line with Royal College of Nursing and British Association of Perinatal Medicine guidance. However, we did not observe the acuity of patients being accounted for when making staffing decisions during the inspection.
- We observed that ward staffing was not in line with Royal College of Nursing guidance to treat the acuity of patients. There was no supernumerary senior nurse on night or weekend shifts. Only two Band 6 staff members were employed within the service. This meant that some night and weekend shifts were led by a Band 5 nurse, with no senior children's nursing cover on site.
- To mitigate this, senior staff told us that Band 7 staff could be called in from the NICU to offer support. In addition, senior nursing staff said that they were available by telephone if staff had any concerns out of hours.
- At the time of our inspection, the ward had 15 patients (six which the ward staff had classed as high dependency as they were children on oxygen therapies, seven children under two years old, and two children over two years old). Guidance states that there should be a nurse to patient ratio of 0.5:1 for high dependency patients, 1:3 for patients under two years old, and 1:4 for patients over two years old. The majority of these patients were being nursed in side rooms, which require additional nursing resource. Three nursing staff were on shift. In addition to this staff also carried the emergency bleep for paediatric resuscitation.
- Staffing of the PAOU was also not in line with RCN guidance that two children's nurses should be available during operating hours, with only one nurse being on duty at any given time. However, due to the co-location of the PAOU within Disney ward, staff could flex between the ward and PAOU easily in times of increased demand.
- The service told us that Disney ward had an establishment of Band 3 healthcare assistants who took a lead in play. At the time of our inspection, we saw that one part time play specialist was employed, with an additional play specialist also acting as a healthcare assistant. Staff told us that play support was available for some week days and at specified outpatient clinics. However, no cover was routinely available at weekends, in accident or emergency, or at most outpatient clinics. This was not in line with The National Service Framework for Children's Services (2004) which identifies that play specialists should be available to all children attending hospital services.

Services for children and young people

Medical staffing

- The proportion of consultant staff reported to be working at the trust was lower than the England average. The trust had a notably larger proportion of junior staff (foundation year 1-2) than the England average, reporting 17% compared to the England average of 7%.
- Between August 2015 and July 2016 the trust reported a vacancy rate of 9% for medical staff at the hospital. Staff turnover was 43.6% and sickness levels were 2.4%.
- The hospital reported use of bank and agency staff to be 1.7%.
- The hospital had seven paediatric consultants. A consultant of the week system was in operation. During the week, one consultant was available for Disney ward and NICU between 9am-5pm. After 5pm, there was a different consultant on call who was non-resident (with consultants covering a one week in six rota).
- The consultant cover did not meet the Facing the Future: Standards for acute general paediatric services (2015) in regard to consultants being present and readily available in the hospital seven days a week or the number of consultants on the rota.
- There were eight middle grade doctors at the hospital, with a further doctor on long term sickness absence. One doctor was available on each of the PAU, Disney and NICU wards between 9am-5pm Monday to Friday. Two doctors were available between 5pm-9pm. One doctor was available overnight from 9pm-9am. There was also one doctor available at weekends.
- There were nine junior doctors or trainees. One doctor was available on each of the PAU, Disney and NICU wards between 9am-5pm Monday to Friday. Two doctors were available between 5pm-9pm. One doctor was available overnight from 9pm-9am. There was two junior doctors available at weekends.
- This meant that overnight, or at weekends, there was routinely only one middle grade and one junior grade doctor on site to cover Disney ward, NICU, the PAOU, and any emergency resuscitation calls. Staff told us that consultants were available and did always attend when requested. However, this still meant that there was a risk that medical staffing at night and weekends was not sufficient to meet demand. Some staff told us that they did have concerns about the medical cover available at these times.
- Medical and nursing staff told us that there were shortages and gaps in the rota. We saw that one incident had been reported where one locum middle grade had been left on duty to cover the hospital at night. This had been due to shortages in the rota and scheduling errors for junior staff.

Major incident awareness and training

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

Are services for children and young people effective?

Requires improvement

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

- There was a lack of senior nursing or medical cover available out of hours and at weekends.
- Healthcare assistant staff told us that they were required to care for patients without completing appropriate training.
- Staff appraisal rates for ward based nurses were below target levels.
- Clinical supervision was not always formally recorded in line with Trust policy.
- National audit data results for diabetes and asthma were worse than national scores.
- The range of transition services available was limited.
- Mental capacity act training rates were below target levels.

However:

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

Evidence-based care and treatment

- A rolling audit plan was in place for the service. This included prescribing, outpatient growth charts and transfer of critically ill children. Audit results were not available to us at the time of our inspection.
- Monthly reports were completed by Matron and submitted to the Head of Nursing. This included audits in relation to ward and NICU record keeping and infection control practices. The latest report from November 2016 identified 100% compliance in the majority of areas, with no significant concerns noted.
- Policies we reviewed were based on appropriate Royal College and National Institute of Health and Care Excellence guidance.
- The trust acquired UNICEF Baby Friendly Level 2 status in 2015 and was working towards a Level 3 accreditation. The assessment was scheduled to take place in January 2017.
- The NICU was in the process of developing and submitting action plans to gain BLISS accreditation and was waiting to hear on the outcome of applications.
- We saw that the NICU used guidance issued by the regional neonatal network. We found that some of the guidance in use was out of date, with renewal dates for three policies being in 2010, 2014 and 2015. There was no evidence that the policies had been reviewed or steps had been taken to consider whether revised guidance was necessary.
- The NICU received feedback and input from the regional neonatal network. The most recent report in November 2016 allowed the opportunity for the service to engage with external scrutiny and comparison. Feedback was largely positive in regard to governance and competence of the unit. Limitations were noted around the lack of management time, medical staffing, and engagement in wider network audit.

Pain relief

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

Nutrition and hydration

- The records we reviewed showed that nutrition and fluid balance sheets had been completed appropriately.
- Protected meal times were in place on the ward to allow children and young people time to eat their meals without clinical interventions taking place.
- Menus were available to children and young people to allow them to select the meals they would like to eat the following day. Staff told us that multi-faith food could be ordered if required.
- Food and drink facilities were available to parents in the parent's room. This included the ability to make hot drinks, store food and heat food.
- Breast milk was stored on the NICU and there were parent rooms available to allow breastfeeding mothers to feed their child in private if they desired.

Patient outcomes

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

- In the 2015 National Neonatal Audit the hospital met or was above the NNAP standard/benchmark for three of the four indicators and was below the NNAP standard/ benchmark for the remaining indicator.
- The hospital was below the NNAP benchmark for 'What proportion of babies of less than 33 weeks gestation at birth are receiving any of their mother's milk when discharged from a neonatal unit?'. The hospital proportion meeting the standard was 44% against a benchmark of 60%. The trust action plan set out that staff would 'continue to promote and support women breastfeeding on the unit and where possible encourage them to continue after discharge'.
- The trust action plan set out that staff would 'continue to promote and support women breastfeeding on the unit and where possible encourage them to continue after discharge'. We saw that breastfeeding was promoted on the NICU and breastfeeding mothers spoke positively about the support they had received.

Competent staff

- As at November 2016, 55% of ward based nursing staff, 100% of outpatient staff, and 80% of medical staff had undergone an annual appraisal compared to a trust target of 95%. On average, 81% of staff across the service had received an appraisal.
- Staff told us that appraisals were helpful and that they had the opportunity to feed into appraisals to identify any development needs.
- Clinical supervision was expected to take place once or twice a year in accordance with the trust policy. Staff told us that supervision took place more frequently, but that this was often informal through team meetings and one to one conversations. This meant that clinical supervision was not always formally recorded to show how frequently this was occurring or what had been discussed.
- We saw that health care assistants were placed in charge of babies in the transitional area. These staff underwent additional preceptorship training over a 12 month period to provide enhanced skills and knowledge in regard to the care of babies. A competency package was also being developed to monitor progress going forward. We saw that the preceptorship training did provide appropriate knowledge and skills to allow safe care to be delivered.
- However, we saw that staff were relied on to provide care without completing all aspects of the preceptorship training. Senior staff told us that this care was usually limited to areas where training had been provided and where support was available from qualified staff. However, some staff told us that this did not always occur, and that due to the demands of the NICU, healthcare staff were sometimes left to care for babies without having completed the correct formal training.
- The NICU had four transitional cot spaces co-located on ward 26 (maternity). This was routinely staffed by one healthcare assistant. They could also be required to carry a caseload of neonates on the NICU, which was located on another level of the main hospital building. This meant that they were not always present in the transitional area. Where this was the case, we were told that the ward staff would provide cover to 'look out' for the children in question.
- Staff told us that they had received reminders and guidance in relation to revalidation. Staff were confident that they could seek additional support if this was required.
- Theatre and recovery staff caring for children did not have specific paediatric training and there were no specialist paediatric anaesthetists available. The trust instead relied on its own anaesthetists who had an interest in paediatric anaesthesia. Staff told us that theatre staff and anaesthetists maintained their competency by treating paediatric patients regularly. However, staff also told us that there were not many children operated on at the trust. This meant that there was risk that staff could not evidence competence to treat these children.

Multidisciplinary working

- The ward was able to access support from therapy services. Staff told us that these staff would not routinely attend ward rounds, but would do so if there was a specific patient that was identified as needing therapy support
- There was a dedicated pharmacist for the children's service available during week days.
- We saw that the MDT notes were clearly recorded in individual medical records.
- The service told us that paediatric transition services were focused on diabetes, which has a monthly transition clinic shared with a paediatric consultant and an adult consultant who jointly saw young people aged from 15 to 19 years. In addition hospital sites undertook

epilepsy transition clinics whereby a paediatrician and adult medical consultant reviewed young people quarterly. The hospital also had a clinic in place for children with ADHD to transition into adult services. Management staff told us that they were currently in the process of establishing an endocrine transition clinic with adult services which will take place at least twice a year.

- For children with physical disabilities, learning disabilities and complex health problems there were currently no transition clinics. Young people were referred to the appropriate adult services between the ages of 16 to 17.5 years old.
- Staff had access to 24 hour, seven day telephone support from the child and adolescent mental health service. In addition, the service told us that CAMHs would contact the ward following a cooling-off period (usually overnight) for admitted patients. CAMHs would routinely see patients in person on the ward prior to discharge.
- In the last CQC children's survey in 2014 the trust scored 8.4 for the question 'Did the members of staff caring for your child work well together?'. This was about the same as other trusts.

Seven-day services

- The medical cover available meant that overnight, or at weekends, there was routinely only one middle grade and one junior grade doctor on site to cover Disney ward, NICU, the PAOU, and any emergency resuscitation calls. Staff told us that consultants were available and did always attend when requested. However, this still meant that there was a risk that medical staffing at night and weekends was not sufficient to meet demand. Some staff told us that they did have concerns about the medical cover available at these times. Two junior doctors were available at the weekend, but one of these only worked from 9am-4pm.
- There was routinely no Band 6 or 7 nursing cover available on Disney ward overnight or at the weekend.
- Staff in the outpatient department told us that unplanned Saturday clinics did take place on occasion to meet patient demand. However, this was not a regular service.
- The PAOU was open at the weekends between 9am and 10pm.
- Staff told us that they were able to access paediatric pharmacy services during week days between 9am-5.30pm. There was a general pharmacy provision at weekends between the hours of 9.00am and 1.30pm. This team could be contacted to provide pharmacy support if required. However, staff told us that this was not a paediatric specialty service. Given this, staff kept a stock of regularly required medication to allow medicines to be provided to patients attending at weekends.

Access to information

- Staff reported no concerns in being able to access patient medical records on site.
- Policies and guidance were available through the trust intranet. Staff told us that it could be hard to locate documents online, but that these were available and could be accessed from any trust computer.
- We saw that discharge summaries were provided to the relevant GP on discharge. Staff told us that GPs could contact the ward to request further information if required.
- However, management staff told us that due to the shortage of medical staff there could be delays in providing discharge letters to GPs. These backlogs were acknowledged as being a problem in times of increased demand.

Consent

- Staff we spoke with were aware of the requirements of Gillick/Fraser competence when considering consent for treatment from children and young people.
- The medical records we reviewed showed that consent had been appropriately considered and recorded where appropriate.
- At the time of our inspection, 42% of medical staff and 53% of ward based nursing staff were compliant with Mental Capacity Act (MCA) training. This meant that there was a risk that medical and ward based staff would be unable to accurately assess the capacity of parents or carers in making decisions about their child's care.

Services for children and young people

Are services for children and young people caring?

Good

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

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

However:

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

Compassionate care

- We spoke with eight parents and one young person. Seven out of eight parents described receiving compassionate care. One parent had concerns around a lack of communication and the impact this had on the care of their child.
- We observed staff providing dignified and compassionate care to the children in their care. This included ensuring that privacy was maintained in bay areas and that children were engaged in their care.
- The most recent NHS Friends and Family data from October 2016 showed that the NICU had received 100% satisfaction scores. However, only two responses had been received. Disney also scored 100% satisfaction ratings, from 15 responses.
- NICU had a 'quiet hour' every day to allow parents time to spend with their baby un-interrupted by medical or nursing staff. Parents told us that they found this very helpful in spending quality time with their child.
- NICU used butterfly stickers in cot areas to identify multiple pregnancies where not all of the children survived. This allowed staff and visitors to be aware and be sensitive of the feelings and needs of these parents.
- The trust performed about the same as the England average for all of 14 questions relating to compassionate care in the CQC children's survey 2014.

Understanding and involvement of patients and those close to them

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

Emotional support

- Open visiting hours were available on the ward and NICU for parents. NICU then allowed visiting subject to prior arrangement with staff. The ward allowed visiting from 2pm-6pm.
- Play specialists were available during week days to support children.
- Parents we spoke to told us that they felt supported by staff and would be comfortable speaking to staff to request emotional support.
- Staff told us that there were leaflets and information available for parents to direct them toward local counselling or support services if needed.
- Staff told us that they understood the need to interact and provide wider support to children, young people and families. They were happy to spend time to offer support, but did comment that this could be limited due to the demands on them.

Services for children and young people

- The trust performed worse than other trusts for one out of three questions relating to emotional support in the CQC children's survey 2014. This question was regarding staff communicating with parents/carers regarding who they should talk to if they were worried about their child post-discharge.

Are services for children and young people responsive?

Requires improvement

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

- The NICU had been closed to admissions on a number of occasions due to capacity or staffing concerns.
- A high number of patients on active referral pathways had no due date for an appointment.
- No specific safe room was used to assess or treat CAMHs patients and no wider ward based risk assessment had taken place.
- Complaints were not always responded to in line with the trust's target timescales and complaint data reported to us was inaccurate.

However:

- Appropriate facilities were available to parents.
- Interpreter services were available if required.
- PAOU was co-located on Disney ward allowing flexibility in how care was approached.

Service planning and delivery to meet the needs of local people

- Disney ward had 18 bed spaces and two high dependency beds. In total, the ward had additional bed spaces available. However, these had been closed to admissions for some time due to being unable to staff to the full ward occupancy level.
- The NICU had 10 cot spaces; with two cots dedicated to intensive care, two to high dependency care and six to special care.
- The PAOU was open between the hours of 9.30am-10pm, seven days a week. The last admission to PAOU was accepted at 7pm. Outside of these hours, paediatric patients would attend the emergency department. Lower risk patients would then be asked to attend Disney for treatment. The PAOU was co-located on Disney ward.
- Outpatient clinics were routinely available between 9am to 5pm, Monday to Friday. These provided consultation to children, young people and families over a range of medical and surgical specialties.
- Up to date escalation policies were available and staff told us that these were followed so that admissions were diverted to Grimsby. When this was not possible, efforts were made to ensure patients could be diverted to other specialist paediatric services within the region.
- Data provided by the trust between July and October 2016 showed that there had been 34 admissions/ transfers of patients aged 14-16 to non-children's wards.
- Data provided by the trust showed that Disney ward had been closed to admissions on two occasions since May 2016 due to a lack of beds. Up to date escalation policies were available and staff told us that these were followed so that admissions were diverted to other sites.
- The hospital told us that it had not routinely collected figures to show the number of times the NICU had been closed to admission in the past year. It was now re-enforcing the need to record this information. However, data was available from 29 September 2016. This showed that the NICU had been closed to admission on 29 occasions since this time.
- There was a purpose built accommodation for parents to be resident with their babies on NICU. The unit had two parent flats which accommodated parents, along with shared dining, bathroom and kitchen facilities. The ward also had a dedicated room for parents to reside. Kitchen, toilet and shower facilities were also available and parent beds and recliners were available on the ward for parents to stay over.

Access and flow

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

Services for children and young people

- The most common reason for admission for children under one year old was acute bronchitis (17.5%). The most common reason for admission for children and young people aged one to 17 years was viral infection (10%). These figures were in line with England averages.
- Between April 2015 and March 2016 the median length of stay for children under the age of one and children and young people aged one to 17 was similar to the England average.
- Between September 2015 and August 2016, neonatal cot occupancy has been continuously below the England average. Occupancy rates continuously fluctuated during this time period with December 2015, February 2016 and June 2016 data from NHS England showing zero occupancy.
- However, an internal trust analysis prepared as part of a neonatal staffing review in May 2016 identified cot occupancy to be 109% at the hospital and 99% at Scunthorpe on average. Staff we spoke with on the NICU told us that cot occupancy was routinely high and that they could not recall occasions where average cot occupancy was below the England average.
- At the time of our inspection, outpatient reporting data for children and young people showed that of 1314 children and young people for follow-up and not on an active referral to treatment pathway, only 48 (3.7%) were overdue an appointment. An additional 34 children and young people (2.5%) were noted as having no due date for an appointment.
- For the 25 children and young people for follow-up on an active referral to treatment pathway, only one (4%) was reported as being overdue for an appointment. However, an additional 20 (80%) of children and young people were listed as having no due date for an appointment.
- For the 102 children and young people awaiting a first appointment, the majority (87 or 85%) were seen within six weeks of referral. Three patients (2.9%) had waited longer than 18 weeks for an appointment.
- A 'failure to be brought' policy was in place setting out the steps that staff should take to refer children and young people back to GPs or discharge them from the service if appointments were not attended.

Meeting people's individual needs

- The service explained that routine contact with CAMHs patients was through the emergency department and such patients were rarely seen on Disney. CAMHs services contacted the ward on a daily basis during weekdays to determine if any patients required support. Patients admitted over the weekend would be seen on a Monday by CAMHs, who would visit patients prior to discharge.
- In total, data from the trust suggested that two CAMHs patients had been admitted to Disney in the 12 months prior to our inspection. This was due to the need for medical intervention.
- However, staff we spoke with on the ward told us that they would see children and young people with mental health problems more regularly; often a number of times a month. In addition, a report prepared on children and young people presenting with self-harming problems, or where this was diagnosed during their hospital stay, showed that between November 2015 and October 2016 there had been 34 such admissions. This meant that there was a risk that this information was not being accurately captured within the service.
- There was no specific safe room used to assess or treat CAMHs patients. Instead, a tool was in use to assess the risk posed to CAMHs patients by the ward environment and prompt staff to remove any risks to their health (for example, oxygen tubing or curtains that could be used as ligatures). Staff told us that support could be provided by local services to provide 'sitters' to remain with patients noted as being at a higher risk of self-harm. Staff told us that no wider ward based risk assessment had taken place.
- A play room was also available for younger children. This included games and activities to allow parents or play workers to engage young children in play.
- Translation services were available on the telephone or could be booked for face to face consultations if required. Leaflets in languages other than English were not routinely kept on the ward or NICU. However, staff told us that these could be requested if required.
- There was a learning disability nurse within the hospital that could be called on for advice or support in helping to meet the specific needs of patients presenting to the service.

Learning from complaints and concerns

- Information provided by the service prior to our inspection noted that there had been one formal complaint made to the hospital in the reporting period. However, when we requested examples of complaints and responses sent by the hospital, we received three

example complaints. These had been made in November 2015, December 2015, and March 2016. This meant that there was a risk that the central information provided to us by the service was not accurate.
- We reviewed two complaint responses provided by the service, and action plan linked to a response, and a separate action plan as evidence of the response to the third complaint. These provided explanations around care received and were in an appropriate tone. We saw that action plans were not robust and did not identify the outcome of discussions or what actions had been taken to prevent similar failings occurring in the future.
- The trust took an average of 49 days to investigate and close complaints, and the children's core service took an average of 46 days (excluding cases with re-negotiated deadlines). This performance was not in line with the complaints policy which anticipated that the majority of complaint (single issue complaints and multiple issue complaints about the service) should be responded to within 30-45 days.
- Parents told us that they were not aware of how to make a complaint. However, parents did tell us that they would be confident approaching staff with their concerns. We did see a complaint leaflet displayed on the ward to direct patients on how to complain.

Are services for children and young people well-led?

Requires improvement

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

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

However:

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

Vision and strategy for this service

- The vision for the child and women's health group was, 'every woman and child in our locality is healthy and happy' and the mission statement was 'to provide safe, effective and leading edge care to the population we cover through nurturing high performing teams that prioritise patient experience'.
- The service had identified five business objectives for the 2016/2017 financial year. This included objectives in relation to staffing, costs, improvement and innovation.
- Staff we spoke with were broadly aware of the wider vision for the service. However, they were not aware of the business objectives provided to us by management staff.
- Staff told us that they had increased cross-site working within the past 12 months and expected that this would increase further as part of the wider vision of services.

Governance, risk management and quality measurement

- A risk register was in place for the service. This identified ten areas of risk (six moderate and four low risk). We saw that some risks had remained on the register for over six years without a resolution being achieved. We saw that some risks had received regular review and follow-up to ensure that mitigating action was in place. However, other risks were simply noted as 'ongoing' or 'to monitor' for a number of months.
- Paediatric medical and nursing staffing was not contained in the service risk register. There was also no consideration of the risk posed to CAMHs patients due to the lack of a safe room for treatment.
- General risks around staffing were contained within the corporate risk register. However, this did not specifically refer to concerns in relation to paediatric staffing or action in place to address this concern.
- A range of governance meetings took place within the service and the wider women and children division. This included monthly team meetings, operations meetings, clinical review meetings, a clinical audit group and morbidity and perinatal mortality meetings.
- These meetings then fed into a monthly care group wide clinical governance meeting. This worked to a set agenda and included dashboard and trend monitoring.

- We reviewed the minutes of the meetings and saw that they were well attended. Issues discussed included: incidents, complaints, patient safety alerts, mandatory training, serious incident and RCA action plans and the risk register. Previous actions were reviewed and monitored.
- Managers told us that they had developed an attendance monitoring system to ensure that senior staff were attending this meeting. This was now linked to job planning with a view to ensuring that information shared in the meeting was able to be shared with staff.
- Staff told us that there was no standard operating procedure in place for paediatric surgery.
- Following our inspection, the service provided us with a copy of an assurance plan developed for the division. This noted concerns around access and flow issues, as well as staffing and skill mix concerns. A staffing and skill mix review was planned alongside process mapping patient pathways through the service. No specific target date had been noted for completion of this work.

Leadership of service

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

Culture within the service

- Staff told us that they were proud to work within the service and did their best to provide excellent care. However, many staff reflected on staffing shortages as causing fatigue and stress.
- The majority of nursing staff did feel part of the wider trust and said that they had good working relationships with staff in Grimsby. A minority of staff felt that there was still a divide between the sites and explained that they did not always feel like a combined service.
- Staff told us that they would receive written warnings for failures to complete standardised daily clinical checklists. Guidance stated that the trust had a zero tolerance approach to checks being missed. However, staff told us that did not take into account times of increased patient need, shortage of staff, or other circumstances meaning that checks were not completed. This impacted on morale.
- Staff felt that many of the challenges they faced were due to staffing issues, but were uncertain what steps were being taken to improve this.
- Staff said that they were encouraged to be 'open and honest' in their dealings with children, young people and families.

Public engagement

- The service used a 'pants and tops' system to allow children to feed back on the care they received. Children filled out 'pants' templates and said what they did not like, or filled in 'tops' templates to say what they did like. At the time of our inspection, completed templates were displayed on the ward. However, these had not been updated since August 2016.
- At the time of our inspection, the service told us that no specific public engagement activities had taken place

within the service. However, a service user group was being developed to include parents of babies/children who had accessed services. The service told us that 'parent participants' had been recommended by staff from the neonatal units and paediatric wards. Terms of reference were in development and the inaugural meeting was scheduled to take place in December 2016.

Staff engagement

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

Innovation, improvement and sustainability

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

End of life care

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

Information about the service

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) provides acute hospital services and community services to a population of more than 350,000 people across north and north-east Lincolnshire and the East Riding of Yorkshire. The trust has approximately 850 beds. The hospitals located in northern Lincolnshire are Diana, Princess of Wales Hospital and Scunthorpe General Hospital (SGH). Goole District Hospital is in the East Riding of Yorkshire. During this inspection, we did not visit Goole Hospital.

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

At the time of our inspection, the trust employed a specialist palliative care team (SPCT). This included a Macmillan lead cancer nurse, two specialist palliative care nurses, and two consultants one of which is based at the hospice. In addition to this, there was also a MacMillan end of life care clinical coordinator and an end of life care practice facilitator. The SPCT worked Monday to Friday from 9am to 5pm.

During our inspection of SGH, we visited eleven wards and departments where end of life care was provided. We spoke with 35 members of nursing staff and four doctors. We also spoke to the senior management team for the service.

We visited the mortuary and bereavement services and spoke with a member of staff from each of these teams.

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

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

End of life care

Summary of findings

At our previous inspection, in 2014, we rated End of life care services as good. At this inspection we rated this service as good because:

- There were low numbers of incidents involving end of life care patients. Staff we spoke with were aware of the duty of candour. All areas appeared clean and well maintained. The trust had policies and procedures in place for the safe handling and administration of medicines. There were also specific policies available to support staff caring for patients at the end of their lives. Specialist palliative nurse staffing was appropriate, patient records were stored securely, and record keeping was of a good standard.
- We saw that trust polices referenced national best practice guidance such as the National Institute for Health & Clinical Excellence (NICE). This included policies relating to care at the end of life, such as anticipatory drug prescribing for end of life care and the pain and symptom management guidance in the last days of life. We saw evidence of local and national audit participation. We saw that patients' pain levels and nutrition and hydration needs were assessed and managed effectively. Staff told us that they had effective clinical supervision. The trust had been involved in the development of a Northern Lincolnshire multi-agency end of life care strategy; from this, the trust had identified seven work streams, each of which had developed key performance indicators to measure the trust's performance and patient outcomes at the end of their life.
- We observed staff being compassionate and caring to patients and their families, without exception. Patients and relatives we spoke with described staff as "brilliant" and "excellent". They said that staff could not do enough for them. We saw that staff provided emotional support to patients and their families.
- Staff on the wards told us that the SPCT was visible and available, and that team members regularly reviewed end of life patients and had discussions with patients and their families. Information received from the trust indicated that 86.5% of patients referred to the SPCT were seen within 48 hours. The bereavement team had developed robust processes to help and support bereaved relatives. Evidence from the trust showed that 82% of patients audited were asked about and 71% achieved their preferred place of death.
- The trust had been involved in the development of a multi-agency end of life strategy that encompassed the whole of the local health economy. The trust was collating and monitoring quality measures such as patient outcomes through seven strategy sub-working groups. There was a non-executive director at board level. Staff reported a positive culture and good working relationships between teams. The trust was supporting the development of staff who were caring for patients at the end of life, and we saw good examples of innovation and staff whose purpose was to maintain and improve the services provided to patients and their loved ones.

However:

- We found that there was limited use of the trust's last days of life documentation, although the SPCT was progressing the rollout of the document across the trust. The trust employed fewer than the National Council for Palliative Care (NCPC) guidance of two wte consultants per 250,000 population. (There had been no specialist palliative care medical staff in place during our previous inspection, therefore this was an improvement.) Chaplaincy support was minimal due to low establishment figures and absences within the team.
- The trust did not meet the NICE guidance for palliative care provision because it did not provide a seven-day service or any advice or support outside of normal working hours. Low numbers of staff had received a yearly appraisal. The trust did not use an electronic palliative care co-ordination system, although the development of this was part of the strategy action plan. We were concerned that consent to care and treatment was not always obtained in line with legislation and guidance, including the Mental Capacity Act 2005, for patients who lacked capacity.
- Not all risks for the service were identified on the risk register for the end of life care service. For example,

End of life care

the lack of seven-day service provision, delayed rollout of the last days of life document, and completion of the deceased patient audit tool were not on the risk register.

Are end of life care services safe?

Good

At our previous inspection, in 2014, we rated End of Life Care services as good for safe. At this inspection we rated safe as good because:

- There were low numbers of incidents involving end of life care patients. Staff we spoke with told us that they were encouraged to report incidents; they were confident in the use of the trust's electronic reporting system and were aware of the duty of candour.
- All areas that we visited, that were providing care at the end of life, appeared clean and well maintained. We saw staff using appropriate personal protective equipment (PPE) and washing their hands before providing care to patients.
- The trust had policies and procedures in place for the safe handling and administration of medicines. There were also specific policies available to support staff caring for patients at the end of their lives.
- The trust was meeting the NCPC guidance for specialist nurse staffing. There were no vacancies within the team and sickness levels were minimal.
- We found that patient records were stored securely and record keeping was of a good standard.
- Staff were aware of their responsibilities in relation to safeguarding and were aware of the process they would follow if they had a concern or needed to raise an alert. Trust safeguarding policies were available to support staff.

However:

- Use of the trust's last days of life documentation was minimal, although the SPCT was progressing the rollout of the document across the trust.
- The trust employed fewer than the NCPC guidance of two wte consultants per 250,000 population. (There had been no specialist palliative care medical staff in place during our previous inspection, therefore this was an improvement.)
- Chaplaincy support was minimal: the trust had an establishment of 2.5 whole time equivalent (wte) chaplains, which is less than the number recommended by the NHS Chaplaincy Guidelines 2015, Promoting Excellence in Pastoral, Spiritual & Religious Care.

End of life care

Incidents

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

Infection Control and cleanliness

- Personal protective equipment (PPE), such as gloves and aprons, was available in all areas. Hand sanitiser was also available at the entrances to all wards and outside patient bays and side wards. We saw staff using appropriate PPE and washing their hands before and after providing care to patients.
- We saw a health and safety policy and a laboratory safety handbook to support staff working in the mortuary. This policy contained guidance relating to infection prevention and control.
- We asked the trust for infection control audits of the mortuary. We were told that the infection prevention control nurses did not formally undertake these at the time of our inspection but that this would be added to their schedule.
- Staff completed infection prevention and control (IPC) training as part of their mandatory training programme.

Environment and equipment

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

Medicines

- The trust had policies and procedures in place for the safe handling and administration of medicines. There were also specific policies available to support staff caring for patients at the end of their lives. These included anticipatory drug prescribing for end of life care and pain and symptom management guidance in the last days of life.
- Anticipatory prescribing ensures that staff are able to provide symptom control medications, in a timely way, to patients as and when they are needed.
- We checked the medication administration charts of seven patients receiving end of life care and found that, where appropriate, all non-essential medications were

stopped and anticipatory medications prescribed for five of the seven (71%) patients. This included medications for pain, shortness of breath, restlessness, nausea, and respiratory tract secretions.
- We spoke with a medical registrar about one of the patients, who was not prescribed anticipatory drugs. The medical registrar told us that they would seek support from the SPCT before prescribing anticipatory medications. This meant that there might be a delay in patients receiving appropriate care and treatment.

Records

- We found that medical and nursing records were stored securely in all areas we visited. This meant that patients' confidential records were kept safe.
- The trust used an intentional rounding tool. Intentional rounding involves nursing staff using predetermined questions to ask patients, on a regular basis, about care needs and checking the patient environment to ensure that it is clean and uncluttered and that everything is in reach of the patient. We saw that these were in place and completed regularly for all patients.
- In the records we reviewed we found that patient's risk assessments were completed. We saw generic trust care plans in place that were appropriate for the patients' needs. However, we did not see evidence that care plans were individualised.
- We looked at eight sets of patient care records and found that, where the SPCT nurses had been involved, a comprehensive review and assessment of the patient's needs was completed.
- In May 2016 an audit of end of life care patient's records had shown that individualised additional information had been discussed with patients' families in 50% of cases. In all of the records that we looked at patient and family involvement was clearly documented.
- We saw limited evidence of advanced care planning for patients approaching the end of their lives. The trust was in the process of implementing end of life care documentation that would support staff in the care and treatment of patients approaching the end of their lives. We only saw this in use on two of the eleven wards that we visited. We discussed this with senior managers, who confirmed that the rollout of the document had taken longer than expected but that the recruitment of more staff to the SPCT would assist with this.

Safeguarding

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

Mandatory training

- The trust target for completion of statutory and mandatory training compliance was 95%. Data showed overall compliance of 91% for the SPCT.
- All clinical nursing staff completed syringe driver training as part of their mandatory training requirement. Most staff we spoke to said they had completed this training. Staff who had not yet had the opportunity to complete the training told us that they were not involved in setting up syringe drivers.
- The trust had recently introduced end of life care as part of all clinical staffs' mandatory training.

Assessing and responding to patient risk

- The trust used a national early warning score tool (NEWS). This tool assists staff in the early recognition of and response to a deteriorating patient. We saw NEWS in use in the care records that we reviewed.
- We also saw that risk assessment tools were completed. This included venous thromboembolism (VTE), falls, pressure area, malnutrition, and moving and handling. When a patient was identified as at risk, we saw that a care plan was created.
- An audit completed in May 2016 showed that 30% of end of life care patients did not have an ongoing daily review by a doctor or an initial assessment of their symptoms. However, in the records reviewed at the time of our inspection, we saw that a doctor had seen all patients daily.
- Advice is issued to the NHS, via the Central Alerting System, as and when issues arise. National patient safety alerts (NPSA) are crucial to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. We saw that national safety alerts, which related to the team, were discussed at the palliative care business and governance meeting, and actions needed were identified and shared.

End of life care

Nursing staffing

- The hospital employed a Macmillan lead cancer nurse and two wte specialist palliative care nurses. This meets the NCPC guidance of one wte specialist palliative care nurse for every 250 beds.
- The specialist palliative care nurses were available Monday to Friday from 9am to 5pm for face-to-face and telephone advice.
- There were no vacancies at the time of our inspection, and we saw that sickness within the team was minimal, with an average of 1.5% each month from April 2015 to April 2016. We were told that staff covered annual leave and sickness within the team.

Medical staffing

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

Chaplaincy, Mortuary and Bereavement Teams

- The trust had an establishment of 2.5 wte chaplains. The NHS Chaplaincy Guidelines 2015, Promoting Excellence in Pastoral, Spiritual & Religious Care, suggest that the trust should employ 6.6 wte chaplains. At the time of our inspection, two wte chaplains were in post and there had been high levels of absence within the team.
- Staff we spoke with raised concerns about the availability of chaplains. We were told that, in the four months prior to our inspection, there had been 44 days with no chaplaincy cover.
- In addition to the chaplains, some chaplaincy volunteers provided additional support. A Roman Catholic chaplain was retained for one session each week and specific Roman Catholic needs out of hours.
- There were no vacancies in the mortuary or bereavement team. We were told that annual leave and sickness was covered within the team.

Major incident awareness and training

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

Are end of life care services effective?

Good

At our previous inspection, in 2014, we rated End of Life Care services as good for effective. At this inspection we rated effective as requires improvement because:

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

However:

- We saw that trust policies referenced national best practice guidance such as that from NICE. This included policies relating to care at the end of life, such as anticipatory drug prescribing for end of life care and the pain and symptom management guidance in the last days of life.
- We saw evidence of local and national audit participation. Where necessary the trust had developed action plans to improve care for patients at the end of their lives.

End of life care

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

Evidence-based care and treatment

- We saw that trust polices referenced national best practice guidance such as the NICE. This included policies relating to care at the end of life, such as anticipatory drug prescribing for end of life care and the pain and symptom management guidance in the last days of life.
- The trust was part of a multi-agency end of life strategy group. NICE guidance was discussed at this group's meetings, and any actions required by the trust were then developed through the trust's strategy working groups.
- The Liverpool Care Pathway (LCP) was developed during the late 1990s at the Royal Liverpool University Hospital, in conjunction with the Marie Curie Palliative Care Institute, with the aim of providing the best possible quality of care for dying patients.
- In June 2014, the Leadership Alliance for the Care of Dying People (LACDP) was formed in response to a report that had criticised the use of the LCP. The report recommended that the LCP should be phased out, and a new approach to improving end of life care be developed using five key priorities of care. The trust had developed a Care in the Last Days of Life document to replace the LCP.
- We saw two care records audits that had been completed for end of life care patients in October 2015 and in May 2016. An action plan created following the audit in October 2015 indicated that the planned completion date for the rollout of the new documentation was April 2016. During a meeting with senior members of the team, we were told that this had been completed on eight wards at this hospital.
- Some staff we spoke with were aware of the new documentation and had used the symptom control guidelines. However, we found that most staff were not aware of the documentation, and we only saw it in use in two of the eleven areas that we visited.
- The records audit completed in May 2016 showed that the new documentation was used in 90% of the records audited. However, data provide by the trust indicated that, from August 2015 to July 2016, of the 761 patients who had died in this hospital, only 75 (fewer than 10%) had been cared for using the Care in the Last Days of Life document.
- The senior team told us that a MacMillan end of life care coordinator and an end of life practice facilitator had been appointed and educational sessions on the new documentation plan were in progress.
- The bereavement team completed an informal audit of the completion of all death certificates. This enabled the team to address any concerns about the completion of the certificates with the relevant clinician.

Pain relief

- We did not see reference to the guidance outlined in the 2015 core standards for pain management services within any of the trust documents that related to pain relief. However, in the records we reviewed, where appropriate, we saw that patients at the end of life were prescribed pain medication in line with NICE guidance.
- We saw, from patients' records, that pain levels were assessed regularly, and patients we were able to speak with said that their pain relief was managed effectively and that staff responded quickly when they needed painkillers.
- The 2015/2016 national care of the dying in hospital audit showed that 55 of the 77 patients audited (71%) had had a pain assessment completed in the last 24 hours of their lives, and 87% of the patients' records had documented evidence that their pain was controlled.
- Two local records audits completed in October 2015 and in May 2016 showed that prescribing of anticipatory medications had improved.

Nutrition and hydration

End of life care

- The trust's own audits, in October 2015 and May 2016, showed that not all patients were being assessed for their nutrition and hydration needs. However, during our inspection we saw nutrition and hydration assessments in most of the care records that we looked at. If patients were assessed as at high risk of malnutrition or dehydration, food and fluid charts had been implemented.
- We saw that some patients were prescribed nutritional supplements and that these had been administered as prescribed.

Patient outcomes

- The trust participated in the End of Life Care Audit – Dying in Hospital: National report for England 2016. The trust scored the same as the England average for one clinical quality indicator, better for two and worse for three of the indicators. The trust met seven of the eight organisational indicators.
- We saw that the trust had created an action plan following the national audit. However, not all recommendations were part of the action plan, for example, the recommendation that all trusts should have access to specialist palliative care services from 9am to 5pm, 7 days a week, was not included.
- The trust was also submitting end of life patient data for the collation of minimum data-set (MDS) information for the NCPC. The MDS for specialist palliative care services is collected by NCPC on a yearly basis, with the aim of providing an accurate picture of hospice and specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services in the voluntary sector and the NHS in England, Wales, and Northern Ireland.
- The Gold Standards Framework (GSF) is a systematic, evidence-based approach to optimising care for all patients approaching the end of life. The trust did not participate in the gold standards framework or an end of life care patient register. However, this had been identified on the trust's action plan, created following the End of Life Care Audit – Dying in Hospital: National report for England 2016.
- In conjunction with other stakeholders, the trust had been involved in the development of a northern Lincolnshire multi-agency, end of life care strategy. From this, the trust had identified seven work streams, each of which had developed key performance indicators to measure the trust performance and outcomes for patients receiving care at the end of their lives. We saw that each working group had developed an action plan and, where applicable, data collection tools, which were being implemented and monitored.
- We saw a copy of an end of life care dashboard and found that this appeared to relate to low numbers of patients. In order to collate patient outcomes effectively the trust had developed a deceased patient audit tool. However, senior staff we spoke with told us that this was not being routinely completed, and therefore the capture of information related to the care provided was not robust. Further awareness and reinforcement of the need for accurate completion of this form was ongoing through the quality and operational matrons.

Competent staff

- The trust provided data that showed that both of the clinical nurse specialists had received clinical supervision. These staff told us that they received effective supervision from both the palliative care consultant and also one of the trust's respiratory consultants.
- We found that some staff had not had an appraisal: Only one of the two specialist palliative care nurses had an up-to-date appraisal, therefore compliance for this team was only 50%. In addition, only 38% of the chaplaincy and bereavement team and 56% of the mortuary staff had received an appraisal within the preceding year.
- End of life care was part of all clinical staffs' statutory and mandatory training. We were told that this was a recent addition and that very few staff had completed the training. Staff on some wards told us that they felt they needed more training in care at the end of life.
- Staff on the wards where care at the end of life was provided were receiving additional educational sessions on the Care in the Last Days of Life document from the MacMillan end of life care clinical coordinator and the practice facilitator.
- There was no formal link nurse group for end of life care. However, the Macmillan coordinator and the practice facilitator told us that they were keen to introduce these forums.
- We were told that staff in the Emergency Department (ED) had not had any training on breaking bad news despite this being a large part of their role. One member of staff told us that they would rely on the older, more experienced members of staff to do this.

End of life care

Multidisciplinary working

- Staff from the wards we visited told us that they were able to refer patients to the SPCT for advice and support. In addition to the SPCT, the trust employed specialist nurses covering a wide range of other disciplines, who were also able to support with the management of palliative and end of life care patients, for example, those with end stage respiratory conditions or heart failure.
- We were told that a weekly multi-disciplinary meeting took place. This meeting was an acute, local hospice, and community combined meeting. Staff we spoke with explained that the palliative care consultant and a specialist palliative care nurse prioritised the patients who would be discussed at the meeting. Staff within the acute service told us that they felt that the meeting was more community and hospice focused.
- On the intensive care unit, we were told that the decision to withdraw care at the end of life was made following a multi-disciplinary review. However, staff also raised concern that sometimes consultants changed the treatment plans for patients on a day-to-day basis. This included reports that decisions relating to resuscitation were made by one consultant and then changed the following day by another. We asked if this had been raised formally as a concern and were told that this was done on a case-by-case basis, but that it had not been reported through the incident reporting system.
- Staff from the bereavement team and the mortuary told us that they had close working relationships with all areas providing care at the end of life, and we witnessed this during our inspection.
- The trust did not use an electronic palliative care co-ordination system. However, the development of this was part of the strategy action plan.

Seven-day services

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

Access to information

- Staff on the wards we visited told us that they were able to access palliative and end of life care policies and guidelines on the trust intranet.
- Some wards we visited had resource folders available for staff.
- We saw information about the five priorities of care displayed on some of the wards we visited.
- The trust had an electronic system that allowed patients who were on the Care in the Last Days of Life document or who had a 'do not attempt resuscitation' decision in place to be identified. This was then visible to staff on a display screen on the ward.
- The bereavement team was able to access the electronic patient records system to ensure that it received in a timely manner details of patients who had died.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment means that a person must give their permission before they receive any kind of

treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.

- We saw staff seeking verbal consent before providing any care or treatment.
- All adults are presumed to have sufficient capacity to decide on their own medical treatment unless there is significant evidence to suggest otherwise. Capacity can sometimes change over time and should therefore be assessed at the time that consent is required. If a patient is assessed as lacking capacity and has not made an advance decision or formally appointed anyone to make decisions for them, careful consideration is needed to determine what is in their best interests before making a decision.
- The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. In certain cases, the restrictions placed upon an individual who lacks capacity to consent to the arrangements of their care may amount to deprivation of liberty.
- When deprivation of liberty might occur the provider of care must apply to their local authority, which will then assess the individual's care and treatment to decide if the deprivation of liberty is in the best interests of the individual concerned.
- Staff at the trust completed MCA and deprivation of liberty safeguards training as part of their mandatory training.
- During our inspection, we looked at do not attempt cardiopulmonary resuscitation (DNACPR) forms for eight patients.
- The forms indicated that three patients lacked capacity. We were unable to evidence that this had been formally assessed. In two cases, we could see no evidence that deprivation of liberty safeguards or best interest had been considered.
- We saw documented evidence in seven of the patients' records that the DNACPR decision had been discussed with the patient or their family.
- Three of the eight forms were not held in the front of the patients medical records, as the form stipulates they should be. However, all forms were signed by a senior clinician.
- The trust audited completion of DNACPR forms each year. We looked at the audit results for 2014, 2015, and 2016. The trust's summary of the audits indicated findings similar to those found during our inspection in that significant improvement was required in relation to the documenting of the mental capacity of patients.

Are end of life care services caring?

Good

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

- We observed ward staff and the SPCT being compassionate and caring to patients and their families, without exception.
- Patients and relatives we spoke with described staff as "brilliant" and "excellent" and said that they could not do enough for them.
- One patient told us that he was very well cared for.
- Staff provided emotional support to patients and their families.

However:

- The trust were unable to provide evidence of the feedback they sought from bereaved relatives as indicated in the National End of Life Care Audit – Dying in Hospital.

Compassionate care

- We observed ward staff and the specialist palliative care nurses being compassionate and caring to patients and their families, without exception.
- We found that staff were sensitive to the needs of patients and their families.
- One patient said that he was cared for very well. Another said that he could not fault the staff and that they were kind and caring. They described the staff as "brilliant" and "excellent" and said that they could not do enough for them.
- The bereavement team had received many compliments from bereaved relatives. We saw these displayed in the team's office. Compliments were also discussed at the palliative care business and governance meeting.

End of life care

- The trust participated in the National End of Life Care Audit – Dying in Hospital. The National report for England 2016 indicated that the trust sought feedback from bereaved relatives; however when asked, the trust were unable to provide any evidence of this feedback.

Understanding and involvement of patients and those close to them

- In an audit carried out by the trust in May 2016 only 40% of the records indicated that there had been communication with the patient to inform them they were in the last days of life. However, 100% of records we reviewed showed that discussion had taken place with the patient or their family.
- Staff told us that they aim to be responsive and engaged in providing support to relatives of end of life care patients.
- We visited the mortuary at the hospital. Staff here talked about being caring and compassionate when dealing with the deceased and their families.

Emotional support

- We saw staff providing emotional support to patients and their relatives during our inspection.
- The bereavement team had recently updated its Help for Bereaved Relatives leaflet. We found that this contained valuable information, including bereavement support services, to support those close to patients who had died.
- We saw that documentation for the general wards had emotional and anxiety assessments that staff completed on admission.
- A psychological and emotional assessment was also part of the Care in the Last Days of Life document. However, we saw limited use of this document during our inspection.

Are end of life care services responsive?

Good

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

- Staff on the wards told us that the SPCT was visible and available, and that team members regularly reviewed end of life patients and had discussions with patients and their families.
- Information received from the trust indicated that 86.5% of patients referred to the SPCT were seen within 48 hours.
- On all wards we visited staff told us that end of life care patients would be cared for in a single room.
- We visited the bereavement office and found that robust processes had been developed to support bereaved relatives.
- Staff from any ward or department could refer patients to the SPCT for advice and support. Data provided by the trust showed that 74.1% of patients were seen within 24 hours of referrals and a further 12.4% were seen within 48 hours.
- Information provided by the trust showed that 82% of patients audited were asked about and 71% achieved their preferred place of death.
- We were told that the discharge and liaison team was responsive to the needs of patients at the end of life and priority was given to these discharges.
- The trust had robust processes for identifying patients with dementia and learning disabilities.
- There had been no complaints relating to the SPCT, mortuary, bereavement service, or chaplaincy teams in the 12 months prior to our inspection.

However we also found:

- During bad weather, bereaved relatives may have to walk outside to reach the hospital mortuary despite there being an internal route.

Service planning and delivery to meet the needs of local people

- Care at the end of life was provided on many wards at the hospital, and staff were able to refer patients to the SPCT if they needed advice and support to care for any patient with complex needs, including symptom management. The team also provided training and education to the staff on the wards. The trust had recently included end of life care as part of all clinical staffs' mandatory training.
- Staff on the wards told us that the SPCT was visible and available, and that team members regularly reviewed end of life patients and had discussions with patients and their families.

End of life care

- Information received from the trust indicated that 86.5% of patients referred to the SPCT were seen within 48 hours.
- Staff we spoke with told us that the discharge liaison team was very responsive when support was needed to achieve a patient's preferred place of care at the end of life.
- Information provided by the trust showed that 82% of patients audited were asked about and 71% achieved their preferred place of death. However, we had concerns that, due to the issues identified about the completion of data collection tools, this figure did not include all patients who had died in the hospital.
- The trust had a My Future Care Plan: Making Plans for My Care document that staff gave to patients who were recognised as approaching the end of their lives. This document was designed to allow patients to specify their preferences and wishes for future care and treatment.
- As part of the end of life strategy, an information technology sub-working group had been developed. This group was working on improving systems and processes for staff to share and receive information when caring for patients at the end of their lives.
- The new processes being developed would also enable general practitioners and other external care providers to access the information.
- The bereavement team was able to access the electronic patient records to ensure that they received in a timely manner details of patients who had died.

Meeting people's individual needs

- On all wards we visited staff told us that, whenever possible, end of life care patients would be cared for in a single room.
- Staff in accident and emergency and on the clinical decisions unit told us that, where possible, patients approaching the end of their life would be nursed in a side room until a ward bed was available.
- On the intensive care unit, we were told that a side ward was not always available for care at the end of life. A member of staff said that they found this upsetting and undignified.
- Staff on one ward told us that, whilst staffing levels were safe, they did not always allow them to provide as much attention as they would like to end of life care patients.
- All staff we spoke with told us that open visiting was available for the relatives of end of life care patients. Some wards had sofa beds available in side rooms and some had a relatives' room with tea and coffee available. On one ward staff said that relatives could have free meals in the hospital dining room, which were then charged back to the relevant ward. Staff also told us that relatives received a concessionary parking pass.
- Staff were able to identify people with dementia or a learning disability on an electronic system. This was then visible to staff on a display screen on the ward. We also saw that patients were identified using 'My Life' symbols, which were displayed near their bedsides.
- We visited the bereavement office and found that robust processes had been developed to support bereaved relatives, including the implementation of an appointment system for relatives to attend to collect paperwork and patients' belongings.
- We looked at the relatives' and viewing room within the mortuary and found it to be well maintained and tastefully decorated.
- There were external and internal entrances (through the pathology department) to the mortuary. We were told that all members of the public were required to use the external entrance. This could mean that in bad weather relatives of deceased patients had to leave the hospital and follow the external route.
- We visited the accident and emergency department at the hospital and were shown the room to which relatives would be taken if they had a loved one who was at the end of their life. We also looked at the room where relatives could view the deceased. Both of these rooms were in the centre of the department. The relatives' room was small and both rooms were not well maintained or nicely decorated.
- Audits completed by the trust in October 2015 and May 2016 showed that patients' spiritual needs were not always considered during end of life care. The lack of chaplaincy cover was also of concern. However, chaplains were able to conduct funerals on behalf of the trust if requested.

Access and flow

- Staff from any ward or department could refer patients to the SPCT for advice and support. Data provided by the trust showed that 74.1% of patients were seen within 24 hours of referrals and a further 12.4% were seen within 48 hours.

End of life care

- Information received by the trust showed that the SPCT had received 524 referrals from October 2015 to October 2016. The ratio of cancer to non-cancer referrals varied each month. However, cancer patients accounted for the highest percentage of referrals each month.
- Staff told us that they could access the discharge and liaison team for support to fast track a patient back to their own home or to the hospice when needed. We were told that, when the local NHS ambulance trust was not able to provide transport in a timely manner, other resources were available for staff to use.
- Staff in the mortuary told us that they had never had any concerns regarding capacity, due to having developed positive working relationships with local undertakers.

Learning from complaints and concerns

- There had been no complaints relating to the SPCT, mortuary, bereavement service, or chaplaincy teams in the 12 months prior to our inspection.
- We saw Patient Advice and Liaison service information displayed on the wards that we visited.
- During our inspection, we discussed complaints with the senior management team members and were told that they would be involved in any complaint that involved a patient at the end of life. We were also told that complaints were analysed for themes, and, where necessary, the senior management team would be involved in the response to the complaint.
- The senior team members told us that they had recognised that complaints related to the service were not always identified because they were addressed to the ward or department where the patient had been cared for. In order to ensure that they were made aware of all complaints relating to the service, they had worked with the complaints team to filter the relevant complaints.

Are end of life care services well-led?

Good

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

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

However, we also found:

- That the risk register for the end of life care service did not identify all of the services risks, for example, the lack of seven-day service provision, delayed roll-out of Care in the Last Days of Life document, and completion of the deceased patient audit tool were not on the risk register.

Leadership of service

- We found that the trust had a robust end of life care management structure supported by the chief nurse, deputy chief nurse, and the deputy medical director at board level.
- The trust's chief nurse was the executive lead for end of life care. The deputy chief nurse was a member of the multi-agency strategy group and had responsibility for the bereavement work stream and the line management of the mortuary and bereavement teams.
- Staff in the mortuary told us that since the deputy chief nurse had been allocated as the lead for bereavement "things had started to move forward".
- The specialist palliative care nurses, the end of life clinical care coordinator, and the practice facilitator were line managed by the Macmillan lead cancer nurse.

Vision and strategy for this service

End of life care

- The trust had been part of a multi-agency group that was set up to devise and implement an end of life care strategy that encompassed the whole of the local health economy. We looked at the document that it had produced and found that the vision and purpose of the strategy was to ensure that appropriate care was provided in the appropriate setting at the right time, access to care was seamless and easy, and the patient's needs and wishes were central.
- Multi-agency strategy group meetings were held monthly. Trust attendance at these meetings included the deputy chief nurse, the deputy medical director, the associate chief nurse for community and therapies, the Macmillan lead cancer nurse, the SPCT, and the end of life clinical coordinator.
- Following ratification of the end of life care strategy in June 2016, seven work streams had been developed by the trust, with a member of the senior team having overall responsibility for a sub-working group. The work streams were education; bereavement; palliative care; do not attempt resuscitation; long-term conditions; IT; and children and neonatal. Each group met separately, and we saw action plans that had been developed to meet the required outcomes of the strategy.
- We saw that some of the working groups had developed visions for their areas of responsibility.
- We saw the trust vision and values displayed throughout the hospital. Staff we spoke with were aware of these.

Governance, risk management and quality measurement

- A palliative care business and governance meeting was held bimonthly. We looked at the minutes from these meetings and saw that governance, risks, and quality measures were discussed. These included complaints and incidents as well as human resource issues such as sickness and recruitment.
- The trust was collating and monitoring quality measures such as patient outcomes through the seven sub-working groups. A quarterly update on the progress of each working group was reported to the board.
- The trust had a non-executive director with responsibility for end of life care. Senior staff we spoke with told us that this provided challenge and support at trust board level.
- We looked at the risk register for the end of life care service and found that not all risks were identified, for example, the lack of seven-day service provision, delayed roll-out of the Care in the Last Days of Life document, and completion of the deceased patient audit tool were not on the risk register. However, we saw that these risks were on the action plans of the sub-working groups. Following our inspection, we received information that indicated that these risks were to be included on the overarching risk register for the service.

Culture within the service

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

Public engagement

- The trust had held 'Dying Matters' roadshows at a number of local venues in May 2016, including supermarkets and community centres. These had been advertised as events to provide advice and sign-posting to members of the public on all aspects of planning end of life care, bereavement, dying, organ donation, and will-writing.
- The palliative care consultant had shared two patient stories at the trust's quality and patient experience meeting.
- The trust had a range of leaflets available for patients and their loved ones, including information relating to specific conditions, as well as the recently updated bereavement booklet and advice and support leaflets for tissue and organ donation.
- The trusts website had a news and events page which patients and carers could access.

Staff engagement

End of life care

- Staff told us that they felt that communication between the team members and the information received from the trust had improved.
- Staff we spoke with told us that they were supported to professionally develop.
- The trust had appointed a MacMillan end of life care coordinator whose role was largely to educate staff and implement the Care in the Last Days of Life document on all wards and departments.
- We were told that all new starters attended 'care camp' where education about care at the end of life and the five priorities of care was provided.
- We were told that the palliative care consultant was planning to increase awareness amongst medical staff about the new Care in the Last Days of Life documentation by attending medical education sessions that were planned for January 2017.
- Staff from the SPCT told us that they had recently had trust board agreement to implement and facilitate a six-week end of life care course that would incorporate education for ward nurses on symptom control, communication, ethics, and spirituality.
- Compliments from patients and other services were discussed at SPCT meetings.

Innovation, improvement and sustainability

- The multi-agency health-economy-wide strategy was an innovative project to ensure that all relevant stakeholders and partners were working together to improve end of life care delivery.
- The trust held an annual 'Best Practice Day for End of Life Care' conference for the third year in 2016. Staff we spoke with who had attended this told us that it was valuable and that they cascaded the learning to other members of their teams.
- The Macmillan end of life care clinical coordinator had been in post for ten months. During that time, 400 staff had attended educational sessions and the new end of life care plan had been implemented on 11 wards. An end of life care facilitator had also been appointed recently. We were told that this role would expedite the rollout of the Care in the Last Days of Life documentation.
- The bereavement team attended the trust induction to ensure that staff were aware of the processes required following the death of a patient. In addition to this, they had also developed guidelines for the completion of death certificates, to support the medical staff to ensure that the certificates were completed accurately and fully, to prevent any delays for bereaved families.
- The bereavement team had also implemented an electronic appointment system for families to collect relevant paperwork following the death of a loved one. This meant that families were seen in a timely manner and that all relevant documents were ready for collection at their designated appointment.
- Staff from the mortuary provided educational sessions to junior medical staff to support them when dealing with end of life care situations.

Outpatients and diagnostic imaging

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

Information about the service

Scunthorpe General Hospital (SGH) had outpatients (OP), phlebotomy, and radiology departments. These were part of clinical support services within the trust. Pathology services were 'Path Links' a service hosted and managed by the Trust and providing pathology services to other organisations.

The radiology department had four general X-ray rooms and a minor specialist room, which was used for interventional radiology. The imaging suite at SGH provided a seven-day diagnostic service for computed tomography (CT), magnetic resonance imaging (MRI), and non-obstetric ultrasound scans. There was a mobile unit in the accident and emergency department, which provided a 24-hour, seven-day service.

The outpatients department (OPD) held clinics that included ophthalmology, general medicine, cardiology, dermatology, rheumatology, gastroenterology, ENT, breast, orthopaedic, urology, immunology, oncology, pain, vascular, and endocrinology. The ophthalmology and ENT clinics were separate from the main OPs area. The OP nurse manager was not responsible for audiology or dermatology.

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

From 1 April 2015 to 31 March 2016, the OPDs at this trust saw 430,847 patients (new and follow-up). Around 9% of patients did not attend (DNA); around 30% were new patients; and 61% were follow-up patients. Radiology attendance figures from January 2016 to December 2016 were 405,662.

From 1 April 2015 to 31 March 2016, the OPD at SGH saw 175,060 patients. The three specialities with the highest number of patients were ophthalmology (24,830), trauma and orthopaedics (16,384), and gynaecology (10,035). Around 8% of patients did not attend (DNA); around 32% were new patients; and 60% were follow-up patients. From January 2016 to December 2016, there were 163,866 radiology attendances at SGH.

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

We spoke with seven patients and relatives in the OP clinics, including ophthalmology, and two patients in the radiology waiting areas, who shared their views and experiences of the service with us. We also spoke with 35 staff including radiologists, consultants, managers in diagnostic imaging and outpatients, nurses, radiographers, support workers, student nurses, and administrative staff.

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

Outpatients and diagnostic imaging

Summary of findings

We rated outpatient and diagnostic imaging services as inadequate overall. Safe was rated as requires improvement, responsive and well-led were rated as inadequate, and caring was rated as good.

Although we inspect the effective domain, we do not give it a rating.

There was evidence of harm to patients because of poor management of follow-up appointment systems, and ongoing significant risk of harm to patients posed by increasing referral to treatment times (RTTs) and patients waiting past their due date for follow-up appointments or with no due date.

When we inspected this service in October 2015, we rated it as inadequate overall. Safe, responsive, and well-led were rated as inadequate, effective was not rated, and caring was rated as good. This was because there was evidence of harm from poorly managed follow-up appointment systems and there were high numbers of patients who did not attend appointments and cancelled clinics, particularly in ophthalmology. There was a backlog of 30,667 outpatients without follow-up appointments, and the service had no clear action plan to address the immediate clinical risk to patients. There were demand pressures in a number of OP specialties, and there was a lack of management oversight of the significant problems with clinic booking systems. We asked the trust to take immediate action and the trust agreed 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
- Focus on validation of ophthalmology lists and, when complete, explore additional validation resources required to look at other outpatient specialty areas.

At this inspection, we found that, while the trust had made progress in some areas, the response to concerns in other areas had been slow, and significant concerns and risks were still apparent.

We found that:

- Audit of follow-up lists was ongoing in August 2016 and a number of cohorts of patients were discovered in unmonitored systems. This amounted to around 18,000 patients (6,000 of these were ophthalmology patients).
- The trust had not significantly reduced the high number of cancelled clinics overall, although this was improved in some areas.
- RTTs were worsening, and the trust told us that it was unlikely to recover a good position until March 2018.
- There continued to be large numbers of patients who were overdue for follow-up appointments or who had no due date on the patient administration system.
- There was a significant risk of potential harm to patients who were waiting long periods of time for first and follow-up appointments.
- The trust had not validated the clinical risk within waiting lists in a timely manner.
- Although the trust had appointed an internal lead to oversee the administration teams and drive the required improvements in OPD booking systems, there appeared to have been little additional support available until autumn 2016.

However:

- The trust had stopped the practice of non-clinical staff cancelling clinics.
- The OPD had addressed issues relating to the facilities and environment, systems for sharing learning from incidents and complaints were evident, and issues relating to the safe storage of refrigerated drugs had been addressed. Staff at all

Outpatients and diagnostic imaging

levels were aware of issues relating to waiting lists for new and follow-up patients, and there was a shared responsibility; staff were working together to make improvements.

- There were no significant concerns identified within the diagnostic services that we inspected. Here we found that patients were protected from avoidable harm and received effective care. Action had been taken to ensure all radiology staff had received training regarding the ionising radiation (medical exposure) regulations (IR(ME)R 2000).
- Systems were in place in radiology and outpatients to ensure that the service was able to meet the individual needs of people, such as those living with dementia or a learning disability and those whose first language was not English.
- Abandoned call rates were now being monitored and patient tracker lists (PTLs) had been developed and were monitored on a weekly basis as part of a performance dashboard.

Are outpatient and diagnostic imaging services safe?

Requires improvement

At our previous inspection of this service, in October 2015, we identified significant safety concerns and this domain was rated inadequate. During this inspection, we rated the service as requires improvement for safe.

This was because:

- There were four serious incidents (SIs) recorded from August 2015 to August 2016 for this hospital. Two of these were in ophthalmology, one was in urology, and one was in ENT. Three of the incidents had resulted in significant harm to patients. The fourth incident was a trust-wide incident report regarding the discovery, in August 2016, of a previously unknown backlog of around 6,000 ophthalmology patients who were waiting for an outpatient appointment. The trust made this report due to the high risk of potential harm to patients who were waiting to be seen.
- There was a subsequent SI in October 2016 relating to missed referral across the trust. This was undergoing investigation into the scale and causes of the issue at time of writing this report.
- Root causes from incident investigations included a lack of standard operating procedures for making follow-up outpatient appointments following histology investigations and a lack of clarity regarding responsibility for booking and monitoring of follow-up appointments needed after an inpatient episode.
- Safeguarding training compliance for the outpatient staff was poor at 64%; the trust target was 95%.
- The trust had been slow to implement clinical validation and assessment of risk within waiting lists across all specialities.

However:

- Cancellation of clinics by non-clinical staff had ceased.
- We found that sharing lessons from incidents had improved and staff reported departmental patient safety incidents and radiation incidents in the appropriate way. These were investigated appropriately.

- The facilities and premises had been improved since our previous inspection and were suitable for differing patients' needs.
- Action had been taken to ensure recording of minimum and maximum fridge temperatures, which was necessary for safety and efficacy of the medicines, and staff knew what to do should temperatures go outside of the correct range. The trust had also introduced an IT system that enabled monitoring and recording to be undertaken by the pharmacy team.
- Although there were 3.5 unfilled vacancies for radiologists (32.2% vacant posts), the department was managing this shortfall and was continuing to try to recruit. Reporting work was outsourced to alleviate workload and we found no detrimental effect on the care and treatment of patients due to this shortage.
- All radiology staff had received training regarding the ionising radiation (medical exposure) regulations (IR(ME)R 2000) and this had been made mandatory.

Incidents

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

Outpatients

- In accordance with the NHS England Serious Incident Framework 2015, the service across the trust reported five SIs that met the reporting criteria set by NHS England, from October 2015 to September 2016. Four of these related to patients who were being seen and treated at SGH.
- Two SIs resulting in patient harm were caused by failure to provide outpatient follow-up appointments following an inpatient episode. These were in the specialities of ENT and Urology. One SI was regarding harm to an ophthalmology patient who did not receive a timely follow-up appointment. The fourth incident was a trust-wide incident report regarding the discovery, in August 2016, of a previously unknown backlog of around 6,000 ophthalmology patients who were waiting for an outpatient appointment. The trust made this report due to the high risk of potential harm to patients who were waiting to be seen.
- Root causes from incident investigations included a lack of standard operating procedures for making follow-up outpatient appointments following histology investigations and a lack of clarity regarding responsibility for booking and monitoring of follow-up appointments needed after an inpatient episode.
- There were also a number of other contributory factors identified, such as the four week booking rule not being appropriate for patients in all specialities and appointment validation not being up to date.
- The trust had implemented a number of actions to reduce the risk of this happening again. For example, the urology service was operating exceptions to the four-week appointment booking window. The speciality administration teams (SATs) we spoke with were aware that there were exceptions to the four-week booking rule and of how the exceptions could be applied. The data quality team had also been assigned to help the urology SAT to complete the waiting list validation and bring it up to date.
- Subsequently, the trust reported an additional SI in October 2016 relating to missed referrals from GPs to the trust. The trust was in the process of working with GP practices and CCGs to identify any patients' referrals that had been missed and to provide appointments. The trust was also still investigating the reasons for the lost communications and liaising with individual GP practices when issues were identified. There had been no harm to patients identified at the time of writing this report.
- From August 2015 to August 2016 the outpatient service, across the trust, reported 527 incidents. One was classified as severe harm, three as moderate harm, 139 as low harm, and 384 as no harm.
- Of these, the ophthalmology service reported 97 incidents. One was classified as severe harm (February 2016), two as moderate harm, 18 as low harm, and 74 as no harm.
- The most frequently reported low and no harm incident categories were:

- 114 patient accident (21.6%)
- 91 documentation (including electronic & paper records, identification and drug charts)
- 83 clinical assessments (including diagnosis, scans, tests, assessments)
- 58 access, admission, transfer, discharge (including missing patient)
- 55 treatment, procedure.

- From September 2015 to August 2016, the outpatient service at SGH reported 124 incidents. One was classified as severe harm, two as moderate harm, 23 as low harm, and 98 as no harm. The severe harm incident is described above as an SI. The two moderate harm incidents were later regraded and reported as SIs (included above in ENT and urology).
- Staff confirmed that incidents were discussed at staff meetings and that they knew how to report incidents. Staff told us they also received feedback and learning from incidents via briefings, newsletters, the intranet, and team meetings.
- We saw from incident reports that duty of candour requirements had been adhered to.

Diagnostic Imaging services

- In accordance with the NHS England Serious Incident Framework 2015, the service reported one serious incident (SI) that met the reporting criteria set by NHS England from October 2015 to September 2016. The incident was reported at SGH as a diagnostic incident including delay of diagnosis and treatment. Although no patient harm was identified, there was a significant delay in treatment and the risk that the treatment would not be as successful.
- There were six Ionising Radiation Medical Exposure (2000) regulations IR(ME)R incidents reported by the trust since March 2016. The CQC's IR(ME)R team reported that this was about average for a trust of this size. Although there were no major concerns or patient harm, a theme of putting the wrong patient sticker on to referrals was identified. This was also reflected in the documentation incidents below.
- From 8 October 2015 to 28 August 2016, 148 low and no harm incidents had been reported in radiology across both hospital sites. The categories with the highest numbers of incidents were:
  - 57 clinical assessment (including diagnosis, scans, tests, assessments). Nine of these were patients who attended MRI with a pacemaker in situ; this is a contraindication for MRI scanning. Radiographers identified these prior to the scan, therefore there was no patient harm
  - 35 documentation (including electronic & paper records, identification and drug charts). The majority of these incidents related to identity issues such as wrong patient details on referral forms
  - 21 patient accident
  - 10 treatment, procedure.
- Incidents were discussed at the monthly governance meetings and we saw minutes of meetings that confirmed this. There was evidence of discussions of root cause analysis (RCA) being carried out, serious incidents, and monitoring of action plans.
- Staff told us that they were able to access the electronic reporting system and knew how to report incidents. They told us that feedback was given at team meetings along with any changes to practice. The staff we spoke with were unable to give any examples of changes because of an incident they had reported. However, we saw from incident reports that information was fed back to relevant staff on an individual basis and through team briefs and hospital newsletters as appropriate.
- Staff we spoke with knew that they should be open and honest with patients if anything went wrong with their treatment or care. Departmental managers took responsibility for ensuring that duty of candour processes were carried out appropriately.

Cleanliness, infection control and hygiene

Outpatients

- Clinical and non-clinical areas in OP appeared visibly clean and tidy, with equipment stored appropriately. Staff told us that domestic staff cleaned the department.
- We saw that staff complied with infection prevention and control policies, for example, wearing personal protective equipment (PPE) and participating in hand hygiene audits
- In OPD at SGH the latest hand hygiene audits (April and July 2016) showed 100% compliance for 'before and after patient contact' and 'bare below the elbows'.
- Overall hand hygiene compliance for audiology staff was 100%.
- We saw that staff segregated waste appropriately.

Outpatients and diagnostic imaging

- We saw that SGH OPD had an overall score of 100% on the trust's infection control and prevention (IPC) 'Frontline ownership audit tool' in July and August 2016,
- We did not see specific training figures for infection control but this would be covered as part of mandatory training.

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

Environment and equipment

- Outpatient and radiology departments were clearly signposted throughout the hospital.
- Staff told us that the majority of equipment used in outpatients was disposable/for single use and any equipment needing sterilisation after use was collected daily and taken to the Sterile Services at the Diana, Princess of Wales (DPoW) hospital at Grimsby, and returned sterile and repackaged.
- We saw, and staff told us, that equipment was serviced annually and there were contracts in place with manufacturers for maintenance and repair of specialist equipment such as microscopes and visual field machines.
- There was a clear process in place for decontamination of endoscopes.
- Staff told us that they cleaned the toys in the children's waiting area weekly. However, this was not recorded anywhere.

Outpatients

- The OPD at SGH was located on the first and second floors. Entry to the building was at ground floor level and there were lifts and stairs available. Ophthalmology and ENT clinics were located on the second floor.
- We saw that work had been undertaken since our last inspection to provide more designated waiting areas for patients, and patients were no longer waiting in corridors. Access was improved for patients in wheelchairs or with mobility difficulties.
- We checked the resuscitation trolleys and found medications were in date and all checks were completed, and up-to-date. There was a paediatric trolley in the ophthalmology outpatients area and there was one adult trolley on each floor.
- We saw that the hypoglycaemia boxes were checked daily.

Diagnostic Imaging services

- Resuscitation trolleys and equipment including suction and oxygen lines were all checked and cleaned daily and checklists were signed and found to be up to date. Trolleys were locked and tagged, and staff made weekly checks of contents and their expiry dates.
- Reception areas experienced busy periods. However, there was sufficient seating to meet demand. The department had designated trolley areas and wheelchair spaces marked on the floor. This made sure that the privacy and dignity of patients was preserved.
- Seating was in good condition and there was a mixture of standard and high chairs to help people with mobility problems to stand more easily.
- Water fountains were provided for patients' use and there was a shop and a café where people could purchase drinks, snacks, and meals.

- During our observations we saw that there was clear and appropriate signage regarding hazards in the imaging department.
- In diagnostic imaging, quality assurance checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protected patients against unnecessary exposure to harmful radiation.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging.

Medicines

Outpatients

- We checked medicines storage in the OPD; all medicines stored were found to be stored securely and in date.
- We saw that staff were recording minimum and maximum fridge temperatures and staff we spoke with were aware of this requirement and knew what to do should temperatures go outside of the recommended range. The trust was in the process of implementing new remote monitoring system for fridges, which will be overseen by pharmacy.
- We noted that medicines were stored at room temperature and the temperature of the room was being monitored.
- A safe and secure medicines audit in February 2016 found that SGH outpatients areas were 88% compliant with the standards.

Diagnostic Imaging services

- In the diagnostic imaging department some interventional procedures required sedation, and a consultant, a nurse, and an allied health professional, such as a physiologist or radiographer, were present at such procedures, and observations were carried out and recorded.
- PGDs (patient group directions) for drugs used commonly in the department were in place for adrenaline and saline.
- Radiology staff's administration of medication competencies were checked, recorded, and reviewed.

Records

Outpatients

- At the time of inspection, we saw that patient personal information and medical records were managed safely and securely within the OPD. All patient records were paper-based.
- Staff told us that if records were not located before a clinic then the administration team would make up a temporary set of records, which would be merged with the original set when located.
- The trust did not collect data regarding the percentage of patients seen without a full medical record.
- Staff told us there was an escalation process in place for them to use when notes were unavailable for clinics.
- We looked at the medical records of five patients attending the ophthalmology outpatient clinic. We found these were of a good standard. They contained sufficient up-to-date information about patients, including referral letters, copies of letters to GPs and patients, and medical and nursing notes.
- We saw from incident records that staff would sometime see patients without their notes if these could not be located. We saw examples where medical staff saw patients using only their referral letter. This meant there was a risk that the staff member carrying out the consultation did not have all of the patient information required.

Diagnostic Imaging services

- Diagnostic imaging and reports were stored electronically and available to clinicians via Picture Archiving and Communications System (PACS).
- Risk assessments were carried out, with ongoing safety indicators for all radiological equipment, processes, and procedures. These were stored electronically and were easily accessible to all diagnostic imaging staff.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation were recorded. Maximum dose levels were displayed in each of the imaging rooms.

Safeguarding

Outpatients

- Level 2 children's safeguarding training was mandatory for all staff in the department. Adult safeguarding training was also mandatory. The trust submitted combined training data for the outpatient service that showed safeguarding training compliance was at 64% for SGH. This was below the trust standard of 95%.

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and children.
- Staff knew how to access policies and senior specialist safeguarding staff within the organisation whom they could speak with for advice.
- The healthcare assistants we spoke with told us they would escalate any concerns to the nurse in charge of the clinic in the first instance.
- Staff were aware that they needed to highlight children who did not attend their outpatient appointments to their safeguarding lead.

Diagnostic Imaging services

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and children. Staff knew that there was a policy on the intranet and that there were staff within the organisation whom they could speak with for advice. All of the staff we spoke with said they would escalate any concerns to their manager in the first instance.
- All staff groups in the department were meeting the trust standard of 90% of staff being up-to-date with safeguarding training requirements at level two for children and level one for adults.

Mandatory training

Outpatients

- Staff we spoke with told us their mandatory training was up to date. They told us they were notified when it was due for renewal.
- Data submitted at 31 October 2016 showed overall compliance with mandatory training was 88% for nursing staff, 88% for audiology staff, and 100% for reception staff. The trust standard was 95%.
- Staff told us that there was some delay in being able to access manual handling training.

Diagnostic Imaging services

- Mandatory training was well managed. The diagnostic imaging departments had systems and processes to ensure staff training was monitored.
- Data submitted at 31 October 2016 showed overall compliance was over the 90% trust target for all staff groups.
- Training was accessed via e-learning and classroom-based training sessions.
- Mandatory training compliance for radiology varied and the rates were: for Fire Safety 93%; Infection prevention and control 96%; Slips, trips and falls 96%; mental capacity 84%; Deprivation of liberty 20%; Conflict resolution 95%; and information governance 89%.
- Staff told us that they were not allocated time to complete mandatory training but only occasionally experienced problems attending.
- All radiology staff had received IR(ME)R training and this was now part of mandatory training.

Assessing and responding to patient risk

Outpatients

- To manage the risks posed by lengthy waiting lists, the outpatient management team told us they had developed a clinical validation policy that had been agreed by all clinical groups.
- Clinical staff were validating waiting lists with a view to prioritising patients for clinic review and discharging patients where appropriate. Alongside this, administrative staff were also reviewing waiting lists with a view to cleansing data by closing down pathways that had been left open in error.
- We saw evidence that clinical validation was ongoing in a number of specialities. Consultants and managers told us of a number of ways in which validation was being managed and risks mitigated.
- We saw that the majority of clinical validation was undertaken by consultants although they did delegate some of this work to other medical staff and some clinical nurse specialists. Junior staff were expected to discuss any case they were unsure about with the lead consultant.
- We saw that some patients were discharged following a case review, others received a telephone consultation prior to discharge or appointment, and others were given appointment due dates depending on the urgency of their clinical need. The trust wrote to the GPs of all patients who were discharged asking them to re-refer if warranted by deterioration in the patient's current condition.
- November 2015 to November 2016, discharge and referral data for SGH indicated that there was not a sustained rise in increased discharges until August 2016. This corroborated what staff had told us about clinical

validation of waiting lists stalling for several months following some initial activity following our previous inspection and re-starting just a few weeks before this inspection.
- The number of discharges reached a peak in September 2016 and was showing a slight decline for October and November 2016.
- Re-referral rates within six weeks were between 1.3% and 3.4%.
- We looked at data that showed validation of cardiology lists was limited before July 2016 despite waiting list issues being raised following the October 2015 inspection. There were 1,258 patients discharged from September 2015 to September 2016; the majority of these (1,161) since July 2016. Sixteen of the discharged cardiology patients had been re-opened or referred back into the service (around 1.5%).
- Weekly meetings were being held with managers, consultants, and staff in the SAT to review the waiting list position and manage/prioritise capacity and demand for appointments.
- The trust had outsourced some new ophthalmology referral work to an independent provider to help address the waiting list issues and was looking at possibilities to outsource work from some other specialities such as gastroenterology.
- Nurse specialist roles were being developed in ophthalmology to run injection clinics to help alleviate lengthy patient waits.
- Managers told us that the pain team had been asked to explore options for their service to improve things for the long waiters for their service and to consider any work that could be undertaken by, or in partnership with, primary care.
- Managers told us that work with NHS improvement had included looking at the reasons why there was a mismatch between demand and capacity, quantifying the capacity and demand in each speciality, and risk rating each of the specialities.
- Managers told us that the SAT teams were now ready to start real-time validation of patient tracker lists (PTLs). This would ensure waiting lists were managed appropriately and the quality of data input was improved, to ensure that patient outcomes (e.g. whether discharged or for further investigation, treatment, or appointment) were correctly coded to prevent issues, such as no due date and pathways left open incorrectly, from happening in the future.
- Staff told us that if a patient became unwell they would seek immediate assistance from medical staff in the department. The patient would then be transferred to the accident and emergency department (A&E) for assessment.
- In the case of a patient collapse in the outpatient department, all staff we spoke with were aware of how to raise the alarm and raise a crash call.

Diagnostic Imaging services

- The department had a process for prioritising the urgency of diagnostic imaging referrals and requests. All urgent referrals were flagged and escalated to ensure that they were given an early appointment. All other requests were triaged and appointments were allocated accordingly.
- There were emergency assistance call bells in all patient areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- Staff were aware of actions to take if a patient's condition were to deteriorate while in the department and explained how they could call for help and access the cardiac arrest team, and the process for transferring a patient to A&E. There were also a number of resuscitation trolleys and defibrillators across imaging departments.
- There were policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- Diagnostic imaging policies and procedures were written in line with IR(ME)R.
- Managers told us that the heads of service were trained Radiation Protection Supervisors and that all but one member of staff had now had IR(ME)R training.
- The department underwent an IR(ME)R audit in March 2016. The audit provided an assurance level of 'Significant'.
- There were named certified Radiation Protection Supervisors to give advice when needed and to ensure patient safety at all times. The trust had radiation protection supervisors (RPS) and liaised with the Radiation Protection Advisor (RPA). The RPA was employed by another trust and there was a service level agreement in place.

Outpatients and diagnostic imaging

- There were two Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holders in the trust; one person was employed by the trust and was responsible for cardiology and the other was an external person responsible for medical physics.
- The ASARC holder for the medical physics elements of diagnostic imaging was employed by another trust with a service level agreement in place. This was because the two previous holders had retired. There were plans in place to identify and train a new radiologist employed by the trust. However, this had not yet happened.The role of the ARSAC advisor was to be contactable for consultation and to provide advice on aspects relating to radiation protection concerning medical exposures in radiological procedures. Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. (Local rules are the way diagnostics and imaging work to national guidance and vary depending on setting.) Policies and processes were in place to identify and deal with risks. This was in accordance with IR(ME)R 2000.
- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room, therefore preserving the privacy and dignity of the patient. This was in accordance with radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and, if the x-ray was still necessary, could wear a lead apron to protect the unborn baby.
- Staff told us that the risks of undergoing an x-ray whilst pregnant were fully explained to patients.

Nursing and allied health professional staffing

Outpatients

- There was a dedicated team of outpatient nurses, receptionists, and support workers working in the OPD.
- Staffing information submitted by the trust showed that there were 7.09 wte nurses in post in the OPD at bands 5 and above and the establishment was 8 wte.
- There were 21.69 wte staff at bands 1 to 4 in post, and the establishment was 24.64 wte.
- Total staffing establishment was 34.4 and there were 29.54 wte in post, leaving a shortfall overall of 4.86 wte.
- From October 2015 to September 2016 the trust reported an overall vacancy rate of 3% and a turnover rate of 18% in outpatients.
- From October 2015 to September 2016 the trust reported a sickness rate of 3% in outpatients
- From October 2015 to September 2016 the trust reported a bank and agency usage rate of 0.1% in outpatients.
- Nursing staff told us that they were able to use agency staff when needed but that usually clinics were covered by regular staff working flexibly or by working additional hours.
- There was a clinical staffing review ongoing across the whole of outpatients.

Clinical administrative staffing

- There were 18 SATs across the trust. These teams booked appointments and dealt with referrals, discharges, and clinic letters, and managed waiting lists for outpatients.
- Staff told us that there were vacancies in medical secretary posts and in the SATs, which were covered by bank and agency workers. Some staff told us that they were still unsure of their roles and responsibilities and had concerns that agency and bank staff lacked the experience needed for some roles and responsibilities.

Diagnostic Imaging services

- We looked at the staffing levels in each of the diagnostic imaging departments at SGH. There were 52.63 wte funded radiographers across the department and 58.22 wte radiographers in post.
- All department managers told us that staff were flexible to be able to ensure cover was available. There were no departments with significant vacancies that would affect the way they were able to function. Staff told us they were very busy but had sufficient staff to meet service and patient needs and that they had time to give to patients.
- The radiology department had nurses and health care assistants who assisted with interventional procedures. There was very little nurse agency use in the department.
- Radiographers staffed the department over two shifts, including a night shift. There were sufficient staff on duty to meet the needs of the service.

- Radiographers and radiography assistants were registered with the hospital bank and carried out additional shifts if needed. The department also worked with a local university to train student radiographers.
- The department employed reporting radiographers. This helped to alleviate the pressure on radiologists and radiologist vacancies.

Medical staffing

Outpatients

- Medical staffing for OP clinics, along with clinic capacity and demand, were managed within each clinical division, such as medicine and surgery. The divisions reviewed and managed their own mandatory training, appraisal, and revalidation for medical staff.
- From October 2015 to September 2016 the trust reported a vacancy rate of 25% and a turnover rate of 23% in outpatients.
- From October 2015 to September 2016 the trust reported a sickness rate of 0% and a bank and locum usage rate of 0.2% in outpatients.

Diagnostic Imaging services

- The Radiology Service was delivered as one service across all three trust sites. The diagnostic imaging service across the trust had a funded establishment of 21.7 wte consultant radiologists. There were 8.57 wte vacancies across the service at the time of the inspection.
- At SGH there was a funded establishment of 10.85 wte consultant radiologists. The hospital employed 7.3 wte staff at the time of the inspection. This meant there were 3.5 wte vacancies.
- The number of radiologists in post enabled the service to provide a core service cover from 9am until 5pm from Monday to Friday. Outside these hours, there was a radiologist on call at SGH and DPoW, with overnight cover for CT scanning provided by an external provider, to reduce the impact of compensatory rest on the normal working day. Radiologists all had viewing stations at home should an urgent report be required.
- The department contracted the reporting of some X-rays and scans to external companies to enable it to meet the demands on the service. There were formal service level agreements (SLAs) in place for this process.
- There was a national shortage of radiologists. However, the trust had held recruitment events worldwide to encourage radiologists to join the trust. These had had some limited success. There was an ongoing recruitment drive to attract radiologists. The trust was also in discussions with other trusts regarding the possibility of joint appointments.
- The trust had not recorded any sickness levels for radiologist staff.
- From August 2015 to July 2016 locum use varied between 2.7% and 4.2%.

Major incident awareness and training

Outpatients

- Service staff had access to major incident and business continuity plans.
- Staff and managers told us there had been a recent major incident declared as a result of a cyber-attack. They told us that they felt the incident had been managed well and they were aware of debriefings and activities in place to learn from the event and improve the response to any future incidents of this type.

Diagnostic Imaging services

- Staff were aware of the action they should take in the event of a radiation incident. There were standard operating procedures in place.
- The various teams within the diagnostic imaging department had business continuity plans in place. In the event of equipment failure, the trust had agreements with local providers to allow them access to equipment such as MRI scanners. There were also maintenance contracts in place to ensure that any mechanical breakdowns would be fixed as quickly as possible.
- Staff knew their roles in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Outpatients and diagnostic imaging services were inspected but not rated for effectiveness:

- Staff had access to policies and procedures and other evidence-based guidance via the trust's intranet. Staff we spoke with was aware of NICE and other guidance that affected their practice.

Outpatients and diagnostic imaging

- The staff working in outpatients and diagnostic imaging departments were competent, and there was evidence of multidisciplinary working across teams and local networks.
- Nursing, imaging, and medical staff understood their roles and responsibilities regarding consent and the application of the Mental Capacity Act.
- Staff undertook regular audits in imaging departments regarding quality assurance to check practice against national standards.

Evidence-based care and treatment

Outpatients

- Staff had access to policies and procedures and other evidence-based guidance via the trust's intranet. Staff we spoke with were aware of NICE and other guidance that affected their practice.

Diagnostic Imaging services

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy, in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with ionising radiation undertaken in the trust was safe as reasonably practicable.
- NICE guidance was disseminated to departments. Staff we spoke with were aware of NICE and other guidance that affected their practice.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The imaging department carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

Outpatients

- Pain relief medication was not routinely administered in the outpatient departments we visited.

Diagnostic Imaging services

- Pain relief medication was not routinely administered in the radiology department unless the patient needed to be sedated.
- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures. Inpatients received pain relief on the ward prior to arriving in the department, and outpatients were asked to bring their normal medication with them. Additional pain relief for procedures such as biopsies was prescribed by radiologists and administered safely as required.

Patient outcomes

Outpatients

- Patient Reported Outcome Measures (PROMS) were collected and reported nationally in line with Department of Health requirements.
- The follow-up to new rate for SGH was lower than England average.

Diagnostic Imaging services

- All images were quality checked by radiographers before the patient left the department. National audits and quality standards were followed in relation to radiology activity.
- Audits carried out in radiology included an audit of MRI patient safety questionnaires and referrer errors. Managers gave examples of audits carried out, such as the appropriateness of ankle/foot x-rays. They also told us that there were processes in place for peer review.
- Discrepancy reports were made, for example, if a multi-disciplinary team (MDT) picked up something on an image that had not been reported.
- The diagnostic imaging department was not Imaging Services Accreditation Scheme (ISAS) accredited. However, the trust employed an ISAS assessor.
- We saw evidence of clinical audits being carried out by the imaging department. Audits carried out were based on adherence to Royal College of Radiologists' standards of practice.
- Where audits had taken place, there were action plans to assist with service improvements.
- The organisation had systems to review NICE guidance and ensure that any relevant guidance was

implemented in practice. In diagnostic imaging these included radiology related to head injury clinical guidance and stroke thrombolysis and non-thrombolysis imaging times.

Competent staff

Outpatients

- Data submitted at 31 October 2016 showed outpatient reception staff were 100% compliant with appraisals at this site. Nursing and audiology staff had compliance levels of 86% and 80% respectively.
- Health care assistants (HCAs) were trained and assessed as competent to carry out decontamination of endoscopes. Competence was audited six-monthly and 100% of staff were assessed as competent at the last audit.
- Staff told us that HCAs were trained and had been assessed as competent to undertake vison tests in outpatients.
- Some members of the SATs told us that they had not had appraisals in the preceding 12 months, and that this was largely due to pressure of work.
- Other staff we spoke with told us they had received an appraisal in the last 12 months.
- The band 6 nurse had undergone additional training and competency-based assessments, which enabled her to work in radiology undertaking a number of tests.

Diagnostic Imaging services

- By August 2016 75% of medical staff across the trust had undergone their annual appraisal. For allied health professionals this was 86% and for nursing and midwifery staff this was 93%.This information was not split by site.
- There were plans in place to ensure that this was 100% for all staff by the end of the year.
- Data submitted at 31 October 2016 showed radiology medical staff and staff groups in general radiology were 100% compliant with appraisals at this site. CT and ultrasound had compliance levels of 79% and 58% respectively.
- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.
- Allied health professionals were supported to maintain their registration and continuing professional development.
- Radiographers working in interventional roles were trained in specialist areas by the clinical leads, for example, in angiography, ultrasound scans, and CT.
- In all departments, staff were encouraged to discuss development needs at appraisal and as opportunities arose. Trust funds were made available for staff to attend external courses including postgraduate qualifications although there were strict criteria for accessing these funds. The department had paid for some radiographers to train to become reporting radiographers.
- There were formal arrangements for induction of new staff. All staff completed full local induction and training before commencing in their roles.

Multidisciplinary working

- Managers told us about a 'perfect week' where radiology and outpatients staff had worked with GPs to look at capacity and demand issues and referral processes. There was ongoing work to improve referral pathways and develop alternatives other than outpatient and diagnostic referral.

Outpatients

- A range of clinical and non-clinical staff worked within the outpatients department. Staff were observed working in partnership with people from other teams and disciplines, including radiographers, nurses, booking staff, and consultants.
- We saw that staff worked well together as a team and that this helped the clinics run smoothly.
- There was evidence of multi-disciplinary team (MDT) working in the outpatients and imaging departments.

Diagnostic Imaging services

- There was evidence of multi-disciplinary working in the imaging department. For example, nurses, radiographers, and medical staff worked together in interventional radiology theatres.
- We saw that the diagnostic imaging departments had links with other departments and organisations involved in patient journeys such as GPs and support services. For example, the radiology department worked A&E to ensure that X-rays, CTs, and other scans were carried out and reported in a timely manner.
- Radiologists attended multi-disciplinary meetings to discuss diagnosis and treatment plans for suspected cancer patients.

- Managers told us that, due to vacancies, the radiologists needed to work across both hospitals to cover MDT meetings (particularly breast staging) and that this work was given priority.

Seven-day services

Outpatients

- Staff in the ophthalmology clinic told us that there was a weekly evening clinic and this seemed to suit elderly patients as it was easier for them to arrange for a family member to bring them, parking was easier, and flow through the clinic was quicker.
- This service also had held weekend clinics and these were now being run by a subcontracted provider.
- There were a number of clinics running until 6.30pm and an evening clinic was held once a week for ophthalmology patients from 5pm to 8pm.

Diagnostic Imaging services

- The imaging service was delivered as one service across all three trust sites. The two radiology departments at SGH and DPoW were open and staffed 24 hours, 7 days a week, providing service for the major trauma units and inpatients.
- CT at SGH and DPoW were staffed from 7.30am to 8.30pm and had an on call service outside these hours. Because the hyper acute stroke unit was at SGH, there was 24 hours, 7 days a week, cover of CT by CT-trained radiographers. This ensured that the trust met the NICE target of patients undergoing CT within 60 minutes of admission.
- MRI at SGH and DPoW was open from 7.30am to 10.30pm on at least 5 days a week, and from 7.30am to 8.30pm on the remaining days. Ultrasound was open 8am to 6pm, 7 days a week. The trust had arrangements in place to transfer patients to another trust should they need urgent MRI scans.
- The imaging department provided general radiography, CT, MRI, and ultrasound scanning and fluoroscopy services for outpatients and inpatients every day. There was a rota to cover evenings and weekends so that patients could access diagnostic radiology when they needed to.
- The different diagnostic imaging departments had different opening hours and there was information available to staff who may need to refer patients about opening hours. A standard operating procedure was in place to make sure that staff were aware of who could make referrals for the different tests and when these services were available. It also clearly set out who was responsible for reporting the images and who was responsible for acting upon the image reports.

Access to information

Outpatients

- The ophthalmology SAT team staff told us that there had been improvements to the IT system, which meant they could easily view their active workload and the patient tracking lists (PTLs) to enable them to be more effective in booking appointments and managing waiting lists.
- For example, the team could see what workload there was regarding clinic letters to GPs. They could see how many notes were at what stage (i.e. awaiting transcription, administrative review, or clinical approval). They could identify individuals where work was outstanding and provide reminders, help, or escalate issues as appropriate.
- The PTLs enabled viewing of things such as the overdue position for each clinician for new and follow-up patients, longest waiting patients, and shortfalls in capacity. The staff told us that this enabled them to escalate shortfalls in capacity, identify vacant slots to discuss with managers, identify any need for additional appointments or lists, and assign vacant slots to priority patients.
- The staff were aware of the recently discovered patient lists from unmonitored systems which were being added back into tracked PTLs.
- The staff told us that weekly meetings were held to discuss this information and prioritise and plan work for the week ahead.

Diagnostic Imaging services

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance, and e-learning.
- Staff were able to access patient information such as imaging records and reports, medical records, and physiotherapy records appropriately through electronic records.

- Radiologists had viewing stations at home. This meant that they could look at images and submit reports without the need to be in the hospital. This meant that cover was more flexible.
- Diagnostic imaging departments used picture archive communication system (PACS) and radiology information system (RIS) to store images, radiation dose information, and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. The systems also flagged outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met.
- Diagnostic imaging departments outsourced reporting of out-of-hours urgent CT scanning to a private provider. There was a service level agreement (SLA) in place. Turnaround times for their reports were a maximum of 60 minutes. This was in line with NICE guidance (CG68) relating to the management of stroke.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients

- Staff told us that consent was always taken for laser treatment.
- Staff were aware of the Mental Capacity Act and what this meant for valid consent. They told us that patients were always asked to consent before attending the department for their treatment, and if there were any issues with consent then treatment did not go ahead.

Diagnostic Imaging services

- Mental Capacity Act and Deprivation of Liberty Safeguards were discussed as part of the trust induction process.
- Information sent to us by the trust showed that 20% of appropriate staff in radiology had attended deprivation of liberty training.
- Mental capacity training was part of mandatory training. Staff compliance was at 84% with 12 staff yet to undertake or update their training.
- Imaging and medical staff understood their roles and responsibilities regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us that, in diagnostic imaging departments, consent was obtained verbally, although consent for any interventional radiology was obtained in writing on the ward prior to attending the imaging department. Staff told us that patient consent was confirmed before carrying out any personal care or interventional procedure. Patients told us that staff had asked for consent before undertaking any examinations or procedures.
- Staff we spoke with were aware of who could make decisions on behalf of patients who lacked or had fluctuating capacity. They were aware of when best interest decisions could be made and when Lasting Power of Attorney could be used.

Are outpatient and diagnostic imaging services caring?

Good

At our previous inspection of this service, in October 2015, we rated caring as good. During this inspection we rated caring as good.

This was because:

- We observed staff in all areas treating patients with kindness and respect. Staff were friendly, kind, and professional.
- Privacy and dignity was maintained at all times.
- Patients were very happy with their care and information from all professional groups.
- Patients told us they understood the information that was given to them and what was happening to them.
- Staff were able to signpost patients to support groups and counselling services when necessary.

Compassionate care

Outpatients

- We spoke with seven patients and their relatives in the general OP waiting area and in the ophthalmology waiting area, and they gave mixed feedback about the service provided. However, they were all positive about the care they received from all staff. They told us the staff were caring and there were enough staff.
- One patient said, “The staff go out of their way to help,” while others told us about a lack of continuity of care and doctors having differing opinions and giving

different information. A relative told us her elderly relative was treated well when in the department but not getting appointments on time felt like they did not matter.

- One patient told us staff at reception spoke too quickly for her to hear properly and another told us that, although the doctor wanted to see him within two weeks of discharge, it was 4 to 5 weeks before an appointment was available. Another patient told us their annual follow-up appointment did not come but, when her family chased it up, they received it within two weeks.
- We observed that staff were caring towards patients, and we heard staff apologising when patients' appointments were late. Patients confirmed that staff kept them informed of delays.
- Friends and family data for outpatients across the trust had shown a decreasing trend in satisfaction from 96% likely to recommend the service in January 2016 to 73% in October 2016. The most recent data, in November, showed this had increased to 80% would recommend in comparison with the national average of 93% would recommend.
- There were very positive patient comments and a high level of satisfaction to do with staff friendliness from the August 2016 outpatient department survey.

Diagnostic Imaging

- We observed patients being supported in a way that preserved their privacy and dignity.
- If patients arrived in the department in soiled clothing, staff supported them to get clean and into a clean gown. This demonstrated that staff understood the importance of dignity for patients.
- Staff were kind and patient with patients. They welcomed patients with a smile and a cheerful manner.
- Staff ensured that patients felt comfortable and safe in the department and were good at putting patients at ease.

Understanding and involvement of patients and those close to them

Outpatients

- Patients told us they understood what the nurses and doctors had told them and they understood what was to happen next.
- We observed staff giving explanations to patients in a way they could understand.

Diagnostic Imaging

- We saw staff explaining procedures to patients and supporting them both prior to and after their scan or treatment in interventional radiology.
- Upon the agreement of the patient, family members were able to be present with the patient to discuss any concerns or raise any questions.

Emotional support

Outpatients

- We observed and heard staff speaking with patients in a kind and caring manner.
- Patients told us they were happy with the care and support from staff.
- In the main OP waiting area, we saw information on display about:
  - A cancer support group
  - How patients could request a copy of the letter the OP department sent to their GP
  - A 'fast track clinic.'
- There were specialist nurses available to be with patients when being given bad news.

Diagnostic Imaging

- On request, if someone was anxious about a procedure such as a scan, they could visit the department prior to their appointment to look at the equipment and understand what to expect. This was also available for patients living with a learning disability.
- In the case of children, parents could be in the x-ray room, protected by a lead apron to ensure that the child felt safe. There was a similar process in place to support patients living with dementia or a learning disability who needed extra support in the scanning or x-ray room.

Are outpatient and diagnostic imaging services responsive?

Inadequate 

At our previous inspection of this service, in October 2015, we rated responsive as inadequate because there were

long backlogs of outpatient appointments and patients waited a long time for follow-up appointments. This meant there was a risk of delay in patients receiving care and treatment. Clinic cancellation rates were high, and there was a lack of clinical oversight of clinics cancelled by administration staff. The service did not have reliable systems or processes to meet the needs of different patient groups. The service received a high number of complaints about the service because of the problems with appointments and answering calls. During this inspection, we rated responsive as inadequate. This was because:

- The trust had a continuing high number of cancelled clinics, although this was improving in some areas (particularly ophthalmology).
- Referral to treatment times were worsening and the trust told us they were unlikely to recover a good position until March 2018.
- There continued to be large numbers of patients who were overdue for follow-up appointments or with no due date on the patient administration system.
- There was a significant risk of potential harm to patients who were waiting long periods of time for first and follow-up appointments, and the trust had not validated the clinical risk within waiting lists in a timely manner.
- Clinical validation of waiting lists/overdue patients was ongoing but had been slow to commence in some specialties.

However:

- There were facilities and processes in place to support the individual needs of patients and staff worked hard to meet individual patient needs.
- Improvements had been made to facilities and waiting areas to improve capacity and better meet the individual needs of patients.
- Imaging services were planned in such a way as to ensure that urgent referrals were given a priority.
- Concerns and complaints were taken seriously, and staff and managers responded positively to patient feedback. There were low levels of complaints for imaging services.

From September 2015 to August 2016, the trust consistently performed better than the operational standards relating to cancer waiting times for people being seen within two weeks of an urgent GP referral and for patients waiting less than 31 days before receiving their first treatment. Since Q3 2015/16, the trust had performed similarly to the operational standard for patients receiving their definitive treatment within 62 days of an urgent GP referral.

Service planning and delivery to meet the needs of local people

Outpatients

- Following the October 2015 inspection the trust was asked to ensure outpatient backlogs were addressed promptly and that patients were prioritised in order of clinical need. It was asked to ensure that the governance and monitoring of outpatients bookings were operated effectively reduce the number of cancelled clinics and patients, who did not attend, and to assess systems and take action to protect patients from unsafe care and treatment. This was to prevent further occurrences of significant harm because of long RTTs and lengthy waits for follow-up appointments.
- Recovery plans were developed and, as part of this, clinical validation of waiting-list patients was commenced. There was some outsourcing of appointments and the trust undertook an administration review and developed SATs with the aim of more effectively managing and monitoring waiting lists. Weekly patient tracking lists and meetings were introduced in September 2016 for surgical specialities and in October 2016 for medical specialities.
- The RTTs had fluctuated over the year and the position had worsened since March 2016. Although the trust felt the RTT position would be fully recovered by the end of December 2016, it announced to commissioners in November 2016 that full recovery would not be possible in the financial year 2016/17. The trust anticipated recovery of its RTT position by March 2018, except for trauma and orthopaedics, which would be later.
- In September 2016, the trust enlisted the help of the NHS intensive support team from NHS improvement to work with it to look at the RTT and other waiting list issues, and it appointed a manager to look at RTT across the whole of the trust in October 2016.
- Because of the data quality issues and need for large-scale validation, the trust had been unable to produce a robust recovery plan or trajectory. The trust told us that it would need to engage with external stakeholders regarding validation.

- A task and finish group reporting to the executive Contract Board was set up in November 2016 with members from the trust and both of its commissioning groups to develop a single recovery plan. The trust told us that the recovery plan would be fully developed by the end of March 2017.
- We spoke to members of staff in some of the SATs regarding service planning and delivery to reduce waiting lists. While the members of the ophthalmology team were very positive, told us of many changes made to the way they worked, and were able to show us the progress they had made reducing lists for new and follow-up patients, other teams were less positive and felt that there were still issues with the systems in place. Staff identified issues including locum doctors not discharging patients when they should and placing unnecessary demand on the services, lack of clinic slots and weekend/evening clinics, lack of leadership, and lack of conviction that not being able to make follow-up appointments in clinic (if outside of four weeks) was the best way of managing follow-up appointments. Administration team members, managers, and clinicians all told us that validation of clinic waiting lists was in process and good progress had been made.
- Managers had recognised that there was inconsistency between the SATs and were developing a training and support plan to improve performance and consistency across the teams.
- The ophthalmology service had outsourced new referrals to a third party provider and consultants and managers told us that this was helping to manage demand and having a positive effect on reducing the waiting list. They recognised that this was not a sustainable, long-term solution to the issues of capacity and demand. However, it was proving beneficial in the short term.
- Staff told us that patient referrals were screened against set criteria before they were passed on to the independent provider. Patients not meeting the criteria were given appointments in the usual ophthalmology clinics.
- The ENT service was discussing with another NHS provider and an independent provider how they could work together to support the service.

Diagnostic Imaging

- Diagnostic imaging services operated extended opening hours. For example, the x-ray department was open 24 hours a day. Other scanning services such as MRI and CT operated clinics on weekends and from early in the morning until late at night. This meant that people who worked were able to arrange their scans outside of working hours
- The CT department had 24 hours, 7 days a week, radiographer cover to ensure that any patients brought to the hospital with a suspected stroke had a CT scan within an hour, in line with NICE guidance.
- The imaging department had good processes in place and, although it was very busy, there was capacity to deal with urgent referrals. There was a service level agreement in place with a private provider to use its scanners in times of demand surge.

Access and flow

Outpatients

- The trust had recently introduced a new email central referral gateway. GPs and other healthcare professionals could refer directly into this system and would receive an immediate automatic response to say the referral had been received. The system would also automatically alert the relevant SAT and initiate the cancer tracking system.
- The piloting of the new system had led to the discovery of a cohort of missed referrals from GPs. Managers told us they were confident in the new system and that referrals could not be lost.
- The trust also continued to received paper referrals from GPs and dentists, and referrals from choose and book.
- There was an internal trust target that all referrals would be registered within one working day of receipt.
- From November 2015 to October 2016 the trust's RTT for incomplete pathways showed a declining trend from around 92% in February 2016 to 84% in September and October 2016. The trust's RTT was better than the England average from November 2015 to January 2016 but fell below the England average from February 2016 to October 2016. The latest figures for October 2016 showed that 81.5% of this group of patients were treated within 18 weeks versus the England average of 90.1%.
- The specialities of ENT, urology, cardiology, thoracic medicine, trauma and orthopaedics, oral surgery,

dermatology, ophthalmology, and other were all performing below the national average for incomplete pathways. 'Other' was the worst performing speciality at 79%.

- Specialities performing better than the England average were geriatric medicine (99.7%), gynaecology (98.9%), rheumatology (97.8%), gastroenterology (92.8%), neurology (91.5%), and general surgery (89%). General medicine was at 94.9%, which was slightly worse than the England average.
- From November 2015 to October 2016 the trust's RTT for non-admitted pathways showed a declining trend from around 95%in March 2016 to around 86% in October 2016. The trust was better than the England average from November 2015 to April 2016 but from May 2016 the trust performance had been worse than the England average. The latest figures, for October 2016, showed 83% of this group of patients were treated within 18 weeks versus the England average of 89.4%.
- The specialities of oral surgery, urology, cardiology, gastroenterology, thoracic medicine, ophthalmology, neurology, and dermatology were all performing below the national average for non-admitted RTT. Dermatology was the worst performing speciality with 73% of patients seen within 18 weeks of referral.
- The specialities performing above the England average were geriatric medicine (99.8%), gynaecology (99%), ENT (95.7%), general surgery (93.2%), and trauma and orthopaedics (92%).
- The trust told us that there were 2,371 patients waiting for over 18 weeks for their first appointments at 11 December 2016.
- The trust told us that there were 21,434 patients whose follow-up appointments were overdue at 11 December 2016. The majority of the longest waits for follow-up appointments were within surgical specialities ophthalmology, colorectal, ENT, and urology. There were 3,947 ophthalmology patients whose follow-up appointments were overdue, with 105 more than 34 weeks overdue. There were 2,702 colorectal patients whose follow-up appointments were overdue, and 247 of these were more than 34 weeks overdue. There were 2,289 ENT patients whose follow-up appointments were overdue, with 98 of them more than 34 weeks overdue, and 1,589 urology patients whose follow-up appointments were overdue, with nine patients overdue by more than 34 plus.
- There were a further 11,208 patients who did not have a due date on the patient administration: 5,097 were booked but had no due date; and 6,111 had no appointment and no due date on the system. The most affected surgical specialities in this cohort were ophthalmology (1,777), colorectal (942), urology (874), and trauma and orthopaedics (749). The most affected medical specialities were rheumatology (950) and cardiology (846).
- Recent work with NHSI had unearthed data quality issues, which highlighted two actual, and other potential and previously unknown, 52-week breaches and around 12,000 patients in unmonitored systems. The trust informed the CCGs of this on 21 November 2016.
  - There were around 430 patients on incomplete pathways whose waiting time clock had been stopped in error, and around 5,800 patients showing as inactive and not being tracked (this cohort posed a significant risk of 52-plus-weeks waiters). The full scale of this problem is unknown at the time of writing this report as this cohort of patients requires validation.
  - A further waiting list of around 6,300 patients was also discovered outside of the patient administration system (PAS) and the patient tracker lists. These patients were those who had had an inpatient episode/treatment but gone on to require a further elective pathway or follow-up. From the investigation of two SIs it seemed that there was an expectation that ward clerks added these patients to lists but that there had been a lack of clarity regarding who monitored this or ensured that bookings were made.
  - A further two cohorts of patients, identified as inpatient planned (1,093) and diagnostic planned (13,024), were not on active tracker lists. Work was needed to assess length of waiting times beyond due date and for these lists to be added back in to the active tracker lists.
- There was also an SI reported in August 2016, which identified an overdue and un-booked cohort of 6,000 ophthalmology patients.
- There was an ophthalmology recovery plan in place for the 6,000 overdue patients identified in August 2016; trajectories had been followed and the department was a month ahead of plan with no patients left to book at SGH by November 2016.

Outpatients and diagnostic imaging

- Although the cohort above had been dealt with, there were still 1,308 overdue review patients and 954 no due date patients in ophthalmology at SGH (correct at 11 December 2016).
- Trust-wide there were 3,481 patients overdue for review and 1,510 no due date patients in ophthalmology at DPoW (correct at 11 December 2016).
- Across all specialities, an audit of overdue patients in August 2016 showed that 18,833 follow-up patients had no appointment and were overdue; following validation 17,827 required an appointment. The trust had reduced this to 22 as of 12 December 2016. The reduction was due to patients either being given an appointment or being discharged.
- From September 2015 to August 2016 the trust consistently performed better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The trust also consistently performed better than the England average for this standard, over time.
- Administrative staff confirmed that two-week referral patients were prioritised by clinical staff and appointments were accessible.
- From September 2015 to August 2016 the trust consistently performed better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis (decision to treat). The trust also consistently performed better than the England average for this standard, over this time.
- Since Q3 2015/16 the trust had performed similarly to the 85% operational standard for patients receiving their definitive treatment within 62 days of an urgent GP referral. The trust consistently performed better than the England average for this standard, over time.
- From April 2015 to March 2016 the 'did not attend' (DNA) rate for SGH was worse than the England average of around 7%. The rate had fluctuated during this time, just above and below 10%.
- Staff in outpatients told us that patients were sent text messages to remind them of their appointment details and this seemed to reduce the numbers of patients who DNA. Other initiatives to reduced DNAs and cancelled appointments included the introduction of new booking rules, which meant that patients could not be given an appointment more than six weeks ahead.
- Administrative staff in ophthalmology told us that now all cancelled clinics were impact-assessed by a consultant and patients were reassigned to other clinics. The team members told us that they felt there were fewer cancellations and that the monitoring and reassignment of these patients was much more effective than it had been previously.
- The trust had seen an overall downward trend in the rate of hospital-cancelled appointments across all sites from October 2015 to September 2016, despite slight peaks in April 2016 and July 2016. The overall cancellation rate for this period was 11%. The overall cancellation rates from August 2015 to July 2016 were 9.9% within 6 weeks and 3.8% over 6 weeks.
- The main reasons for cancellations reported by the trust were:
  - Clinic session amended
  - Clinic session cancelled
  - Clinical reason for slot change
  - Annual leave.
- SGH position for the 12 months to the end of October 2016 was 10.5% cancellation rate; this was slightly better than the trust overall position.
- The four specialities with the highest cancellation rates across the trust were as follows: Community paediatrics was the speciality with the highest outpatient cancellation rate of 25% over this time; anaesthetic appointment cancellation rate was 22% over the year, but had shown improvement since May 2016; the pain management service had a similar rate over the year with significant fluctuations above and below this throughout the period; and rheumatology cancellation rate was 19% over the year.
- There were a number of SATs who coordinated clinics, made appointments, prepared clinic lists, and ordered records. These teams worked closely with the outpatient nurses and consultants and helped to manage waiting list initiatives, which included the implementation and monitoring of patient tracker lists (PTLs) and agreeing with consultants extra clinics and urgent appointment slots.
- We were told that PTLs were monitored weekly and long-waiting patients were reviewed daily by the SAT team leaders, who would alert the consultants' secretaries, to be discussed with the consultant and clinically reviewed as appropriate.
- The SATs told us that there had been a significant turnaround in the preceding 12 months with changes to

rotas and clinic timetables, changes to booking rules, extra clinics, validation of waiting lists, and outsourcing of new ophthalmology patients, all of which had helped greatly reduced waiting lists.
- The newly discovered cohorts of patients in unmonitored systems were not on the PTLs prior to their discovery in August 2016. It was unclear whether the trust had added all of the previously unmonitored lists back into the active PTLs by the time of this inspection.
- The ophthalmology team hoped that the backlog of patients would be cleared by December 2016.
- Dermatology and orthoptic clinics were offered from one of the GP surgeries in the area.
- A one-stop laser clinic had been introduced, which had reduced the need for multiple appointments, and staff told us that there was now direct referral into this clinic. Other one-stop clinics were running or being piloted.
- Clinical nurse specialists ran clinics alongside consultants to improve capacity and access.

Diagnostic Imaging

- Diagnostic waiting times against the 6-week standard, from November 2015 to October 2016 were generally lower (better than) than the England average, with the exceptions of April 2016, May 2016, and October 2016 when they were higher (worse). With the exceptions of April 2016 and May 2016, all other months showed that fewer than 0.025% of patients waited more than 6 weeks for a diagnostic test.
- Subsequent data provided by the trust showed that the number of patients waiting more than six weeks for a diagnostic test was high. As at 4 December 2016 there were 799 patients who had been waiting more than four weeks for a diagnostic test. There were 12,130 waiting less than four weeks.
- As at 4 December 2016, 589 patients had been waiting more than 6weeks for a CT scan, 82 patients waiting more than 6 weeks for an MRI scan, and 145 patients waiting more than 6weeks for a non-obstetric ultrasound. There were 483 patients waiting for radiology 'other' diagnostic test.
- The most recent weekly active waiting list report (11 December 2016) indicated that 93% of patients had waited five weeks or less for diagnostic imaging. At this time 732 patients had waited between five and eight weeks and 147 patients had waited over nine weeks for their test.
- We identified no concerns about patients breaching the two-week urgent referral timescales and, in the case of lung x-rays, where a concern was identified, patients were automatically referred for a chest CT so that, by the time they attended their outpatient appointments, their doctors had diagnoses and were starting to create treatment plans.
- Staff carried out a continuous review of planned imaging sessions in relation to demand and seven-day working arrangements. Staff organised additional evening sessions to accommodate urgent diagnostic imaging requests as necessary.
- Waits in diagnostic imaging once in clinic were short. We observed that patients often waited no more than 10 to 15 minutes. The trust told us that it did not collect this information. We did see inpatients waiting for porters to return them to their wards following procedures. These patients were placed in designated trolley areas with curtains to protect their privacy and dignity.
- Referrals to diagnostic imaging were actioned by the clerical team who liaised with the radiography staff to check the urgency of the referral. Staff liaised with the wards to request porters to bring inpatients into the department near the time of the procedure.
- Reporting times for diagnostic images were on the whole around a day for non-specialist imaging such as x-rays and ultrasound. The trend for CT, MRI and radioisotopes reporting times performance had increased from 1.27 to 5.13 for CT from March 2016 to August 2016, for MRI from 2.6 to 6.48 days in the same period, and for radioisotopes from 2.06 to 10.24.These figures were across both sites and there was no specific information for this site.
- Managers told us that if reporting looked like it would exceed a 10 working day period then they would outsource additional work to keep within this limit.

Meeting people's individual needs

Outpatients

- We saw that the main reception desk was set low and enabled wheelchair users to speak to reception staff easily.
- We saw that there was access to hearing loops for patients with hearing difficulties and appropriate signage for people who were visually impaired.
- We saw there was a photographic board for patients to be able to identify staff and what uniforms meant.

- Waiting areas had televisions to distract patients who were waiting.
- There were refreshment machines available in waiting areas.
- There was a large sign in the ophthalmology waiting area about 'What happens in this clinic', which included an explanation of why it may seem that patients were not seen in order of arrival.
- There was a separate waiting area for children with a selection of toys.
- Staff told us that they held a weekly audiology clinic for children only.
- The rooms in ophthalmology where children were seen did not have anything in them to make them child-friendly.
- There was an HCA nominated to be the learning disabilities champion in outpatients at SGH. However, the individual had not received any support or additional training and so was yet to feel comfortable in this role. The learning disabilities lead for the organisation was based at DPoW but covered both sites.
- Staff were aware that they could access interpreters for telephone and face-to-face translation. There was also a process in place to have written patient information translated.

Diagnostic Imaging

- Vulnerable patients, such as those with dementia or learning disabilities, were identified as part of their referral and given longer appointment times. Their relatives, carers, or social workers were accommodated to attend with them in consulting and treatment rooms. Often quiet areas of the department were used to help these patients feel safe.
- Patients who were required to be at the hospital for long periods of time, for example, those with multiple appointments or waiting for ambulances, were able to access food and drinks from vending machines, a café, and a shop.
- Bariatric furniture and equipment was available and accessible.
- Staff were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives, and provisions were made to ensure that patients were seated in quiet areas and seen quickly.
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient designated space to manoeuvre and position a person using a wheelchair in a safe and sociable manner. There were allocated bays for patients in hospital beds.
- Patients had access to a range of information. Information was available on notice boards and leaflets. There was information that explained procedures such as x-rays. There was information about various illnesses and conditions including where to go to find additional support.
- Patient information leaflets could be accessed in formats and languages other than English if required. There were posters displayed about general health advice.
- The bookings teams organised interpreter services for patients who did not speak or understand English. Staff told us that they experienced no difficulties in accessing interpreters. However, booking staff had to rely on GPs and hospital referrers making the trust aware of a patient's requirements. Staff told us that interpreters were preferable to friends and family to ensure that clinical messages were put across correctly and also to maintain patient confidentiality.

Learning from complaints and concerns

Outpatients

- From September 2015 to August 2016 there were 119 complaints about outpatients. The trust took an average of 57 working days to investigate and close complaints. This is not in line with its complaints policy, which states that category 1 complaints (single issue) should be completed within 30 working days. The most common complaint theme was regarding clinical treatment.
- SGH had received 54 complaints, taking an average of 56 working days to close.

Diagnostic Imaging

- The diagnostic imaging department received two written complaints about services from September 2015 to October 2016. One of these required a complaints action plan. One complaint was for MRI and one for general radiology.

Outpatients and diagnostic imaging

- We looked at three months of business meeting minutes and saw that complaints were not part of the agenda. However, complaints and the patient advice and liaison service (PALS) contacts were a standing item on the governance meeting minutes.
- Staff told us that patients did not often complain but, when they did, it was usually about having to wait.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments, and concerns were discussed at team meetings, actions were agreed, and any learning was shared.
- Information was accessible on the trust web site, including the complaints policy. We saw posters distributed within the departments.

Are outpatient and diagnostic imaging services well-led?

Inadequate

At our previous inspection of this service, in October 2015, we rated well-led as inadequate. During this inspection we rated well-led as inadequate. This was because:

- The trust had failed to address the following actions, from the October 2015 inspection, in a timely manner:
  - Audit patients on the follow-up lists. This had led to the discovery of cohorts of patients overdue and in unmonitored systems during August 2016.
  - Strengthen the monitoring arrangements in place in relation to OPD follow-ups. This had led to two SIs in the trust, where patients had suffered harm because the booking of outpatient appointments following discharge from hospital was not monitored.
  - Strengthen arrangements for monitoring of short notice clinic cancellations. Although we did note areas of good practice, such as ophthalmology, where all cancellations had to be approved by the clinical director, clinic cancellation rates remained high.
  - Appoint a senior over-arching lead to drive the required improvements in OPD booking systems. Although the trust had appointed an internal lead to oversee the administration teams and drive the required improvements in OPD booking systems, there appeared to have been little additional support available until autumn 2016.
  - Clinical validation of clinical services other than ophthalmology was not started in earnest until August/September 2016.
  - RTTs were worsening and the trust was struggling to match capacity with demand. The trust did not expect to recover a good position until March 2018.
- There was mixed feedback from staff in a number of roles regarding leadership and an expressed reluctance to raise concerns regarding management or services, for fear of reprisals.

However:

- The diagnostic imaging department had a five-year strategy in place to ensure that the department was future-proof and had governance processes in place to ensure that risks were mitigated.
- Improvements had been made in OPD to ensure there were systems and processes in place to facilitate shared learning from incidents and complaints.
- The diagnostic imaging and OP departments had actively sought and acted on patient feedback.
- All staff were now aware of the problems relating to the RTT position and waiting lists of follow-up patients. We saw that staff felt a sense of shared responsibility and were working together to make service improvements.
- The trust was working closely with commissioners, other providers (NHS and independent), and NHSI to make improvements to outpatient services.
- Staff we spoke with felt supported by their immediate line managers and colleagues.
- Action had been taken to ensure all radiology staff had received training regarding the ionising radiation (medical exposure) regulations 2000 (IR(ME)R) and this had been made mandatory.

Vision and strategy for this service

Outpatients

- The trust was continuing to work closely with the commissioners to address the significant capacity and demand issues within ophthalmology. An ophthalmology focus group had been established to review potential models of care to support delivery of ophthalmology services in the future.

- The trust was exploring sub-contracting options for colorectal work.
- The trust had recently held a workshop to review clinical pathways and models of care and was linked to the Healthy Lives Healthy Futures work streams.
- The managers of the clinical services and the administration/performance managers were aware that they needed to review outcomes of the Clinical Administration Review (CAR) held in November 2015 and the effectiveness and consistency of the SATs. Managers and staff told us that a support/training programme had been piloted with one of the SATs and was to be rolled out to the others in order of priority.
- Staff we spoke with knew what the issues were in relation to waiting lists and RTTs, and there was a feeling of shared ownership to make improvements. This was particularly evident through the whole of the ophthalmology team from administrators to consultants.
- The expressed, shared vision at all levels of staff was to effectively manage waiting lists (to provide patients with a good, safe service) and eradicate data quality issues.

Diagnostic Imaging

- The management team of the department was keen to tell us about the five-year strategy that it was working on to ensure that the department was able to cope with future demands on services. This involved the expansion of the diagnostic imaging department and the purchase of further MRI and CT machines.
- The trust was carrying out a review of the administrative and clerical function within the trust. A full staffing workforce review to plan for future needs and identify any gaps had begun. Succession planning was ongoing with human resource input. Diagnostic imaging reporting was electronic.

Governance, risk management and quality measurement

Outpatients

- Until recently the trust had continued to find cohorts of patients in unmonitored systems, and new systems to ensure this did not happen in the future were in their infancy.
- There had been a lack of oversight of a number of systems and processes such as monitoring of appointments booked following an inpatient episode, data quality, and receipt of GP referrals.
- Staff involved in waiting-list management and performance told us they had weekly meetings to review the PTLs, look at performance, and prioritise actions for the coming week. However, the trust acknowledged that this was not yet fully embedded and effective across all SATs.
- The trust had developed new processes and standard operating procedures following incidents but these had not had time to become embedded.
- Following the inspection in October 2015 the trust told us it would:
  - Audit patients on the follow-up lists. We saw that audits were not completed until August 2016 and had led to the discovery of cohorts of patients overdue and in unmonitored systems during August 2016
  - Strengthen the monitoring arrangements in place in relation to OPD follow-ups. Two SIs resulted this year following lack of monitoring of patients who needed an appointment following an inpatient episode.
  - Strengthen arrangements for monitoring of short notice clinic cancellations. We saw that clinic cancellations were being closely monitored and administration staff felt numbers of cancellations had improved. However, this was not yet evident in the data provided.
  - Appoint a senior over-arching lead to drive the required improvements in OPD booking systems. Although the trust had appointed an internal lead to oversee the administration teams and drive the required improvements in OPD booking systems, there appeared to have been little additional support available until autumn 2016. Include call abandon rates as part of the key performance indicators to be monitored monthly. We saw that this action was complete.
  - Provide waiting list information in a more 'user friendly' dashboard. We saw that this action was complete.
  - Explore the additional validation resources required to look at other OP specialty areas. Both clinical and data validation was ongoing in all specialities, although it was acknowledged that some of the SATs needed support and training.

Outpatients and diagnostic imaging

Diagnostic Imaging

- The department had a risk register that it shared across the three sites and with the outpatient department. There were six identified risks specific to the diagnostic imaging department. Two were rated high, two moderate, and two low. These had been reviewed regularly. There was evidence of mitigation in place and action taken to reduce risks to patients.
- Managers and staff were aware of the main risks to their department, for example, capacity and demand, particularly around MRI and CT, and equipment breakdowns.
- SIs were discussed at multi-disciplinary clinical governance meetings and, where appropriate, escalated through the governance committees.
- Department managers carried out investigations of incidents and reported back to teams. Incident investigations were undertaken by managers and reports fed back to staff at team meetings. Where necessary, policies and procedures were updated in line with guidance received.
- There were governance arrangements, which staff were aware of and participated in.
- The organisation had systems to review NICE guidance and ensure that any relevant guidance was implemented in practice.

Leadership of services

Outpatients

- We found that there were clear lines of management responsibility and accountability within the outpatient services.
- Although there was no matron for outpatients and no line manager between the band 7 OP nurse manager at each site and the planned care manager, the band 7 and band 6 nurses told us they felt they had adequate line management support.
- Administration staff gave us mixed feedback about leadership; some felt empowered and supported, and told us that they were very much involved with service improvements. They felt a shared ownership of waiting list issues and list management, and their ideas were welcomed to help improve the current situation. They felt their efforts were appreciated and success was acknowledged. One of the SATs had been nominated for a trust award for its hard work and success. Other staff told us that they still felt unsure in their roles following the previous administration review, that they felt unsupported, and that managers had not shared any learning from the previous administration review with them.
- They said this had been like a 'car crash' and had left some teams with vacancies and too many bank or temporary staff, and people were not clear in their roles or familiar with the complex administration and booking systems. They told us support had been lacking for staff moved to new areas.
- Some administrative staff felt that there was a threat in the air about performance and that communication from higher up in the organisation was poor about lessons learned from the last administration review
- However, we spoke with other administrative staff who told us their managers were supportive and listened to staff ideas for improving services and concerns and worries.
- The ophthalmology team told us that the clinical lead for this speciality was leaving the trust and team members had put a proposal together for a new leadership model for their team. We were told that the board had accepted in principle the proposal for a 'collective leadership model'. The team would nominate the lead from within the team and this would shift to another clinician when felt appropriate by the team.
- There was mixed feedback from senior managers and clinicians regarding the trust executive team. Some told us they felt well supported, their services had significant investment, and they were appropriately challenged, while others described a difficult relationship where they felt unsupported and intimidated. Some were concerned that that the general culture/atmosphere would have an adverse effect on the retention or return of junior medical staff and locums.
- Some senior managers spoke highly of the medical leadership and felt that they had responded appropriately when concerns were raised.
- Nursing staff and most of the administration staff we spoke with were positive about their immediate line managers and support available to them. They told us they felt included as part of the team and felt part of the wider MDT, with a shared responsibility for improving patient waiting lists in particular.
- We had concerns about the leadership of the outpatient department because, after our previous inspection, the trust was slow to react to some actions, and

appointments to key positions to support the administrative function had not taken place until July and August 2016, some eight months after our inspection.

Diagnostic Imaging

- Diagnostic imaging was managed as one service across the trust with a single senior leadership team. There was a diagnostic imaging site manager and a service lead for each of the specialities at SGH and DPoW.
- Staff told us they were happy with the support they received from their line managers.
- Departmental managers were supportive in developing the service and practice. Staff felt that they could approach most managers with concerns and feel listened to. We observed good, positive, and friendly interactions between staff and managers.
- The associate chief operating officer (ACOO) held monthly staff meetings where finance, departmental problems and pressures, complaints, recruitment, and vacancies were discussed.
- All the staff we spoke with told us they were content in their roles and many staff we spoke with told us that they had worked at the hospital for many years.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Staff told us that they were encouraged to manage their own personal development.
- Staff were able to access some training and development provided by the trust, although some staff told us this was not as easy as it had been in the past due to staffing levels and time pressures.

Culture within the service

Outpatients

- We had mixed feedback regarding the culture of the organisation.
- All staff felt they were open and honest, and incidents were reported and investigated fairly, and any issues dealt with proportionately.
- All staff we spoke with clearly wanted to deliver a safe service and give patients the best experience possible.
- However, a number of staff in different job roles did not feel confident to raise concerns about service delivery or management, as they were not confident that they would not suffer any reprisals.

Diagnostic Imaging

- During our inspection we identified some concerns about the culture of the trust. However all of the staff we spoke with told us that this diagnostic imaging department had a good culture.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Staff were passionate about their patients and felt that they did a good job. Staff in all the diagnostic imaging departments said that they felt part of a team and empowered to do the job.
- Staff told us that they felt there was a culture of staff development and support for each other.
- We saw that there was a friendly but professional working relationship between consultants, radiographers, nurses, healthcare, and support staff.

Public engagement

Outpatients

- We saw that staff displayed friends and family feedback results in patient waiting areas with 'you said we did' information.
- Managers told us there was ongoing public consultation regarding the centralisation of ENT services at DPoW.
- Managers told us the trust was sharing waiting list positions with GPs and had notified them of changes to booking rules.
- The outpatient service had carried out its annual patient satisfaction survey in August 2016. More than 80% of patients rated the service as satisfactory, good, or excellent across all elements of the survey. We saw that the main issues from patients were to do with appointment cancellations and waiting times. We saw that staff had acted on feedback where possible. For example, they had sourced a drinks dispenser in the SGH waiting area.

Diagnostic Imaging

- There was recurring, annual programme of patient satisfaction surveys that included all of the specialities.

Staff engagement

Outpatients

- We were given mixed feedback about levels of engagement in service delivery and improvement. Some staff felt very empowered and involved while others did not.
- The ophthalmology SAT was clearly engaged in the improvement of its service and evidently felt a shared ownership in the problems and shared pride in the improvements made to date. The team had been nominated by managers for a trust award for hard work and success.
- Staff told us of some of the staff benefits/activities in place at the trust. For example, there was a staff lottery, Christmas shopping trips had been arranged, and a consultant told us that he had provided a free staff eye clinic in his own time.

Diagnostic Imaging

- The department distributed team briefs to ensure that staff were up to date with any issues or changes in the department.
- Staff had regular team meetings and we saw minutes of these.
- The trust was in the process of undertaking a staff survey at the time of inspection.
- The senior management team members were clearly proud of their team and told us of a number of staff who had been nominated for awards from the trust and the Health Service Journal.

Innovation, improvement and sustainability

Outpatients

- Staff and managers told us that work was ongoing to develop a virtual clinic for patients suffering from macular degeneration.
- The trust had a number of working groups set up and was working with staff, stakeholders, other providers, and NHSI to streamline pathways to address capacity and demand issues and to ensure services were sustainable.

Diagnostic Imaging

- The diagnostic imaging departments had begun a pilot in conjunction with primary care for radiologists to refer patients straight to CT following an abnormal chest x-ray. When patients were seen in clinic as a two-week wait, they already had CT scans and results available for the clinician at their first appointments. This potentially reduces lung cancer patients' length of pathway.
- Reporting radiographers were being trained to undertake reporting responsibilities to support the department's shortfall of radiologists.
- The ultrasound department had started to develop a specialist practitioner role to extend staff competencies and release radiologist time. It also envisaged that this would assist with recruitment and retention of staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

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

Emergency and Urgent Care

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

Critical Care

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

Maternity

- The trust must ensure that effective timely assessment and/or escalation processes are in place, including the use of the Modified Early Obstetric Warning Score (MEOWS).

Outstanding practice and areas for improvement

- The trust must continue to improve obstetric skills and drills training among medical staff working in obstetrics.
- The trust must continue to improve midwifery and medical staff competencies in the recognition and timely response to abnormalities in cardiotocography (CTGs) including the use of 'Fresh eyes'.

Children and Young People's Service

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

Outpatients and Diagnostic Imaging

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

Action the hospital SHOULD take to improve

- The trust should continue to address the areas where they do not meet the Guidelines for the Provision of Intensive Care Services (2015), for example, supernumerary nurse, medical staffing and work patterns that deliver continuity of care.
- The trust should ensure that patients are assessed for delirium in line with national guidance.
- The trust should monitor the number of patients ventilated outside of critical care.
- The trust should review the formal processes in place to collect patient or relative feedback.
- The trust should identify a board level lead for paediatric services.
- The trust should ensure that access to breast milk fridges is risk assessed and secured.
- The trust should take steps to ensure that an appropriate environment and staff are available to children and young people receiving anaesthesia and recovering from surgery, in accordance with national guidance.
- The trust should ensure that it completes risk assessments concerning the risks posed by the ward environment to children requiring Child and Adolescent Mental Health Services (CAMHS) The trust should take steps to ensure that appropriate numbers of play specialists are available in accordance with the national framework.
- The trust should take steps to ensure that appropriate transition pathways are in place for children and young people moving from paediatric to adult services.
- The trust should ensure that medical records are appropriately completed by medical staff.
- The trust should ensure that staff complete Mental Capacity Act training.
- The trust should ensure that mandatory training rates are improved for all staff.
- The trust should take steps to improve its staff and public engagement activities.
- The trust should ensure that resuscitation equipment is regularly checked and tested consistently and in line with trust policy.
- The trust should ensure that clinical supervision is regularly recorded and monitored.
- The trust should ensure that Patient Group Directives for nursing staff are completed and up to date.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met: Care and treatment of patients in ED did not always meet their basic needs.** • Ensure that patients are assessed for pain relief; appropriate action is taken and recorded within the patients' notes. Regulation 9(1)(a) and(b). • Ensure that patients in ED receive the appropriate nursing care to meet their basic needs, such as pressure area care and being offered adequate nutrition and hydration, and that this is audited. Regulation 9(1)(a) and (b).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **How the regulation was not being met: We found that on occasion, people's right to privacy and dignity was compromised.** **The trust must:** • Ensure that mixed sex accommodation breaches are monitored, addressed and reported. Regulation 10(1). • Ensure that the number of non-clinical transfers and from critical care units are reviewed and reduced. Regulation 10(2)(a).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met: Some patients did not have clearly documented when they lacked capacity to make decisions which was not accordance with the Mental Capacity Act (2005).** **The trust must:** • Ensure that patients' capacity is clearly documented and where a patient is deemed to lack capacity this is assessed and managed appropriately in line with the 2005 Mental Capacity Act. Regulation 11(1) and (3).
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met: Care and treatment was not always provided in a safe way for patients.** **The trust must:** • Continue to improve its paediatric early warning score (PEWS) system to ensure timely assessment and response for children and young people using services. Regulation 12 (2)(a) and (b). • Ensure that effective timely assessment and/or escalation processes are in place, including the use of the National Early Warning Score (NEWS) and Modified Early Obstetric Warning Score (MEOWS), so that patients' safety and care is not put at risk, especially within ED. Regulation 12(2)(a) and (b). • Ensure the proper and safe management of medicines including: checking that fridge temperatures used for the storage of medication are checked on a daily basis in line with the trust's policy. Regulation 12(2)(g). • Ensure that there are the appropriate systems in place to maintain the cleanliness of the ED at SGH to prevent the spread of infections. Regulation 12(2)(h). • Ensure that ambulance staff are able to promptly register patients on arrival at the ED. Regulation 12(2)(i).

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
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 always operated effectively to assess, monitor, improve services, and mitigate any risks relating the health, safety and welfare of people using services and others.** **The trust must:** • Ensure that policies and guidelines in use within clinical areas are compliant with NICE or other clinical bodies. Regulation 17(2)(a). • Ensure it audits compliance with NICE CG83 rehabilitation after critical illness and acts on the results. Regulation 17(2)(a). • Ensure that the five steps to safer surgery including the World Health Organisation (WHO) safety checklist is implemented consistently within surgical services. Regulation 17(2)(a). • Ensure that effective processes are in place to enable access to theatres out of hours, including obstetric theatres, and that all cases are clinically prioritised appropriately. Regulation 17(2)(a). • Ensure that timely initial assessment of patients arriving at ED takes place and that the related nationally reported data is accurate. Regulation 17(2)(a). • Ensure that service risk registers are regularly maintained with substantive updates and that these evidence all relevant risks to the children's services. Regulation 17(2)(b). • Ensure there are effective planning, management oversight and governance processes in place, especially within maternity, ED and outpatients. This includes ensuring effective systems to implement, record and monitor the flow of patients through ED, outpatients and diagnostic services. Regulation 17(2)(b). • Complete the clinical validation of all outpatient backlogs and continue to address those backlogs, prioritised according to clinical need. Regulation 17(2)(b). • Must continue to take action to reduce the rates of patients who DNA.Regulation 17(2)(b).

This section is primarily information for the provider

Requirement notices

- Continue to take action to reduce the numbers of cancelled clinics. Regulation 17(2)(b).
- Continue to strengthen the oversight, monitoring and management of outpatient bookings and waiting lists to protect patients from the risks of delayed or inappropriate care and treatment. Regulation 17(2)(b).
- Continue to work with partners to address referral to treatment times and improve capacity and demand planning to ensure services meet the needs of the local population. Regulation 17(2)(b).
- Ensure that actions are taken to enable staff to raise concerns without fear of negative repercussions. Regulation 17(2)(e).
- Ensure that, following serious incidents and never events, root causes and lessons learned are identified and shared with staff especially within maternity and surgery. Regulation 17(2)(f).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met: There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of patients using the services. Not all staff were receiving the support, training, professional development, supervision and appraisals that were necessary for them to carry out their role and responsibilities.** The trust must: • Ensure that there are effective processes in place to support staff and that staff are trained in the recognition of safeguarding concerns including all staff caring for children and young people receiving the appropriate level of safeguarding training. Regulation 18(2)(a). • Ensure that the number of staff who have received training in advanced paediatric life support is in line with national guidance and the trust's own targets. Regulation 18 (2)(a).

This section is primarily information for the provider

Requirement notices

- Continue to improve obstetric skills and drills training among medical staff working in obstetrics.Regulation 18(2)(a).
- Continue to improve midwifery and medical staff competencies in the recognition and timely response to abnormalities in cardiotocography (CTGs) including the use of 'Fresh eyes'. Regulation 18(2)(a).